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Save the Children

Audio Diaries Synthesis Report

FOUNDATIONS RESEARCH PROGRAMME

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Introduction

This qualitative analysis of the audio diaries workstream of the Foundations project aims to explore the lived experiences of adolescents, caregivers, and mentors involved in the Foundations project intervention package. It focuses on adolescent sexual and reproductive health (ASRH) rights, overall wellbeing, and the impact of the Foundations project on their lives over time, with particular attention to their experience of discriminatory social norms that can prevent their acceptance and use of ASRH.

Data collection for the audio diaries research component ran from February 2025 to December 2025, with three rounds in Mali, Niger and Sierra Leone over that period. The sample consisted of 30 participants per country including adolescents, their mothers, fathers and – in the last round - the husband of girls married as children, as well as project mentors. Participants were included from two distinct sites: one located closer to a more urban centre and the other in a more remote, underserved area, with all sites receiving at least one component of Foundations programming. In the last round, community leaders were also included in the sample to examine their perceptions social norms and to explore any changes among young people, parents and the broader community resulting from participation in Foundations programming.

The core themes of this study are how changes in knowledge and understanding of ASRH can impact attitudes and behaviours, not only among adolescents, but also among their families, peers and social norm change within the community at large. In the conclusions, we reflection on key implications for future programming so as to strengthen support for diverse adolescents' ASRH decisions and choices.

Methodology

The *audio diaries* component of this multi-method longitudinal qualitative study was designed to capture adolescents' voices through participatory methods. Each of the three rounds drew on different interactive tools which were designed to capture how programming might be contributing to changes in the knowledge and experiences of ASRH, as well as in how parents, husbands and ultimately other community stakeholders perceived and responded to those changes.

Data collection for each round was also conducted in slightly different ways, with the research team exploring and adapting different methods to provide adolescents with an opportunity to express their voices and perceptions.

During the first round (February-March), data collection was conducted via community facilitators. GAGE's national research partners trained two local facilitators in each community (teachers and or nurses) on how to have a semi-structured conversation with adolescents and adults in the sample, recording the conversation for analysis. The hypothesis informing this approach was that adolescents and adults in the community would be better able to engage in conversations on culturally sensitive issues with local interviewers than with external researchers. (See discussion on limitations below).

The second round (June-August) adopted a different approach. The same facilitators were provided with pre-recorded vignettes and questions, prepared by the international and national research teams. In this case, the facilitators were asked to give the phone/recorder with the vignette and questions to the adolescent, providing them with a private space for them to self-record their reflections.

The approach in the third round (October-December) was further modified, particularly as it was important for the third and last round to capture whether and how the Foundations project has affected social norm change, both for adolescents and adults in the community. Based on learning from the two first two data rounds, the team decided that having the qualitative research team conduct interviews with adolescent and community members, using participatory research tools, would be the most conducive for delving into the complexities of norm change processes.

Table 1: Research sample for rounds 1 and 2

Type of locality	Category of project participants							
	Boys in-school	Boys out-of- school	Unmarried girls	Married girls	Parents of adolescents involved in the project	Disabilities (girls)	Mentors (50% man/ 50% woman)	Total
Close community	2	2	3	3	2	1	2	15
Remote community	2	2	3	3	2	1	2	15
Total	4	4	6	6	4	2	4	30

Table 2: Research sample for round 3

Type of locality	Category of project participants							
	Boys in-school	**Boys out-of-school**	**Un-married girls**	**Married girls**	**Girls with disabilities**	**Parents of adolescents involved in the project**	**Additional FGD**	**Total**
Close community	2	2	3	3	1	1. FGD mothers 2. FGD fathers	1. FGD mentors 2. FGD community/ religious leaders 3. FGD husbands of adolescent girls	**16**
Remote community	2	2	3	3	1	1. FGD mothers 2. FGD fathers	1. FGD mentors 2. FGD community/ religious leaders 3. FGD husbands of adolescent girls	**16**
Total	**4**	**4**	**6**	**6**	**2**	**4**	**6**	**32**

As noted above, research in each country was conducted in one "proximate" and one "remote" site, as presented in the following table:

Table 3: Research sites

Country	Site closer to village	Site further from village
Mali (Koutiala District)	Mpessoba	Sincina
Niger (Maradi District)	Oura	Magaria
Sierra Leone (Kailahun District)	Manowa	Follah

All participants interviewed were involved in at least one component of the Foundations intervention either directly or indirectly (through their children or wives), with the possible exception of adolescent girls with a disability and some of the community leaders participating in the FGDs.

Limitations

The participatory research approach with adolescents faced several challenges across study sites that may have limited the depth of information collected.

In the first round, there was considerable variability in facilitators' ability to engage adolescents in open-ended conversation without resorting to leading questions. The research team also found that facilitators frequently deviated from the prepared question guides, resulting in data that did not always align with the research objectives.

To address these issues, the second round gave recorders directly to adolescents, along with a pre-recorded story and questions for them to answer independently. However, in several communities, adolescents — who have limited exposure to technology and few opportunities to express their views in this way — found it difficult to record responses to all the questions. As a result, while the findings were insightful, they captured less information than anticipated.

In light of these experiences, the third round employed local data collectors with prior experience in qualitative research, including with adolescents. These collectors were trained to administer the research tools and facilitate focus groups, enabling the collection of additional data on changes in social norms.

Further, in Mali, the second round of data was not collected. Challenges with data collectors during the first round caused initial delays. By the time the team was ready to proceed, the security situation in the country had deteriorated, further postponing fieldwork. When access to the sites was finally possible, it coincided with the summer holidays, and most previously interviewed adolescents had left their villages. As a result, audio diary data in Mali was collected only in rounds one and three.

Country	Round 1 participants (N)	Round 3 participants (N)	Participated in both rounds 1 and 3	Retention %
Mali	21	21	11	52.38%
Niger	22	22	16	72.73%
Sierra Leone	22	22	21	95.45%
Total	65	65	48	73.85%

Despite these limitations, the data collected from adolescents yielded relevant analysis and insights that capture results from the Foundation's programming. It was possible to draw useful lessons from the findings and formulate recommendations for the Foundations project as implementation continues.

Key findings

This section presents findings from the different rounds of audio diary data collection, shedding light both on the general findings per round as well as on the specific insights from conversations with adolescents, with parents and community leaders. The section includes short case studies with adolescents which illustrate the pathways through which the knowledge acquired shaped SRH decision-making and service access between rounds one and three.

Overarching findings over the three rounds

Niger

Round 1

Adolescents across both sites identified the Foundations project and their immediate families as their primary sources of SRH information, with older adolescents in particular crediting the project for correcting misinformation they had previously acquired informally. Both boys and girls described their participation as highly useful, reporting that they had gained practical knowledge on menstrual hygiene management, contraception, exclusive breastfeeding, STI prevention, and where to report violence. Notably, even a ten-year-old boy in Magaria demonstrated detailed knowledge of puberty, FGM, child marriage, and family planning, attributing it entirely to the project. Girls in particular reported feeling empowered to access health services independently — something they had not previously considered possible — and several described sharing what they had learned with peers and family members who were not enrolled. Early signs of behavioural change were evident: mentors reported that girls were now attending school during menstruation, adolescents were visiting health centres on their own, and traditional gender roles were beginning to be questioned, with some adolescents noting that men could share in household tasks. However, adolescents in Magaria showed more limited knowledge of GBV and FGM compared to those in Oura, suggesting uneven depth of results across sites, with the more proximate site's better access to services and information serving as a platform for the program to have a stronger results.

Case study 1 : Omair's[1] experience in Magaria, Niger

● **Omair** | 15, adolescent boy — Magaria, Niger

Omair is a 15-year-old boy based in the Magaria site, currently attending 5th grade. In the first round of interviews, his understanding of FGM, GBV, and child marriage was extremely limited:

[1] All names used in the case studies presented are pseudonyms

Interviewer: Do you have information about FGM? — Omair: ... — I: Female genital mutilation. Cutting. — O: No. — I: And sexual violence based on gender? Girls who are raped? — O: No, really. — I: And child marriage? — O: No.

This changed rapidly with continued attendance at Foundations. By Round 2, Omair pointed to the growing understanding of the dangers of early and forced marriage:

When a girl is married off at a young age, she can experience difficulties in childbirth that require surgical treatment. Forced marriage also presents lots of risks like the girl running away or committing suicide.

He also became more aware of GBV:

I learned about violence against girls, boys who take advantage of them to rape them. I learned about forced marriage… For me the most important thing is to stop forced marriage of adolescents, because it is a big risk for girls during childbirth.

In Round 3, Omair noted that attitudes among Foundations participants have changed noticeably:

We had some changes because, between us and those who do not come to learn at the Foundations programme, there is a clear difference… We who have received training from Foundations believe that violence against women is not good.

Some things have still not changed. Child marriage persists, and Omair appears to accept some community logic:

Times have changed, because nowadays if they are left unmarried they can become victims of pregnancy outside of marriage.

Nevertheless, Foundations has significantly increased Omair's sensitivity to the dangers of GBV and FGM.

Round 2

Using vignette-based scenarios, this round explored adolescents' perceptions of the realism of SRH situations in their communities. A key finding was the emergence of adolescent agency: several girls described cases in which they or their peers had refused forced marriage, with one recounting a girl who filed a formal complaint at the departmental level and successfully had a forced marriage annulled. Adolescents attributed this newfound capacity to assert their rights directly to the Foundations project. Married adolescent girls reported that the project had opened their access to family planning and birth spacing, with some saying they had not previously known they could obtain these services at health centres. At the same time, important barriers persisted: unmarried girls reported feeling shame when seeking contraception, and health workers were described as treating married and unmarried adolescents differently. A recurring theme was that the project had facilitated communication within families — adolescents, particularly boys, reported being able to discuss SRH topics with parents and peers for the first time. The majority of respondents, both boys and girls, singled

out awareness-raising on child marriage as the most important and useful aspect of the project, describing it as an escape from a problem that had long affected their communities.

Round 3

This round, which expanded the research design to include focus group discussions with mentors, fathers, mothers, community leaders, and husbands alongside individual adolescent interviews, brought social norms into sharp focus. On the positive side, participants across both sites reported continued reductions in child marriage (with respondents indicating they had observed marriage age shifting from 13 to 16–18 years), a decline in GBV (with women now filing complaints when subjected to violence), improved menstrual hygiene practices, and increased uptake of contraception and health centre visits by adolescent girls. Adolescents were also forming independent peer discussion groups to share what they had learned with non-participants. However, deeply rooted social norms emerged as a significant area of tension. The most prominent was widespread resistance — from mentors, fathers, husbands, and community leaders alike — to unmarried girls accessing contraception, which was viewed as encouraging sex outside marriage and transgressing religious and cultural boundaries. Mentors themselves were not fully aligned with the project's message, acknowledging that community leaders had warned them against promoting anything perceived as contrary to Islamic teaching. Fathers expressed concern that giving adolescents rights and decision-making power over their own bodies would lead to "rebellion" and social instability. While mothers were generally more supportive than fathers of adolescents' SRH participation, some remained unable to discuss SRH topics with their children due to taboo. Other persistent norms included husbands preventing wives from attending project activities out of fear of their growing independence, grandmothers resisting contraception because they wanted many grandchildren, and boys and men continuing to avoid SRH services, viewing them as exclusively for women. Site differences were also notable: adolescents in Oura were better informed and more engaged than those in Magaria, where mentors were less proactive and some adolescents prioritised farming or commerce over project sessions. On the other hand, according to responses, FGM remained practiced in Oura despite its legal prohibition, whereas it had largely ceased in Magaria, even before Foundations began its work there.

Case Study 2: Halima's experience in Oura, Niger

●**Halima** | 17, unmarried adolescent girl — Oura, Niger

Halima is a 17-year-old girl who had just dropped out of secondary school when she joined Foundations. She absorbed new information about giving birth in health centres and prenatal/postnatal care:

Pregnant women must go to the health centre to give birth, because when they give birth at the health centre, they avoid complications… the woman can bleed a lot until

she becomes anaemic, she may require a caesarean, or the baby may be born with health problems.

From the beginning, Halima demonstrated exceptional buy-in, particularly on FGM and GBV. She was immediately persuaded of Foundations' social effectiveness regarding child marriage:

Child marriage existed before in Oura, but, with the arrival of the Foundations project, now it is no longer here… we are now aware of the harmful consequences of child marriage.

This positive assessment continued into Round 3:

Among adolescents, girls know how to manage their periods. Before, we were stressed — we could not even go out… We know how to live in a healthy environment and how to go to the health centre when we need to.

Despite her optimism, she confirms unmarried girls still have less access to family planning:

I think that they don't have the right to Family Planning because they are not married – it is not good for a girl to have sexual relations outside of marriage.

Though there may be some gap, in Halima's view, "everything has changed" because of Foundations.

Insights from adolescent case studies

Across the Niger case studies, adolescents showed a clear trajectory of growing knowledge and confidence between rounds. Haniya (17, married adolescent girl) moved from learning the basics of prenatal care to articulating a broader understanding of harmful practices including FGM, forced marriage, and the importance of girls' schooling, all of which she credits to Foundations. Halima (17, unmarried adolescent girl) demonstrated strong buy-in from the start, reporting that child marriage had effectively disappeared in Oura due to the Foundations project, and that girls now manage their menstruation confidently and visit health centres without embarrassment. Ruqayah (younger girl) recounted a case of a girl successfully lodging a legal complaint against a forced marriage, attributing this assertiveness to Foundations' teaching on rights. Sele (20, young man) developed a detailed understanding of contraception, childbirth complications, and STI prevention, and actively spreads awareness among peers. Another important case of transformation identified among research participants was Omair (15, adolescent boy), who in Round 1 had never heard of FGM, GBV, or child marriage, but by Round 3 clearly distinguished between these issues and was able to distinguish project participants among his peers based on their knowledge and attitudes. Rimsha (14, adolescent girl with disability) gained confidence to refuse child marriage despite two older sisters having been married young. Yet adolescents also identified cases where challenges remain firmly rooted: unmarried girls who seek contraception are stigmatised as having "bad morals," parents without project exposure mock Foundations as teaching "perversities," girls still lack bodily

autonomy as decisions require parental or spousal approval, and child marriage persists in part because some — including Omair himself — still rationalise it as protection against out-of-wedlock pregnancy.

Case study 3: Haniya's experience in Oura, Niger

● **Haniya** | 17, married adolescent girl — Oura, Niger

Haniya is a married girl, 17 years of age. In Round 1, she expressed her understanding of prenatal consultations:

> *We have been taught the themes effectively… It is important because it allows women, as well as their babies, to have good health.*

In Round 3, she reflects that Foundations filled a gap:

> *Before, there weren't any teachers capable of teaching us certain things. But now we have gained knowledge: encouraging girls to go to school, going regularly to health centres, bad practices like female circumcision, forced marriage, and child marriage…*

However, cultural norms regarding bodily autonomy have not changed:

> *My parents and my husband cannot support me if they do not agree with this or that decision that I want to make.*

Haniya believes only continued awareness-raising may reduce these practices:

> *If there are people who understand the merits of these things, they can convince their partners… but whatever you do, there will always be resisters.*

Since her first involvement, she has expressed her desire to spread awareness:

> *To spread my knowledge to those who do not have the chance to be in the programme.*

Case study 4: Ruqayah's experience in Oura, Niger

● **Ruqayah** | Younger adolescent girl — Oura, Niger

Ruqayah participated in all three rounds. In Round 1, her mother expressed strong support:

> *It is only Foundations, this is the project that has come with its programme and by which our children have been made aware.*

By Round 2, Ruqayah demonstrated awareness of the right to refuse forced marriage, discussing a girl who resisted:

> *I know a girl whose parents wanted to force her to marry, but she kept her cool and made a complaint to the authorities. She won the case, and the marriage was annulled… girls have the right to protest and we gained this awareness through Foundations.*

In Round 3, she noted changes but also persistent discrepancies:

Before the project, married girls did not know the importance of family planning. Girls did not know what to do when their periods came… The changes are the result of the knowledge we acquired through Foundations.

In Oura, unmarried girls do not go to the health centre alone to get contraceptive products, and those using them are considered girls of bad morals.

Despite challenges, Ruqayah believes adolescents are putting what they learned into practice. Her case demonstrates that strong parental support is key to effective change.

Case study 5: Sele's experience in Oura, Niger

- **Sele** | 20, older adolescent boy — Oura, Niger

Sele is a twenty-year-old adolescent. During Round 1, he learned about health centres and noted a FGM case leading to arrests:

I heard of a case here in the village. A girl had it removed in the house and it caused complications… Those responsible were arrested and sanctioned.

By Round 2, he demonstrated detailed SRH knowledge:

They explained to us why child marriage is not good… The girl becomes pregnant when her body is immature and cannot give birth without complications (haemorrhages, fistula)… We know our rights, and if our parents insist, we can leave the village or lodge a complaint.

In Round 3, he described healthier behaviours but noted that attitudes among those without Foundations exposure remain a barrier:

The parents who think the programme is not a good thing are those whose children are not in the programme, and they mock its work. They say that we are taught perversities.

Sele believes continued awareness-raising is key:

To pass on what we have learned we must meet with our peers… awareness-raising is the best way.

Case study 6: Rimsha's experience in Oura, Niger

- **Rimsha** | 14, adolescent girl with disability — Oura, Niger

Rimsha is a fourteen-year-old girl with a disability. In Round 1, she described prenatal consultations. In Round 2, she noted persistent inequitable norms:

In Oura, it is above all married girls who go to the health centre for contraceptive products. It is rare to see an unmarried girl going on her own, because she will be asked a lot of questions and judged.

By Round 3, she noted improved attitudes:

Before Foundations, we felt embarrassed and could not go to the health centre without being scared that we would be turned away.

Girls understand that they have rights that others must respect. They go to the health centre without constraint.

Though two of her sisters married before adulthood, Rimsha refuses:

Interviewer: So, since you are 15, you will marry next year. — Rimsha: Absolutely not. We also have the support of the healthcare professionals, who encourage us.

Sierra Leone

Round 1

Adolescents in both communities reported accessing SRH information from a wide range of sources — friends and peers, schools, NGO programmes (Girl Shine, Ark Champions, 'Foundations clubs' with Real Fathers sessions), health facilities including Marie Stopes mobile clinics, family members, and social media. However, the quality and accuracy of information varied considerably across these channels: school-based SRH education was often perceived as insufficient, peer information was sometimes unreliable, and many girls — particularly older adolescents in Manowa — felt uncomfortable discussing SRH with their parents. Foundations project participation was associated with notable early gains: adolescents reported increased understanding of STI prevention, contraception, and menstrual hygiene, and several described accessing health services for the first time, including obtaining contraceptive implants. Girls valued the interactive, non-judgmental format of Girl Shine sessions, and boys appreciated learning about condom use and personal responsibility through Foundations clubs. At the same time, cultural resistance was already evident, particularly around child marriage and initiation into the Bondo secret society (involving FGM), where some community elders and religious leaders continued to endorse traditional practices. Adolescents also flagged practical gaps: limited access to contraceptives in rural areas, parental restrictions on attendance, and the absence of adolescent-friendly centres where they could discuss sensitive topics confidentially. A gendered pattern was clear, with girls relying more heavily on NGO programmes and peer discussions for SRH information, while boys tended to receive guidance from community leaders and obtaining condoms at shops.

Case study 7: Baana's experience in Follah, Sierra Leone

- **Baana** | 19, married adolescent girl — Follah, Sierra Leone

Baana is a 19-year-old married girl. In Round 1, her SRH knowledge was limited but Foundations instilled positive attitudes:

They taught us that we should space our children like five or six years so that you will feel free rather than having a child every one year.

In Round 2, she credited Foundations for changing attitudes towards child marriage:

Before the Foundation project, most adolescent girls like me had wanted to get into child marriages… which is why I was eager to be part of the Girls Shine club.

I never knew about adolescent SRH, not even menstrual hygiene… until I started participating in the Girls Shine session.

However, patriarchal control persists:

Why do you prefer telling your mother? — Because my mother is a woman like me and understands me better. If I tell my father, he will shout at me.

I usually ask my husband for his consent, and he allows me to go and take contraceptives.

Despite continuing norms, there is now more community resistance to forced marriage:

Our mothers, fathers, husbands, and even the chief support us. Sometimes the chief tells parents that girls should not be forced to make decisions without their consent.

Round 2

Using vignette-based scenarios, this round found that adolescents across all categories — younger and older girls, boys, married and unmarried — considered the stories broadly realistic, reflecting lived experiences of early pregnancy, forced Bondo initiation, and limited SRH knowledge in their communities. Girls reported significant behavioural changes: improved menstrual hygiene, uptake of modern contraceptives (implants, pills), delayed sexual activity, and greater confidence in asserting their rights, including refusing child marriage and secret society initiation. One girl described correcting her own mistakes after a Girl Shine session and overcoming her shyness. Boys similarly reported consistent condom use and greater caution around sexual activity, with several noting that they now prioritised protection against both STIs and unwanted pregnancy. A standout finding was the shift among parents: both mothers and fathers described moving from attitudes of resistance — where contraceptives were seen as promoting promiscuity and FGM was viewed as culturally necessary — to actively supporting their adolescent children in accessing health services. Fathers in particular described sitting down with their children to discuss SRH for the first time. Mentors reported gains in their own knowledge and confidence. However, persistent gaps included the lack of adolescent-friendly centres in both communities, occasional conflicting information from mentors due to irregular refresher trainings, stockouts of family planning commodities at health facilities, and the fact that some parents still resisted boys collecting condoms. Adolescents strongly advocated for dedicated safe spaces where they could learn and access services without adult interference.

Round 3

Among adolescent girls, a striking finding was their articulate understanding of how patriarchal power structures contribute to girls being unfairly blamed for pregnancy and sexual behaviour, and their active practice of saying "no" to unwanted sexual advances — a direct outcome they attributed to the project. Girls reported sharing SRH knowledge widely with peers at school, in hair-braiding settings, and at riversides, suggesting organic diffusion of project messages. Mothers confirmed positive changes — reduced night-club attendance by girls, improved study habits, and greater openness in parent-daughter communication about menstruation and family planning — though they also revealed a persistent belief that girls "chase boys for sex," reflecting enduring gendered blame. A community taskforce against underage Bondo initiation was active in Manowa, catalysed in part by the deaths of two young girls in a neighbouring village. However, deeply entrenched norms posed substantial barriers. Husbands of adolescent girls, while appreciating family planning for managing family size during economic hardship, still expected wives to fulfil all domestic duties and insisted that men should give approval before women use contraceptives; some had prevented wives from attending sessions. Fathers overwhelmingly favoured abstinence over contraceptive use for adolescents, with many Muslim fathers describing family planning as morally wrong and contrary to God's will. Some fathers continued to support FGM, believing it controls sexual desire in girls. Community stakeholders echoed concerns that project components were overly girl-focused, leaving boys with limited knowledge and thereby perpetuating harm. Boys themselves confirmed this imbalance and added that many disliked using condoms due to perceived reduced pleasure, instead encouraging female partners to use other methods. Across all groups, the strongest and most consistent recommendations were to establish adolescent-friendly centres, ensure a steady supply of family planning commodities, include more boys in programming, combine SRH education with livelihood and skills training to reduce economic vulnerability and transactional sex, and involve religious leaders and husbands more directly to address normative resistance.

Case study 8: Esie's experience in Manowa, Sierra Leone

● **Esie** | 19, unmarried adolescent girl — Manowa, Sierra Leone

Esie is an unmarried 19-year-old. From the beginning, she demonstrated awareness of the importance of contraception:

> *When the topic of Family planning was discussed, I responded that girls should not be pregnant while attending school and that abortion is a risk… They applauded me because they knew I was saying the right thing.*

In Rounds 1 and 2, she described concrete changes:

> *It used to happen before the Girls Shine program… the safe space has created lots of awareness. The issue of early pregnancy has stopped.*

Parents would force their children into child marriage… But since the intervention, that has changed. They now listen and do not force their children into marriage because of money.

In Round 3, Esie described improved access to informed choice:

What I like about the health facility is that they test you and ask which type of contraception you want. Before, we would just buy without knowing which was best. Now we can talk to health workers and get advice.

However, resistance persists among men and boys:

I believe boys should also be included. When girls try to protect themselves, boys sometimes request that they remove the contraceptives. So boys should be involved so they can understand and not harm them.

Insights from adolescents' case studies

The Sierra Leone case studies show substantial shifts in adolescent knowledge, confidence, and health-seeking behaviour between Rounds 1 and 3, with particularly strong narratives around contraceptive access. Baana (19, married adolescent girl) went from limited SRH knowledge to understanding menstrual hygiene and birth spacing, and described community-wide support — including from chiefs — against forced marriage. Esie (19, unmarried adolescent girl) progressed from initial awareness to actively visiting health facilities where she now receives counselling on the best contraceptive method for her, a level of informed choice she did not previously have. Maizah (12 adolescent girl), who initially learned about contraception anecdotally from a friend's experience, by Round 3 could articulate the value of family planning for both married and unmarried girls and felt confident about accessing services independently. Ismail (12, adolescent boy) demonstrated strong knowledge of STI prevention and condom access, and credited the community leadership's enforcement of by-laws for widespread uptake among adolescents. Bintu (13, adolescent girl with disability) moved from basic awareness to independently obtaining a contraceptive implant during a Marie Stopes outreach, reflecting a remarkable gain in confidence and agency. However, patriarchal gatekeeping persists: Baana still requires her husband's consent for contraception, and her father would "shout at her" if approached about it. Esie highlighted that boys sometimes pressure girls to remove their contraceptives, and advocated strongly for including boys in programming to address this. Manu (19, young man in the project and health centre worker) noted that some girls discontinue contraception once parental monitoring lapses, pointing to a gap between initial uptake and sustained practice. The absence of adolescent-friendly centres in both communities remains a consistent barrier to confidential access to services and peer discussion.

Case Study 9: Maziah's experience in Follah, Sierra Leone

● **Maizah** | 12, younger adolescent girl — Follah, Sierra Leone

Maizah is a 12-year-old participant interviewed in all three rounds. At Round 1, her understanding was limited — she learned about contraception anecdotally:

> *One day, a friend came to me and said she wanted to prevent… She didn't want to get pregnant… From this, I learned that if a person doesn't want to get pregnant, they can prevent.*

In Round 2, she demonstrated greater understanding:

> *They encourage us to go to the health facility and get preventives so we will not get pregnant… Our mentors supported us to understand and take preventives so we will not marry early.*

In Round 3, Maizah reflected on how understanding has improved:

> *The knowledge about contraception was very useful because I never knew about it before. But now I understand contraceptive methods… Initially, we did not know about condom use, and there were many sexually transmitted diseases.*

Despite some male resistance, Maizah is secure:

> *I believe contraceptives are for both married and unmarried girls… For unmarried girls, it helps prevent unwanted teenage pregnancy.*

Case Study 10: Ismail's experience in Follah, Sierra Leone

● **Ismail** | 12, younger adolescent boy — Follah, Sierra Leone

Ismail is a 12-year-old participant. From Round 1, he absorbed warnings about FGM and child marriage:

> *They said adolescents should not be forced into initiation because it has health implications… We usually report such issues to the Family Support Unit,, Save the Children, or the chief.*

In Round 2, he described personal benefits including STI prevention knowledge:

> *We have learned how to prevent ourselves from STDs because it is life-threatening, and some are not curable… they informed us that if we need condoms, we should visit the health facility.*

In Round 3, Ismail noted community leadership's strong backing:

> *The community stakeholders ensure everyone attends the engagement… there are byelaws that protect every adolescent. I sometimes visit the health facility for condoms without informing my father.*

But the lack of adolescent-friendly facilities remains a concern:

> *Since there is no adolescent-friendly centre for us to meet and discuss, some of us don't feel comfortable visiting the health facility because there is no confidentiality.*

Case Study 11: Manu's experience in Follah, Sierra Leone

● **Manu** | 19, older adolescent boy and health centre worker — Follah, Sierra Leone

Manu is a 19-year-old participant who also works at the community health centre. In Rounds 1 and 2, he reflected on the project's impact:

> *They taught us a lot about the dangers of child marriage, teenage pregnancy… We had no knowledge of these before, but now we do, thanks to Save the Children.*

In Round 3, he pointed out challenges around sustained contraception practice:

> *Most of the adolescent girls, at that very moment after getting the information, they will go and take the contraceptives but after a while when their parents have forgotten they will take it off… parents don't monitor their child so that is why some will get pregnant.*

Manu recommends further outreach for parents:

> *Let them continue to bring in more projects which they'll be monitoring. People should be coming round giving advice to the parents for them to be monitoring their child.*

Case Study 12: Bintu's experience in Follah, Sierra Leone

●**Bintu** | 13, adolescent girl with disability — Follah, Sierra Leone

Bintu is a 13-year-old participant with a disability. In Round 1, she learned about family planning and STI prevention:

> *They said we should not rush into having sexual intercourse… They told us that STI is a sickness we get when we sleep with multiple sex partners without protection.*

In Round 2, she stressed that education has been instrumental in changing attitudes:

> *Terrible things used to happen — child marriage, early pregnancy, FGM, and abortion. We appreciate the Foundations Project for educating us… Girls Shine has been important for us to understand our body.*

In Round 3, she cites reductions in harmful practices:

> *Since the start of the program, this has stopped. The chiefs now have a law that nobody should initiate a child under 18… child marriage has reduced, people now value education.*

Bintu herself now accesses contraception confidently:

> *I was using an implant, but it expired. During the Marie Stopes outreach, I went and got a new one… other girls like me can go and get it themselves. The program has taught us this, and we are more confident.*

Mali

Round 1

Adolescents in both sites reported gaining knowledge on puberty, bodily changes, menstrual hygiene, the risks of early pregnancy and child marriage, and STI prevention through Foundations' educational discussion sessions ("causeries"), delivered in schools and community settings. Health centres, peer educators, schools, and — for girls especially — mothers and grandmothers were cited as key sources of SRH information alongside the project. Several adolescents described improved communication with parents as a direct benefit, with one boy in Sincina noting that Foundations had given him the confidence to discuss puberty with both his mother and father for the first time. Unmarried girls focused on prevention — avoiding pregnancy, understanding puberty, and refusing child marriage — and found the information empowering for their future. However, significant cultural barriers were already evident. Discussing sexuality between parents and children remained deeply taboo, with one adolescent stating that such communication simply "should not exist" between parent and child. Perceptions of FGM were strikingly contradictory: while most participants described it as harmful, one married girl in Sincina asserted that excision was essential for both girls and boys to be able to have children, revealing how deeply embedded certain beliefs remained despite awareness-raising. Parents in Sincina reported reductions in early pregnancy and forced marriage in the community, but several adolescents noted they had not been invited to visit health services despite being in the project, and out-of-school adolescents were identified as particularly underserved. The report also highlighted that marital status shaped receptiveness: married girls sometimes held more conservative views on practices like FGM than their unmarried peers.

Case study 13: Kadia's experience in Sincina, Mali

● **Kadia** | 17, unmarried adolescent girl — Sincina, Mali

Kadia is a 17-year-old unmarried girl. In Round 1, she accessed SRH information through school, her mother, and Foundations:

> *We find information at school and there is a project for that… I talk a lot with my mother about puberty and managing menstruation. My mother told me that our behaviour causes child marriage — because once you get your period and chase after boys, that's why our fathers give us in marriage.*

She recognised the project's benefits:

> *Through the project's intervention, we now know we were lost… This project gave me knowledge about child marriage, early pregnancy, and puberty… This information helped me avoid early sexual relations, whether consensual or not.*

By Round 3, Kadia named Foundations as a catalyst but identified resistance from fathers and religious leaders. Like others in her community, she herself remains favourable to FGM:

> *The community thinks that a girl who has not been excised is not considered a woman…*

Round 3

This round revealed a mixed picture of progress and persistent normative resistance. Among adolescents, girls in both sites demonstrated broadened knowledge spanning contraception, GBV, FGM risks, menstrual cycle management, and the importance of visiting health centres. Behavioural changes were evident: some mothers were now accompanying their daughters to health centres to adopt family planning, girls reported managing menstruation with greater confidence and privacy, and boys described stopping harassment of girls and risky sexual behaviours. In Sincina, girls reported that communication about sexual health and rights had become more accepted, even among some religious leaders who supported the project through their sermons, and parents' perceptions of family planning and violence had shifted. However, deeply rooted social norms continued to limit the project's reach on several fronts. FGM persisted in both sites — mothers in Mpessoba and Sincina confirmed that no change had occurred in the practice, and community leaders in Mpessoba acknowledged that while many had abandoned it, the practice was not fully eradicated. In Sincina, boys reported that FGM was still justified on the grounds that non-excised girls face complications during childbirth, indicating the persistence of misinformation. Contraceptive use by unmarried girls remained widely unacceptable across both communities: parents and community members opposed it, viewing it as promoting promiscuity, and misconceptions persisted — including the belief that condoms cause male impotence. In Sincina, married women's ability to exercise their right to refuse their husband's sexual demands had not evolved, and unwanted pregnancies continued because girls often only discovered they were pregnant after falling ill and visiting a health centre. Many parents in both sites refused to let their children participate in the project, some imams and traditionalists openly opposed it, and fathers in Mpessoba noted that the project's reach was too limited — too few people had been selected, leaving large parts of the community unaware of its activities. Child marriage also continued, and boys received fewer sessions than girls, a gap flagged by adolescents themselves.

Case study 14: Seydou's experience in Mpessoba, Mali

● **Seydou** | 14, younger adolescent boy — Mpessoba, Mali

Seydou is a 14-year-old schoolboy in a rural Malian community. In Round 1, he cited Foundations as his source of information on puberty, child marriage, and GBV. By Round 3, he was pleased to have learned much more:

> *When they get their period, they can better manage their menstrual cycles without people knowing.*

He understood the link between bodily changes and pregnancy risk:

> *Yes, we have stopped certain kinds of reckless play with girls…*

However, Seydou is opposed to family planning despite appreciating the reduction in unwanted pregnancies:

> *I think that neither married nor unmarried women should adopt family planning because it has consequences… it damages organs in the belly.*

Insights from adolescents' case studies

The case studies from Mali illustrate that adolescents — both girls and boys, younger and older — gained meaningful knowledge through Foundations on puberty, menstrual hygiene management, the risks of child marriage and pregnancy, and family planning. Salimata (18 married adolescent girl) reported that women in her community, married and unmarried, now feel more independent in making decisions about contraception and sexuality, and described improved communication with her husband. Kadia (17, unmarried adolescent girl) credited Foundations with helping her avoid early sexual activity, and Mamadou (17, adolescent boy) overcame shame to discuss puberty openly with both parents — something he attributed directly to encouragement from project facilitators. Younger adolescents also showed gains: Assetou (14 adolescent girl) observed that fewer families were practising FGM, and Seydou (14 adolescent boy) reported that boys had stopped risky behaviour with girls. However, significant resistance persists. The community broadly rejects the idea that unmarried girls should access contraception, and both Seydou and Kadia's accounts reveal that adolescents themselves have internalised these norms — Seydou opposes family planning for any woman, believing it damages internal organs, while Kadia accepts FGM as a prerequisite for marriage, showing that misinformation persists despite sensitisation by the Foundations project.

Case study 15: Salimata's experience in Sincina, Mali

● **Salimata** | 18, married adolescent girl — Sincina, Mali

Salimata is an 18-year-old mother, married at 16. In Round 1, she attended the health centre for pregnancy management and family planning:

It was done at the health centre… for prenatal consultations… The health staff already know our illness and, when we cannot cover costs, they agree to treat us and let us pay later.

She noted the high rate of early pregnancies and considers awareness-raising on sexuality and family planning as key strengths of Foundations:

You see girls of 14 and 13 with children — this information can protect these girls against early pregnancies.

By Round 3, she confirmed changes:

Family planning has prevented unwanted pregnancies and the dishonour linked to out-of-wedlock pregnancies among young women.

Today, married and unmarried women are independent in deciding for themselves about family planning and sexual activity.

She also described improved communication with her husband and better menstrual management:

In the past, we did not understand our menstrual cycle — we could be laughed at by boys when our period appeared during class. But today, we know our period day, especially with the use of cotton pads.

Case study 16: Assetou's experience in Mpessoba, Mali

● **Assetou** | 14, younger adolescent girl — Mpessoba, Mali

Assetou is a 14-year-old schoolgirl. In Round 1, she accessed information on puberty, FGM, and child marriage through Foundations:

The project comes to share information in our classroom. They say that child marriage is not a good thing… if the girl gets pregnant, she or her baby can die during childbirth… she might harm her husband or commit suicide.

By Round 3, she noted changes regarding FGM:

In my opinion, FGM has changed for the better. Many people no longer practise it… because it prevents some women from having children. During awareness sessions, the facilitator tells us about these things.

However, FGM continues despite awareness:

The community has not accepted abandoning this practice. People say you cannot go to your husband's home unless you have undergone it.

Mothers are divided on adolescents' use of contraceptives:

Sometimes mothers accompany their children to the health centre for SRH services… but some don't support them, saying you are a badly raised child.

Case study 17: Mamadou's experience in Sincina, Mali

- **Mamadou** | 17, older adolescent boy — Sincina, Mali

Mamadou is a 17-year-old schoolboy. In Round 1, he learned about puberty and family planning but had not visited the health centre. By Round 3, he expressed satisfaction at gaining more knowledge. He visited the health centre and learned about risks linked to bodily changes:

> *They tell us that from the age of 14 we should not get too close to girls and there are dangerous games to avoid, otherwise it can cause unwanted pregnancies.*
>
> *They say that if a man needs contraceptive methods, he should use condoms, which is the method for men.*

Mamadou now discusses puberty with his family regardless of gender:

> *Before, I was ashamed to approach my mother and father, but through my involvement in the project… the facilitator says we should not be ashamed to discuss these topics… which encouraged me to talk about it with my mother and my father.*

Case study 18: Mamadou's experience in Mpessoba, Mali

- **Banassou** | 17, adolescent girl with disability — Mpessoba, Mali

Banassou is a 17-year-old schoolgirl with a disability. In Round 1, she learned about menstrual hygiene and risks of child marriage:

> *If you get your period at home, you look for a piece of cloth and protect yourself. You also keep a cloth in your bag in case it comes at school — you go to the toilet and continue your classes.*
>
> *I know that child marriage and early pregnancy greatly affect girls' schooling. I was very happy to receive this awareness-raising… I have abandoned many behaviours I had before.*

By Round 2, her knowledge of menstrual hygiene was reinforced:

> *Personally, I did not know about menstrual cycle management… They told me to wash with soap, wash the cloth I use and lay it out in the sun covered by another cloth, so people don't know.*

She spreads information to parents and peers:

> *After the awareness sessions, we inform our parents about the consequences of child marriage…*

She reports that parents now ask suitors to wait until their daughter reaches the appropriate age.

Social norms analysis: mothers, fathers and community leaders

The third round of audio diaries had a strong focus on exploring changes in discriminatory social norms, and also understanding why there is still resistance to change. The case studies with adolescents illustrate how this has shaped the experiences of adolescents. In round three the research also included focus group discussions (rather than individual interviews) with mothers, fathers, and husbands of adolescent girls, and included an additional category of respondents: community and religious leaders to explore how the Foundations project components have shaped attitudes and behaviours around social norms in the three countries.

Niger

Perceived benefits of the project

Focus group discussions with caregivers, husbands, and community leaders in Niger revealed predominantly positive perceptions of the Foundations intervention. Respondents consistently described improvements in adolescents' knowledge, behaviours, and engagement with SRH services. Community leaders and parents observed that adolescents were forming discussion groups and actively sharing what they had learned. A father from Oura noted:

"Young people, whether girls or boys, are constantly discussing what they're being taught; you often see them in small groups discussing this or that topic, and everyone gives their opinion. They now know how to lead a safe life." (FGD with fathers, Oura).

A community leader from Oura similarly observed broader behavioural shifts, noting that young brides were using health services for antenatal check-ups and childbirth, while boys had stopped taking harmful substances and engaging in violence.

Improved communication between adolescents and caregivers

A recurrent theme across the FGDs was improved parent-child communication on SRH. Mothers in particular described a shift from shame and silence to open dialogue. A mother from Magaria stated:

"There's no question of shame; since our children are aware and tell us what they're learning, and now that we communicate, we've seen a reduction in many problems." (FGD with mothers, Magaria).

Mothers also reported discreetly accompanying children to health centres for SRH concerns. However, a marked gender divide persisted in parental engagement. Fathers acknowledged their discomfort discussing contraception or menstrual management with their daughters:

"With our daughters we cannot discuss SRH, particularly regarding the use of contraception or menstrual management. But with the boys, we can talk because they're leaving home, and we need to advise them, especially on using condoms." (FGD with fathers, Oura).

The limited involvement of fathers in SRH conversations was a recurring finding.

Child marriage: shifting attitudes, persistent practice

Participants across focus groups reflected growing awareness of the harms associated with child marriage and a change in attitudes attributed to the Foundations intervention. A father from Magaria noted:

"The issue of child marriage and rape has been abolished; personally, I have a 17-year-old daughter whom I cannot give in marriage, to protect her from the potential consequences, such as fistula." (FGD with fathers, Magaria).

Mothers linked changes to increased school attendance, with one from Magaria observing:

"Things are changing because the children are starting school, so once a child starts school, we can't talk about marriage." (FGD with mothers, Magaria).

However, mothers from Oura noted that despite these gains, child marriage persists, particularly driven by fathers:

"The negative reaction is regarding child marriage; there are parents, especially men, who, as soon as the child starts to grow up, begin to think about marriage… this practice has decreased but it still persists." (FGD with mothers, Oura).

Contraception for unmarried adolescents: a contested norm

While there was broad support for family planning among married couples, opinions diverged sharply regarding unmarried girls' access to contraception. A husband from Magaria stated:

"In my opinion, an unmarried girl should not take contraception; it is a mistake, because nowadays any girl who has access to contraception has the opportunity to commit adultery." (FGD with husbands, Magaria).

Others framed contraceptive use in terms of fertility expectations:

"There are those who see it as a sign of weakness if a wife goes more than two years without becoming pregnant." (FGD with husbands, Magaria).

Fathers emphasized monitoring what was being taught, with one from Oura stating:

"*We're very keen for them to uphold our values, particularly the dignity of girls."* (FGD with fathers, Oura)

A more nuanced position was expressed by a father from Magaria, who acknowledged that unmarried girls might need protection — but only in specific circumstances such as rape, not for voluntary sexual activity.

FGM: reframed but not abandoned

Respondents stated that FGM was not actively practised in their communities, but closer questioning revealed that it continues in a reframed form — as a medical response to perceived "clitoral deformity." A husband from Magaria explained:

"We don't practise FGM here; only if a girl is born do we call a barber to check whether there is any deformity of the clitoris." (FGD with husbands, Magaria).

A mother from Magaria similarly stated:

"In our community, we have stopped these practices; we no longer perform FGM, except if the child has a clitoral deformity." (FGD with mothers, Magaria).

When asked about Foundations' awareness-raising on FGM, a mother from Magaria responded: "Normally it's inappropriate to talk about FGM and contraception in front of adolescents" — suggesting that the topic itself remains sensitive and resistant to open discussion.

Sierra Leone

Improved adolescent knowledge and parental views on abstinence

Caregivers in Sierra Leone acknowledged improvements in adolescent knowledge of contraception as a result of the Foundations project. However, several parents — both mothers and fathers — emphasised that abstinence should remain the primary message. A father from Manowa stated:

"As a man, if I approve of my adolescent daughter taking Family Planning before she turns 18 years, it means that I am the one who has approved their promiscuity to sleep around with any type of man because she is protected from getting pregnant. That is why I emphasize abstinence." (FGD with fathers, Manowa).

Mothers, while also supportive of delayed sexual debut, tended to describe more pragmatic approaches. A mother from Follah recounted:

"For me, when my child reached maturity, I took her to the health facility and asked the nurse to give her a contraceptive that works well for her." (FGD with mothers, Follah).

Another mother described a shift from punitive to communicative parenting:

"Before, if a child went out and came back late, I would beat her without asking questions. We didn't have the confidence to talk about menstruation or contraception. Now we know it is not a barrier, and we talk to them." (FGD with mothers, Follah).

Changing communication dynamics within families

The FGDs revealed a positive shift in parent-child communication on SRH. Mothers were the primary interlocutors — adolescents were described as feeling more comfortable discussing SRH with mothers than with fathers. Mothers from Follah noted that they now explain the health risks of early pregnancy, including fistula and surgical complications, to instil caution in their daughters. However, mothers also highlighted a significant gap in male engagement:

"Most men are not talking to the children, especially the boys. They don't talk to them… We are just thankful for Save the Children, IRC, and other organizations because they are the ones talking to our boys. The men are not doing it." (FGD with mothers, Follah).

Shifting attitudes among religious leaders and fathers

A notable finding was the reported shift among religious leaders. Mothers from Follah described how imams who had previously opposed contraception had changed their position after attending workshops:

"Initially, they preached against it. But now even the imams want their children to learn, so they are accepting it… After attending workshops in Kailahun, they came back and started preaching that using contraception does not mean going to hell; it is protection." (FGD with mothers, Follah).

Some fathers also articulated progressive views. A father from Follah stated:

"Save the Children has made us realize that adolescents have the full right over their bodies; we need to guide them in the decisions they make." (FGD with fathers, Follah).

Another father from Manowa argued that both married and unmarried girls should have equal access to SRH information so that unmarried adolescents could learn from others' experiences and correct future outcomes.

FGM: reduced but normalised for those over 18

FGM emerged as a continuing practice, reframed rather than eliminated. The community appears to have converged on an age threshold — restricting initiation to girls over 18 — rather than abandoning the practice. Mothers described the sensitivity of the topic:

"FGM is sensitive. Some parents may not be happy if girls go home talking about it… The mentors tell the girls that what is discussed in the safe spaces should remain there because FGM is very sensitive." (FGD with mothers, Follah).

A mother from Follah who is part of the community taskforce described its enforcement role:

"During initiation, we stand at the door and check the girls. Any girl under 18 is sent back… There was a time when two girls died during initiation in a neighboring community. After that, the practice was banned, and the task force was strengthened." (FGD with mothers, Follah).

The framing suggests harm reduction rather than abolition of FGM.

Persistent misconceptions about contraception

Despite the project's positive effects, fathers in Follah reported that some adolescent girls continue to reject family planning due to the belief that contraception leads to infertility:

"There are more adolescent girls who don't like Family Planning based on the myth that it can render them sterile and not be able to give birth, so with this set of adolescents, when their boyfriends request that they get pregnant for them, they do so without thinking." (FGD with fathers, Follah).

Mali

Fathers' emerging role in SRH communication

A distinctive finding in Mali, compared to the other two countries, was the more visible role of fathers in communicating SRH-related knowledge to their daughters. This was attributed to specific training on adolescent-parent communication delivered as part of the project. A father from Sincina stated:

"*Thanks to the training, fathers give advice to their daughters on sexuality without the mother acting as an intermediary. I can only say that this is a great thing."* (FGD with fathers, Sincina).

A mentor from Mpessoba confirmed the trend:

"Many fathers tell us that they do talk to their daughters. It is actually the mother who feels awkward when she sees the father discussing SRH issues with his daughter, whereas the daughters feel no awkwardness at all." (FGD with mentors, Mpessoba).

A mother from Sincina framed the shift in terms of shared responsibility:

"The father and mother need to communicate and exchange ideas about bringing up children. It is important to realise that raising children is not just the mother's responsibility; the father must also be involved." (FGD with mothers, Sincina).

Puberty, menstrual health, and access to services

Parents across both sites reported significant improvements in adolescents' knowledge and management of puberty and menstruation. A father from Mpessoba stated:

"Many girls experience their periods without their parents talking to them about how to manage them. But thanks to the project, they have learnt how to manage their periods." (FGD with fathers, Mpessoba).

A mother from Sincina described her 13-year-old daughter managing her period independently: *"Sometimes I realise she's on her period when she asks me for money to buy sanitary towels, but apart from that, she manages the rest on her own."* Parents also noted reduced stigma around health-seeking. A father from Sincina observed:

"Adolescents used to be too ashamed to come for sexual and reproductive health consultations. From what I've observed, teenagers are now visiting the health centre." (FGD with fathers, Sincina).

Parents linked improved knowledge to reductions in early pregnancy, with a mother from Mpessoba stating: *"We now let our girls talk to the boys, and there have never been any teenage pregnancies."*

Child marriage and gender-based violence: reported reductions

Caregivers reported decreases in both child marriage and violence against adolescents. A father from Sincina stated:

"Before, rape was common in the village; now it is rare." (FGD with fathers, Sincina).

Another father quantified the change: *"There has been a significant reduction in violence against adolescents. Compared to the previous year, we are down by about 25%."* Mothers described using their influence to delay marriage, with one from Mpessoba explaining:

"If they want to give a daughter in marriage, we talk to them about the consequences this may have, and as a result, they postpone the marriage plans until she is 18." (FGD with mothers, Mpessoba).

The protective role of education was also highlighted by husbands, with one noting that educated girls will *"see for themselves that if they do not marry, it will not bother them in the slightest."*

Husbands: support for family planning within marriage, ambivalence beyond it

Husbands expressed growing acceptance of contraception within marriage, with some describing active accompaniment of wives to health centres — a noted change from prior practice. A husband from Mpessoba stated:

"Even I accompany my wife to the health centre for antenatal and postnatal check-ups… Before, women used to go to the health centre for check-ups on their own, without their husbands

accompanying them. But now, husbands accompany their wives." (FGD with husbands, Mpessoba).

Others linked contraception to girls' educational outcomes*: "Girls have realised that by using contraception, they aren't bringing shame on their parents and can continue their studies."* However, views on unmarried girls' access to family planning were more restrictive. A young man from Sincina stated:

"In my opinion, they shouldn't have the same access as married women. An adolescent must be accompanied by an adult or one of her parents so that she can access family planning." (FGD with husbands, Sincina).

While child marriage was perceived by some husbands as increasingly rare, challenges around enforcement were acknowledged, particularly in ethnically diverse communities where verifying age is difficult.

FGM: acknowledged persistence despite awareness

Community leaders offered the most candid assessments of what had and had not changed. On FGM, a community leader from Sincina stated:

"Female genital mutilation, let's be honest, the practice is still going on. The way it is carried out has changed." (FGD with community leaders, Sincina).

Another leader acknowledged partial progress:

"We are not 100% there. I think that as for female genital mutilation, many have abandoned the practice. It is the same with family planning. Because some people will never accept it unless they are victims of it themselves." (FGD with community leaders, Sincina).

Mentors highlighted positive shifts in menstrual hygiene and adolescent confidence, with one from Mpessoba noting that parents had reported their children managing menstrual cycles properly thanks to the project's awareness-raising. But the overall picture from leaders was one of gradual, incomplete normative change — with FGM and resistance to family planning representing the areas of greatest inertia.

Conclusions

Overall our findings point to five broad cross-cutting conclusions:

- Across all three countries, the Foundations project achieved demonstrable increases in adolescent SRH knowledge, health-seeking behaviour, and agency over the study period. Adolescents moved from limited or inaccurate understanding to articulate engagement with issues of contraception, child marriage, GBV, and menstrual health — with many actively sharing knowledge with non-participant peers, suggesting organic diffusion of project messages beyond the direct target group.
- Contraceptive access for unmarried adolescent girls represents the single most contested norm across all three contexts. Opposition from fathers, husbands, community leaders, and religious figures was consistent and deeply rooted in concerns about promiscuity, religious morality, and social control. This norm consistently emerged as the area where the gap between project objectives and community acceptance is widest, and where future programming will need the most sustained and culturally sensitive engagement.
- FGM persists in all three countries despite increased awareness of its harms, with communities adopting reframing strategies — medicalisation in Niger, age thresholds in Sierra Leone, and continued practice in modified form in Mali — that allow the practice to continue under different justifications. This pattern suggests that awareness-raising alone is insufficient and that deeper, sustained community-level engagement with the social and cultural drivers of FGM is required.
- The project's impact on social norms was strongest where it engaged multiple layers of influence simultaneously — adolescents, parents, mentors, religious leaders, and community structures. The most notable normative shifts — such as the reversal of imams' positions on contraception in Sierra Leone or fathers' active SRH communication in Mali — occurred where project's activities specifically targeted these adult gatekeepers, underscoring the importance of a multi-generational, multi-stakeholder approach to norm change.
- Structural barriers — including the absence of adolescent-friendly health spaces, stockouts of family planning commodities, uneven project coverage, and insufficient inclusion of boys — consistently limited the translation of knowledge gains into sustained behavioural change. Addressing these barriers will be essential for the project to consolidate and deepen the normative shifts it has initiated.

There was, however, considerable diversity across the three focal countries in terms of project impact pathways and outcomes.

Mali

- A distinctive finding in Mali was the emergence of fathers as active communicators on SRH with their daughters, a shift directly attributed to project training on adolescent–parent communication. This represents a departure from the pattern observed in Niger and Sierra Leone, where fathers remained largely peripheral to SRH conversations with daughters.
- Adolescents in both sites gained meaningful knowledge of puberty, menstrual hygiene, contraception, and child marriage risks, and reported behavioural changes including independent health-seeking, improved menstrual management, and — among boys — a reduction in harassment of girls. These gains were evident despite the loss of the second data collection round due to security and logistical challenges.
- However, adolescents themselves had internalised some of the restrictive norms the project seeks to change. Boys opposed family planning on the grounds that it damages internal organs, while some girls accepted FGM as a prerequisite for marriage — indicating that misinformation persists alongside and sometimes overrides project messaging.
- FGM proved to be the area of greatest normative inertia. Community leaders acknowledged candidly that the practice continues, even if in modified form, and both parents and adolescents confirmed its persistence in both sites. The project has shifted awareness but has not yet achieved the community-wide consensus needed to end the practice.
- The project's limited reach was a recurring concern. Too few community members were selected as participants, leaving large portions of the population unaware of its activities. Additionally, some parents actively prevented their children from attending, and opposition from certain imams and traditionalists further constrained engagement — pointing to the need for broader community inclusion and sustained dialogue with gatekeepers.

Niger

- The Foundations project produced a visible increase in adolescent SRH knowledge and health-seeking behaviour across rounds, with even younger adolescents demonstrating detailed understanding of puberty, contraception, FGM, and child marriage by the final round — knowledge they consistently attributed to the project.
- Adolescent agency grew significantly over the study period. By Round 3, some girls were refusing forced marriages, filing formal complaints, and accessing family planning independently, while boys were actively sharing SRH information with peers through self-organised discussion groups.

- Parent–child communication on SRH improved substantially, particularly among mothers, who shifted from silence and shame to open dialogue and discreet accompaniment of children to health centres. However, fathers remained largely disengaged from SRH conversations with daughters, limiting the reach of normative change within the household.
- Contraceptive access for unmarried adolescent girls emerged as the most contested norm. Husbands, fathers, and community leaders — and even some mentors — viewed it as encouraging promiscuity and transgressing religious values, revealing a significant gap between project messaging and community acceptance.
- FGM persists in a reframed form, described as a medical response to perceived "clitoral deformity" rather than a cultural practice. This reframing suggests that awareness-raising has shifted the language around FGM but has not yet eliminated the practice itself, and the topic remains resistant to open discussion.

Sierra Leone

- Adolescents in Sierra Leone demonstrated some of the strongest behavioural shifts across the study, including uptake of modern contraceptives, delayed sexual activity, improved menstrual hygiene, and — among girls in particular — a growing ability to articulate how patriarchal structures shape gendered blame around pregnancy and sexual behaviour.
- The project catalysed meaningful change among parents and religious leaders. Mothers moved from punitive to communicative parenting on SRH issues, while imams who had previously preached against contraception reversed their position after attending project workshops — a particularly significant shift in a context where religious authority shapes community norms.
- Despite these gains, a persistent gender imbalance in programming left boys with less knowledge and engagement than girls. Boys themselves, as well as community stakeholders, flagged this gap, noting that boys' limited involvement perpetuates harmful behaviours — including pressuring girls to remove contraceptives — that undermine the project's impact on girls.
- FGM was reduced but not abolished. The community adopted an age threshold — restricting initiation to girls over 18 — reflecting a harm-reduction approach rather than the elimination of the practice. The framing of FGM as sensitive and confidential ("what is discussed in the safe spaces should remain there") suggests that open community-level dialogue on the practice remains limited.
- The absence of adolescent-friendly centres in the community and recurrent stockouts of family planning commodities at health facilities were identified consistently across all

respondent groups as the most critical structural barriers to sustaining gains. Adolescents themselves advocated strongly for dedicated safe spaces for confidential learning and service access.

Recommendations

Overall the findings from the three rounds of audio diary data collection point to the following programming implications. Our recommendations are targeted to Save the Children country offices and their implementing partners, understanding that the Foundations project is in its last stage of implementation and seeking to identify areas where shifts or strengthening in programming can shape results for adolescents.

Mali

1. **Scale the father-engagement model.** Mali's success in getting fathers to communicate directly with daughters about SRH is a distinctive achievement that should be deepened in the final phase. The programme should document this approach — including the specific training content and facilitation methods used — and expand it to reach more fathers, particularly in communities where opposition remains strong, and even expand the approach to other Foundations countries.

2. **Directly counter persistent misinformation about ASRH among adolescents.** The finding that adolescents themselves have internalised harmful beliefs (boys believing contraception damages organs, girls accepting FGM as necessary for marriage) suggests that information delivery alone is not breaking through, or that there are problems when information is being shared. The final phase should introduce interactive, myth-busting formats — such as guided debates, testimonials from health workers, or Q&A sessions with trusted health workers— that allow adolescents to voice and interrogate these beliefs in a supported setting.

3. **Broaden community reach beyond direct participants.** Fathers and community leaders consistently noted that too few people were selected, leaving most of the community unaware of the project. The final phase should consider lighter-touch community-wide activities — public information sessions, radio messaging, or community dialogue events — that extend awareness beyond the direct participant group without requiring full project enrolment.

4. **Engage resistant religious and traditional leaders through dialogue rather than confrontation.** Some imams and traditionalists openly opposed the programme, and some parents prevented children from attending as a result. Rather than bypassing these figures, the final phase should seek structured dialogue with them — potentially facilitated by

community leaders already supportive of the programme — to understand their specific objections and find areas of common ground, particularly around child marriage and education.

5. **Increase session frequency for boys and ensure parity with girls' programming.** Boys themselves flagged that they receive fewer sessions, and the data shows that boys' knowledge and attitudinal shifts lag behind girls'. Equalising the dosage of project sessions and ensuring boys' content addresses the specific norms they hold (opposition to family planning, justification of FGM) is critical for the programme's final phase.

Niger

1. **Intensify engagement with mentors on contraceptive access for unmarried girls.** Mentors themselves were not fully aligned with project messaging on this issue. The final phase of the project should include dedicated sessions with mentors to address their own reservations, equip them with responses to community pushback, and ensure they can deliver consistent, rights-based messaging to diverse adolescents – married and unmarried.

2. **Design targeted activities for fathers.** Fathers' near-total disengagement from SRH conversations with daughters and some sons is a bottleneck for norm change at the household level. Short, structured sessions — potentially facilitated by male mentors or community leaders already sympathetic to the project — could create entry points for father–adolescent communication, building on the approach that proved effective in Mali. Targeted sessions with fathers only as well as inter-generational sessions should be trialed.

3. **Address the medicalisation of FGM directly.** The reframing of FGM as a response to "clitoral deformity" allows the practice to continue unchallenged. The Foundations project should work with health workers and community health committees to explicitly name and counter this reframing, clarifying that routine inspection of girls' genitalia by barbers is itself a form of gender-based violence. In line with a rights-based framing, a zero tolerance approach should be clearly communicated by all project staff and partners.

4. **Reduce disparities between sites by strengthening mentor support in Magaria.** Adolescents in the more remote site consistently showed lower knowledge and engagement, partly due to less proactive mentors. The final phase should prioritise additional mentoring, supervision, and refresher training in underperforming sites to close this gap, as well as knowledge sharing sessions to reflect on promising practices from sites with more demonstrable impacts.

5. **Create structured peer-sharing activities.** Adolescents are already forming informal discussion groups to share what they have learned. The programme should formalise and support this by providing simple facilitation guides or discussion prompts that peer groups

can use, extending the programme's reach to non-participants without requiring additional staff. Providing small low-cost incentives such as certificates for participation could also be considered to increase participation rates.

Sierra Leone

1. **Expand programming for boys as a matter of urgency.** The gender imbalance in programming was flagged by every respondent group — boys, girls, parents, and community stakeholders. Boys' limited engagement directly undermines gains among girls (e.g., boys pressuring girls to remove contraceptives). The final phase should increase the frequency and depth of boys' sessions and ensure content addresses masculinities, consent, and shared responsibility for ASRH. Providing targeted refresher training to mentors for boys' sessions would also be advisable.

2. **Advocate for and support the establishment of adolescent-friendly spaces in the community.** This was the single most consistent recommendation from adolescents and adults alike. Even if permanent centres are beyond the programme's scope, the final phase could pilot designated hours or spaces within existing health facilities or community buildings where adolescents can access services and peer discussion confidentially. It will be important to ensure that such spaces are equally accessible and appealing to girls and boys, including possibly separate hours.

3. **Coordinate with health supply chains to reduce commodity stockouts.** Gains in contraceptive uptake are undermined when adolescents visit health facilities and find nothing available. The programme should engage district health management teams to flag facilities serving programme communities for priority restocking, particularly for condoms, implants and other long-acting methods that adolescents prefer. Feedback mechanisms where adolescents can flag stock-outs in a confidential and anonymous way would be useful to institutionalize and raise awareness about.

4. **Sustain and deepen engagement with religious leaders.** The shift among imams — from opposing contraception to actively preaching its acceptability — is one of the project's most significant achievements. The final phase should consolidate this by organising follow-up dialogues with religious leaders, potentially pairing supportive imams with those still resistant, and documenting their testimonies for use in other communities.

5. **Address the harm-reduction framing of FGM.** The community's convergence on an age threshold (over 18) for FGM does not promote elimination of the practice, and overlooks the fact that entrenched social norms condone this violation of female bodily integrity. Programming should work with the existing community taskforce to move the conversation away from age restrictions toward a broader discussion of bodily autonomy and the health

risks of FGM at any age, using the deaths that catalysed the taskforce as a locally resonant reference point.

Overall Recommendations

1. **Adopt a multi-stakeholder approach to tackle the most resistant norms.** The findings show clearly that norm change on contraceptive access for unmarried girls and FGM cannot be achieved by working with adolescents alone. The final implementation phase should ensure that every community has structured, ongoing engagement with fathers, husbands, religious leaders, and community authorities on these specific issues — not as one-off sensitisation events, but as repeated dialogues that allow positions to evolve over time.

2. **Rebalance programming to close the gender gap in boys' participation.** Across all three countries, insufficient engagement of boys emerged as a systemic weakness that limits the programme's overall impact. The final phase should treat boys' programming not as a secondary component but as an equal priority, with content that addresses masculinities, consent, shared responsibility, and the specific misinformation boys hold about contraception and FGM.

3. **Strengthen mentor quality and value alignment through ongoing supervision and refresher training.** Mentor inconsistency — in knowledge, proactivity, and alignment with project messages — was a recurring finding across countries and rounds. The final phase should institute regular check-ins, refresher sessions focused on the most contested topics (unmarried girls' contraceptive access, FGM), and a simple supervision mechanism to identify and support underperforming mentors (including through exposure to promising practices from other sites or countries) before disparities between sites widen further.

4. **Invest in sustainability mechanisms that outlast the project.** Adolescent peer-sharing groups, community taskforces, and supportive religious leaders represent organic structures that could carry programme gains forward. The final phase should actively identify, equip, and connect these local actors — providing them with materials, facilitation support, and links to health services — so that the project leaves behind functioning local capacity rather than dependence on external delivery.

5. **Strengthen coordination with health systems to ensure supply meets the demand the project is creating.** It is counterproductive to encourage adolescents to seek SRH services if facilities lack commodities, trained staff, or adolescent-friendly protocols. While the project has supported strengthening of health systems for adolescent responsiveness around SRH, the final phase should increase coordination with district health authorities – and perhaps other NGOs such as Marie Stopes - to ensure that health facilities in project communities

are adequately stocked and that health workers are equipped to serve adolescents without judgment — turning the programme's demand-side gains into actual service uptake.