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Save the Children

Health Services Research Report

FOUNDATIONS PROJECT QUALITATIVE RESEARCH

gage GENDER & ADOLESCENCE: GLOBAL EVIDENCE

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Acronyms

ANC/PNC – Antenatal Care / Postnatal Care
ASDAP – Association de Soutien au Développement des Activités de Population
ASRH – Adolescent Sexual and Reproductive Health
ASRHR – Adolescent Sexual and Reproductive Health and Rights
CSCOM – Community health centres (Centres de Santé Communautaire)
CSREF – Centre de Santé de Référence (district referral health centre)
CSI – Centre de Santé Intégré (Integrated Health Centre)
FGM/C – Female Genital Mutilation / Cutting
GBV – Gender based violence
HIV – Human Immunodeficiency Virus
HPV – Human Papillomavirus
IMC – International Medical Corps
IUD – Intrauterine device
NGO – Non government organisations
PAC – Post-abortion care
PNP – National Population Policy
RMNCAH – Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG – Sustainable development goals
SRH – Sexual and reproductive health
SRHR – Sexual and reproductive health and rights
SSRAJ – Santé sexuelle et reproductive des adolescents et des jeunes (adolescent and youth sexual and reproductive health)
STI / STD – Sexually transmitted infection / disease
UNDP – United Nations Development Programme
UNFPA – United Nations Population Fund
UNICEF – United Nations Children's Fund
WASH – Water, sanitation and hygiene
WHO – World Health Organisation

Introduction

Progress towards Sustainable Development Goals 3 and 5 in West Africa has been uneven and constrained by structural, socioeconomic, and gender-based inequalities, raising serious concerns about the region's ability to achieve improved health outcomes and gender equality by 2030. The United Nations Development Programme's Africa Sustainable Development Report 2025 outlines that the factors affecting the attainment of SDG 3 include disparities in access to health services, inadequate infrastructure, shortage of healthcare professionals, limited access to essential medicine and diagnostics, conflict, and limited public health expenditure (United Nations Economic Commission for Africa et al., 2025). This is in many ways accentuated by the gaps in attaining SDG 5 that warrants a holistic approach to gender equality. Discriminatory laws and social norms pose significant barriers for women accessing resources and opportunities, including access to health care, especially sexual and reproductive health services (United Nations Economic Commission for Africa et al., 2025).

Despite these challenges, governments across West Africa have taken notable steps to address structural weaknesses and strengthen health systems and gender-responsive service delivery. The UNDP SDG Dashboard indicates that Sierra Leone is on track to achieve universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes. In the 2017 baseline year, 44.7% of women and girls aged 15–49 had their demand for family planning satisfied with modern methods (UNDP SDG Diagnostics Dashboard, Sierra Leone). Additionally, the Sierra Leone government has made significant progress towards improving and fortifying health care access and services. The *National Health Compact 2025* highlights that the government is committed to 'expediate the realization of Universal Health Coverage', by upgrading primary health care facilities, investing in expanding and training healthcare professionals, improving access to water, sanitation and hygiene (WASH) facilities, essential commodities and equipment. One of the key reforms that the Compact targets is to integrate training modules on SRHS and GBV response into the continuous training and certification for community health workers and primary health staff (World Bank, 2025).

According to the UNDP SDG dashboard, Mali has shown limited progress in maternal mortality, which stood at 490 deaths per 100,000 live births in the base year 2015. Similarly, the under-five mortality rate was 116 per 1,000 live births in the same year. Furthermore, the proportion of women aged 15–49 who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care declined by 5.3% in 2019, indicating that Mali remains off track in this area (UNDP SDG Diagnostics Dashboard, Mali). However, programmes such as the *Roadmap on Gender, Elections and Reforms*, implemented in 2024 by the Malian government in collaboration with UN Women, have been working to make a difference.. The intervention seeks to strengthen women's participation in political and administrative decision-making by targeting a 30% increase in women's representation at political and administrative levels (United Nations Sustainable Development Group, 2024).

Niger faces some of the most severe adolescent sexual and reproductive health (SRH) challenges globally, shaped by extremely high rates of early marriage, adolescent pregnancy, and persistent barriers to youth-responsive services. Adolescents and young people aged 10–24 constitute around one-third of the population, placing their health and wellbeing at the centre of Niger's human capital and demographic transition agenda (Barrow, et al, 2016). Yet a large majority of girls are married before age 18, many before age 15, exposing them to early and repeated pregnancies and contributing substantially to maternal morbidity and mortality (Barroy, et al, 2016; Mengjia et al., 2019). Despite these structural challenges, Niger has made notable—though uneven—progress in reducing maternal and child mortality. The maternal mortality ratio declined by an estimated 50 percent between 2000 and 2020, alongside reductions in

neonatal and under-five mortality, largely due to expanded coverage of key maternal and newborn health interventions (Kanté et al., 2024). These gains reflect improvements in health programmes rather than shifts in fertility patterns, which remain characterised by very high total fertility and adolescent birth rates; neonatal mortality, in particular, has stalled in recent years (Kanté et al., 2024).

Policy and legal reforms in the early 2020a signalled growing political commitment to addressing adolescent SRH and gender inequality. The government adopted strategies that explicitly prioritise adolescents, including a National Plan for Adolescent Sexual and Reproductive Health and family planning initiatives aimed at expanding access to modern contraception, strengthening youth-friendly services, and addressing harmful social norms (African Women's Development and Communication Network, 2022). Legal reforms reduced institutional barriers by allowing married adolescent girls to access family planning services without parental or spousal accompaniment (Silverman et al., 2025), and by expanding school health clubs that provide comprehensive, scientifically grounded reproductive health information to support pregnancy prevention and school retention (African Women's Development and Communication Network, 2022). Nevertheless, gaps in service quality, accessibility, and adolescent-responsive design persist. However, the 2023 military coup and subsequent regional sanctions have further disrupted public services and external assistance, including programmes supporting adolescent health and education. The suspension or withdrawal of some donors has weakened oversight and slowed implementation of gender and SRHR reforms, despite these remaining formally in place. In insecure areas, particularly those under the influence of extremist groups, restrictive gender norms and limitations on women's public participation further constrain adolescents' access to SRH information, services, and community-level interventions (Crisis Group, 2024).

Aim and objectives

The aim of this report is to assess adolescents' uptake of and satisfaction with SRH services, including what aspects of current service provisioning are working well, what the barriers and challenges are and implications for the Foundations project's adaptive programming. This research component focuses on exploring the results of the support of the Foundations project to health services in the three project countries (Mali, Niger and Sierra Leone). It presents analysis of research conducted with health officials at the national, district and community level through local health centres and health officials. It looks specifically at the extent to which the services provided by health centres are adolescent and youth-friendly, as well as gender responsive.

Structure of the report

The report includes an overview of the methodology and sample used for the research. It is followed by country focused sections for Mali, Niger and Sierra Leone where research findings and country-specific recommendations are made. Lastly, overarching cross country conclusions and recommendations are presented at the end of the report.

Methods and sample

The health services workstream formed a complementary qualitative component of the quantitative health services research conducted by SickKids to explore advances in the Foundations project's contributions to sexual and reproductive health service provision for adolescents aged 10 to 19. In the three countries, qualitative research teams conducted in-depth interviews with 60 adolescents and 24 health service providers to explore which aspects of current sexual and health service provision are working well, the barriers and challenges encountered, and the implications for the Foundations project's adaptive programming. In particular, the research examined the extent to which health services are adolescent- and youth-friendly, as well as gender responsive. The study employed an exploratory qualitative design and was conducted in Mali, Niger and Sierra Leone in the period between May and August 2025.

In each country, three health centres were purposively selected: two that had participated in the Foundations project and one comparison or control facility not supported by the Foundations project, but which could have other types of services supporting ASRH including government and NGO services.

Data were collected from both the supply and demand sides of SRH service provision. Supply-side data were gathered in all three countries through in-depth interviews with national- and district-level health officials and with health facility staff responsible for adolescent and youth SRH services. These interviews explored providers' roles, available services, referral mechanisms, perceived strengths and gaps in service delivery, and recommendations for improving adolescent access and uptake. In addition, structured observation was conducted in each selected health centre using a standardised checklist to assess adolescent-friendly and gender-responsive service standards of the centre.

The demand side data was collected in Sierra Leone and Mali through in-depth interviews with thirty adolescent service users from each country. Participants included married and unmarried adolescents who had sought SRH services for a range of reasons, including contraceptive counselling, abortion care (where legal), HIV (Human Immunodeficiency Virus) testing and treatment, sexual violence survivor care, management of Female Genital Mutilation (FGM)-related complications, pre-marital genetic counselling (where relevant), and antenatal, maternity and post-natal care. Interviews focused on experiences of service access, perceived provider attitudes, satisfaction with service quality, follow-up care, and adolescents' recommendations for strengthening service uptake. Interviews with adolescents were not conducted in Niger given budget limitations.

Health facilities were selected purposively based on Foundations project participation and comparability. Adolescents were recruited through a combination of snowball sampling via Save the Children and partner organisations and facility-based recruitment, whereby adolescents attending health centres over a two-week period were informed about the study through flyers and invited to participate voluntarily. All interviews were audio-recorded with consent, transcribed verbatim and translated into English where necessary. The interview transcripts were then thematically coded using MAXQDA software and analysed based on a comprehensive codebook developed for the health services intervention.

Ethical approval was obtained in each study country from nationally accredited ethics boards. Informed consent was obtained from all participants, with assent and guardian consent procedures applied for minors in accordance with national guidelines. Confidentiality and anonymity were ensured throughout, and safeguarding and referral protocols were in place for participants disclosing sensitive experiences.

Table 1: Sample size

Respondent	Mali	Niger	Sierra Leone
National level / Ministry of Health (Department head working on ASRH)	1	1	1
District bureau of Health	1	1	1
Healthcare provider interviews	3	3	3
Facility observations	3	3	3
Adolescent girls service users	18	0	18
Adolescent boy service users	12	0	12
Total number of interviews	**38**	**8**	**38**

Limitations

The health services study encountered the following limitations:

- The limited budget available for this qualitative study meant that it was not possible to conduct data collection with adolescents in all three countries, reason for which data collection in Niger focused on health service providers and health centre observations.
- While there was an initial aim to triangulate qualitative findings from this study with quantitative findings from the SickKids study, given that both studies were conducted simultaneously, triangulation was done through exchanges of preliminary findings by research teams only, yet some insights from the quantitative research informed the qualitative analysis.
- Research teams on the ground initially found it difficult to identify adolescent respondents who had sought ASRH services in health centres without breaching confidentiality or exposing them in the community. Working with Save the Children local teams, it was possible to mobilize the necessary respondents without putting them at risk.

Findings

Mali

Knowledge and implementation of legislation and policies around ASRH

District health authorities in Koutiala (project sites) and Bougouni (control site) report good awareness of national adolescent sexual and reproductive health (ASRH) policy, particularly at CSREF (*Centre de Santé de Référence*, or district referral health centre), level. Respondents are able to cite key elements such as international SSRAJ norms, adolescents' rights to information and health, and the requirement to create adolescent-friendly spaces within health facilities. In Bougouni, authorities also explicitly link ASRH to the National Population Policy (PNP) and to national norms and procedures guiding what providers should and should not do to promote adolescent sexual and reproductive health (SRH). Additionally, there is a relevant circular letter number 003205/04 from October 2019 relating to the creation of spaces dedicated to adolescents and young people in all public health structures. The Foundations Project is supporting its roll out with 30 spaces for adolescents equipped to date.

The Foundations project has supported and continues to support health centres in its impact area for the creation of species dedicated to the care of adolescents. To date, the project has equipped more than 30 rooms dedicated to adolescents

In both districts, authorities state that the policy is implemented in principle, with recognition of adolescents' rights to information and care. However, they emphasise that service quality and effective adaptation for adolescents remain limited. In Koutiala, officials note that Mali still lacks properly adapted adolescent consultation areas. In Bougouni, respondents highlight long waiting times, overburdened staff, and the absence of adolescent-specific rooms, which hamper providers' ability to deliver confidential, age-tailored care.

Capacity-building on ASRH is described by authorities as largely project-driven. In Koutiala, the Foundations project provides targeted training and follow-up on SSRAJ (*santé sexuelle et reproductive des adolescents et des jeunes* or adolescent and youth sexual and reproductive health) quality of care, while routine government trainings generally include only a brief SRH module. In Bougouni, respondents did not identify specialised ASRH capacity-building and sometimes conflate population policy awareness with provider training. This is indicative of important constraints in broader health system capacity and the reliance on NGO support to develop relevant capacities among staff.

Implementation and support by other partners

In Koutiala, district respondents describe a relatively dense landscape of partners supporting ASRH, including the Foundations project, the Association de Soutien au Développement des Activités de Population (ASDAP), ONG Dambe and UNICEF. These actors work in different villages and contribute to different aspects of SRH, GBV prevention and adolescent-friendly service delivery through community based approaches. The Foundations project is consistently described as a central actor, equipping Reference Health Centres (CSRrfs for their name in French) and the community health centres (CSCOMs for their name in French) training providers, supporting supervision on quality of care, and delivering SRH information through schools and community activities.

In Bougouni district, authorities mention Dambe, Santé Monde and International Medical Corps (IMC) working with adolescents at community level, mainly through discussion sessions on puberty. However, these activities do not cover Kléssokoro (the control research site in Bougouni district), and district

authorities report no awareness of the Foundations project´s work, which is understandable as the project is not implemented in the district.

Across districts, respondents emphasise that few initiatives are truly adolescent-specific. Several partners are described as focusing on SRH in general, education, or GBV rather than offering comprehensive ASRH. This reinforces reliance on a small number of external partners, with limited institutionalisation of ASRH within district health systems.

Barriers to implementation

District officials in Koutiala highlight strong socio-cultural resistance as a major barrier. Community members often misunderstand ASRH initiatives, perceiving them as encouraging sexual permissiveness. Confusion between GBV programming and broader initiatives on gender equality and empowerment further complicates acceptance. Fear of stigma and reprisal also suppresses reporting of GBV and SRH concerns, limiting institutional response.

Behavioural and systemic challenges further undermine implementation. Authorities point to adolescents' sexual activity and early pregnancy in contexts where community opposition to contraception restricts access despite service availability. Weak communication between adolescents, families and providers persists. Project-based trainings are also weakened by frequent staff transfers and limited involvement of district ASRH focal points, reducing continuity and ownership.

Adolescent-inclusive health service provision

Table 2 below presents findings from the checklist filled out on the basis of services available at the health centres in Mali, the three locations, both through observations and brief interviews with health service providers. In the intervention region of Koutiala, the research team visited one CSREF, as well as one CSCOM in Sincina and one CSCOM in Mpessoba, both of which are Foundation Project intervention sites. In the contol region of Bougouni the research team visited one CSREF, and then one CSCOM in Klessokoro.

Table 2: Mali health centre checklist

Domain	Mpessoba (Project/Remote)	Sincina (Project/Proximate)	Klessokoro (Control/Remote)
Services offered to adolescents	The facility provides family planning counselling, SRH awareness in schools and communities, HIV/STD (Sexually transmitted disease) screening, post-abortion care, and GBV referrals.	The facility offers family planning counselling, SRH awareness, HIV/STD screening, HPV vaccination, GBV referrals, and FGM follow-up.	The facility offers family planning counselling, SRH awareness, and HIV/STD screening.
Services NOT provided	Limited flyers, no adolescent-specific privacy, and no online SRHR (sexual and reproductive	Lack of privacy, or confidentiality training.	The facility does not offer disability inclusive services, or

	health and rights) information.		IPV/GBV referral documentation.
Staff attitudes	Staff are friendly and trained, but confidentiality training is limited.	The midwife ("kanoubaga dogole") is friendly but no confidentiality training is provided.	Staff are friendly, but trainees often replace regular staff and confidentiality training is missing.
Privacy/confidentiality	No separate space/facility for adolescents; confidentiality is practiced by providers.	No privacy; personal data handled publicly; confidentiality is practiced by providers yet midwives/trainees were noted as not being discreet	There is no separate room/facility for adolescents and staff are not trained in confidentiality.
Awareness raising	Awareness is raised through posters and school and community discussions.	Awareness uses posters and picture boxes led by community leaders.	Very limited with lack of posters, flyers or door-to-door campaigns
Information availability	Some brochures; tools in French but delivered in local languages	Picture-based tools; virtual SRH platform planned	Lack of information availability online and offline
Disability accessibility	Stairs but no ramps; sign-language via gestures	Handrails in some blocks; but communication barriers severe	No ramps; no materials
Product availability	A full range of products is offered, though occasional shortages occur.	Full range but support from MSI has ended.	IUDs (Intrauterine device) are unavailable, and injectables and pills are often out of stock.
Referral systems	GBV focal point that can make referrals. Maintains records of the referrals made.	The facility collaborates with NGOs for referrals, including to the NGO l'Association des Jeunes pour la Citoyenneté Active et la Démocratie (AJCAD) and to one-stop centres.	No GBV case-handling allowed; no referral records
Feedback mechanisms	Feedback is collected by phone.	Feedback is also collected by phone.	There is no feedback system.

As can be seen in Table 2, the three health centres show broad similarities in the types of ASRH services offered in principle, but there are clear qualitative differences in how these services are delivered and used, particularly between project and control sites. Both Mpessoba and Sincina (project sites) provide a wider and more consistently supported package of services, including family planning, HIV/STI (sexually transmitted infection) screening, SRH awareness activities and (Gender based violence) referrals, with Sincina additionally offering the HPV vaccination and providing support when FGM procedures have caused infection or haemorraghing. In contrast, Klessokoro (control site) offers a more limited service package, with notable gaps with regard to GBV referral mechanisms, disability inclusion and product availability. Across all sites, weaknesses in privacy, confidentiality and adolescent-specific spaces persist, but these are more acute in the control site, where staff have received minimal training. “Hotlines” are available in the two project sites where feedback is collected via phone. There is not such mechanism available in the control site. The most salient difference across sites is not service availability per se, but demand and effective utilisation: in Mpessoba and Sincina, Foundations-supported sensitisation of adolescents, parents and communities appears to have stimulated health-seeking behaviour, while in Klessokoro demand remains low, reflecting limited awareness-raising, weaker community engagement and more fragile referral and follow-up systems.

Health service provision and quality of care

Across the project sites of Sincina and Mpessoba, adolescents and providers describe a gradual normalisation of adolescents’ presence in health facilities for SRH-related concerns. While observations at the health centres noted that no separate spaces for adolescents and that some information and documentation is not always treated discrtetely, adolescents interviewed mentioned that they perceived that health service providers treaterd their consultations confidentially, and that respectful care and gender-equitable messaging is evident. These changes are far less visible in the control site of Kléssokoro.

In project sites, adolescent girls and boys report that providers are welcoming, attentive and respectful. Consultations are described as confidential, with staff listening carefully and providing clear explanations. Adolescents feel more comfortable seeking care as a result. Older married adolescents in Sincina also underline that mentors and health workers now provide detailed information on contraception, birth spacing, consent and violence, and that staff keep discussions confidential, which encourages adolescent girls to seek services jointly with their husbands.

Providers report adjusting service organisation to better respond to adolescent needs, including guided facility visits, dedicated counselling time, and assigning female staff for adolescent SRH consultations. Adolescents report receiving information on puberty, menstrual hygiene, contraception, infections and GBV.

“There is improved quality of ASRH services thanks to knowledge gained through the Foundations project’s training; consultations for adolescents are no longer done in the same way as for adults, and providers now take more time with them.” (Health service provider, Mpessoba)

In Kléssokoro, adolescents mainly experience respectful curative care but do not view providers as a routine source of SRH information. Health workers acknowledge constraints related to space and staffing that limit adolescent-friendly service delivery.

Barriers and limitations to service delivery

Across sites, providers highlight structural constraints, including lack of adolescent-specific consultation rooms, overcrowding and insufficient human resources. Adolescents queue alongside adults, which exposes them to judgement and undermines confidentiality.

Routine capacity-building remains limited: SSRAJ content is often confined to small modules within broader trainings, with no systematic stand-alone ASRH training outside Foundations-project supported activities.

According to adolescents and health providers interviewed in project sites, school-going adolescents benefit most from programming, while there are still many out of-school adolescents that are not reached by the community level programmes such as Girl Shine. In the control site, adolescents report almost no structured ASRH information or adolescent-specific services, even when pregnancy complications occur.

Adolescent attitudes and health-seeking behaviour

In intervention areas, older adolescents boys and girls increasingly recognise health centres as legitimate spaces for SRH information and services. Guided visits and repeated sessions have reduced fear and shame, particularly among younger unmarried girls.

"There is improved quality of ASRH services thanks to knowledge gained through the Foundations training; consultations for adolescents are no longer done in the same way as for adults, and providers now take more time with them." (Health service provider, Mpessoba)

Older adolescent girls report seeking information on pregnancy prevention and menstrual hygiene, and some use contraception or emergency contraception. Adolescent boys describe greater willingness to accompany partners to services and support girls facing unintended pregnancy, though they less frequently seek SRH care themselves.

"The practical demonstrations of family planning methods, especially condoms, were very useful." (Unmarried adolescent girl, single, 15–18, Sincina)

"Health centre visits were the most useful because we learned about all contraceptive methods, including condoms and IUDs." (Adolescent boy, 15–18, Mpessoba)

In the control site, however, adolescents' were generally not aware of health centres as safe places to seek information and services related to ASRH, so their use by adolescents was limited.

"Adolescent girls rarely come to the health centre for family planning; they feel ashamed and prefer to go through a traditional midwife, obtaining information indirectly from her." (Health service provider, Klessokoro)

Puberty and menstrual hygiene management

Substantial gains in knowledge about puberty and menstrual hygiene are reported in project sites. Girls describe improved practices, including more frequent changing, washing with soap, and sun-drying materials. Boys report learning about their own pubertal changes and the importance of responsible sexual behaviour.

"Even before my first menstruation, we were told that we must change three times a day—morning, midday and evening—and that we must wash our cloths with soap and dry them in the sun. ." (Unmarried adolescent girl, 15–18, Sincina)

"Before, I did not change menstrual cloths three times a day or dry them in the sun. Now I do, and I have adopted proper menstrual hygiene like many of my friends." (Younger adolescent girl, 10–14, Sincina)

"Health workers are more qualified on these issues than the school. At school, we were not taught how to wash our underwear (menstrual management), which is something that was explained at the health centre." (Younger adolescent, 10-14, Sincina).

Nevertheless, even if in project sites where there have been important knowledge gains around menstrual hygiene management, some interviews uncovered some elements of misinformation resulting from entrenched social norms, cultural beliefs and historically limited school-based SRH instruction, among other reasons. For instance, some girls still believe that men can get an infection if they have intercourse with a woman who is menstruating, so it is important to continue monitoring messaging to ensure that misinformation is dispelled and that adolescent girls have the correct information improve both their overall and their sexual and reproductove health.

Contraception, child marriage and abortion

In project sites, married adolescent girls and some unmarried older girls identify contraception and birth spacing as important strategies that they have learned about through the Foundations programming, particularly in health centres. Adolescents demonstrate increased awareness of methods and risks of unsafe abortion, though stigma by parents and community members remains strong.

"You can protect yourself against diseases by going to the health centre. There is a method called 'allumeti kissèni', which means matchsticks (implants). It prevents unwanted pregnancies, as do condoms. For me, the benefit is not being the cause of a pregnancy that a girl does not want." (Adolescent boy, 15–18, Sincina)

"Many girls now manage menstrual hygiene properly and protect themselves from unwanted pregnancies through planning or emergency contraception." (Younger adolescent girl, 10–14, Sincina)

In Kléssokoro, some older adolescent girls describe coping with unintended pregnancy through unsafe abortion or concealing pregnancy and avoiding antenatal care, reflecting limited engagement with the health system for SRH.

"In our community, even if a girl becomes pregnant at an early age, she aborts using toxic products that are harmful to her health. Those who cannot manage to abort keep the pregnancy but do not attend antenatal care; some even leave the village and only return after giving birth." (Married adolescent girl, 15-18, Klessokoro)

Shifts in parental attitudes

Some gradual shifts are reported, particularly among parents and husbands exposed to project messaging. Married girls describe greater spousal support for contraceptive decision-making. However, resistance persists, especially regarding sexuality education for unmarried girls and contraception, particularly before marriage.

"Many adolescents fear going to health centres because family planning is seen as encouraging immorality." (Younger adolescent girl, 10–14, Sincina)

"Girls are ashamed to seek sexual and reproductive health information at the health centre for fear of criticism." (Adolescent boy, 10–14, Sincina)

"Parents prevent girls from seeking information about sexuality because they view health centres negatively." (Adolescent boy, 10–14, Sincina)

Broader social and behavioural changes

As a result of Foundations project sensitization, adolescents report reduced harassment, improved peer relations, and greater respect for girls, including understanding of women's right to consent to sexual

intercourse with their husbands . Many describe acting as peer educators, sharing information on SRH, GBV, consent and hygiene.

"Before, boys forced girls and committed acts of sexual violence. Thanks to the Foundations project's sessions, these practices have changed." (Adolescent boys, 15–18, Sincina)

"When boys play with girls, they may desire one of them. If they cannot control themselves, they may have sexual intercourse with her. That is why we were told to stop playing with girls..... If she becomes pregnant, her parents may expel her from the home, which can even lead her to think about suicide." (Adolescent boy, 10–14, Sincina)

"Even if a girl provokes you, as a man you must control yourself. If you see a man forcing a girl to do something she does not want, you should advise him to change his behaviour." (Adolescent boy, 10–14, Mbpessoba)

"Before, I touched girls inappropriately, thinking it was normal. After the Foundations project's sensitisation, I stopped, and my friends changed too." (Adolescent boy, 15–18, Mbpessoba)

Adolescent boys are increasingly exposed to messages about equality and non-violence which they are starting to embrace.

"I understood that men can work and women can also work like men. I used to think that the man was the only head of the household and that whatever he said was final…when a woman works, it reduces household expenses. When she does not work, the man bears all the expenses alone, which is difficult." (Adolescent boy, 15–18, Mbpessoba)

"Mockery of boys doing 'girls' work' has decreased, and we understand that both men and women can do the same work." (Adolescent boy, 15–18, Sincina)

Nevertheless, they operate in peer environments where harassment, unwanted touching and pressure on girls are common and sometimes socially rewarded, showing the limits of attitude change in peer groups. Boys also note that norms around male dominance in decision-making and reluctance to engage in "women's work" persist, with those who share domestic tasks sometimes mocked by peers and older men.

"*Some boys have not changed and continue to harass girls despite advice from parents and teachers."* (Adolescent boy, 15–18, Mpessoba)

"Some men now help with cooking or allow their wives to work, while others still believe a woman's place is only in the home." (Adolescent boy, 15–18, Mpessoba)

Both married and unmarried adolescents in Sincina and Mpessoba highlight improved communication within couples and families, with some married girls reporting that they now openly discuss contraceptive choices and relationship issues with husbands and in-laws. Many adolescents—girls and boys—also describe gaining confidence to act as peer educators, sharing information on puberty, menstrual hygiene, consent, contraception and violence with friends, siblings and neighbours. This confidence building that enables adolescents to talk to their peers is one of the elements that the Foundations project supports through its community level work.

"Before, I did not discuss my marital life. After participating in the project, I asked my husband to accompany me to the health centre, and he understood that I was not at fault. Now we communicate more, and he supports family planning decisions." (Married adolescent girl, 15–18, Sincina)

"Before, I was ashamed to communicate with my family, but now I talk openly with my parents, my husband, health workers, and project staff." (Married adolescent girl, 15–18, Sincina)

"Thanks to the Foundations project's activities, I introduced three people who adopted proper menstrual hygiene and family planning." (Unmarried adolescent girl, 15–18, Sincina)

Pervasive adverse social norms

Across all sites, deeply entrenched norms around gender roles, sexual behaviour and marital obligations continue to shape adolescents' attitudes and choices, often undermining the programme's more progressive messages. Girls—particularly married girls and older unmarried girls—describe persistent expectations that wives must not refuse sex and that girls should accept men's advances to preserve harmony and avoid blame, even when they personally endorse concepts of consent learned through the programme.

*"For me, what is important is to ask for the woman's consent; that is what is respectful and what is also good for the woman. Because if you force her, she can become ill as a result of that violence." (*Married adolescent girl, 15–18, Sincina)

"This is something I did not know, because we are used to hearing that once married, a woman must not refuse her husband in bed." (Unmarried adolescent girl, 15–18, Mbpessoba)

"Awareness-raising helped men understand the importance of consent, and many now ask their wives for consent." (Adolescent girl, 15–18, Sincina)

Still, several adolescents and health workers identify consent within marriage as a domain where beliefs have largely "not changed," despite programme messaging on bodily integrity.

"The husband must have the woman's consent; this is not taught at school or in the community. In the community, it is said that a woman must obey her husband and must not refuse his sexual advances." (Younger adolescent girl, 10–14, Sincina)

Unmarried girls highlight ongoing stigma around contraceptive use, with family planning commonly framed as encouraging adultery or promiscuity; even married women often feel compelled to use contraception discreetly. Younger girls report limited positive communication with parents or elders about sexuality or menstruation, and in some cases direct opposition to sessions on consent, early marriage and SRH on the grounds that these topics violate cultural norms.

Adolescent boys, although increasingly exposed to messages on equality, consent and non-violence, continue to operate in peer environments where harassment, unwanted touching and pressure on girls remain common and at times socially rewarded, underscoring the limits of attitude change at peer level. Boys also note the persistence of norms around male dominance in decision-making and resistance to engaging in "women's work," with those who share domestic tasks sometimes mocked by peers and older men.

Remaining challenges

Despite progress, significant challenges persist, particularly structural health system barriers, social and gender norms and adolescent specific access barriers. These challenges are most pronounced in Kléssokoro which is not a Foundations project site, but challenges remain present in all sites.

Structural health system barriers

Structural and service-delivery barriers continue to constrain adolescents' use of SRH services, even where attitudes have become more favourable. Across sites, adolescents cite long waiting times, lack of adolescent-specific consultation spaces, limited confidentiality in overcrowded facilities, and occasional

gaps in information as key deterrents. Financial constraints, uncertainty about service costs, and transport difficulties further restrict access, particularly for poorer households and those living farther from facilities such as Mpessoba, which is a more remote location.

Social and gender norms

Gender gaps in service use remain marked, with married girls as primary users of SRH services. Unmarried girls and boys, especially younger adolescents, continue to face barriers related to stigma and access.

"It is still a taboo subject. Those most affected are adolescents who are not in school and who do not interact with other children." (Health service provider Mpessoba)

Adolescent specific access barriers

Out of-school adolescents—especially unmarried girls and younger adolescents—remain largely excluded from SRH information and services, as they have limited contact with both school-based and facility-based sensitisation activities. At community level, parental and spousal gate-keeping remains a significant barrier, with many adults restricting adolescents' participation in SRH services for fear that such information promotes "debauchery." Adolescents also report fear of being seen by elders when entering health facilities, concerns about being assumed to be seeking abortion services, shame in discussing sexual matters with adults, and uncertainty about where to access confidential care.

"There is still shame associated with attending the health centre as a young girl." (Health service provider, Sincina)

"*One of the barriers that prevents adolescent girls from coming to the health centre is the lack of parental permission to participate in the Foundations project's awareness-raising activities due to household or agricultural work."* (Health service provider, Sincina)

Key similarities and differences between sites

Across all sites, stigma, shame and parental control strongly influence adolescents' access to and use of SRH services. At the same time, early marriage and limited parent-child communication remain common.

Behaviour changes resulting from Foundations programming reported in project sites are largely absent or sporadic in Kléssokoro, with adolescents across cohorts reporting less awareness about key ASRH issues, and far less uptake of services.

With respect to project sites, in both Mpessoba and Sincina, all cohorts of adolescents – married and unmarried girls, and boys – face strong social norms around early marriage, female obedience, and silence on sexuality, and in both places they describe shame, parental control, and fear of stigma as central barriers to using SRH services. Among unmarried girls 10–14 and 15–18, there is a shared pattern of learning about menstruation, pregnancy risk, and family planning through Foundations project sessions and schools, while still struggling to attend the health centre without being judged as sexually active or seeking an abortion. Boys in both Sincina and Mpessoba describe learning about harassment, consent and contraception and some report reductions in violence and harassment towards girls, but they also note that many peers still reject consent and continue to harass girls, particularly in Mpessoba, which is the more remote site.

The main difference lies in how these norms play out across cohorts in a more proximate site like Sincina versus a more remote site like Mpessoba. In Sincina, married and unmarried girls and boys across age groups report relatively better access to information, guided health-centre visits, and more positive provider attitudes, with older girls and some boys starting to use family planning and to talk about consent,

even if stigma and parental control still limit younger and out-of-school adolescents. In Mpessoba, by contrast, married girls 15–18 dominate SRH service use (ANC, delivery, some FP), while unmarried girls and boys, especially those not in school, have poorer knowledge of services, are more dependent on seeking contraception in secret or from peers, and are more exposed to parental and religious backlash against SRH projects and consent messaging. For all cohorts, the remote context of Mpessoba adds stronger structural constraints – fewer adapted services, weaker provider capacity, and less community acceptance – so that while individual adolescents describe important attitude changes, these changes are more fragile and uneven than in Sincina.

Implications for policy and programming

Overall the findings to point to the following key implications for ensuring adolescent-friendly sexual and reproductive health policy and programming:

Support the institutionalization of adolescent friendly SRH services. Findings highlight the importance of institutionalising adolescent-friendly SRH services within primary health care to improve services delivered to adolescents, as well as begin shifting attitudes and behaviours of adolescents and some community members, even if many of these are pervasive and change takes time. This institutionalization supported by the Foundations project through provider training, improved privacy, and proactive engagement particularly with married and unmarried adolescent girls, and older adolescent boys has shown positive results in behaviours and practices.

Sustain engagement with parents, husbands and community leaders. While engagement with parents, adolescents' husbands and community leaders has been carried out as one of the Foundations project's core pillars, interviews with adolescents and health service providers note that further community engagement is required so that messaging is well understood and is better accepted. However, while adolescent health services are being strengthened, it is essential to focus on this community level work to reduce stigma and challenge restrictive norms that limit adolescents' uptake of services available. This could be done by integrating messaging into meetings of rotating savings groups, mosque sermons, community health worker door to door visits, among other community events that have an audience. While activities such as Girl Shine and health centre visits actively target out of school adolescents, the perception from interviewees was that outreach to out-of-school adolescents could be strengthened, including by strengthening coordination between health and education sectors.

Support peer to peer learning and dissemination. There is evidence of peer to peer learning and support taking place with adolescents sensitized through Foundations project supported activities sharing information with their peers. This is a positive development which could be an avenue toward the sustainability of knowledge sharing, so it could be further and more proactively fostered by the project for both in school and out of school adolescents. Peer to peer learning could also be leveraged to reach more out of school adolescents, either directly, or through their peers.

Promote greater integration of ASRH into district planning. Scaling up and sustainability of the Foundations project initiatives requires integration of ASRH into district planning, monitoring of gender and age disparities, and meaningful adolescent participation in service design. The latter could be fostered through creation of adolescent committees at district level, organised through adolescents participating in community sessions, for example, or engagement via student school committees.

Niger

Knowledge and implementation of legislation and policies around ASRHR

National and regional health authorities interviewed demonstrate solid familiarity with the main policy instruments guiding adolescent sexual and reproductive health and rights (ASRHR) in Niger. These include the fundamental principles of health and public hygiene'' (Law no. 2022-34, July 2022), reference document which replaces and repeals the SR 2010 law of Niger and the Health and Social Development Plan (PDS), which contains a dedicated axis on adolescent and youth health, and the Adolescent and Youth Sexual and Reproductive Health Plan (Plan SSRAJ). Authorities further explain that a multisectoral national strategic operational plan for 2024–2026 has been developed to operationalise these policies across sectors including health, education, population, youth and sports, and vocational training, in collaboration with technical and financial partners. The Foundations project supports the mid-term review of this national multisectoral operational plan for adolescent reproductive health.

Respondents emphasise that, despite this robust policy framework, ASRHR remains highly sensitive due to strong socio-cultural and religious norms. Policy design and implementation therefore require careful negotiation to avoid perceived conflicts with local values. Authorities stress that external proposals on ASRHR are closely scrutinised to ensure alignment with religious and community norms. At the same time, they note that SRH services are increasingly accessible to adolescents and better aligned with their needs, including improved contraceptive availability, even though uptake remains constrained by stigma.

Implementation relies on multiple programmes—family planning, reproductive health, and STI/HIV/AIDS—to translate policy into practice. Capacity-building is a central strategy, with training intended to influence both service delivery and community attitudes. Two core reference documents underpin this approach: one on gender- and youth-centred methodologies, and an adolescent and youth health orientation programme, each comprising multiple modules. Peer educators and community relays embedded within health structures are expected to extend ASRHR work beyond facilities and engage the entire health pyramid, although this does not necessarily happen in practice.

Implementation and support by development partners

Authorities underline that ASRHR implementation in Niger depends heavily on collaboration with national and international partners. While health providers deliver some training, most ASRHR capacity-building is led by NGOs such as Save the Children and SongES Niger (Solidarité pour le Développement Endogène Durable au Niger) and through programmes such as KULAWA and the Foundations project. Respondents cite a wide range of actors—including the Association Nigérienne pour le Bien-Etre Familial's (ANBEF), Save the Children, Marie Stopes, Pathfinder, PSI, Solthis, WHO, UNICEF and UNFPA—supporting ASRHR through technical assistance, service delivery, training and community mobilisation.

Within this landscape, the Foundations project implemented by Save the Children is well known and viewed positively. Officials describe its focus on adolescent SRH, family planning, gender-based violence and child marriage in Maradi (Aguié and Tessaoua) and Diffa regions. National-level respondents report involvement in Foundations-supported document development, training of trainers and supervision, while district officials emphasise improved adolescent awareness of SRH services and increased attendance at CSIs (*Centres de Santé Integré* or Integrated Health Centres) particularly among unmarried girls.

Officials also reference other relevant programmes, notably the Adolescent in Transition in West Africa (ATWA) programme financed by the Netherlands and KULAWA, funded by USAID, that have implemented project in those communities in the past. Authorities noted that it would be desirable for KULAWA's and Foundations project's youth clubs and male-focused initiatives ("husbands' schools" and "future husbands'

schools") to remain in place to strengthen the engagement with boys and young men. While national stakeholders describe the Foundations project as innovative, they note weaker engagement from the Ministry of Health compared to the Ministry of Education, pointing to uneven sectoral ownership.

Barriers to implementation

Despite strong policy commitments and partner engagement, multiple barriers hinder effective ASRHR implementation. Sensitisation sessions and health talks that have expanded under the Foundations project also cover basic information on bodily changes, menstruation and hygiene. Socio-cultural and religious resistance is prominent, with district respondents describing Islam as a sensitive factor in discussions of sexuality and contraception. The absence of participatory communication tools such as sketches and visual sensitisation materials ("pagi-volts") by the different NGO supported projects working on SRH is seen as reducing the effectiveness of community engagement.

Institutional and systemic constraints compound these challenges. District health officials report limited resources for supervision and follow-up of project activities. At national level, respondents highlight the suspension of SSRAJ curriculum content in schools as a major obstacle, significantly reducing adolescents' access to structured information. Financial constraints linked to political instability, shortages of trained personnel and uneven skills further limit consistent implementation, particularly in remote areas.

Adolescent-inclusive health service provision

Table 3 below presents findings from the checklist filled out on the basis of services available at the health centres in Niger, the three locations, both through observations and brief interviews with health service providers.

Table 3: Niger Checklist

Domain	Oura (Project/Proximate)	Magaria Sud (Project/Remote)	Gararé (Control/Remote)
Services offered to adolescents	FP, prenatal consultations, awareness-raising (CSI, community, schools), STI/HIV screening, premarital genetic counselling, GBV referral, FGM follow-up.	Offers family planning, prenatal consultations, awareness-raising through community relays, STD/HIV testing, and premarital genetic counselling.	Provides family planning, prenatal consultations, awareness-raising via community visits, STD/HIV screening, and premarital genetic counselling.
Services NOT provided	Post-abortion services are not offered.	Post-abortion services are not offered and GBV cases are not reported to the health centre due to community secrecy.	Post-abortion services are not offered and GBV cases are not reported to the health centre due to community secrecy..
Staff attitudes	Staff are friendly and see adolescents at night for privacy. Capacity building training has	Staff are friendly with girls (boys unknown), few are qualified, and workloads are heavy. Capacity building	One friendly SRH provider sees adolescents even at dawn.

	been conducted by Foundations project.	training has been conducted by Foundations project.	
Privacy/confidentiality	No separate adolescent room, but staff are trained and use night-time visits for privacy.	No dedicated space, staff are trained, and the FP room is used for all consultations.	No separate space, but staff are trained to maintain confidentiality.
Awareness raising	Awareness is raised through posters, flyers and door-to-door and during ANC/PNC.	Awareness is raised through poster, flyers and via community relays and ANC/PNC.	Awareness raised through posters, flyers and through health workers.
Information availability	SRH brochures exist but cannot be taken home by adolescents due to limited availability; no online access.	SRH brochures exist but are insufficient; no online access.	No brochures and no online access.
Disability accessibility	Ramps are available, but braille/recorded materials are not available. Staff are trained.	No ramps or materials adapted for adolescents with disabilities.	No ramps, materials, or staff training for disabilities.
Product availability	Full contraceptive range available.	Full contraceptive range, but shortages occur.	Full contraceptive range.
Referral systems	GBV referral systems exist, and the records are maintained.	No GBV referral although the staff have been trained. Referral records are maintained, but due to the stigma surrounding sexual violence the community tends hide them.	GBV referral systems exist, and the records are maintained.
Feedback mechanisms	Feedback mechanism is available.	Not available.	Not available.

From the checklist, we can highlight that there are no major differences in principle in terms of the services and supplies available for adolescents at health centres, although the differences are more “qualitative”. While there is trained personnel in both control and project sites, in project sites there are one to two trained personnel who have received Foundations capacity building, while in the control site it is only one person (the midwife) who has received some basic training from health authorities to support adolescents. The most relevant differences are rather in terms of the demand for services reflecting the fact that project sites have sensitized adolescents, parents and community members, stimulating health seeking behaviour

in relation to ASRH, while in the control site, demand is more limited, as we can see from the findings below.

Positive changes in service delivery and provider practices

Based on interviews with health service providers, findings indicate that adolescent use of SRH services has increased, particularly in Foundations project sites, although access remains highly gendered – that is, mostly married adolescent girls access family planning and STI services while adolescent boys rarely visit health centres - constrained by stigma. In Oura and Magaria Sud, providers describe how, prior to the Foundations project, adolescents rarely came to the CSI, whereas now they feel more able to approach staff whom they know will receive them "with open arms". As a result of Foundations project training, providers increasingly view adolescents as legitimate SRH clients and thus report adopting more welcoming, flexible and confidential practices, including receiving girls outside peak hours or at night to minimise social exposure.

"We have received extensive training on adolescent SRH care, counselling, and guided visits — all thanks to the GAC… Our behaviour has changed. When an adolescent has a problem or seeks information, the training from the GAC allows us to welcome them easily and provide all the information they need ." (Head of CSI, Magaria Sud)

"In the morning we deal with adults; in the afternoon with adolescents, most of whom come at night. If a parent announced their daughter's arrival, we scheduled the appointment at night for more discretion." (Nurse, CSI Oura)

Providers in Oura and Magaria Sud emphasise that adolescents can come at any time of day and that appointments are sometimes arranged at night for girls whose parents wish to avoid community scrutiny, illustrating providers' willingness to adapt to adolescents' realities. Providers explicitly attribute these changes to the Foundations-project supported training, which has strengthened their skills and confidence in counselling adolescents and explaining contraceptive methods.

"Nowadays, this is no longer a problem. As soon as an adolescent has a need, they run to the CSI. At the CSI they know where to go, and the health worker has been trained, so they welcome them openly, make them feel comfortable while ensuring confidentiality. All of this is thanks to the capacity strengthening we received from the Foundations project." (Head of CSI, Magaria Sud)

Even in the control site of Gararé, a highly committed midwife had similar attitudes, though without the same level of structured training and institutional support.

"That is why we used to only carry out screening for divorced girls, because with these young people who are in a hurry to obtain the contraceptive products of their choice, we never had the time to do screening." (Head of maternity, CSI Gararé)

"Adolescents have no specific hours. They come at any time, even at dawn." (Observation, CSI Gararé)

Adolescent health-seeking behaviour

In project sites, CSIs are increasingly seen as places for information, counselling and contraception, not only curative care. Guided visits and repeated sensitisation sessions have normalised adolescent attendance, particularly in Magaria Sud. Adolescent girls primarily seek services to prevent unwanted pregnancy, often after early marriage or a first birth, while boys—mainly older adolescents—access condoms discreetly to avoid being seen and rarely seek counselling.

Studies reveal that adolescent boys and young men in these contexts often underuse health centres for condoms and SRH because services are not designed or perceived as welcoming, and because social norms make clinic attendance feel risky, embarrassing, or inappropriate for "real men." Across studies, the dominant explanation is a mix of stigma, restrictive masculinity norms, poor confidentiality, judgmental providers, and limited youth-friendly service design (Sidamo, et al, 2023). While the Foundations project is working to change some of these factors, such as increasing confidentiality and improving the friendliness of providers and services, stigma and restrictive masculinity norms persist, reducing the willingness to openly seek SRH services at health centres.

"We always explain all the available services from A to Z. Thanks to the Foundations project, adolescents now know exactly where to go." (Head of CSI, Magaria Sud)

Unmarried girls in Oura often attend services accompanied by mothers, reflecting continued parental control alongside emerging parental endorsement of prevention, particularly as pregnancy outside marriage is seen to bring shame to the family. Routine contact points such as antenatal and postnatal care and vaccination sessions are used strategically by service providers to disseminate SRH information.

"In this health center, we receive girls aged 15–17 accompanied by their mothers to obtain a modern contraceptive method… These mothers bring their daughters to the CSI because they have noticed their daughters are seeing boys, so to avoid unwanted pregnancy they secretly resort to family planning." (Head of maternity, CSI, Oura)

Puberty and menstrual hygiene management

Sensitisation activities increasingly integrate information on puberty and menstrual hygiene into routine health talks. Providers describe discussing puberty and menstrual hygiene with girls when they come for other services, including antenatal consultations and vaccination sessions, and community relays reinforce these messages during home visits and community gatherings. This integrated approach helps to position puberty and menstrual hygiene as part of routine health care rather than as taboo topics, even if the main documented drivers of service use remain concerns around pregnancy and contraception.

Contraceptives, family planning, early marriage and abortion services

Contraception remains the dominant entry point to SRH services, with long-acting methods favoured for their discretion. Early marriage remains common (with some adolescent girls marrying as young as 13, but in most cases around the ages of 15 or 16), shaping service use patterns. Girls seek methods to avoid a first unwanted pregnancy in an early marriage, to prevent a second pregnancy after an early birth outside of marriage or to manage fertility after divorce, often in secret.

"For reasons of discretion, 100% of women in Oura choose implants. They say pills require monthly visits, injections every three months, and too many visits draw attention. With Implanon, a woman goes unnoticed and only returns if she wants it removed." (Nurse, CSI, Oura)

Abortion is universally framed in the three research communities as unacceptable and officially absent, though providers acknowledge the likelihood of clandestine practices, which limits open discussion of post-abortion care.

"Clandestine abortion is not something we encounter in Oura. With the sensitization of adolescents, they do everything to avoid pregnancy rather than think about abortion." (Nurse, CSI Oura)

Shifts in parental attitudes

Parental attitudes in project sites show nuanced change. Parents increasingly bring adolescent daughters for contraception to avoid social shame associated with premarital pregnancy. Sensitisation activities have helped some caregivers reframe contraception as protective rather than immoral, though resistance remains uneven and contested. Health service providers, highlight the importance of continuing to involve parents, schools and community structures in SRH programming to consolidate these emerging positive shifts.

"With sensitization sessions, the population has understood the importance of SRH services. Bringing one's daughter to the health center for contraception is no longer a problem for mothers in Oura." (Nurse, CSI Oura)

In Gararé (control site), families may publicly frame girls' pregnancies as rape, but they typically support the continuation of the pregnancy and facilitate antenatal care rather than seeking clandestine abortion, reflecting a strong anti-abortion stance alongside some concern for girls' health.

Pervasive discriminatory gender norms

Entrenched discriminatory gender and social norms are still pervasive. Across sites, modern contraception is widely associated with promiscuity, especially for unmarried girls and divorced women, and women who use contraception risk being labelled as sexually unconstrained or opposed to childbearing. This stigma pushes many girls and women to seek services covertly and reinforces the idea that adolescent SRH is shameful rather than protective. In Magaria Sud, cases of sexual violence and other SRH violations are often hidden by families and communities despite provider training on referral pathways, reflecting persistent silence and victim-blaming around gender-based violence.

"What really needs to change is people's behaviour, especially adolescents', through sensitization, sketches, and the use posters with attractive images and messages (pagi-volts). Through them, young people understand the consequences of their actions." (Head of CSI, Magaria Sud)

Gender gaps in service uptake

Service uptake remains highly gendered: girls are the primary users of SRH services, while boys' engagement is limited. Boys rarely seek SRH services at health centres, except when older and seeking condoms or pills for partners. In Oura, providers note that boys almost never attend the CSI; instead, condoms are made available in a discreet village location for anonymous access. While this improves contraceptive access, it limits opportunities for counselling, HIV testing and broader risk-reduction support. Girls frequently seek services covertly, constraining method choice.

"Adolescents visit the CSI 100%. However, when it comes to contraceptives, we place male condoms in different corners of the village. After a few hours, if we go back, there is nothing left because the young boys have taken everything." (Nurse, CSI Oura)

"In Gararé, young adolescents come to the CSI to obtain contraceptive products such as condoms and pills that they take to their partners… But these are young men aged 20 and above, unlike the case of an adolescent who once came to the health centre at the age of 15 because of an illness." (Head of maternity, CSI Gararé)

Additional challenges to service delivery

From a service-delivery perspective, none of the sites has dedicated adolescent spaces or specific consultation hours, requiring adolescents to use the same waiting areas and consultation rooms as adults. This undermines privacy and heightens fears of being seen and judged. Adolescent-tailored information materials are also scarce: Magaria Sud has a limited number of brochures that cannot be taken home, Oura's materials are not adolescent-specific, and Gararé lacks printed SRH materials altogether and has no online or SMS-based channels due to network constraints and low phone ownership.

Human resource constraints are particularly acute in Magaria Sud, where a single nurse often delivers most services and therefore has limited time for the tailored adolescent counselling envisaged in training. At national and district levels, stakeholders also cite financial constraints, political instability and weak supervision as major obstacles to scaling up and sustaining adolescent-responsive SRH services, even where motivated staff and promising practices exist.

Adolescents with disabilities face additional access barriers due to limited inclusive infrastructure and provider training.

Similarities and differences between project and control sites

All three sites offer a similar formal SRH service package, but none has adolescent-specific spaces or hours[1]. Across sites, stigma, negative masculinity norms and moral judgement discourage boys' engagement and drive clandestine service use - either boys accessing condoms in other places or during times where they are unlikely to be seen.

In both project and control sites, stigma, gossip and moralising community attitudes drive girls to seek contraception discreetly and discourage boys from openly using SRH services. In Oura, providers note that boys almost never attend the CSI; instead, condoms are made available in a discreet village location for anonymous access. Given that there are alternative providers of family planning services, such as Marie Stoppes, it is likely that adolescents access contraceptives through them if they perceive this type of distribution to be more discreet, but this was not explored through the study's data collection that was focused on access through health centres.

Across all three facilities, adolescent service provision relies heavily on opportunistic counselling during antenatal and postnatal visits and on the initiative of committed individual providers. While formalised adolescent-specific protocols are available, these are not always well known or used, leaving services vulnerable to staff turnover and competing priorities.

Project sites benefit from targeted capacity-building, structured sensitisation and innovations such as guided visits, which are largely absent in Gararé. Oura, which is the most proximate of the two project sites, has made progress on disability-responsive infrastructure and training, for example installing ramps and integrating inclusion modules, while Magaria Sud and Gararé lack many basic physical adaptations and inclusive communication tools. In the control site, individual provider commitment partially compensates for the lack of project support but remains insufficient to sustain broader change.

[1] While some adolescents spoke about their preference to have specific hours assigned when they could visit health centres without coinciding with adults, from a public health perspective, the provision of specific schedules for adolescents can also seen as a source/path of stigmatization of adolescent users. Giving them a specific schedule could expose them to identification of curious people.

Implications for policy and programming

Overall the findings to point to the following key implications for ensuring adolescent-friendly sexual and reproductive health policy and programming:

Support the institutionalization of adolescent friendly SRH services. Findings underscore the need to institutionalise adolescent-friendly SRH services through sustained provider training, modest facility adaptations and reliable contraceptive supplies. Outreach and awareness-raising should be scaled up using participatory communication tools suited to low-literacy contexts. Having an integral system that supports confidentiality in a space dedicated to adolescents when they seek services could encourage more adolescents to approach health centres.

Strengthen work with boys and men as a more salient part of project activities. Tailored strategies are required to engage boys and men, including discreet access points and male-focused dialogue spaces and husbands schools, both for men married to adolescent girls as well as unmarried adolescent boys so as to contributing to improving their future spousal relationships. Proactive engagement with religious and traditional leaders is essential to legitimise ASRHR services and protect providers from backlash.

Incorporate lessons from monitoring of the Foundations project supported activities into programming: Finally, stronger monitoring, feedback mechanisms and evidence-informed adaptation are needed to ensure that learning from the Foundations project contributes to broader health system strengthening and more equitable adolescent SRH outcomes.

Sierra Leone

Knowledge and implementation of legislation and policies around ASRHR

National-level officials describe a relatively comprehensive ASRHR policy framework that now aligns with international standards and has been formally launched with high-level government and stakeholder endorsement. Key elements highlighted include adolescent sexuality education, prevention of adolescent pregnancy, prohibition of child marriage, the Sexual Offences Act, and a Child Rights Act, combined with policies such as the School Health Policy, the National Strategy for the Reduction of Teenage Pregnancy, the Family Planning Policy and the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) strategy. Together, these policies explicitly mandate provision of SRH information and services in schools and health facilities, GBV response, and meaningful youth participation in policy development.

Officials stress that these are not imported frameworks but have been adapted to the Sierra Leonean context through consultative processes involving a range of stakeholders, including adolescents and youth themselves, underscoring efforts to ensure relevance, ownership and contextual appropriateness.

Both national and district respondents emphasise that these policies are not purely normative but explicitly call for coordinated implementation between the health and education sectors so that school health services and facility-based SRH are mutually reinforcing. District officials in Kailahun underline that adolescent SRH services are now integrated into routine service delivery—through family planning, school health services and "one-stop centres" for GBV and SRH—framing ASRHR as an essential part of the overall primary health care package rather than an add-on. As one District Health Official explained, "I think the most important part of the policy is the adolescent sexual reproductive health services, especially the part that is linked with school health services. These children are our future leaders. If we don't build their capacity to understand their sexual and reproductive rights, it will be a big problem."

At national level, the key informant similarly highlights the deliberate move towards integrated, adolescent-friendly care. Health workers are now trained to engage with adolescents in a non-judgmental manner, and current guidance encourages providing services in a way that reduces the sense of separation or stigma. As the National Health Official in Freetown noted, "Health workers are trained in providing adolescent-friendly services, so they are aware of how to counsel adolescents in a non-judgmental manner. In some setting integrated services are encouraged so that adolescents don't feel like they are having services somewhere separate, but in some areas, provision of adolescent-friendly services where specific areas are identified for adolescents to be able to access services. But one of the things they are encouraged now to do is to ensure that adolescents get integrated services, not just SRH services, so that it can help to avoid stigmatization."

At the same time, respondents note policy–practice gaps: while the framework is strong on paper, implementation is uneven across districts, with some areas benefitting from adolescent-friendly services and safe spaces supported by partners, and others lacking consistent access to trained personnel, commodities and infrastructure. This underscores the importance of looking beyond policy formulation to issues of coverage, resources and local capacity.

Implementation and support by development partners

National informants report substantial capacity-building efforts to operationalise policies, led by the Ministry of Health through the Directorate of Reproductive, Child and Adolescent Health structures and implemented by national and district trainers. Health workers "at all levels" (PHUs and hospitals) receive training on adolescent-friendly services, non-judgemental counselling, family planning, post-abortion care,

GBV and STIs, with content tailored to adolescents' age categories and backed by standard operating procedures and guidelines developed under the national reproductive health programme.

Standardised SOPs and training guidelines are developed by the reproductive health programme and then shared with partners—including Save the Children, Health Alert, Partners In Health, Focus 1000, Concern Worldwide, Helen Keller and others—who use them when conducting training in their respective focus areas. According to national authorities, youth advocates are also trained and engaged as peer educators and community-level facilitators, strengthening outreach to vulnerable adolescents and creating additional community-based entry points for ASRHR information and services.

Kailahun District Health Management Team (DHMT) officials describe concrete partner contributions: The Foundations project /Save the Children and others fund and organise large-scale trainings (e.g. 460 providers on long-acting reversible contraceptive methods like Jadelle), equip facilities with refrigerators, solar systems, furniture and safe-space infrastructure, and support community-based safe spaces and school health clubs where trained community workers and peers deliver ASRHR messages. District actors also stress the importance of national teams backing up district-level trainers and of NGOs such as PIH, IRC and GIZ (past and present) in strengthening maternal/reproductive health, emergency obstetric care and community sensitisation, including radio discussions and stakeholder meetings after maternal deaths.

The Foundations project is seen as strongly **aligned** with national ASRHR strategies, particularly because of its emphasis on community-level engagement, safe spaces, adolescent education and health-worker capacity building. A distinguishing feature, compared with some other NGO interventions, is its strong coordination and reporting through steering committee structures at national and district level, which facilitates oversight, feedback and shared ownership by DHMTs and central programmes. At the same time, national respondents caution that locating steering committees too high in the political hierarchy (e.g. deputy-minister level) can delay meetings due to competing priorities, and that more operational coordination at directorate/programme level—with periodic high-level engagement—may be more effective for timely decision-making.

Barriers to implementation

Health officials at national and district levels identify a set of persistent barriers that limit the full realisation of ASRHR policies in practice.

Demand side barriers

At national level, low general education and SRH literacy among adolescents and communities is seen as a foundational obstacle, driving poor health-seeking behaviour, reliance on non-medical options, adolescent pregnancy and unsafe abortion, especially where young people struggle to access accurate information. As one respondent notes, *"the more people are not educated, it makes it difficult for people to adopt the right SRH behaviours,"* highlighting the tight linkage between education, service uptake and outcomes.

Supply side barriers

Commodity insecurity (irregular availability of contraceptives and other SRH supplies), gaps in provider training quality, and strongly conservative socio-cultural norms that make it "difficult to engage in SRH discussions" are also highlighted as major constraints. Adolescent-friendly services delivered in separate spaces can sometimes inadvertently increase stigma, leading to a growing emphasis on integrated service delivery so that adolescents can access SRH alongside other services in a non-judgemental environment.

System-level barriers

District officials in Kailahun add operational and contextual barriers. They note that while training is extensive, monitoring and supportive supervision are weak: facilities can go 4–5 months without a supervisory visit, leading to poor reporting, misuse of equipment (e.g. refrigerators) and inconsistent application of adolescent-friendly standards. Geographic and cultural factors further hinder outreach—seasonal and traditional practices can render certain communities temporarily inaccessible, requiring integrated teams with local members to "penetrate" these areas without provoking conflict.

Finally, specific service gaps persist even where policies and training exist. STI treatment is cited as a critical missing piece: family planning commodities may be improving, but drugs for treating STIs are often unavailable or unaffordable for adolescents, leaving young people with unmet needs and reinforcing power imbalances in relationships. Officials also noted a weak referral pathways and continuity of care: while referral systems between community structures, adolescent-friendly centres and facilities exist on paper, they are not always well understood or consistently used, especially in remote or underserved communities. Inadequate SRH commodity availability, limited follow-up mechanisms and fragile links between community safe spaces, school clubs and health facilities can disrupt service continuity.

To address these barriers, respondents point to existing policy, legislative and programmatic responses—the Child Rights Act, Prohibition of Child Marriage Act, school health initiatives, safe spaces, capacity building for health workers and community engagement and behaviour-change strategies—while emphasising the need to optimise and scale these interventions in rural and hard-to-reach communities. Extending services beyond urban areas, strengthening education for parents and caregivers, reinforcing school health clubs and mother support groups, and embedding ASRHR within routine health system structures (rather than short-term projects) are framed as priorities for sustainability and long-term impact.

Adolescent-inclusive health service provision

Table 4 below presents findings from the checklist filled out on the basis of services available at the health centres in Sierra Leone, the three locations, both through observations and brief interviews with health service providers.

Table 4: Sierra Leone checklist

Domain	Manowa (Project/Remote)	Follah (Project/Proximate)	Luawa (Control/Remote)
Services offered to adolescents	Provides family planning, awareness activities, HIV/STI screening, prenuptial counselling, FGM follow-up, HPV vaccination, and GBV referral.	Provides family planning, awareness activities, and HIV screening only.	Provides family planning, awareness activities, HIV/STI screening, FGM follow-up, HPV vaccination, and GBV referral.
Services NOT provided	Provides some post-abortion services.	Does not provide post-abortion services.	Does not provide post-abortion services.
Staff attitudes	Staff are dedicated and friendly.	Staff are dedicated and friendly.	Staff are dedicated and friendly.

Privacy/confidentiality	Has special hours, though not adolescent-specific. Has no separate space but staff are trained in confidentiality.	Has no separate space but staff are trained in confidentiality.	Does not have adolescent-specific hours and uses the ANC room. Has no separate space but staff are trained in confidentiality.
Awareness raising	Conducts door-to-door, school-based, and community outreach.	Conducts door-to-door, school-based, and community outreach.	Conducts door-to-door outreach and community discussions.
Information availability	Provides no brochures but offers safe spaces.	Provides no brochures but offers safe spaces.	Provides no brochures and has no online information.
Disability accessibility	Does not have ramps.	Does not have ramps.	Has ramps for accessibility.
Product availability	Offers the full range except for IUDs.	Offers the full range except for IUDs.	Offers the full contraceptive range.
Referral systems	Has referral mechanisms and maintains records.	Has no formal referral system.	Provides GBV/IPV referrals and keeps records.
Feedback mechanisms	Feedback can be provided by phone or online, but are rarely used	Feedback can be provided by phone or online, but are rarely used.	No feedback mechanisms are available.

The checklist shows that all three facilities offer core adolescent SRH services with dedicated and friendly staff, but project sites (Manowa and Follah) have somewhat stronger systems and broader outreach than the control site Luawa. Manowa and Follah, as well as Luawa, conduct door-to-door and community outreach but while Maowa and Follah provide school-based outreach and offer safe spaces, Luawa does not. Only Manowa provides some post-abortion services and prenuptial counselling while both Manowa and Luawa provide HPV vaccination, HIV/STI screening and FGM follow-up. Out of these services, Follah provides HIV screening. None of the three sitew provides IUDs nor operate without separate adolescent corners, relying instead on staff trained in confidentiality. Referral and accountability systems are also stronger in Manowa, which has formal referral mechanisms, records and phone/online feedback, whereas Follah lacks a formal referral system (despite feedback channels) and Luawa has GBV/IPV referral and records but no patient feedback mechanism at all. Neither project site has ramps to allow for disability access. As noted, Luawa provides a wide package of services, offers the full contraceptive range and has disability ramps, yet lacks post-abortion services, adolescent-specific hours, brochures, safe spaces, formal feedback mechanisms and relies on ANC space without a separate adolescent area.

Positive changes in service delivery and provider practices

Service delivery for adolescents has become more intentional and structured in the project sites of Follah and Manowa than in the control site of Luawa Baoma. Health workers in project facilities describe deliberate efforts to make services adolescent-friendly, including assigning focal nurses, setting aside specific times for adolescents, integrating SRH into school outreach and routine contacts, and building in more confidential, one-to-one counselling.

"Don't ever tell an adolescent to go get consent from the parents first… If they come to you, be a mother to them… If you question his maturity and tell him to go and get parental consent, the next thing you will hear is that he has impregnated someone." (Health Service Provider, Manowa)

Adolescents' accounts show how these changes play out in practice. Boys in Follah and Manowa describe particular midwives or nurses as "the ones for adolescents", who invite them into offices, use posters to demonstrate condom use, speak respectfully and avoid shouting, in contrast to other nurses perceived as hot-tempered or unwelcoming. Girls, especially older or married adolescents, report that these trusted providers have made it easier to seek family planning and antenatal care before and after first pregnancy, while in Luawa Baoma services feel more like standard antenatal care(ANC) and curative care, with fewer adolescent-specific adaptations and no specialised SRH training for staff.

"Contraceptives are good for adolescent boys and girls, but getting adolescents like me is not easy because I get ashamed when I am in the presence of adults… that is why we need an adolescent-friendly centre that can accommodate only us and the people that we trust… The health authorities should ensure that there is no stockout of FP contraceptives, especially condoms, as that will expose us to STDs and expose the girls to pregnancy." (Adolescent boy, 15-18, Manowa)

"Most adolescent boys are shy of facing the nurses to request condoms; they should have a place where condoms can be deposited, for them to collect them from there… School health clubs should be formed… we, as adolescents, influence over ourselves; we know how to convince each other." (Adolescent boy, 15-18, Luawa Baoma)

"I was not a family planning expert… but through the family planning trainings I have known the advantages and disadvantages of family planning, the appropriate age to take commodities, and how to diagnose a medical condition and choose the right method… It has made me confident to treat patients, even for post-abortion care." (Health Service Provider, Manowa)

Adolescent health-seeking behaviour

Adolescent health-seeking patterns differ by gender, marital status and location, with project sites showing more proactive and diversified use. In Follah and Manowa, providers see more girls coming before first birth for contraception, menstrual pain and pregnancy testing, and some adolescents now treat SRH visits as routine rather than exceptional; in Luawa Baoma, girls typically present once pregnant or facing complications, making adolescent mothers the main female SRH users.

Boys across all sites most often seek care for condoms and STI treatment and less frequently for HIV testing or general counselling. Young unmarried boys in Follah and Manowa describe visiting in the evenings or at weekends, as advised by nurses, to avoid community scrutiny, and say that counselling at facilities has made condom use feel normal and protective of their education and future.

"Family Planning is not strange in the community… I also visit the health Facility for condoms… the nurses who distribute the condoms to us are so accommodating… they don't shout at us when we visit the health facility to collect condoms." (Adolescent boy, 10-14, Follah)

"While I am still attending, I have not impregnated any girl; I don't need to worry about STDs, hence I am using condoms. I am now used to using condoms anytime I want to have sex." (Adolescent boy, 15-19, Manowa)

"We visit the health facility in the evening or at night based on the advice of the nurses for confidentiality purposes, because when people see that we visit the health facility besides being sick, they may want to know what is the purpose of the visit." (Adolescent boy, 15-19, Follah)

In Luawa Baoma, a smaller group of "bold" boys access HIV testing and condoms, while many peers continue to rely on friends, teachers and phones for information and only come when symptomatic.

Marital status shapes girls' trajectories: married adolescents and young mothers, especially in project sites, are more visible in ANC/PNC and postpartum family planning, whereas unmarried girls are more likely to "hide"—seeking help late in pregnancy or only after a first birth, and often going first to mothers rather than nurses because of fears around judgement and breaches of confidentiality.

Puberty and menstrual hygiene management

Information on puberty and menstrual hygiene reaches adolescents through a mix of health-sector, school and NGO channels, with richer content and more touchpoints in project sites. Providers in Follah and Manowa report integrating puberty and menstrual hygiene into facility sessions, school visits and outreach with partners such as Marie Stopes and Save the Children, and say that girls engaged in these activities ask more questions and show greater understanding of bodily changes than those who are not reached.

"When I experienced my first menstruation, I had to visit the midwife at the health facility… after explaining everything to her, she told me that if I did not use contraceptives like implants or pills I will get pregnant when I have sex… My friend told me that if it were her, she wouldn't have the courage to inform the midwife about it." (Unmarried adolescent girl, 10-14, Manowa)

Adolescent narratives underscore these differences. Boys and girls in Luawa Baoma and Follah recall school lessons on hygiene and puberty—body hair, wet dreams, menstruation, voice changes—sometimes reinforced by nurse visits that link puberty signs to pregnancy and STI risks and encourage condom use and contraceptive uptake. Girls in Follah also describe evening sessions such as Girl Shine – with messaging aligned to that provided at health centres - where they learn about menstruation and contraception, often attending quietly when parents are hesitant or opposed.

Contraceptives, family planning, early marriage and abortion services

Across sites, boys tend to receive more information on condoms and STI prevention than on girls' menstrual health or family planning methods used by women, while girls have better knowledge of menstrual management but may still know little about the full range of contraceptive options. Younger unmarried girls in particular often encounter methods such as implants for the first time in the clinic, with limited explanation of alternatives or side-effects, and providers in Luawa Baoma themselves note that they rely on general experience rather than formal adolescent SRH training when counselling on implants and injectables.

"When you visit the health facility for a condom for the first time as an adolescent, they ask for your age, after which they will give you a poster or a guide with an explanation on how to use the condom… The nurses will call you privately in their office for teaching and counselling; it is confidential, and they don't do it in the open." (Adolescent boy, 15-18, Manowa)

"It is uncommon for a boy, in these parts, to meet you and tell you that they would like to start sexual intercourse… So most times, I would go and meet them and tell them that condoms are available, then they would come for the condom." (Health Service Provider, Manowa)

The main contraceptive methods used by adolescent girls in the three research sites are implants (especially the "Captain Band"), pills, injectables and condoms, with implants increasingly preferred in project communities because they are perceived as easy and effective for avoiding pregnancy. Girls in both project and control sites describe valuing implants because they "don't get pregnant" while using them, but many report limited information about other methods, and sometimes only one option is actively presented. Misunderstandings about the duration and effects of injectables and emergency contraception, and fears that Depo-Provera may cause future infertility in childless girls, remain common and are echoed by some providers.

"She told me this is the Captain Band, which can be applied so that one does not get pregnant… No, she did not say anything else; we only talked about the captain's band." (Unmarried Adolescent girl, 15-18, Follah)

"They are not afraid, but they know that when such matters come up, it will compromise them. We talk to them even when they are pregnant. We talk to them about the availability of family planning commodities, even after they have given birth. We try to encourage them to take preventives" (Health Service Provider, Follah)

Adolescent boys in Manowa, Follah and Luawa Baoma rely primarily on condoms and see them as a way to prevent both STIs and unintended pregnancies. Many boys frame consistent condom use as essential to avoid being forced into early marriage if a girlfriend becomes pregnant and to protect their schooling and financial future, linking condom access directly to life plans.

On the service side, providers in Manowa report extensive family planning training, improved skills in method choice and diagnosis, and some capacity to deliver post-abortion care, albeit with inadequate tools and continued need for referral of complex cases. In Follah, which is a more proximate site, and especially Luawa Baoma, staff acknowledge having little or no formal training in post-abortion care (PAC), and say that adolescent abortion complications are largely managed within broad obstetric care or referred onwards, while most adolescents and their families assume pregnancy should end in childbirth and see abortion as morally problematic.

"The adolescents do not do abortion. The moment they find out that they are pregnant, they would decide to give birth to the child… We hardly see abortion cases, maybe one or two in a year… When they come with bleeding, we pull the girl to the side and probe, and we treat her, but the community is never aware about it." (Health Service Provider, Manowa)

"Sometimes it's not just young girls—even older girls do it. Some will come to us when they start experiencing bleeding. Sometimes we do handle some of the cases here, but if there is too much bleeding involved, then we refer—so that we don't hold on to the case until the point where the person cannot survive" (Health service providers Luwa)

Shifts in parental attitudes

Parental attitudes towards adolescents' uptake of ASRH are slowly shifting, particularly among mothers in project sites, both through sensitization conducted directly with them by community health workers and through their daughters who have been sensitized in schools and in community activities. However, many parents remain ambivalent and attitudes are strongly gendered, with fathers more difficult to persuade Facility staff and district officials note that more mothers in Follah and Manowa now accompany daughters

to health centres and explicitly request contraception to safeguard education and avoid early pregnancy, while similar support in Luawa Baoma is present but less consistent and more reactive.

"Here in this Follah town, we have a young girl who is not yet 14 years old… she went to access family planning commodities… she replied that she doesn't want to become pregnant at an early age; she wants to be educated first. Her mother became very happy and said, 'You have a good idea." (Married adolescent girl, 15-18, Follah)

Adolescent accounts add depth: an unmarried young woman in Luawa Town credits her late mother with encouraging her to take an implant, while boys across sites say they know mothers who quietly support their daughters' contraceptive use even when fathers disapprove. At the same time, both adolescents and providers recount cases where fathers respond with shame or anger when they discover daughters on implants, including one instance where a father insisted on removal, after which the girl became pregnant.

"Yes, most of the adolescents who are in school don't show up for Marie Stopes services, except those who are married, and also adolescents are in Senior Secondary School. Most fathers do not approve of contraceptives for JSS, especially Implants. My father always says that if he allows her daughter in JSS to start using contraceptives, especially Captain Band, that means he is the one who has sent her daughter to have free sex." (Married adolescent girl, 15-18, Manowa)

Married girls and adolescent mothers enjoy somewhat more acceptance for family planning, particularly postpartum, but even breastfeeding mothers in the control site can feel stigma when discussing contraception openly. Unmarried girls rely heavily on mothers and friends for covert support, and boys describe fathers, older brothers and peers as their main confidants, with health workers becoming trusted sources primarily in the better-resourced project sites.

Pervasive discriminatory gender norms

Discriminatory gender norms continue to shape adolescents' SRH experiences and choices despite policy and programmatic gains. Providers and adolescents alike describe how girls are judged harshly for visible sexual activity or contraceptive use, with unmarried girls in particular fearful that pregnancy or clinic visits will spark gossip and accusations of promiscuity. In Follah, girls expect some nurses to reveal their pregnancies reinforcing both secretive pathways to care and lack of confidentiality by providers.

"I will first tell my mother [if I get pregnant]… Yes, they [nurses] will reveal it to others… They are angry about the fact that a little girl has gotten pregnant." (Unmarried adolescent girl, 10-14, Follah)

By contrast, boys' sexuality is more tolerated and sometimes valued once they have fathered a child, and boys experience less social sanction for being seen collecting condoms or seeking STI treatment, as long as they avoid overtly "weak" behaviours such as openly discussing fears or testing. Boys report peer norms that discourage condom use because of perceived reduced pleasure or myths about condom materials, and some see repeated STI treatment as preferable to consistent protection.

Early pregnancy is closely linked to expectations of marriage and responsibility. Boys in Manowa explain that impregnating a girl typically leads to being compelled to support or marry her, which they fear will derail their education and finances. Some girls, meanwhile, consciously seek pregnancy as "security" in relationships, believing that bearing a child will bind a partner and reduce the risk of abandonment, illustrating how gendered power and economic insecurity shape fertility choices in all three sites.

"Yes, some [boys] do that by encouraging their girlfriend to use contraceptives while they use condoms. The majority of the boys in this community are condom users, while most of the girls don't care about contraceptives, which is why there are lots of pregnancies." (Unmarried adolescent girl, 10-14, Manowa)

Underlying gender norms around chastity, masculinity and parental authority remain sticky, slowing change even where services have improved. Providers and national actors characterise these norms as "difficult to change": girls continue to hide contraceptive use from fathers and some health workers, and often confide first in mothers rather than going to facilities, particularly in the control site.

"No, my father is not aware that I have it… he would get angry with me and would say that if I ever became pregnant, he would send me out of his house. One of my friends had a mother who was angry and refused to let her take the Captain Band. But the girl went on her own to the hospital and got it because she was a student and wanted to continue her education." (Unmarried adolescent girl, 15-18, Follah)

"Some mothers bring their children to the centre… But I know of a girl who took an implant and later her father found out and instructed her to take it out; now that same girl is pregnant… Generally, the fathers do not have time with the children." (Health Service Provider, Manowa)

Adolescents' stories confirm that boys still avoid services that might signal vulnerability—such as counselling or HIV testing—and rely heavily on peers and phone-based content for sexual information, especially in Manowa and Luawa Baoma. Many youths were said to ignore ASRH school sessions but later show up pregnant or with STIs, reflecting the disjuncture between public norms and private behaviour.

Community expectations that pregnancies should be carried to term and that children be valued mean that induced abortion remains rare, clandestine and morally sensitive. Health workers in both Manowa and Luawa Baoma describe adolescents generally choosing to give birth once pregnant, with families and providers focusing more on quietly managing complications than on challenging the social conditions that drive early and unintended pregnancies.

Gender gaps in service uptake

Gender gaps in SRH service uptake are narrowing in the project sites but remain pronounced overall, with different patterns for girls and boys. Providers in Follah and Manowa report that girls, especially older and married adolescents, use a broader range of services—contraception, ANC, PNC and SRH counselling—more regularly than boys, while in Luawa Baoma girls' use of SRH services is still largely tied to pregnancy and childbearing.

"We have learned about STDs at the health facility from the health workers that has made us use condoms whenever we have sex. To continue our education, we encourage our girlfriends to continue using Family Planning contraceptives, We were made to understand from the health workers that if we allow them to get pregnant at a young age, it will affect their health and education. That is why we communicate with them regularly to ensure that they are safe and that they continue to use contraceptives, though we are using contraceptives if we experience any changes like STDs we report to the health facility for treatments because the nurses assured us that we should not be ashamed to report to them when we experience any signs of STDs for prompt treatments". (Adolescent Boy, 15-18, Follah)

Adolescent narratives show that small circles of young, unmarried boys in project sites have normalised regular condom collection and clinic contact, but many other boys continue to avoid services unless ill, complain about loss of pleasure, or rely on withdrawal when condoms are unavailable. Boys in the control site portray condom and HIV testing as useful but still exceptional, taken up by a more "exposed" minority.

"The new thing that I have learned is that besides the contraceptive used by my girlfriend, it is also important that I use a condom to prevent myself and my girlfriend from contracting an STI… as students, if we are not careful, we would contract STIs that would cost money to be treated." (Adolescent boy, 15-18, Follah)

"For the fact that he has come to us, we have to counsel him. We cannot let him go, because if we do and he goes on to have sex without protection, his partner may end up with a pregnancy they did not plan for. We will counsel him and make sure to give him a condom, because the condom will prevent both pregnancy and STIs " (Health Service Provider, Follah)

For girls, marital status and schooling are decisive. Unmarried school-going girls in Luawa and Follah can and do access implants and injectables, often with quiet maternal backing, but still have partial knowledge of methods and depend heavily on the attitudes of specific providers. Married girls and adolescent mothers across sites become regular users and are more openly targeted with counselling and postpartum family planning, while younger unmarried girls receive more age-appropriate information, but when they need to access services, they do so more covertly.

"When our mother took us to the hospital to get the captain band… [the nurse] told us they expect us to continue our education, and so no man should tell us to remove the captain band… if we fail to see our period… we must go and tell them." (Unmarried adolescent girl, 15-18, Follah)

Additional challenges to service delivery

Structural and health-system constraints significantly limit the reach and quality of adolescent-friendly SRH services in all sites. Commodity stockouts—especially of condoms, pills and injectables—are recurrent problems; adolescents describe being forced to buy condoms or revert to withdrawal, and providers in Manowa report sometimes purchasing commodities themselves to avoid turning adolescents away.

Staffing shortages and weak infrastructure compound these issues. Manowa's main midwife emphasises limited manpower and competing demands (ANC, PNC, outpatient care) that leave little time for adolescent-specific services or follow-up, while Luawa Baoma staff report having no pamphlets or IEC materials, only basic STI tests (HIV and syphilis) and no formal training in family planning or abortion care. Adolescents in Follah and Luawa Baoma report variable confidentiality and provider attitudes: some nurses are supportive and advise evening visits; others gossip about pregnancies or request payments for prevention, undermining trust particularly among younger unmarried girls.

Across all three sites there are no fully developed adolescent corners, limited systematic follow-up and little formal use of peer educators beyond organically formed youth circles. Health workers themselves call for more consistent monitoring, better use of the infrastructure already provided (such as furniture and refrigerators), and additional tools—posters, counselling guides, community-facing materials—to help explain the mandate for adolescent SRH services and manage potential community sensitivities around contraception and post-abortion care.

Similarities and differences between project and control sites

All three facilities provide a comparable core package of SRH services to adolescents—family planning, pregnancy testing, ANC/PNC, STI treatment and some HIV testing—and face similar social barriers related to stigma, parental opposition and privacy. Peer dynamics around condoms, parental emphasis on abstinence and double standards that scrutinise girls more than boys are present across project and control sites.

What distinguishes Follah and Manowa is the layering of adolescent-specific adaptations and external support onto this baseline. Project sites have adolescent focal staff, more frequent school and community outreach, NGO-supported safe spaces and youth activities, and stronger investment in provider training for family planning and, in Manowa, post-abortion care, which together foster earlier and more diversified SRH use among girls and more routinised condom uptake among some boys.

Luawa Baoma, by contrast, relies on standard outpatient structures, a single secondary school for most adolescent SRH messaging, and generalist health workers without adolescent-specific training or NGO backing. As a result, adolescent engagement is more emergency-driven, with girls accessing services mainly around pregnancy and childbirth and boys largely absent from preventive SRH, illustrating how similar policy frameworks can play out quite differently depending on local resourcing, partnerships and service adaptations.

Implications for policy and programming

Overall the findings to point to the following key implications for ensuring adolescent-friendly sexual and reproductive health policy and programming:

Embed and scale adolescent-friendly standards. Formalise adolescent-friendly norms (confidentiality, non-judgement, privacy, dedicated time and focal staff) and ensure they are implemented system-wide, with particular attention to under-resourced control sites and to sustaining trained staff in project facilities.

Take specific action against SRHR misinformation at the community level. Collaborate with mentors and community allies, including adolescents, to identify misinformation around SRH and develop specific communication materials and session contents to dispel such misinformation which can put adolescents at risk. This includes, for example risky behaviours incurred by adolescent boys given misinformation related to masculinity and the use of condoms, or infertility associated with contraceptive methods.

Deepen gender- and age-responsive community work. Intensify engagement with fathers, male leaders and religious actors to address double standards and stigma, and tailor interventions to younger and unmarried adolescents through safe spaces, school clubs and peer-led outreach that speak to different age groups and lived realities. Strengthen community sensitization around Girl Shine to help increase community acceptance.

Support providers as consistent change agents. Move from reliance on individual "champions" to a broader cadre of trained, supervised providers, with regular monitoring, feedback and practical tools ((job aids, vignettes, youth-friendly counselling guides) to facilitate constructive conversations on puberty, menstrual hygiene, contraception and HIV with adolescents of all genders. This can equip them to manage tensions between clinical guidance and community norms while upholding adolescents' rights to quality SRH care.

Stabilise commodities and expand method literacy. Strengthen supply chains for condoms, pills, injectables and implants, and equip providers with clear job aids and IEC tools so they can present a wider method mix, address misconceptions and promote dual protection for girls and boys.

Cross-country conclusions

Improvement in ASRH services and delivery across project sites

Across Mali, Niger and Sierra Leone, project sites show clear improvements in the organisation and content of ASRH services. Support through the Foundations project has contributed to more systematic adolescent-directed counselling, guided visits, strengthened provider skills in SRH, GBV and, where legal, post-abortion/PAC, and modest adaptations in service organisation (e.g. flexible hours, safer spaces, better referral and follow-up). However, gaps remain across countries in privacy, dedicated adolescent spaces, disability inclusion and consistent commodity availability, indicating that adolescent-friendly approaches are being layered onto still-fragile primary health systems rather than fully institutionalised.

Positive changes for adolescents exposed to Foundations programming

In project facilities, adolescents describe more regular and confident use of SRH services, including contraceptive counselling, HIV/STI testing, ante-natal and post-natal care and, where available, GBV care and post-abortion care. Girls and boys in Mali and Sierra Leone particularly highlight improved provider communication, clearer information on methods and side-effects, and greater comfort asking questions, with some reporting shifts from crisis-driven attendance (pregnancy, infection) toward more preventive visits. Older married adolescents in Mali and young mothers in Sierra Leone also report that services and mentoring supported by the Foundations project have helped them negotiate birth spacing and contraceptive continuation with partners, suggesting early gains in decision-making power for some cohorts.

Positive changes in community and parental attitudes toward ASRH

Based on interviews with health service providers and adolescents, evidence collected indicates gradual but meaningful softening of parental and community attitudes, especially among mothers, some community leaders and selected male champions. However, based on the sense of stigma still reported by adolescents and health workers that continues to limit adolescents' demand for ASRH services, religious messaging, pervasive discriminatory norms, attitudes by many fathers and community elders remain a barrier, In all three countries, community dialogues, school-based activities and safe spaces supported by the Foundations project are credited with making adolescent contraception, HIV testing and facility use more accessible, even if not fully accepted, and with legitimising the role of health workers as appropriate interlocutors for young people. Mothers in the three countries increasingly accompany daughters for contraception and antenatal care; in Niger and Mali, religious and traditional leaders engaged by the project have begun presenting birth spacing, GBV response and girls' schooling in ways that align ASRH with valued norms such as protection, responsibility and family wellbeing.

Pervasive social norms

Despite these advances, restrictive social norms around gender, sexuality and age remain powerful cross-country constraints. Across project sites, girls still face stronger sanctions than boys for visible sexuality, pregnancy outside marriage and contraceptive use, and unmarried adolescents of both sexes must navigate expectations of abstinence and obedience that limit open SRH discussion with adults. Norms that value fertility, child marriage, FGM (especially in Sierra Leone and Mali) male sexual freedom and female modesty—often reinforced by economic insecurity—continue to shape which adolescents can safely access services, under what conditions, and with how much autonomy, leaving younger, poorer and unmarried girls particularly vulnerable. Further, messaging around child marriage and FGM appear to be

relatively weak in health service messaging around ASRH in project sites researched, so information and messaging around these would benefit from being strengthened.

Attitudes and behaviours toward ASRH

Attitudinal change has outpaced behavioural transformation for many adolescents and adults. In all three countries, adolescents in project sites demonstrate better SRH knowledge, greater awareness of rights and services, and more positive views of health workers, but their practices remain mediated by fear of stigma, partner dynamics, parental control and cost or stockout barriers. Boys frequently endorse condoms and see their value for education and future plans, yet some still prioritise pleasure or peers' approval over consistent use and neglect STI detection or treatment; girls may value implants or injectables as they consider them to be more discreet contraception methods, but still discontinue or delay use due to side-effect concerns, partner opposition or breastfeeding norms. Health workers in project facilities increasingly endorse adolescent-friendly, gender-sensitive care, but some continue to struggle with moral judgements, confidentiality breaches and the tension between policy commitments and local expectations.

Policy implications and recommendations

Local level recommendations:

Strengthen adolescent-friendly organisation of services inside facilities
Designate at least one adolescent focal provider per health centre, with clear responsibility for youth SRH, and adjust workflows so adolescents can be seen at predictable times (e.g. after school, specific afternoons) without queuing for long with adults. Create low cost privacy solutions—simple screens, rearranged seating, separate registration lines for "youth clinic hours", and confidential recordkeeping—to reduce visibility and gossip, even where there is no purpose built adolescent room.-

Provide further and ongoing practical, recurring skills support for frontline providers
Promote further training through onsite coaching cycles focused on nonjudgemental communication, confidentiality, counselling on side effects and dual protection, and handling cases of very young or unmarried adolescents. Incorporate simple tools—job aids on method options, scripts for difficult conversations with parents, checklists for confidentiality and GBV screening—into routine supervision, and use adolescent feedback (via suggestion boxes, short interviews) to identify and correct harmful practices such as scolding, breaches of confidentiality or informal fees.

Deepen community and peer-led mobilisation around ASRH
At community level, promote safe spaces in all health centres and support school clubs as ongoing platforms where trained peer educators and trusted adults (mentors, teachers, community health workers) jointly deliver age segmented SRH sessions, link adolescents to named providers, and foster continued peer sensitisation. Involve mothers, fathers and religious/traditional leaders in periodic sensitisation and dialogue circles hosted by the health centre and in community groups using local stories and simple data from the facility (e.g. adolescent pregnancy, STI trends) to discuss why contraception, HIV/STI testing and GBV care for adolescents are framed as protection and support rather than moral failure. Strengthening community sensitization around Girl Shine and GREAT as core community learning activities for girls using the spaces mentioned above is necessary to foster community acceptance, as current resistance by some parents and community members and parents may put girls who attend the sessions secretly at risk of harm.

Specifically target misinformation through community sessions with adolescents, parents and leaders

Use spaces such as community sessions with adolescents (Girl Shine, Great, Real Fathers, EMAP) and with parents and community leaders as well as deploying communication materials such as posters, with specific messaging that identifies myths or misconceptions that circulate in the community, using examples, and provide concrete evidence and scientific information about why that information is wrong, and what risks adolescents face by believing it. Where possible, provide access to further online or printed material that allows them to learn more.

Scale community and school-based engagement that target entrenched norms

Local authorities and partners could institutionalise the most effective Foundations project approaches—safe spaces, school clubs, community dialogues, peer educators and work with religious/traditional leaders—within district plans and education and social protection systems. Programming needs to remain explicitly gender- and age-responsive, with differentiated messaging for very young, middle and older adolescents, and with specific attention to younger and unmarried girls whose access remains most constrained.

Policy implications

Institutionalise adolescent- and gender-responsive service standards

The Foundations project could continue contributing to upstream advocacy work to engage ministries of health and professional councils to embed adolescent-friendly, gender-responsive norms (confidentiality, non-judgement, privacy, respectful communication, GBV response) into national quality standards, supervision tools, pre-service curricula and continuous professional development, rather than relying on project-specific guidance. This includes minimum requirements for adolescent-appropriate spaces or scheduling, basic disability access and clear protocols for SRH and GBV care for under-18s.

Stabilise commodities and expand method choice

Support the government in the strengthening supply chains for a full contraceptive and SRH commodity mix (including STI diagnostics and treatment, and PAC where legal) is essential to translate new demand into sustained use. Policy should prioritise ring-fenced adolescent-SRH commodity budgets at district level, simple stock-monitoring systems and explicit guidance on dual protection so that boys and girls can combine condoms with longer-acting methods where appropriate.

Invest in provider support, supervision , monitoring and evaluation, and retention of trained staff in project districts

Policies should prioritise retaining trained staff in project facilities, reducing disruptive transfers of personnel and resourcing regular supportive supervision that includes observation of adolescent consultations, coaching on values clarification and feedback from adolescent clients. Dedicated adolescent/young-people focal persons at facility and district level can help sustain momentum, mentor peers and champion ASRH within broader UHC and RMNCAH agendas. Strengthening monitoring efforts not only by Foundations project staff but by district health officials, and strengthening the collection and reporting of administrative data, would be central to the continued improvement of adolescent-friendly service delivery.

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