(*Adolescent SRH Service Satisfaction*), photo credit: Sylvia Hebron, Foundations-Sierra Leon

Adolescent Sexual and Reproductive Health in West Africa

Synthesis Baseline Report for Foundations Project

Authors: Mariam Diakite, Shruthi Dileep, Aichatou Hamadou, Nicola Jones, Hadiza Kadri, Muallem Kamara, Henrietta Kumba Koroma, Fodié Maguiraga, Christine Makia, Bintu Mansaray, Marlene Ntsinda Tchoffo and Paola Pereznieto[1]

[1] Authors' names are listed alphabetically

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1. Introduction

Sustainable Development Goal 3.7 calls for the realisation of universal access to sexual and reproductive health-care services, including for family planning, information and education, by 2030. West Africa faces the highest levels of unmet need and adolescent fertility rates globally. In fact, a 2023 report by the United Nations Economic Commission for Africa concluded that the trend in the region was 'moving away from the target' (p,37).

Against this backdrop, this report summarises the baseline findings of a longitudinal qualitative research assessment being conducted in Mali, Niger and Sierra Leone exploring the barriers and facilitators to adolescent sexual and reproductive health (ASRH) knowledge, practices, and access to services. The aim is to understand how the multi-component, multi-year (2020-2027) Foundations project (funded by Global Affairs Canada and implemented by Save the Children Canada in partnership with Save the Children International (Mali, Niger, Sierra Leone), the International Rescue Committee (IRC), Equipop, ODI and SickKids) is improving adolescent knowledge, attitudes and behaviours on sexual and reproductive health, broadly defined through changes among adolescents as well as their enabling environment, including their family, community, and service providers. This is an operational research study with the goal of informing programming for Foundations and for findings to be used in advocacy activities.

In all three countries, the study sites are divided between those where Foundations' multi-pronged, multi-year programming is being rolled out ('treatment' sites), and those that will have no programming ('control' sites). This will allow the programme to explore, over time, how it is contributing to change in adolescent sexual and reproductive health. The study also pays particular attention to differences based on gender, education, disability and marital status. It aims to generate evidence-informed recommendations for how to strengthen ASRH education and services in the three countries, in line with the Sustainable Development Agenda commitment to ensure health and well-being for all.

The report is organised as follows; After providing a brief overview of the state of adolescent sexual and reproductive health in Mali, Niger and Sierra Leone (section 2), we present the research sample, methodology and tools (section 3). In section 4 we present the findings, which we have organised thematically, on: adolescent access to sexual and reproductive health information; contraceptive use and uptake; abortion awareness and practices; access to sexual and reproductive health services; gender-based violence; child marriage; and female genital mutilation and cutting (FGM/C). Within each theme the findings are presented by country. Section 5 concludes and discusses the implications of our research findings for policy and programming.

2. Background context

Adolescents in Mali, Niger and Sierra Leone face significant challenges around their sexual and reproductive health, shaped by diverse socio-cultural contexts. This section outlines the background context for adolescent sexual and reproductive health (ASRH) in each of the three countries, providing an overview of the key challenges across these country contexts. Table 1 provides a concise overview of the relevant data, highlighting key indicators and trends.

Table 1 SDG Sexual and Reproductive Health Indicators for Mali, Niger, and Sierra Leone

Sustainable Development Goal (SDG) SRH indicator	Mali	Niger	Sierra Leone
Proportion of women (aged 15–49) whose need for family planning is satisfied with modern methods	44.2% in 2018 (World Health Organization [WHO], 2024f)	44.1% in 2017 (World Health Organization [WHO], 2024f)	53% in 2019 (World Health Organization [WHO], 2024f)
Adolescent birth rate (aged 15–19 years) per 1,000 women in that age group	144.8 (National Institute of Statistics [INSTAT], National Program for the Fight Against Malaria [PNLP], & ICF, 2022)	150.3 (National Institute of Statistics [Institut National de la Statistique, INS] & ICF, 2023)	101.9 (Demographic Health Survey [DHS], 2019)
Proportion of women (aged 15–49) making informed decisions about sexual relations, contraceptive use, and reproductive health care	7.7% (Demographic Health Survey [DHS], 2018)	7.30% (Demographic Health Survey [DHS], 2012)	36.3% (Demographic Health Survey [DHS], 2019)
Maternal mortality ratio (per 100,000 live births)	440 in 2020 (World Health Organization [WHO], 2024g)	441.1 in 2020 (World Health Organization [WHO], 2024g)	442.8 in 2020 (World Health Organization [WHO], 2024g)
Proportion of births attended by skilled health personnel	43.7% in 2015 (World Health Organization [WHO], 2024b)	43.7% in 2021 (World Health Organization [WHO], 2024b)	86.9% in 2019 (World Health Organization [WHO], 2024b)
Under-5 mortality rate (per 1,000 live births)	94	117	101

	(United Nations Inter-agency Group for Child Mortality Estimation. 2024)	(United Nations Inter-agency Group for Child Mortality Estimation. 2024)	(United Nations Inter-agency Group for Child Mortality Estimation. 2024)
HIV incidence (new infections per 1,000 uninfected adolescents aged 10–19 years)	0.08 per 1,000 (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2022)	0.01 (UNAIDS, 2022)	0.7 per 1,000 (UNAIDS, 2022)
Child marriage	54% of girls and 2% of boys are married before age 18, and 16% of girls marry before age 15 (Demographic Health Survey [DHS], 2018)	76% of girls are married before age 18, and 28% before age15 (Demographic Health Survey [DHS], 2012)	Before the age of 15, 8.6% Before the age of 18, 29.6% (Demographic Health Survey [DHS], 2019)
Female genital mutilation/cutting	75% of girls experience FGM before age 5, and 86% of girls aged 15–19 have already been cut. (UNFPA, 2021)	FGM prevalence is 2% among women aged 15–49 (Demographic Health Survey [DHS], 2012)	71% of adolescent girls were cut before the age of 15 (Demographic Health Survey [DHS], 2019)
Gender-based violence	49% (Demographic Health Survey [DHS], 2018)	38.2% (Institut National de la Statistique [INS], 2022).	Physical violence, 38.4% Sexual violence, 6.2% Psychological violence, 38.3% (Demographic Health Survey [DHS], 2019)

Mali

Mali faces significant challenges in improving adolescent sexual and reproductive health, with progress being impeded by high adolescent birth rates, child marriage, FGM, and limited access to essential health services. The adolescent birth rate remains alarmingly high at 144.8 births per 1,000 women aged 15–19 (INSTAT, PNLP & ICF, 2022), reflecting gaps in preventing early pregnancies. While 44.2% of women aged 15–49 reported having their family planning needs met using modern methods (DHS, 2018), only 7.7% of women of reproductive age (including adolescents) make informed decisions about their sexual and reproductive health (DHS, 2018). Legal restrictions exacerbate these issues, as outlined in Article 13 of the 2002 Reproductive Health Law, which prohibits abortion except to safeguard the life of the pregnant woman or in cases of rape or incest (Traoré & Bulthuis, 2018). Though post-abortion care is legal, the restrictive nature of the law leaves many women, particularly adolescents, at risk of unsafe procedures, underscoring critical gaps in reproductive health care.

Maternal and child health indicators highlight further areas of concern. The maternal mortality ratio has risen to 440 deaths per 100,000 live births in 2020 (WHO, 2024), and only 43.7% of births are attended by skilled health personnel, particularly in rural areas where healthcare access remains limited (WHO, 2024). These deficiencies contribute to a high under-5 mortality rate of 94 deaths per 1,000 live births (UNICEF, 2024). Although HIV incidence among adolescents aged 0–14 years is relatively low at 0.08 per 1,000 (UNAIDS, 2022), comprehensive health services for adolescents are insufficient to address broader SRH challenges. Efforts to integrate SRH education into the school system were halted in 2018 due to opposition from religious leaders, further limiting adolescents' access to critical SRH knowledge and services (Cone & Lamarche, 2021).

Harmful practices, such as child marriage and FGM, remain pervasive, rooted in cultural norms and exacerbating gender-based violence. Approximately 54% of girls and 2% of boys are married before age 18, and 16% of girls are married before age 15 (DHS, 2018). FGM affects 75% of girls before age 5, with 86% of adolescent girls aged 15–19 already having been cut (UNFPA, 2021). Gender-based violence is widespread, with nearly 49% of women reporting experiences of violence (DHS, 2018). These interlinked issues, combined with legal barriers to abortion and insufficient access to health care, highlight the urgent need for culturally sensitive, community-driven interventions to address gender inequalities and protect adolescent girls' health and rights.

Niger

In Niger, adolescents and youth face significant social, physical, and economic challenges that hinder their ability to fully realize their sexual and reproductive health and rights. The country has the highest fertility rate globally, averaging 6.82 births per woman, and the youngest age for marriage and childbearing in the region (African Women's Development and Communication Network, 2022). These factors contribute to severe obstacles in accessing education, healthcare, and other essential services, undermining the potential for improved SRHR outcomes for adolescent girls.

The proportion of women of reproductive age (15–49 years) whose need for family planning is satisfied with modern methods has shown gradual progress, increasing to 44.1% in 2017 (WHO, 2024). Despite this improvement, significant challenges remain, particularly for adolescents. In 2020, the adolescent birth rate was recorded at 150.3 births per 1,000 females aged 15–19 years (National Institute of Statistics [INS] & ICF, 2023), highlighting persistent high rates of early pregnancy. Only 7.3% of women reported making informed decisions about sexual relations, contraceptive use, and reproductive health care (DHS, 2012), underscoring a substantial gap in education, empowerment, and awareness.

Maternal health in Niger is also a major concern. The maternal mortality ratio was recorded at 441.1 deaths per 100,000 live births in 2020 (WHO, 2024), indicating significant risks associated with childbirth, especially in rural areas with limited access to quality healthcare. Only 43.7% of births were attended by skilled health personnel in 2021 (WHO, 2024), which compounds the likelihood of complications during delivery. This, combined with inadequate sexual and reproductive health education, contributes to a high under-5 mortality rate of 117 per 1,000 live births in 2022 (United Nations Inter-agency Group for Child Mortality Estimation, 2024). However, Niger has relatively low HIV incidence, with new infections at 0.01 per 1,000 uninfected adolescents aged 10–19 years in 2023 (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2022), reflecting some positive health outcomes in terms of controlling HIV transmission among young populations.

Harmful traditional practices such as child marriage, female genital mutilation (FGM), and gender-based violence (GBV) are also prevalent in Niger. According to the Demographic and Health Survey (DHS) data from 2012, 76% of girls were married before the age of 18, with 28% marrying before age 15. Gender inequality and child marriage remain politically sensitive in Niger with efforts to combat these often facing backlash from social groups and religious leaders.

According to the *National Survey on Fertility and Child Mortality Under Five in Niger 2021* conducted by the Institut National de la Statistique (INS) and Utica International (2022) gender-based violence (GBV) affects 38.2% of women and teenagers. Six in ten Nigerien women (59.6%) find it justified for a man to beat his wife (African Women's Development and Communication Network, 2022). While FGM is less widespread compared to other regions, affecting only 2% of women aged 15–49 (DHS, 2012), the practice persists among certain ethnic groups, particularly in areas bordering Mali and Nigeria. FGM is often viewed as a means to maintain female purity and enhance marriage prospects. Niger has legislation prohibiting FGM under Law No. 2003-025 (the Penal Code), adopted in June 2003 (FGM/C Research Initiative, 2020). However, the enforcement of this law remains weak, with few prosecutions taking place.

Sierra Leone

Sierra Leone has made notable progress in adolescent sexual and reproductive health over the last decade. According to WHO (2024), 53% of women aged 15–49 have their family planning needs met with modern contraceptive methods. The adolescent birth rate stands at 101.9 births per 1,000 adolescents aged 15–19 years (DHS, 2019), which is significantly lower than the rates in Mali and Niger. Furthermore, 36.3% of women of reproductive age, including adolescents, report making informed decisions about sexual relations, contraceptive use, and reproductive health care (DHS, 2019).

In Sierra Leone, maternal health remains a critical challenge with the maternal mortality ratio at 442.8 per 100,000 live births (WHO, 2024). While 86.9% of births are now attended by skilled health personnel (WHO, 2024), disparities persist, particularly in rural and underserved areas. Unsafe abortions contribute to approximately 10% of maternal deaths, a consequence of restrictive abortion laws that compel women to seek unsafe and clandestine procedures (Mangwana, Omao, & Kamara, 2023).

The under-5 mortality rate in Sierra Leone is 101 per 1,000 live births (United Nations Inter-agency Group for Child Mortality Estimation, 2024), reflecting persistent public health challenges. HIV incidence among adolescents aged 10–19 years is relatively low, at 0.7 new infections per 1,000 (UNAIDS, 2022).

Child marriage continues to be a serious issue, particularly in rural areas. According to the 2019 DHS, 8.6% of girls are married before the age of 15, and 29.6% are married before 18. It is estimated that around 800,000 girls in Sierra Leone are currently married, with half entering into marriage before the age of 15. In a significant step toward addressing this issue, the Sierra Leone Parliament enacted the *Prohibition of Child Marriage Bill* in 2024, criminalizing marriage under the age of 18.

Female genital mutilation (FGM) remains highly prevalent, with 71% of adolescent girls reporting being cut before the age of 15 (DHS, 2019). The *Child Rights Act of 2007* includes provisions that prohibit any form of torture or cruel, inhuman, or degrading treatment or punishment of a child. This extends to any cultural practice that dehumanizes or harms the physical or mental well-being of a child.

Section 2 of the Act defines female genital mutilation (FGM) as the "cutting or removal of any part of the female genitalia," but the term FGM is not mentioned elsewhere in the Act (28 Too Many, 2018). While this definition helps recognize the practice, the absence of direct references to FGM in other parts of the law shows the need for clearer and more comprehensive legal measures to tackle this harmful practice effectively.

Gender-based violence (GBV) is also widespread, affecting many women and girls. Some 38.4% of women report experiencing physical violence, 6.2% report sexual violence, and 38.3% report psychological violence (DHS, 2019).

3. Methodology

The research teams employed a qualitative research design to capture and triangulate in-depth perspectives from adolescents, caregivers, community members and key informants. The study used a combination of key informant interviews (KIIs), body mapping, social mapping, community mapping, and adolescent in-depth interviews (IDIs), as well as focus group discussions (FGDs), to gather data in both programming and non-programming sites. These tools were employed at baseline to assess the existing knowledge, attitudes and practices related to sexual and reproductive health, gender-based violence, child marriage and FGM in the study communities.

Participants

The baseline study included a total of 547 adolescents across the three countries, alongside their caregivers, community members, and key informants to provide a comprehensive understanding of the broader social and cultural context in which these adolescents live. Tables 2, 3 and 5 provide a summary of the number of participants in each category, by country (see also Annex 4: Participants per tool per country) .

Table 2 Tools and types of participants per community in Mali

Method	Activities	Number of participants					
		Sincina	Namposela	Mpessoba EPR	Mpessoba Zantiéla	Bougouni	TOTAL
Social Norms FGD	Fathers	0	10	0	5	10	25
	Mothers	0	7	0	6	10	23
	Stakeholders	8	0	6	0	7	22
Body Map FGD	Boys	8	8	6	?	10	34
	Girls	8	0	8	0	10	26
Individual adolescent interviews	Married girls	3	3	3	4	10	23
	Unmarried girls	6	4	3	1	7	21
	Unmarried boys	4	6	4	2	7	23
	Married boys	0	0	0	0	0	0
Community mapping	Unmarried girls	8	0	6	0	8	22
	Unmarried boys	8	0	6	0	6	20
	Married girls	0	8	0	6	10	24
KIIs	Police	1	0	0	0	2	3

	Male teacher	1	0	1	1	1	3
	Female teacher	2	1	1	1	0	4
	Traditional leader	0	2	1	1	1	4
	Religious leader	1	1	0	0	1	3
	Health worker	1	0	1	0	2	3
	Marie	0	0	0	0	1	1
	Protection agent	1	0	1	0	0	2
	Promotion of women	0	0	0	0	1	1

Table 3 Tools and types of participants per community in Niger

Method	Activities	Number of participants						
		Garare	Ouara	Maiguijé	Magaria	Awache	Total number of interviews	Total number of participants
Social norms FGD	Fathers	1 (8)		1 (8)		1 (8)	3	24
	Mothers	1 (8)		1 (8)		1 (8)	3	24
	Stakeholders	1 (8)			1 (8)		2	16
Body map FGD	Boys	1 (8)		1 (8)		1 (8)	3	24
	Girls	1 (8)	1 (8)		1 (8)		3	24
Adolescent IDI	Married girls	6	3	2	3	2	16	16
	Unmarried girls	5	5	3	2	2	17	17
	Unmarried boys	7	4	3	3	3	20	20
	Married boys							
Community mapping FGD	Unmarried girls	8	8		8		3	24
	Unmarried boys	8	8		8		3	24
	Married girls	8		8		8	3	24
Key informant interview	Police	1	1				2	2
	Male teacher	1	3		1	1	6	6
	Female teacher							
	Traditional leader			1			1	1

	Religious leader			1			1	1
	Health worker	2	1	2	1	1	7	7
	Community leader	3		2		1	6	6
	Protection agent	2	1		1	2	6	6
	Women's Development Agent	1				1	2	2
Total							**107**	**268**

Table 4 Tools and types of participants per community in Sierra Leone

Method	Activities	Number of participants						
		Manowa	**Bunumbu**	**Follah**	**Gbahama**	**Woroma**	**Total number of interviews**	**Total number of participants**
Social norms FGD	Fathers	1(8)	1(6)	2(7+7)		1(8)	5	36
	Mothers	1(8)	1(8)	1(6)		2(8+8)	5	38
	Stakeholders	1(7)		1(8)	1(8)	1(8)	4	31
Body map FGD	Boys	1(7)	2(16)	1(6)		1(8)	5	37
	Girls	1	1	1	1		4	4
Adolescent IDI	Married girls	1	1		5	1	8	8
	Unmarried girls	5	1	3	1	6	16	16
	Unmarried boys	6	5	2	7	7	27	27
	Married boys						1	1
Community mapping FGD	Unmarried girls	1(8)	2(7)	2(6)		1(8)	6	29
	Unmarried boys	1(7)	1(8)	1(7)	2(8+7)	1(8)	6	45
	Married girls	1(8)	1(8)	1(7)		1(8)	4	31
Key informant interview	Police	2	3				5	5
	Male teacher	1		2	2	1	6	6
	Female teacher	1	1	1	2	1	6	6
	Traditional leader		2	2		2	6	6

	Religious leader	1	1	1	1	1	5	5
	Health worker	1			2	1	4	4
	FGM cutter	1	1	1		2	5	5
	Protection agent						3	3
	Women's Development Agent						2	2
Total							**133**	**345**

Study sites and sampling

The study sites (see also Annex 2: Maps with study locations) were divided into two categories:

Programming (treatment) sites: These are areas where Foundations' multi-pronged, multi-year programme is being implemented. Data from these communities will allow the study to assess the impacts of the Foundations invervention on adolescent sexual and reproductive health outcomes over time. Here we selected communities with programming that were both close to district-level health and education services, as well as those that were more remote.

Non-programming (control) sites: These sites do not receive any programming interventions from Foundations. They serve as a comparison to assess the changes attributable to the intervention versus those that are due to other external factors e.g. government policy changes, external shocks, other NGO interventions.

This comparative design allows us to investigate how the Foundations package of interventions contribute to improvements in adolescents' sexual and reproductive health knowledge, attitudes and practices, including addressing harmful gender norms and practices such as child marriage, gender-based violence and FGM.

Data collection tools

The data collection tools (see also Annex 1: Key research questions and tools) employed at baseline included:

Key informant interviews (KIIs): Conducted with community leaders, health professionals, and other local stakeholders including teachers, religious leaders and health workers to gather insights on community-level sexual and reproductive health issues, gender-based violence, child marriage and FGM.

Body mapping: A participatory tool used with adolescents to facilitate discussions about their bodies, their knowledge of sexual and reproductive health, and personal experiences with health and gender-based issues.

Social mapping: A method used to understand the social networks and influences on adolescents within their communities.

Community mapping: A tool to identify key services, resources, and social norms related to sexual and reproductive health, gender-based violence and FGM in each community.

Adolescent in-depth interviews: These interviews provided qualitative data on adolescents' personal experiences, challenges and aspirations regarding sexual and reproductive health, gender norms and violence.

Timeline

This baseline study was conducted between December 2023 and April 2024, sequentially in the three countries, drawing on lessons from research implementation in one country to improve it in the next country. Data collection by the Mali team took place in February 2024; in Sierra Leone it took place in March 2024; and in Niger in April -May 2024.

Study objectives

In line with the Sustainable Development Goal (SDG) commitment to ensuring health and well-being for all, particularly for adolescents in vulnerable settings, the ultimate objective of the Foundations programme is to enhance the empowerment of adolescent girls, especially the most vulnerable and marginalised, enabling them to exercise their sexual and reproductive rights in Mali, Niger and Sierra Leone. t

By examining the experiences and perspectives of adolescents and their communities, the study at baseline aims to:

- assess the baseline knowledge, attitudes and practices related to sexual and reproductive health, gender-based violence, child marriage and FGM;
- evaluate the role of Foundations' multi-pronged programme in improving adolescent sexual and reproductive health outcomes;
- provide evidence-informed recommendations for enhancing sexual and reproductive health education and services in the three study countries.

Ethics approvals

The ethical integrity of this research was ensured through comprehensive review and approval by relevant national ethics boards. Prior to data collection, ethical approval was obtained from the National Committee on Ethics for Health Research in Niger, *Comité d'éthique pour la santé et les sciences de la vie* (CNESS) in Mali and the Sierra Leone Ethics and Scientific Review Committee, adhering to international standards for research involving human subjects. Key ethical considerations included an information notice about the study's scope and purpose, informed consent, confidentiality, and the protection of vulnerable populations, particularly adolescents. All participants were informed of their rights, the voluntary nature of their participation, and the measures in place to ensure their anonymity. Safeguarding protocols were established to address any disclosures of sensitive information, such as gender-based

violence, child marriage, or female genital mutilation (FGM), ensuring that appropriate support and referrals were available. Ongoing oversight was maintained to monitor compliance with ethical standards throughout the research process. Table 5 provides an overview of research approvals.

Table 5 Overview of Research Approvals

Institution/organisation	Country	Approval reference number	Date of approval	Approval duration	Remarks
Comité d'éthique pour la santé et les sciences de la vie (CNESS)	Mali	2024 001	5 January 2024	Until the end of the first round of data collection	The national committee, *Comité d'éthique pour la santé et les sciences de la vie* (CNESS), reviewed the protocol, proposed improvements, and provided the approval letter, authorising data collection within the community.
National Committee on Ethics for Health Research	Niger	No. 14/2023/CNERS	27 February 2024	Indefinite	Submit the final study report to the Ethics Committee
Sierra Leone Ethics and Scientific Review Committee	Sierra Leone	004/12/2023	18 December 2023	1 year	

4. Findings

We now turn to discuss the research findings, which are organised by theme. For each theme, we begin by presenting cross-country findings in a summary box, then disaggregate the findings by country setting, given the importance of tailoring programming in accordance with context specificities.

Sexual and reproductive health information

Cross-country key findings

- Adolescents rely predominantly on family and friends for information on sexual and reproductive health issues, given limited access to information provided by government service providers.
- Due to stigma and conservative social norms, many young people (especially adolescent boys) are often reticent to seek out such information.
- Location differences were notable, with adolescents living in urban centres and in more proximate research sites having significantly better access to sexual and reproductive health information and services.
- In some settings, health workers and doctors organise awareness-raising sessions with girls and women, and human biology classes in school also provide some factual information about sexual and reproductive health issues.
- In less accessible locations, where non-governmental organisations (NGOs) are operational, they are often key sources of accurate sexual and reproductive health information and supplies.

Mali

Our findings show that overall, in the Malian research sites, adolescents (and particularly girls) often obtain information about sexual and reproductive health, particularly on changes during puberty and family planning from close and trustworthy sources, such as friends or some family members (especially their elder sisters and mothers) given that, particularly in more remote sites, they have limited access to official sources of information. In the case of Bougouni, which is the more developed site, adolescent girls have better access to information on family planning and HIV thanks to greater accessibility to information (radio, television, social media), as well as more accessible health centres and a relatively higher level of education than in the two more remote sites. Adolescents also spoke about receiving basic information about puberty at school, and in one of the more remote sites, M'pessoba, older adolescents cited an NGO programme (not Save the Children) as a source of information, but such services are absent in the other remote site, as noted by a younger adolescent boy participating in a body mapping in Namposela:

> *'We don't know of any sexual health services here' 'There is no service or institution where we can get information on sexual and reproductive health'*

In all cases, however, adolescents' knowledge of sexual and reproductive health varies according to their experiences; those who have already reached menarche (first onset of menstruation) have a better

understanding of menstruation, the risks of pregnancy and family planning, whereas those who have not yet begun menstruating often lacked this essential information.

The interviews indicated that many adolescent girls linked the physical changes in their body with their reproductive capacity, identifying the menarche as the key sign marking the start of this new phase in their lives. For many, the onset of menstruation is often seen not only as a rite of passage to adulthood, but also as a concrete indicator of their reproductive potential. This biological phenomenon thus becomes central to their understanding of femininity, leading them to associate puberty with the possibility of pregnancy and, by extension, with their future role as a mother. As a younger adolescent girl involved in a body mapping focus group discussion (FGD) in Bougouni noted:

> *Many think about helping their parents, their bodies change, they start menstruating, etc... The breasts get bigger, the mind changes, you think about working... Some think about boys. If you start having relationships, you don't listen to your parents anymore. All the thinking revolves around boys.*

The findings underscore that location matters when it comes to accessing information on sexual and reproductive health. In Bougouni, a village that is only 8 km from Koutiala, the district centre, adolescent girls reported having good access to information on family planning and HIV given that the community has better service accessibility than in the more remote locations, including a relatively high level of education, and active outreach by health workers who organise awareness-raising sessions with girls and women. As an unmarried older adolescent girl from Bougouni explained:

> *It's the doctors who talk to us about sexual and reproductive health issues. They bring together married women on one side and single girls on the other to talk about sexual and reproductive health... This information is enough to meet our needs. For example, if you're married and have children, you can space out your children. But if you're not married, it's difficult. Single people don't have to have sex, and there's no reason to take contraceptives or anything else.*

Overall, adolescent boys had greater access to information about pubertal changes and sexual and reproductive health. Many boys interviewed had an in-depth knowledge of the physical changes that occur during adolescence, and could clearly identify a range of changes associated with pubertal transitions among males, including the appearance of a beard and moustache, muscle growth, and a change in voice (becoming deeper). As an older adolescent boy who participated in a body mapping FGD in Bougouni explained: *'When you grow up, your face undergoes a lot of changes. Your face ages, your beard and moustache start to grow*.'

The interviews also indicated that such changes are often seen as markers of masculinity, symbolising the transition from childhood to adulthood. Boys associated these shifts not only with physical maturation, but also with the emergence of new behaviours and desires, particularly sexual desire. One boy in a body mapping FGD in Bougouni emphasised that: '*When you grow up you feel the desire to have sex all the time, that's why you look for girlfriends.'*

However, boys in remote areas, such as Mpessoba and Namposela, had more limited access to reliable sources of information, sometimes leading them to seek out less reliable alternatives such as traditional healers who are influential in these communities. The findings highlight that physical changes during adolescence can be a source of anxiety for many young people in Mali, who find themselves faced with rapid and often confusing transformations to their body. Adolescent boys explained that this feeling of

fear is fuelled by uncertainty and a lack of understanding of what is happening to them, leading them to ask questions about their health, their identity and their future. Accordingly, these changes – which should be a normal stage in their development – become a source of stress and can create a sense of isolation from their peers.

Although some adolescents are lucky enough to receive support and information about pubertal changes from family and especially friends, many adolescents do not have access to the same support network. A fear of failure and rejection often leads them to live through these changes alone, exacerbating their anxiety and depriving them of the resources they need to navigate this crucial period of their lives confidently. Adolescent boys involved in a focus group discussion in Mpessoba explained that:

> *When you see these changes (hair, pimples)... you wonder if you're not sick, or if the same thing happens to everyone... It's when you talk to your friends that you understand what it is... You feel afraid that you might fail at school because you might not be fit to succeed at school.*

Out-of-school adolescent girls and those who were already married appeared to be at particular risk of limited access to information about puberty and sexual and reproductive health more broadly. An older adolescent girl in Bougouni noted that: '*I don't know what changes occur during puberty in teenage girls. I don't have my period yet and I don't have any information about that.'*

In terms of sexually transmitted infections, there were mixed levels of awareness about how HIV is transmitted. Some adolescents had good knowledge of the risk factors and prevention. An older unmarried girl from Mpessoba EPR noted that:

> *For us, HIV is a transmissible disease. It is transmitted by blades, scissors, knives infected with the blood of an HIV carrier. STIs* [sexually transmitted illnesses] *are transmitted through sex. Girls who go out with several men are more likely to get this disease.*

However, among other adolescents, there was both limited and erroneous information about STIs, their risks and prevention. A younger adolescent girl participating in a body mapping FGD in Bougouni, for example, stated that, '*If you start having sex early, you risk getting sick: HIV, malaria, stomach ache, unwanted pregnancy',* while an unmarried older adolescent girl in Namposela mentioned that: '*Concerning STIs, there is a risk of being in the toilet which is not clean… through sexuality…*' Similarly, a married older adolescent girl from the same community erroneously thought that HIV could be transmitted by saliva: '*You can even catch HIV by drinking from the same bowl as an HIV carrier.'*

Some adolescents were aware of the risk of pregnancy following sexual intercourse, and that they are more at risk of contracting STIs if they engage in transactional sex (for example, in cases where their parents do not have enough money to support them). An older unmarried adolescent boy from Mpessoba EPR emphasised both the physical and social risks of such behaviours:

> *If she [a girl] asks the man for the money, that's fine, but I also tell her that by taking the man's money, things can happen such as sexual intercourse, which can lead to pregnancy when your parents are doing their utmost for you. This act can dishonour your family by having a child out of wedlock, and the man can refuse paternity of the child by threatening to kill you.*

Niger

The findings underscore that many adolescents in Niger have good knowledge about pubertal changes, with many expressing confidence that they can get necessary information from older peers, family members and teachers, and (distinctively in Niger), at various cultural gatherings for young people. In a body mapping FGD with girls from Ouara, one participant noted, '*She sees how it is with her older sisters and knows that one day it will happen to her too… Sometimes there are certain things you learn from your friends*.' Public squares and local festivities remain places of entertainment and exchange between young people, and were referenced as a point for meeting and information sharing, including on issues around sexuality.

Girls also reported that water collection points are an important space where they seek information on puberty and sexual and reproductive health issues (especially menstruation and marriage) as these are female-only spaces and venues that they regularly frequent. Also of relevance is that girls in all sites highlighted that some key information on hygiene and menstrual health was obtained from school from subjects like life and earth sciences and home economics.

Boys noted that they have access to information through peers at *dandali* (cultural gatherings for adolescents) and through *fada* (local youth groups), a space where they can rely on having access to information about courtship, bodily changes, and health services. Similarly, markets, barber shops, public squares and ceremonies, mosques and *marabouts* (religious leaders) also provide opportunities to exchange information with peers. In an FGD with older adolescent boys in Maiguijé, one participant said, '*We hear the elders talking about it* [sexual and reproductive health issues]*'.* Some boys also noted that they get information about sexual and reproductive health and contraceptives from social media – in contrast to girls, who generally had limited access to phones and were not very familiar with social media.

Mothers also noted that they provide information about menstrual hygiene management, albeit after girls reach menarche. In an FGD with mothers in Awache, one woman explained:

> *As soon as they start to see their periods, we try to explain to them how to take care of their bodies. So that the periods don't come as a surprise to them, we guide them on the ways and means to follow so that everyone understands the situation they find themselves in.*

However, many mothers confirmed that communication between themselves and their daughters on broader sexual and reproductive health matters was relatively limited, and that they tended to confirm physical changes but not to discuss the wider implications because they felt '*uncomfortable*' doing so, due to conservative social norms. Fathers of adolescent children, while acknowledging that they were aware of the changes their children were undergoing, noted that they prefer to leave awareness-raising about sexual and reproductive health issues for girls up to the girl's mother, whereas for boys, the responsibility tends to rest with paternal or maternal uncles. Most fathers considered puberty as a marker of readiness for marriage for both girls and boys. For girls, they emphasised the need for daughters to marry early before bringing '*shame*' to the home (through out-of-wedlock pregnancies). For boys, fathers underscored the importance of advising their sons about the need to secure an independent livelihood in order to be able to provide for their family once they marry. In an FGD with fathers in Magaria, one man explained:

> [How can a girl tell if she's going through puberty]... *It's when she starts to see her periods and the appearance of breasts... If the boy reaches puberty in this community, the first thing we do is find him a job like sewing or in a garage, so that even if he gets married, he has enough to feed his family.*

Adolescents reported that they had only limited information about sexually transmitted infections. Part of the challenge appears to relate to the attitudes of health care workers towards adolescents and youth. Even though adolescents were aware that health care workers were in theory an important source of information and support on sexual and reproductive health issues, many complained that in practice, those workers are rude or 'challenging', and often intimidated adolescents. In an FGD with girls involved in a community mapping in Ouara, one participant said that, *'Often, if a person arrives late for a meeting, training course or even a consultation, the health workers will humiliate them…'*

Sierra Leone

In Sierra Leone, adolescents reported using a variety of sources of information on sexual and reproductive health information among adolescents. Some adolescents – particularly younger adolescents - reported getting information from their families, especially mothers and older siblings (for girls and boys alike), as well as peers – especially about menstrual hygiene, contraceptives, pregnancy and how to prevent STIs. An unmarried adolescent boy from Gbahama noted that: '*I will go to my mother first as the advice that I am getting from my mother is the best and it is sufficient for me.*'

Many adolescents also turn to their peers and partners for information due to confidentiality concerns. An unmarried adolescent girl from Follah explained that while she would go to her mother regarding general physical health issues, she tended to rely on peers for information on sexual and reproductive health: '*When I am sick, I go to my mother, but if it is about discussing other things, I will go to my friend.'*

In terms of formal service providers, some information on sexual and reproductive health is provided through the school curriculum and community health centres. Interviewees in Manowa and Follah reported some SRH education, including personal hygiene, was being taught in secondary schools as part of the Physical Health Education curriculum. Some adolescents in Gbahama reported receiving SRH education in school but not all, with NGOs and clinics being their main sources of SRH information.

A teacher in Gbahama, for example, noted that, '*They* [schools] *also teach them* [students] *some basic hygiene during that period* [adolescence] *and how to… access contraceptives to avoid teenage pregnancy.'* However, only a minority of adolescents mentioned these as important sources of information.

Adolescents, especially in research sites closer to the district town, were more likely to note that they are getting important information on sexual and reproductive health issues from NGOs, including from Marie Stopes International, the Planned Parenthood Association of Sierra Leone, and Save the Children, which provide educational outreach in schools and to the community. A teacher from Manowa explained that children's knowledge about pregnancy prevention and menstrual hygiene management had markedly improved as a result of Save the Children's awareness-raising activities:

> *Save the Children are doing well for us and everyone in the community… Now, people and the children themselves know what they should do to avoid pregnancy. Before, we did not discuss menstrual cycles and family planning with our children, but now, through these discussions, a clear understanding has been established.*

Our findings also point to a range of barriers that adolescents face in getting reliable and accurate information on sexual and reproductive health issues. Age appears to be an important factor: young adolescents (10–14 years) emphasised that they are often excluded from conversations on sexual and reproductive health, and have very limited understanding of contraceptives, STIs and abortion. In an FGD with girls in Gbahama, one participant said: '*They said we are too young or small to know about it* [reproductive health].' This sense of exclusion was often compounded by a sense of embarrassment and shame when discussing sexual and reproductive health issues with parents, especially among boys.

A number of adolescents also complained that the information they do get on sexual and reproductive health issues is insufficiently detailed, including on the different types of STI, and prevention and treatment options: '*We were not told about that yet*.' Moreover, adolescent girls noted that sexual and reproductive health information is often presented by community members in gender discriminatory ways that restrict girls' personal mobility, with girls being seen as responsible for family and community morality. In an FGD with adolescent girls in Follah, one girl emphasised that:

> *They restrict us from going out...* [the boys] *are not restricted. They say they are boys, and they do not just roam about for nothing. They only go out for work, but because we are girls. They don't allow us to go out… They told us that moving from one man to another leads to pregnancy. They told us not to move around during night hours. They also tell us not to watch pornographic materials at the cinema and on phones, because that will give us the urge to chase men and get pregnant.*

Our findings also revealed resistance to efforts to provide greater awareness-raising about sexual and reproductive health issues, especially among some male adolescents and fathers, who regard access to such information (and especially information about contraceptives) as encouraging young people to engage in sexual relations, with risks of promiscuity among adolescent girls.

Contraceptive awareness and use

Cross-country key findings

- Awareness and use of contraceptives among adolescents appears to differ by age and by gender, with boys typically perceiving contraceptive use as girls' responsibility, and older adolescent girls having better access and knowledge.
- Once married, access to contraceptives is often proscribed by husbands due to social norms around the desirability of early fertility within marriage.
- Mothers tend to be more supportive of contraceptive use in order to prevent out-of-wedlock pregnancies, whereas fathers expressed greater resistance due to religious reasons and also out of fear that giving adolescents information on contraceptives could lead to promiscuous behaviours.

Mali

The findings revealed a marked difference in awareness about contraceptive use and access between those adolescent girls who had reached menarche and those who had not. Girls who have already begun their periods reported having a good knowledge of menstruation, family planning, and the risks of pregnancy. They know about menstrual hygiene management and are familiar with their menstrual cycle, which enables them to better manage their reproductive health, including how to avoid unwanted pregnancy. By contrast, adolescent girls who have not yet begun their periods often lacked this crucial knowledge. An unmarried girl from Sincina explained that, '*I don't know anything about reproductive health. I have no idea about family planning methods*.' As adolescent girls pre-menarche have not yet confronted this biological reality, they are not yet aware of the issues surrounding menstruation, pregnancy and family planning. This difference in levels of knowledge underlines the importance of reproductive health education from an early age, to prepare all girls to manage their body and make informed decisions for their future.

Again, we find that location matters. Bougouni is a relatively developed region, where adolescent girls benefit from reproductive health education, including easier access to the media, proximity to health centres, and a relatively high level of education. Our findings emphasise that some adolescent girls in Bougouni have good knowledge of modern family planning methods and their usefulness. They are also well informed about how HIV is transmitted and how it can be prevented through the use of condoms. In a body mapping FGD with younger adolescent girls, one participant noted that, *'Yes, we know, there are pills, injections, 'mounounani' [family planning menthod], allumettini [implant]. Where can we find these methods of contraception? At the hospital, at the pharmacy.*' Similarly, in one of the 'proximate' research sites, where access to education and health services is higher, a married girl had detailed information from her previous schooling about contraceptives and STIs:

> *Reproductive health: as far as I know, the different methods are: injectables, injections, 'jadelle' [contraceptive implant], etc. What I learnt at school about HIV is that it is transmitted through sexual relations, scissors, wounds, etc. STIs are transmitted through intimate relations or lack of hygiene.*

The findings suggest that in terms of accessing information about contraceptives, both girls and boys know of places where modern contraceptive products can be obtained, particularly health centres and pharmacies. Adolescents - particularly older adolescents - know about several modern family planning methods such as the pills, injectables, IUD, as well as male and female condoms. Adolescents generally obtain information about modern contraceptive methods through the media, through peer networks, and health centres (such as those supported by Marie Stopes).

Some adolescents had also heard of the possible side effects of family planning and cited cases linking contraceptives to infertility. A married older adolescent girl in Mpessoba EPR explained that:

> *Three people had problems after* [using] *contraception* [blood flowing from the genital area]. *The first went to hospital to have it removed, and now she's having babies very close together. The second had the same problem, and the third felt dizzy, lost weight, and her complexion became pale. But some of them did it without any problem*.

However, some girls (especially those in more remote research sites and those with lower levels of education) were unaware of contraceptive methods, with some having never even heard of them. Often, with younger girls, family or community members do not want them to know about these products, so they are not talked about. Many parents also think that talking to a girl about family planning methods will encourage her to have sex because she knows she can use a family planning method to avoid pregnancy; on account of conservative gender norms, they therefore avoid sharing such information.

Niger

The findings show that in Niger, overall knowledge about contraception and contraceptive methods was relatively limited. Some adolescents had heard of pills or injections, but many noted that they had not sought out any information, as they do not have access to contraceptives at health centres.

In contrast to fathers, who did not have a lot of knowledge/information (but were aware of STIs although they did not promote the use of condoms), mothers across all sites were aware of the need for contraceptives; some even supported their daughters' access to contraceptive methods to prevent pregnancy. Mothers explained that as soon as their daughters began menstruating, they would take them to the health centres for contraception (specifically implants) to help provide them with a sense of security that their daughter will be able to avoid pregnancy out of wedlock, which is highly stigmatised. In an FGD with mothers in Awache, discussing social norms, one woman explained the approach as follows:

> *In reality the protection here is that we follow ways that will protect our children from unwanted pregnancy... To do this as soon as a teenager reaches puberty we seek protection for them. This is so as not to commit a sin against Our Lord. Because the mother cannot understand where her child is going. True, they are our children, but we cannot know what they are doing out of our sight. To avoid the shame of what may happen before marriage, we must seek protection for them*.

Interviews with married girls revealed that most were not allowed to use contraceptives by their husband upon marriage, and they had difficulty accessing modern contraceptives as they are not able to go to the hospital alone. Using contraceptives without their husband's knowledge could result in divorce.

Our findings indicate that boys have access to information about contraceptives but do not have access to contraceptive products because of a sense of 'shame' when they go to health centres, and the refusal of health workers to provide them with these products without an adult guardian. For this reason, boys opt to buy condoms from street vendors.

Sierra Leone

In Sierra Leone, there were significant differences in terms of information and access to contraceptives between older adolescents (15–19 years) and younger adolescents (10–14 years). Older adolescents have some awareness about contraceptive methods, referring to implants as 'Captain Band' and

injections as 'Depo' (Depo-Provera). By contrast, younger adolescents faced significant barriers to contraceptive access and knowledge, requiring parental consent.

Among those who reported having information and access to contraceptives, NGOs played a key role. The interviews underscored widespread dependence on NGO-supplied contraceptives, especially from Marie Stopes International via medical vans in communities, as well as more recently through Save the Children support to community health centres.

Some adolescent respondents expressed fear or reluctance to use contraceptives due to perceived side effects or misinformation about their use and effectiveness. A married adolescent girl from Bunumbu explained that:

> *Yes, I haven't taken it* [contraceptive] *since they [health professionals] advised us [to use contraceptives], but I have made my decision to take it now. I was afraid to take this contraceptive because we were told that it has an effect, especially if it doesn't fit your system. So as a result of this, I was afraid to take the contraceptives, and this led me to become pregnant for the second time because I failed to take preventive measures not to get pregnant.*

Social norms were also a key barrier to contraceptive uptake. Whereas mothers, teachers, and some community leaders in the research sample perceived contraceptives as important in preventing adolescent pregnancy and supporting girls to stay in school, fathers in particular reported resistance to supporting contraceptive use among their adolescent children, due to religious values. The father of an adolescent girl in Manowa (for example) underscored that:

> *Even if they have to kill me for it, but no one will stop me from telling my child not to take family planning, I will talk and discipline you. If government makes it a law, I will sit down [and resist'…, but for me to take you go join you or ask you…[I am not concerned about this] It is next world I am afraid of.*

Other males (adolescents and fathers alike) expressed negative perceptions about contraceptive use as they believe it leads to casual sex and promiscuity among adolescents. As a traditional leader in Follah, who was concerned about increasing availability of contraceptives, emphasised:

> *Before the preventive injections were introduced, female students were able to complete their education without needing such measures. Now, with the availability of these injections, there is a perception that sex has become more casual and prevalent among them, so it is a big challenge.*

Part of the reason for this male bias against contraceptive use appears to be because even sexually active adolescent boys regard girls as being primarily responsible for taking contraceptives. In an FGD with unmarried boys, one boy explained: *'She needs to take preventive measures.'* Some boys also reported that they lacked access to information on contraceptives and were unsure where to turn to for information on family planning. An unmarried boy from Gbahama noted:

> *I don't know what contraception is and we are not taught about family planning at school. I don't have someone teaching me about family planning, that is why I don't understand anything about family planning.*

Abortion awareness and practices

Cross-country key findings

- In all three contexts, abortion is illegal; although post-abortion counselling and care is permitted in Sierra Leone, it is generally deemed unacceptable for religious reasons.
- Abortion is highly stigmatised, resulting in widespread use of unsafe abortions by unqualified health providers, and the use of traditional and chemical abortifacients (drugs causing an abortion).
- Young people have some awareness of the physical and social risks associated with abortion, but unmarried adolescents have particularly limited access compared with married girls and women, due to the added stigma associated with out-of-wedlock pregnancies.
- Some health care providers may provide an abortion if the mother's life is in danger.

Mali

In Mali, adolescents have some awareness about clandestine abortions and related risks. Respondents reported that abortions are not carried out in a safe way by qualified people, and may involve using the services of unqualified health workers or using street or traditional medicines or even chemical poisons. In some cases, they noted that unsafe abortions may result in death or infertility. An older unmarried adolescent girl from Namposela explained that:

> *In the event of an unwanted pregnancy, the teenager seeks an abortion. Some go to hospital to have the doctors assist them, while others do it clandestinely with those who sell the drugs in the street, exposing them to death or condemning them to no longer be able to give birth.*

Similarly, an unmarried older adolescent girl from Bougouni noted that: '*There was an old woman in the village who did abortions on all women, whether you were married or not. She gave you traditional medicines.*'

Abortion is carried out in secret, often outside the girl's community, because it is highly stigmatised. As such, it is very challenging for adolescents to access abortion because of taboos around extra-marital sex. A married older adolescent girl from Bougouni explained that, '*Anyone who wants an abortion goes to another community to get access and then comes back, so I don't know how they do it.*' Adolescent girls participating in a body mapping exercise in Sincina underscored that girls would risk being shunned by their family if they sought an abortion, with one saying: '*Parents will get sick, they hate you, they hide you.'*

Parents themselves confirmed that abortions are very uncommon due to the physical and social risks entailed. In an FGD with mothers in Namposela, discussing social norms, one woman said:

> *During the abortion the mother may have difficulties, she may no longer have a child, perhaps it was her only child. Unless it's an act of God, otherwise there are no induced abortions here… If you have an abortion, you don't know whether the child is a girl or a boy or what will happen to the aborted child. When you have an abortion, it is an offence to God.*

Service providers further emphasised that while abortions do take place in health care facilities, they are out of reach for unmarried girls. As one health care worker in Bougouni said, '*Yes, abortion is carried out in hospital by doctors on married girls who become pregnant without wanting to. No, teenage girls don't have abortions here.'*

The legal prohibition on abortion (except in the case of rape or incest) means that the providers of abortion services are often seen as murderers and punished by the judicial system. In an FDG with mothers in Namposela discussing social norms, one woman explained that:

> *When a girl becomes pregnant and is in conflict with her parents, she goes to the health centre to have an abortion. The norm is to punish the health worker who carries out the abortion... Those involved in the abortion are taken to the judicial authorities.*

However, some health workers noted that in some cases, it is necessary to perform an abortion to save the life of the pregnant girl, and there is some covert leniency if an abortion is carried out early in the first trimester. A female Community Health Officer in Mpessoba EPR noted that:

> *Health workers don't agree to abortions, they do it to save the teenager's life. At three months, if you're not careful, she could die. Otherwise, at one or two months, you can have an abortion without any consequences for the child or the health workers.*

Niger

In Niger, abortion is illegal, except to save a woman's life or preserve her health. Across sites, adolescents had some awareness about the risks of abortion, including risk of infectious diseases and even death of the mother. However, our findings underscored that adolescents perceive abortion as sinful and shameful. An unmarried adolescent girl who becomes pregnant and then has an abortion is committing two crimes in the eyes of society: pregnancy out of wedlock, and abortion. Such girls would face scorn from their family (parents), while others would be thrown out of the family home. Some adolescents reported that girls who experienced unwanted pregnancies would often go into hiding to carry out an unsafe abortion using traditional methods (tree bark, a few herbs). This was the same across all study sites, and for both married and unmarried adolescents.

Sierra Leone

As in the other two countries, abortion is highly stigmatised in Sierra Leone – because of moral and legal sanctions (it is illegal except for medical reasons). In an FGD with community stakeholders in Manowa, one participant explained that:

> *Most of the girls that are doing abortions, they are doing so because they are in school. It is a shameful act for a girl to be in school and become pregnant, so most of them will prefer to abort the pregnancy.*

Similarly, an unmarried adolescent girl from Bunumbu explained that: '*Actually, it has never happened to me, though in my first pregnancy I thought of having an abortion because I was suffering, but I was encouraged not to do it.'* Older adolescents, especially those in larger communities, had more information on abortion but largely related negative consequences of unsafe abortions, and primarily

from older siblings and peers. As a married adolescent girl from the same community emphasised: *'Yes, sometimes it may lead to death and also, to destroy life is not good. Also, if you destroy the child you are pregnant with, maybe that is the only child given to you by God, you may not give birth anymore.'*

Our findings underscored that respondents had limited understanding of abortion risks and services due to limited information provision about abortion in schools and the unwillingness of actors to discuss abortion with adolescents. As an unmarried girl from Bunumbu explained: '*I know about it* [abortion] *but I don't understand it.'* Similarly, an unmarried adolescent boy from Gbahama explained: '*No, I have never received information about abortion before, not even at school, but I know abortion is not good because during the process, the woman may likely die or get a sickness that will kill her later.'*

Despite the multiple physical and social risks associated with abortion, adolescents gave several examples of how girls can obtain access. Traditional herbs and medical abortion with drugs bought from un-named sources were the main methods reported. However, adolescents were careful not to give identifying information or name people and places where these pregnancy terminations occur.

Respondents also reported that communities actively police possible providers of abortion services. In an FGD with community stakeholders in Manowa, one participant said:

> *We do not allow that* [abortion] *to happen in this community and the law that we have about that is, if we notice a nurse in such activity, that nurse will be reported at the council. The nurse will be asked to pay a fine and that nurse will be asked to leave the community.*

Abortion is perceived to be in part driven by boys who do not take responsibility for contraceptive use in their relationships, but who see it as a fallback option to avoid the responsibility of parenthood and also parental wrath. According to a participant in an FGD with stakeholders in Manowa:

> *The boys are influencing abortion because they want to have sex, but they do not want the responsibility because they are either going to school or they are afraid of their parents. Most of the times they will plan to do an abortion without the knowledge of their parents until the abortion is not successful.*

It should be noted that in Sierra Leone, although health care providers are unable to offer abortion services, they can offer post-abortion care. This is provided in all health facilities, including community health centres, and by Marie Stopes International.

Adolescent sexual and reproductive health service access and uptake

Cross-country key findings

- Stigma surrounding access to sexual and reproductive health services constitutes a major barrier to usage across all three country contexts.
- Distance to services, especially for adolescents living in remote rural communities, is a major challenge, compounded by inadequate information about services and limited outreach to adolescents to encourage uptake.

- Inadequate training of health service providers in the provision of adolescent-friendly health services was repeatedly raised as a significant barrier to regular service uptake.
- For adolescents with disabilities, intersecting stigma (based on disability and social norms that proscribe access to sexual and reproductive health services prior to marriage), along with poorly adapted facilities, are key challenges to uptake.

Mali

In Mali, the stigma attached to early pregnancy and abortion is a major obstacle to young girls accessing sexual and reproductive health services. In many communities, pregnant adolescent girls are perceived as having transgressed social and family norms, which often leads to rejection by their family and community. For example, a traditional leader in Namposela noted that:

> ...*Often some children between the ages of 10, 15 and 16, you will think that the child knows nothing, you will see that the latter risks getting pregnant by a man out of wedlock. This act hurts the parents so much that it cannot be qualified, often it can cause misunderstandings between the father and the mother, because the father will accuse the mother of knowing about his daughter's nonsense.*

This rejection creates a hostile environment that discourages young girls from seeking medical care or psychological support, for fear of being stigmatised and ostracised.

Although NGOs and external programmes play a key role in the provision of sexual and reproductive health advice and services, their intervention often remains sporadic and time limited. These programmes (which provide young people with information and services about sexual relationships, contraception and disease prevention) are not always easily accessible to all adolescents, particularly those living in rural or marginalised areas. Married girls in particular face significant obstacles linked to their financial dependence on their husband, which limits their autonomy and access to care. However, there appear to be some positive changes in parental attitudes towards family planning, particularly in rural communities such as Namposela. For example, a mother from Namposela noted that:

…*When she goes to school, it's not possible to keep an eye on her, so we take teenage girls to health workers to implant products.*

Social norms play a determining role in access to sexual and reproductive health services for adolescents. As an older adolescent boy from Mpessoba Zantiela noted, *''Sexuality is a real taboo at home, a subject we can't discuss with our parents... There's no one here we can go to get contraceptives* [condoms].*'*

The situation is even more challenging for adolescent girls. In many communities, girls are required to obtain permission from their parents or guardians to access these services, which limits their autonomy in making decisions about their own reproductive health. Young girls are often reluctant to discuss these sensitive issues with their parents for fear of being judged or reprimanded, which can prevent them from accessing the services they need, such as contraception or screening tests for sexually transmitted infections.

Niger

In Niger there was a broad consensus that young people, especially unmarried adolescents, tend to avoid going to health centres for SRH needs for fear of being misjudged or stigmatised by health providers. Boys in particular emphasised that they prefer to go to private service providers at the market rather than encounter health service workers at the health centres. Several boys spoke of feeling 'shame' when they go to the health centre to seek condoms and some reported that health workers refused to give them these products without an adult present.

Interestingly, an adolescent girl with a disability from Oura had a more positive view about treatment at the health centre and noted that contraceptive availability was good at the health centre she used.

> *We look for these products in health centers. There are pills and injections. Moreover, we don't find it difficult to obtain these contraceptive products. It's really easy to get them, unless the person hasn't been to a health center.....To regain your health, prevent sickness or pregnancy, you have to go to a health center. Of course, you have to use traditional products, and it's Allah who gives you health, but you have to go to a health center for treatment, for example.....The welcome is good, the products are available, and everything's really going well.*

Sierra Leone

In Sierra Leone, adolescents rely predominantly on community health centres for their health needs, including accessing services for STIs and gender-based violence, and adolescent girls noted that they encourage male partners to seek treatment in the case of STIs. As an unmarried adolescent girl from Bunumbu noted, *'…you have to be very careful when you are dating. If you suspect your partner of having such sickness, you must encourage him to go and take treatment.'*

A lack of services tailored to boys was also highlighted by some research participants. As a school director in Manowa explained: '*The clinic and NGOs providing family planning services are focused solely on the girls. The boys do not benefit from these services at all.'*

Gender-based violence

Cross-country key findings

- Domestic violence is common and generally accepted when girls and women are seen not to be complying with traditionally proscribed roles for girls and women.
- Sexual violence is common and often condoned, and both younger and older adolescents are aware of these risks.
- There is some progress in acknowledging that sexual violence and rape are crimes, and some girls and women are willing to denounce them as such, but in many cases, harmful social norms still prevail, with girls who are raped prevented by their families from talking about it for fear of being shamed.
- Girls who are rape survivors are often forced to marry the perpetrator to preserve family honour.

Mali

Analysis of domestic violence reveals power dynamics that are deeply rooted in social norms among communities. Violence – physical and psychological – is often seen as a legitimate form of correction when a man feels that his wife is not respecting the social roles assigned to her. Young adolescents who have grown up with these norms also abide by them, as a younger adolescent boy in Bougouni noted: *'A husband also has the right to hit his wife when she does not behave well at home.'* In these communities, husbands exercise their authority by inflicting violence on their wives, under the pretext of maintaining domestic order and respect for traditions, particularly if the wife is considered to be disrespectful towards her husband's family. This violence is not only physical but can also be verbal, as explained by an older adolescent girl in Bougouni: *'Where I come from, a man can insult his wife and nobody says anything, because we think he has that right.'*

Domestic violence is accepted as long as it does not exceed certain physical limits, such as hitting a girl or woman so hard that it draws blood. However, even when the violence becomes more serious, it is often normalised. For example, in Bougouni, an older adolescent girl referred to a case in which a woman who was seriously injured by her husband returned home after the only consequence to the husband was for the local leader to advise him to take care of her. This form of community mediation, often led by traditional chiefs, aims to maintain family harmony while minimising the seriousness of the violence meted out to women. During the interviews, there were some references to women who had fled these abusive households (since they were aware that they would not be protected by the community) or even asked for divorce, but these cases were rare.

Despite this, some extreme cases, such as gang rape within marriage or feminicide reported via the media, highlight the scale of violence against women and girls, and the need for wider awareness and changes in social norms so that these practices are no longer acceptable in society.

The data collected for this baseline study also indicates that sexual violence – including unwanted touching, rape and forced marriage – is still present in many communities. Some severe cases of violence that were referenced by research participants seemed to be justified in cases when a wife refused to have sex with her husband (which is seen as an obligation). This can lead to anything from beating, to more severe violence such as the woman being forced by several men to have sex with her husband. An older adolescent boy in Bougouni shared the following community practice: *'After the marriage, if the woman refuses her husband, your peers will come at night and take the woman, tie her up and offer her to her husband... We do it so that we can have children...'*

Other forms of gender-based violence are common, particularly sexual harassment. Again, in such instances, it is common for the community (and even a girl's family) to side with the male perpetrator. In Mpessoba Zantiéla, an older adolescent girl explained that:

> *It is common for a certain man to make advances towards a girl, and if the girl refuses, he continues to harass her, and sometimes he goes to ask her father for her hand in marriage without her consent. If the girl refuses, the father will hit her and take her away by force*.

There were mixed perceptions about how widespread gender-based violence is, with some respondents saying it is common and others saying it is not. However, given the number of references to gender-

based violence shared during interviews and focus group discussions, it would seem that it is very common, particularly in Bougouni.

Awareness of gender-based violence and sexual violence among younger adolescents is mixed. Several younger adolescents have no information about sexual violence, or violence between peers. Others learn about it mainly from their social network. Among younger adolescents who did talk about sexual violence, there was an understanding that sometimes the girl is revictimised by her parents, although sometimes parents will punish the boys perpetrating the violence, as a younger adolescent boy from Namposela said:

> *Sexual violence also occurs here, because often some boys, when playing with girls, take the opportunity to force them to have sex with them. But if their parents find out, they hit them to stop them doing it again.*

Some older adolescents who spoke about sexual violence showed an awareness of its consequences for girls, with one older adolescent girl in Namposela saying:

> *Gender-based violence, sexual violence or violence between peers – these different forms of violence are practices that we often expect people to talk about, which causes a lot of harm to girls, including early pregnancy, forced marriage, etc.*

Older adolescents identified sexual violence more clearly and often spoke of rape. During interviews, some girls noted that women and girls are the ones often blamed for rape for having provoked the boy through proximity alone.

Adults known in the community (such as teachers) were also sometimes referred to as being perpetrators of rape. In the communities where research was conducted, girls mentioned that some teachers take advantage of girls' vulnerability to rape them, and some girls become pregnant as a result. As a female teacher in Sincina reported:

> *I spoke to another girl who said that when she was in year 9, one day the teacher asked her to go and drop the sheets of paper off at his house. It was a trap, and when she went in, he closed the door and stopped her from shouting, and raped her… She couldn't tell her parents what had happened because she'd be accused of the fact that she'd gone to the teacher's house..*

Some rape victims confide in their peers but others hide it because they know that if a complaint is lodged, perpetrators will not get charged putting the girl at a greater risk. This indicates that there is little trust in the legal processes for seeking justice.

Despite gender-based violence being common, participants explained that there have been important changes in recent years in how sexual violence is perceived and treated. For instance, in the past, girls who were raped could not report their attacker without risking being accused themselves and being revictimized. Today, as a result of small changes in attitudes, girls who are raped can lodge a complaint with the police. This was highlighted by stakeholders in different communities:

> *You know, rape hurts the girl, but today there is no taboo, you can even complain to the police, but in the past it was a taboo, the girl could not denounce it because she would be accused and would be punished again. She remained frozen until her marriage, bruised in her soul.*

(Female teacher, Sincina)

…You can sweet-talk a girl but this is different from rape – rape is forbidden here and you can be punished for it. It's a law that exists here.
(Community stakeholder, Mpessoba EPR)

However, while legal recourse is now a possibility for individuals who have been raped, it is not always the course of action that is followed. Survivors usually do not file complaints, and cases are dealt with in the community and out of court. When a complaint is lodged, the accused is often arrested only briefly by the authorities and nothing is done. What is worse, social norms often imply negative consequences for girls who, as a result of rape, may be forced to marry the rapist to minimise reputational loss to the girl and the family. As an older adolescent girl from Bougouni explained:

In the community, girls are raped by boys. These are things that are settled amicably because we are all the same – either she marries the boy who raped her, or after giving birth, she gives the child to the boy's family after the child has been weaned. But very often they marry for the honour of the victim's family. No, we don't go to the police for that.

According to the interviewees, government actors and NGOs are increasingly involved in prevention and response to gender-based violence, but action is still falling short considering the scale of the problem. One-stop centres were highlighted as places where individuals can get support if they are experiencing gender-based violence. According to the interviewees 'One Stop Centres'are key players in the fight against sexual violence and GBV in the communities where they are in place as they help channel responses to support survivors. These centres appear to play a multisectoral role, acting as a single support platform. These were mentioned in Namposela and Koutiala, although there were also some references to the services were seen as inconsistent. As a key informant from Namposela noted, '*…Yes, at the moment, there are services that fight against sexual violence and gender-based violence, like the one-stop centres, if you can call them, they can take action.'*

Niger

Among younger adolescents (10–14 years) in the research locations, sexual violence was identified as an issue – rightly defined as forced sex or sex without consent, punishable by law, and considered wrong:

When you're stopped on the road and you have sex with a girl without her consent, that's sexual violence. You've been forced... It's practised for girls and even women... For under-age girls, the culprit can be imprisoned with a fine.
(Young girl, Magaira)

During the winter season, especially when the millet grows taller than a person, there are men who follow behind the women when they leave for the bush...
(Young boy, Garare)

However, girls and boys held different views about whether rape is the fault of the girl (who is considered to have provoked it) or the man or boy who perpetrates it. Not all adolescents blamed the perpetrator. This perception among young adolescents seemed to be also based on the reactions from the community towards the girl. As a younger adolescent girl in Magaria said:

> *Of course we know sexual violence exists, but it's not for everyone. It's for girls who mingle* [interact with boys]… *The way people look at her is that other people know she's been sexually abused, but other people will think it was her who looked for it. They'll call her a prostitute. We laugh at each other as soon as we look at her.*

Younger girls reported similar perceptions across all research sites, showing the need for education and sensitisation on sexual violence among this age group. Knowledge of the courses of action during such an incident are clearer in sites where there are sexual and reproductive health projects sensitising the community. In Ouara, for instance, adolescents mentioned that girls who have been sexually abused can be taken to the village chief or to a women's and children's protection organisation.

Boys in general perceived that sexual violence towards a girl was wrong, and at times the male was at fault and not the girl, though some others thought the girl was at fault in all cases. The concept of sexual violence was clearer among older adolescents (15–19 years), again with varying views on who is at fault in cases of rape.

Older adolescent girls described gender-based violence as common in the villages, especially from older adolescent boys, and this was usually linked to drug consumption, or just bad behaviour by boys. Younger adolescent girls in Awache explained that, '*Yes, when you go to school there are boys who come up to you and tell you that they love you… If you don't take them into consideration they can hit you… There are those who take tramadol* [strong painkiller].*'* Indicating a particular concern about adolescent boys and young men that are engaged in substance abuse.

Nevertheless, as with younger adolescents, many older adolescents also believe that rape is generally the girl's fault. This reflects social norms which dictate that the only reason for being near a boy is to have a sexual relationship, as noted by an older married adolescent girl in Awache:

> *Yes, rape is sexual intercourse without consent, but I think boys only rape girls when these girls want it… Sincerely, every girl who is raped gave an accord, so I think it is with their consent. Why will you even listen to the boy in the first place if you are not interested? Until you let him get close to you. Then you want it…*

Older adolescents are well aware of risky places where a girl could be easily assaulted. These include '*on her way to market*', '*fada*' (social gathering for adolescents), as well as going to the farm alone. In an FGD with older unmarried girls aged 15–19 in Garare, one participant said, '*If a teenage girl goes to the market alone, on the way back, men can psychologically lure her away to have sex with her, or even forcibly rape her.'* Another (unmarried girl) said, '*Fada* [social gathering or meet point for adolescents] *is very dangerous for teenage girls, especially the younger ones. They can't go unsupervised. They run the risk of being raped.'* And another unmarried girl said, '*If you go to the field alone as a woman and a man follows you without your knowledge, he can rape you without you being able to defend yourself*.'

Some older adolescent girls also identified closest relatives and friends as the first person to confide in, should they experience sexual violence, before telling parents or other senior persons. An older adolescent girl in Garare noted the following:

> *If i was ever raped, i will tell Faiza before any one or her alone...she is closest to me, she is my elder sister*

Some girls also spoke about being sexually assaulted either by their own boyfriend or a male member of their family. In relation to this, they explained that when an adolescent girl encounters gender-based violence at the hands of a relative, her family generally tries to hide it and deal with the situation within the family, which can have adverse consequences for the girl's mental health.

Adolescent girls who are sexually assaulted in most cases know their attacker, who is rarely brought before competent authorities (courts, village chief); whenever they are, the punishment is light, sometimes only resulting in a monetary fine. A young girl in Maiguijé gave the following example: *'They found the boy at home, that's where things happened* [sexual intercourse] *and when we found out, things went to court in Tessaoua and the person responsible was held only briefly.'*

Very few cases of sexual violence are reported to the police, as most people prefer hiding it, especially as they perceive that the offender will not be punished seriously and the girl will be disgraced for nothing. In a key informant interview, a community youth leader in Garare explained, '*They just corrected him a little by giving him a fine…´.* Another key informant (a community health worker) in the same location described one case:

> *A girl had been raped during a ceremony. After the trial in Ourafane, the man in question refused to take the girl in marriage, but agreed to recognise the child and take care of her until she gave birth. The girl gave birth right here at the health centre, and the man had come to settle the financial situation.*

As in Mali, these comments suggest that in some communities in Niger, it is deemed socially acceptable to force a girl who has been raped to marry the perpetrator.

Health professionals deal with cases of sexual assault, and occasionally advise parents of the survivor to bring the perpetrator to justice, but most times these suggestions are not followed, particularly if the perpetrator is a family member. As well as the physical and emotional trauma of rape, it was also noted that it has major social consequences for girls, including blame, social stigma, shame or exclusion, as rape would make her unmarriageable for someone other than the perpetrator. As a key informant (community health worker) in Garare reported, '*And if she is going to get married, we can inform her husband and give him written proof that the girl has been raped to avoid mistreatment by her husband because of the rape.'*

Across sites, the support available to girls who had been raped varied according to the presence of NGOs or other institutions who have in place sexual and reproductive health programmes for sensitisation and support within the communities. This also extended to social norms and legal justice. As an example, in Magaria, where the Foundation programme is being implemented alongside other programmes focusing on adolescent sexual and reproductive health, social structures exist within the community to assist and channel cases of sexual violence for adolescents to the relevant authorities. There are also clearer sanctions (both legal and social) for such violence, and psychosocial support for the adolescent concerned. In an FGD with fathers in Maiguijé, discussing social norms around sexual violence, one man explained:

> *The perpetrator is really in trouble... He needs to be imprisoned as the norm, rape is a serious act, especially if it's a student, even her guardians and parents will do anything to get her put in her rights. As per my standards too, anyone who uses violence is imprisoned, especially if it's rape.*

It is important to note that in Niger, social norms do not recognise sexual violence within marriage, because according to the Muslim religion, a woman must never refuse to have sex with her husband.

In terms of progress in reducing the incidence of sexual violence and strengthening responses to it, awareness-raising and sensitisation were cited as key to advocating against acts of violence, especially violence that is gender-based or sexual in nature. This was especially common where mentors were based in organisations working on adolescent sexual and reproductive health. As a key informant (mentor) in Awache said:

> *We raise awareness in groups or from fada to fada. We're not the only ones, there are also female mentors who look after women too. You can't go off and talk to someone else's wife, but it's more accessible for women to talk to women.*
>
> *It is to seek out the perpetrators and make them available to the local authorities in the event of such violence... Go to the health centre to check the victim's state of health. Before, the community was in the dark, but now we've become aware of these kinds of practices thanks to constant awareness-raising...*

Sierra Leone

The research with adolescents in Sierra Leone found a mixed understanding of gender-based violence in the community, particularly among younger adolescents, who view it as similar to other forms of physical violence. Older adolescents have a clearer understanding of what is meant by gender-based violence, with one explaining that, *'Sexual violence is when a man meets a girl or a woman without the permission of the girl/woman. He will want to play with the breast of the girl or woman, which is wrong.'*

In one community, boys who had learned about gender-based violence through the radio recognised women and girls as more vulnerable. In an FGD with unmarried boys aged 10–14 in Bunumbu, one participant said, '*Girls are the ones who suffer sexual violence the most.'*

In another community, adolescent girls confirmed that sexual harassment by teachers occurs, but did not mention whether this is reported, or if they know the processes involved in making such reports. In an FGD with girls aged 10–14 in Follah, one participant stated that, *'Some of the teachers make love proposals to the girls in school. The teachers harass the girls for sex.'*

Although it is mainly women and girls that experience gender-based violence, males (particularly boys) can also be at risk. As an older adolescent boy from Woroma said:

> *Yes, my girlfriend forced me to have sex with her and my friend... He is forcing me to have sex with my girlfriend. It is a boy's game, that is how it will remain. I will not discuss it with anybody, because I am ashamed to explain it to someone.*

A teacher from Woroma who was interviewed shared her concerns about inappropriate sexualised interactions between students, and explained what actions they take within the school to establish boundaries between the sexes. The quote below illustrates some of the concerns related to this interaction, particularly in the case of older adolescents.

> *Younger adolescents have a lower understanding of the issues, either conflating it* [gender-based violence] *with physical violence or, to an extent, still seeing it as play… Older adolescent girls and boys in school like to joke with their private parts. Like boys hitting girls' waist and touching their breasts. These are some of the cases I settled among them.*

There have been legal changes introduced at all levels of government to promote greater awareness of the legal consequences of crimes linked to sexual violence. In this sense, adult community members have a good level of awareness about regulations prohibiting violence against women and girls. As a community key informant in Manowa said, '*Some of the laws that we have here are if the child is aged 10–17 years, no man should tamper* [have sex] *with that child. If you tamper with a child within that age range, you will be asked to pay.'*

The First Lady's Hands Off Our Girls initiative has contributed significantly to this awareness. Additionally, some community members highlighted that campaigns against harmful traditional practices like FGM, child marriage and sexual and gender-based violence were already underway, with NGOs being given due credit for this. A community stakeholder in Gbahama noted, in an FGD, that:

> *Some changes have occurred due to the arrival of Save the Children because most of the things like child marriage and sexual and gender-based violence are not happening again. They were common, but now a lot of things have changed.*

Despite progress, in some communities, local leaders (who are also generally part of the board of community schools) interfere in cases of sexual and gender-based violence involving adolescents in favour of the perpetrator, telling schools not to report to the police and instead opt to settle these cases in the community. When girls are sexually abused, they are often blamed, with reasons such as street trading, improper clothes or bad friends given as the cause. As a stakeholder in a community mapping exercise in Manowa noted, '*…girls are contributing a lot because the way they are dressing right now is very tempting.'*

Transactional sex involving adolescent girls is a known and common practice, which respondents related to poverty, with parents often condoning the practice. As a stakeholder in an FGD in Manowa stated, *'…Other girls, if they see their colleagues are wearing a particular dress, they will want to buy the same dress and because they do not have money, that is where the men will misuse them.'* However, in some communities, recent bylaws are seeking to end the practice of transactional sex and sanction the men instead.

Many adolescents are not aware of the legal channels for reporting gender-based violence and the processes they would need to follow. They say they will depend on their father, mother, and even aunts for protection. Stigma surrounding gender-based violence and a lack of survivor-centred care are major barriers to adolescents reporting and accessing care. The Hands Off Our Girls campaign has raised awareness of gender-based violence among older adolescents. However, younger adolescents (aged 10–14 years) have little knowledge of the issue.

Child marriage

Cross-country key findings

- Pressure on adolescents (particularly girls) to marry early is common, with associated physical and psychological consequences for girls in later life.
- Child marriage is often a way to avoid pregnancy out of wedlock, so it is arranged for many girls as soon as they reach puberty.
- Despite some increased awareness of the importance of gender equality, social norms change very slowly, and the practice of child marriage persists.
- As a result of policies and legal frameworks in place against child marriage, Sierra Leone has made important progress over the past five years in increasing awareness and strengthening the regulatory framework to foster the reduction in the practice of child marriage.

Mali

In the study communities, adolescents (particularly girls) feel pressure to marry at an early age, which has both physical and psychological consequences for them in later life. Families, motivated by social norms, often push their daughters to marry as soon as they reach puberty, even if this means forcing girls to give up their studies or other personal aspirations. As an older adolescent girl in Bougouni noted, *'Once married, you leave school. Because they say you can't do the housework and learn at the same time.'*

Indeed, the pressure to marry early is often greater for young people who are studying, because their parents feel that if they continue studying they will take too long to get married, even if adolescents themselves do not want to marry. An older adolescent boy in Bougouni articulated this concern: '*It's young people who are studying who are under too much pressure to get married. Because their parents think they take too long to get married, or that they don't want to get married early.'* This shows how social and family pressure to marry can hinder young people's education and future opportunities, creating a form of coercion sometimes accompanied by physical or psychological violence.

Although early marriage is common in both rural and urban areas, it is more prevalent in rural communities where girls marry as soon as they start to grow breasts or when they get their first period. During interviews, girls noted that this is for religious reasons. It is common for girls to get married between the ages of 13 and 16. Furthermore, if a girl shows interest in a boy and starts to see him, she is at greater risk of getting married, since the family will fear that she may start having a sexual relationship with the boy and get pregnant; so rather than face the reputational loss, they prefer marrying her. An older adolescent girl in Bougouni explained:

> *Most of the time, it's because the child's education hasn't been consolidated. For others, when the girl only sees her menstrual period, they give her away at marriage. Because for the parents, if the girl sees her period and is not given in marriage, all the stupid things she will do are the parents' responsibility.*

Girls very rarely choose their own husband; the decision rests with men in the family, particularly uncles, the village chief, and the father. Mothers and female relatives have little or no official say over girls' marriage, although they do have the power to influence daughters' choices in some cases, particularly to persuade them not to go look for other boys. This type of arranged early marriage is seen by many girls and boys as a standard practice that they cannot refuse. An older married adolescent girl in Namposela commented:

> *There is no such thing as forced marriage. At the age of 10 to 17, you are free to marry the man of your choice. On the other hand, some girls are forced to marry by the decision of their parents, and the girl who refuses is chased out of the house and marginalised by the community.*

Another older married adolescent girl from Mpessoba Zantiéla said, *'If you say no, they threaten you, chase you out of the house and call all the other parents and tell them you've been disrespectful… If you have a conscience or if you love your parents, you can't refuse.*

Girls who refuse to marry, mostly schoolgirls who want to continue with their education, have very few options. Some respondents mentioned anecdotes about girls running away to live outside the village to avoid marriage, but this was seen as rare, as an older adolescent girl in Bougouni explained:

> *Girls who don't want forced marriages tend to run away from home, if not from the village itself. When they come back years later, they will no longer be married to this one but always the parents choose her husband.*

Many girls are married off at an early age to avoid them having sex before marriage, which brings shame to the family and the community. According to a community stakeholder in Sincina, *'When girls are left until the age of 18, if we're not careful, they'll start having sex. For me, the norm is to marry at 15.'* Girls in several of the communities, even if not married yet, were aware that they would marry at a young age, and that the marriage would be arranged by their father. As a younger adolescent girl from Bougouni noted, '*I know that a lot of people get engaged as babies or when they're very little... I was engaged at the age of 10.'*

In these communities, in most cases, once a girl is married, the husband takes control of the household, decides where to build the house and, importantly, when to have children. The girl has no say in these decisions.

Although marriage practices were very similar in four out of the five communities researched, in the Koutiala area, unions are decided by the will of the partners, through marriage by kidnapping. This means that the man kidnaps the girl he would like to marry, and some time later, the girl's hand is given to him without asking for her consent.

Some key informants mentioned that they are beginning to see changes, especially among mothers, whose perspectives on child marriage are slowly evolving. According to a few key informants, this change has essentially resulted from the information and messages disseminated by the media regarding child marriage risks, as well as the efforts of some NGOs and community health workers, who collaborate to disseminate information on this issue. As one community health worker in Bougouni said, *'Yes, I've learned about children's rights, sexual and reproductive health, early marriage and rape through PLAN* [International]. *It works in this area.'*
Still, these changes seem to be scarce, with mothers still lacking agency in the decisions about their daughters' lives. One older adolescent girl from Bougouni said, '*She* [the mother] *tells us very often that early marriage has many consequences yet the mothers have no choice but to accept their husband's decisions*.'

Some organisations have sensitised communities on the consequences of early marriage and early pregnancy. During interviews, respondents made reference to these consequences, including dropping out of school, as well as pregnancies and births being higher risk. There have also been efforts to stop

forced marriage, raising awareness of the consequences for girls' mental health (which include depression), but the practice persists.

Niger

In Niger, across all research locations, most mothers who were interviewed said that as soon as a girl starts menstruating (usually between the ages of 13 and 15), she is given in marriage either to a close relative (cousin or family friend) or to someone she loves, when possible and convenient for the family. Parents prioritise social expectations and family honour over their daughters' autonomy. They may engage their daughters to marry from a young age, sometimes even from birth, to boys from other families. If the girl grows up and rejects the chosen partner, parents are dishonoured, so they will still push for the marriage.

The majority of married adolescent girls interviewed were aged between 15 and 18; some had been married since age 15, and had already had their first child before the first anniversary of the marriage. In Niger, fathers have most say in the decision about when, and to whom, a girl will marry.

During the interviews, some adolescent girls mentioned cases where girls have rebelled against being forced into marriage at such a young age, resulting in divorce, which is severely frowned upon in these communities and leads to social isolation. In principle, girls can also denounce their early or forced marriage with the *marabouts* (traditional religious leaders), but this is rare, as the practice is widespread.

Girls who attend school are also married off at an early age to avoid pregnancy outside of marriage, which is seen as a growing risk that parents try to avoid, given the social stigma attached to it. As a community leader in Garare explained:

> *There are little girls who spend their time, sometimes nights, with boys. The parents are afraid and give her in marriage, and anything she thinks of doing will be done at her husband's. The parents avoid shame in the village*.

Aligned to this thinking, many parents regard marriage as a means to protect children from the ill-intentioned men who want to have sex with unmarried girls.

Adolescent boys, on the other hand, usually marry when aged between 18 and 20 or over, because, according to prevailing norms, they must first have the means to support a family.

Once married, some young men leave their communities in search of work, leaving their wife (adolescent girl) and children with no means of support. This practice was found to force some young adolescent girls into transactional sex in order for them to have the basic means to support their families.

In some cases, socioeconomic struggles were found to drive parents to marry off their daughters early. They hoped that the financial support from the son-in-law would help alleviate their financial burden. However, in general, the trigger for early marriage was social norms.

Most adolescents who were interviewed, who have been raised in this context of early and arranged marriages, do not see it as a problem, as they cannot imagine any alternative. Adolescent girls are

accustomed to this practice, and believe that if a girl refuses marriage, that is punishable by Allah, since it would mean disobeying her parents.

According to interviewees, girls who try to find their freedom by running away from home or refusing to have sex with their husband receive corporal punishment at the hands of the husband, which is regarded as socially acceptable.

There was some difference across sites in community stakeholders' perceptions of child and forced marriage as problematic, based on their role in the community, their sex, and whether they had been exposed to NGO programming on sexual and reproductive health. In the same communities, women community leads in particular were more conversant or aware of these practices than men. One key informant in Garare, a female community mobiliser, said, '*Yes, it* [forced marriage] *exists. But it is rare, as most cases of forced marriage are not reported or are resolved quickly with the girl accepting to marry.'*

Community stakeholders who were interviewed noted that child marriage is no longer rampant in their communities, though the study found it to be widespread, despite growing knowledge about the effects of forced child marriage and, in particular, early pregnancy. A peer educator from Awache, working with women and children, explained that:

> [Child marriage is*] abnormal, because it can have multiple consequences. Even girls who are quite tall often encounter the problem of fistula, especially young girls… Forced marriage or marriage under the age of 18 is a thing of the past in our community. It doesn't happen anymore… What is the point of a forced marriage, even if the marriage took place? She will never stay with the husband, but at least if he lets her choose her husband herself, she will have no reason to return to her parents in the event of marital conflict.*

In terms of the consequences of child marriage, some health workers who were interviewed reported encountering cases of fistula, as well as complicated childbirth caused by early pregnancy.

Sierra Leone

In Sierra Leone, by contrast with Mali and Niger, child marriage is now illegal under the Prohibition of Child Marriage Bill 2024, which protects individuals under the age of 18. However, the practice persists, particularly affecting girls, with poverty being a key driver. Many families viewed marrying their daughters to wealthy or influential men (such as community chiefs) as a way to gain financial security or social standing. As one participant in an FGD with community stakeholders in Manowa said, *'If you are a chief, most families want their daughters to marry you so that they will get influence in the community, and the chiefs also were using their influence to get girls that they want…'*

Over time, rates of child marriage in Sierra Leone have declined due to legal consequences for offenders and increased awareness efforts by NGOs about the harmful effects of child marriage. Another community stakeholder in Manowa explained that, *'We are not encouraging child marriage in this community anymore because we have realised that those that are doing so are just trying to destroy our children at the end, they will not take care of them.'*

Driven by the legal push against child marriage, adolescent respondents demonstrated awareness that it is illegal, and of its negative impacts on girls, identifying its detrimental effects on girls' education and on

their potential for economic empowerment. An older unmarried adolescent boy in Gbahama reported that:

> *Child marriage is not good because girls' education is very important right now. If you take your girl child and force her to marry, she will not be able to complete school. It is bad to force them to marry when they are supposed to be in school.*

Nevertheless, social norms around child marriage persist, with a similar driver as in the other two countries: avoiding the social stigma linked to pregnancy out of marriage. Indeed, early pregnancy is common in Sierra Leone, triggering most of the child marriages that do take place. When a young girl becomes pregnant, she either moves in with the boy or man, or their families arrange a marriage to the boy or man responsible, without reporting it as a possible sexual crime (if the man is an adult). In some interviews, it was reported that girls themselves decide to move in with their boyfriend, either due to peer pressure, or to leave their current living situation. In an FGD with community stakeholders in Manowa, one participant said:

> *Someone will just look at your child and get her pregnant. What will you do? Will you take her and bring her home and call the man and tell him? We will call the man, ask him if he is the one that got the child pregnant. If he answers, then there is no other way because we will not encourage her to abort the pregnancy, so we have no option except they continue.*

Poverty continues to drive many parents to consider early marriage for their daughters and, in some cases, their sons. The immediate financial reward from such arrangements resulting in having fewer dependents in the household often outweighs the longer-term benefits of keeping girls in school.

One concerning finding of this research is the lack of support systems for children to discuss these issues. Many children and adolescents lack resources in their communities, schools and social networks to address the pressures of early marriage. Instead, they often get their knowledge and attitudes about marriage from their parents, who are perceived as more knowledgeable and experienced in these matters, yet it is often parents who perpetuate child marriage.

Changes in the community

In addition to national legislation prohibiting child marriage, some communities have taken the initiative to implement their own disciplinary measures against offenders. For instance, through unanimous decision, community members in Manowa have established a fine for those caught arranging child marriages. This fine serves a dual purpose: it acts as a deterrent, but also provides funds to pursue legal action against offenders. These local measures go beyond monetary penalties. If an offender holds a leadership position within the community, they face the additional consequence of being stripped of their title. This applies to various community leaders, including chiefs, imams and pastors, who are expected to actively prevent child marriages rather than condone and facilitate them. This multi-faceted approach, combining financial penalties, legal action and social consequences, demonstrates some communities' commitment to eradicating child marriage and protecting their young people. By taking such decisive action at the local level, these communities are seemingly reinforcing the national law and creating a more comprehensive framework through which to combat the harmful practice of child marriage.

Female genital mutilation

Cross-country key findings

- FGM is a widespread practice in Mali and Sierra Leone, and in some parts of Niger, even if there is some awareness of its harmful consequences for girls' and women's health.
- The dominant types of FGM in Sierra Leone, Mali and Niger (Orchid Project and 28 Too Many, 2022; 28 Too Many, 2021; 28 Too Many, 2020) are Types 1and 2[2].
- Information about the physical harm FGM causes is mixed with misinformation about it being necessary for giving birth without complications, as well as to increase the pleasure for the husband and reduce the sexual pleasure for women to avoid them wanting to have extra-marital relationships.
- FGM is frequently considered a rite of passage and linked with community traditions, such that girls themselves often want to undergo the practice, but with only partial awareness about the practice's physical and psychoemotional risks.
- In Niger and Sierra Leone, the issue of FGM violating children's rights has been circumvented by establishing a minimum age for FGM. While this is generally not respected, and many girls are cut from a very young age (5 years or younger), the larger issue is that it is still practiced at some point during the girl's or woman's life with lifelong consequences on their health and wellbeing.
- There is still significant social support for this harmful practice based on its association with cultural identity and in the case of Muslim communities reference to it being a religious mandate.
- In Niger, a worrying finding is that it FGM was found to be practiced in some health centres, which would suggest its broader acceptance and could make it more challenging to eradicate.

Mali

FGM is a widely accepted practice in most areas of Mali. Although some of those who continue with the practice are aware of its harmful impacts on young girls' health, there is a great deal of misinformation about what happens during intercourse if a girl has not been cut (such as men feeling pain), or making it easier for a woman to give birth if she has been cut, as articulated by an adolescent boy in Mpessoba: '*No, excision poses no risk to girls. On the contrary, it allows them to have children when they are married.'* And an older adolescent girl in Bougouni said, '*The community thinks it's a good thing. People say it makes it easier for women to procreate.'*

In the study locations, FGM is considered a compulsory practice, carried out by women on girls who are typically grouped together to be circumcised. It is a special community event, which adds to its appeal, with the village chief typically determining the time of the year when cutting will take place. There is no standard age for girls to undergo the practice, but it is usually done at a very young age, when girls are aged between 3 and 8 years. But it can take place at any age, including during adolescence. An older

[2] According to WHO definitions, Type 1 FGM is the the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans). Type 2 FGM is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva) https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

adolescent girl in Bougouni reported that, *'It's between 2 and 4 years old. Excision is carried out at the age of 3 and as a group, for which the parents pay the costs. But those who can afford it, excise their daughters when they are 1 year old.'*

The practice is not carried out in hospitals in Mali as it is prohibited there; this increases the risk of infections or complications, with adverse consequences for girls.

The most frequently cited reason for continuing with this harmful practice is the need to reduce girls' sexual desire, particularly before marriage, to avoid them engaging in premarital sexual relations. As an older married girl in Mpessoba EPR said, '*In our context, we say that if you haven't been circumcised it's not good for you. You cannot abstain, you will have more desire for sex and on the bed the man will be in pain.'*

Research participants had a favourable attitude towards excision, although a few recognised that it can have negative consequences for girls, as one younger adolescent girl in Bougouni explained: *'If it's well done, there's no risk, but if it's badly done, there's a risk that you won't give birth.'*

Adolescents, particularly girls, are aware of excision from a young age and have some information about its consequences, but there seems little interest in changing social norms around FGM. Rather, most respondents noted that a girl who has not been excised will not find a husband.

Adolescent boys, in particular, do not know the reasons for excision, although they know that the practice takes place. They learn about why it is done later in life. Once they learn about it, the misinformation leads them to expect it as they become older, as one older boy in Bougouni said:

> *I asked him* [father] *why excision was practised, and he told me that a girl who has not been excised cannot be sexually satisfied by her man, that's what I know about it. It's practised every year in our community, it's done in groups. It's the old women who do it, the excisers, it's been done for many years.*

More information is starting to reach communities about the potential risks of FGM for girls' health, but there is a great deal of resistance to changing the practice, as the mother of an adolescent girl in Namposela reported:

> *To tell the truth, on the radio we're told to abandon the practice, otherwise it means that our community has no values, they say we don't understand, they say that at the time of childbirth the woman can have a lot of difficulties... The woman's uterus comes out, sexual intercourse is difficult, but before there were no such difficulties.*

In Mali, there are no formal sanctions against FGM, but health workers are forbidden to carry out this harmful practice. Although it is not forbidden within communities, in some cases there have started to be agreements with NGOs and health authorities to discourage the practice, but still with limited penetration.

Niger

In Niger, FGM was discussed with parents, who described it as 'clitoris removal'. The widespread perception is that the clitoris is a 'deformity' that needs to be removed. Although in the past it was customary for girls to undergo genital mutilation from birth, nowadays, parents prefer to wait until just before or after their daughters' marriage. Those who are not cut are seen as unsafe from sexual assault and vagrancy. One mother from Awache said, '*In the past, the gourya[clitoris] was not removed very early so that the girl would not have sexual relations outside marriage.'*

Genital mutilation is carried out by a traditional cutter called '*wanzam*', invited by the parents of the adolescent girl concerned, but some interviewees mentioned that on occasions it is done at the hospital. The practice is seen as important to improve the husband's experience of sexual intercourse with his adolescent wife. A community leader in Oura explained that:

> [What is cut] *is a kind of covering that is in a girl's vagina and prevents her from having normal sexual intercourse… because during intercourse with the girl, she won't feel comfortable. It's because of this that we see this, we ask an old lady to check the girl and the traditional cutter will remove this covering and it will be followed by a small treatment of hot water with leaf powders. And now, thank God, everything's going well, because in the past there was a lot of risk, because even in the health centres we do it.*

Importantly, the absence of cutting is seen as problematic for husbands, who are culturally made to think the clitoris is a deformity that gets in the way of sex. If the girl has not been cut prior to marriage,, which is uncommon, the husband can ask to have the girl cut, as an older adolescent girl from Ouara noted, *'It is the husband's choice. What he decides is what has to be done… or it is the parent before the girl marries. But the husband can request it too if he sees she has a problem…'*

One married adolescent girl from Garare said, during an individual interview:

> *The problem is that if a girl hasn't been mutilated since childhood, she doesn't accept a man for sex, and her parents hit you and her husband hits you, because they don't know what's going on. And in this community they don't check whether a girl has it or not, they don't check girls to identify problems, they only give the girl in marriage and she suffers a lot.* [Interviewer asks: But why don't parents check?]*… Here, parents only care about age, whether a girl reaches marriageable age or not…*

FGM is understood to have some potential health risks for girls, with several cases of fistula reported at all study sites, which is problematic. Fistula may in turn lead to divorce and/or contempt on the part of the husband.

Many of the interviewees regarded FGM as a form of violence against young girls because it affects them psychologically and physically, so it was seen as something to do preferably when the girl is older and about to marry out of a belief that she would be better able to tolerate the impacts. This is, however, not the case and may be a belief that shifts the attention from the problem of combatting FGM at all ages. At any age, when FGM is done prior to first sex is often especially painful as girls may still be healing from FGM, in addition to the additional health consequences it can have, as noted above (WHO, 2024).

Mentors working with NGOs in local communities (many of them from those communities) are considered as a means of changing behaviours and contributing to the well-being of their community, even if the

process is complex and takes time. They raise awareness that FGM is a harmful practice, as one key informant from Awache noted:

> *We really have our role as mentor. I will try to give them good advice because our role is to be able to bring about change in the community. Not even here in my village, if I learn about it elsewhere I can intervene to prevent these bad practices. And even if you can't prevent it, you can use all means to counteract this practice.*

Sierra Leone

Sierra Leone currently lacks a national law explicitly prohibiting FGM (which is also known as Bondo). However, the Child Rights Act of 2007 protects individuals under 18 years of age, implicitly suggesting that only women 18 and older can legally consent to join Bondo societies.

Stakeholders involved in Bondo rituals often claim that the practice does not negatively affect girls, and assert that initiations are scheduled during school holidays, particularly Easter, and only for girls aged 18 and above, to conform to government law.

Despite this legal framework and a decrease in FGM rates over the years, community pressure to participate in Bondo activities remains strong, as it is still considered an important rite of passage, and so girls want to be part of it.

The initiation process involves several key elements: a 'Mammyqueen' who decides who is initiated, an initiation fee, and the involvement of cutters (usually elderly women known as 'soweis'). Girls seeking advice typically consult female figures such as female friends, mothers, older sisters and soweis, due to their experiences. Initiation groups often include a mix of older and younger girls and women.

Despite the legal provisions, reports suggest that as long as the fee is paid, age can be disregarded, and so girls can be subject to FGM from a young age. Many girls who were interviewed confirmed that they were initiated as young as 5 or 6 years old.

Girls reported experiencing peer pressure and discrimination for not undergoing Bondo rituals, with one girl mentioning that her friends laughed at her because her father could not afford the initiation fee. Girls do not want to be left out of this experience, as a community stakeholder (in an FGD in Manowa) said:

> *There are a few who are joining the Bondo society out of peer group pressure. Some of them admire their friends just because they were given enough clothes and other things that they are using during initiation, so the other girls feel if they join the society their parents will do the same for them.*

Many of the girls reported that the Bondo society represented more than just the cutting ritual for them; it served as a learning space. This environment taught them various skills and knowledge, including how to sing, how to transition into womanhood, and how to be equipped to tackle complex situations in life.

There have been instances where girls entered the Bondo bush intending to be initiated but subsequently changed their minds. According to respondents, girls were allowed to leave as soon as they withdrew their consent.

A stakeholder in Follah mentioned that practices have changed over the years due to education, awareness, and legal actions, with fewer girls marrying early and a decrease in girls being cut before they tun 18. However, some stakeholders in other communities did not perceive that FGM was a violent procedure against girls. This situation highlights the complex interplay of legal, cultural, social and economic factors surrounding FGM in Sierra Leone, underscoring the challenges in enforcing age restrictions and protecting young girls from premature or coerced participation in these practices.

5. Conclusions, and policy and programming implications

Overall, our baseline findings underscore that although some adolescents (especially those in more developed and urbanised settings) have relatively better access to sexual and reproductive health information and services, there are a range of areas that need to be prioritised in order to ensure that all young people in Mali, Niger and Sierra Leone are able to claim their full rights to sexual and reproductive health and well-being, in line with SDG 3.7. Practices that violate children's rights, including gender-based violence, child marriage and FGM/C, are still widespread in the communities researched and where the Foundations project will be implementing activities, so it is critical that specific measures are taken to improve the potential impact of the project on improving adolescents' sexual and reproductive health, and reducing their exposure to harmful practices, in line with SDG 5.

Our research points to the following priorities for policy and programmatic action, which we have clustered in terms of short- and longer-term priorities, paying particular attention to gender and urban–rural differences.

1. Improve adolescent sexual and reproductive health knowledge and access:

Short-term priorities

- Provide age-appropriate sexual and reproductive health education in schools, in more grades and with greater depth, especially regarding STIs; this should include younger adolescents aged 10–14 years, so as to prepare them for impending changes in their lives.
- Involve families (mother, fathers, older siblings, aunts), as they are already trusted sources of information.
- Create safe spaces where adolescents – especially the most vulnerable, including those who are out of school and adolescents with disabilities – can access information on sexual and reproductive health through cost-effective, peer-to-peer approaches, leveraging adolescent-friendly cultural gatherings where appropriate.

Longer-term priorities

- Develop and disseminate context-tailored curricula and offline and online materials to support adolescents' access to robust information on sexual and reproductive health and rights.
- Develop disability-adapted versions of materials (for example, in braille, online with voice-activated information, and videos with sign language interpretation), and include examples of young people with disabilities to ensure inclusivity.
- Invest in specialised training for rural health workers to better support young people and their families. Simultaneously, work with schools to play a more central role in health education, and promote coordination between educational institutions and health services.

2. Ensure greater contraceptive awareness and uptake:

Short-term priorities

- Educate fathers, older brothers, husbans and male community leaders on contraception and their role in raising empowered adolescents.
- Sensitise the community to disassociate contraception from promiscuity, and instead focus messaging on contraceptive use as a means to avoid early pregnancy and the associated risks for girls' physical and mental health.
- Raise awareness among adolescent girls, boys, young women and men about contraceptive options and where they can access them, through school-based gender clubs facilitated by trained teachers for in-school adolescents, and through adolescent-friendly community platforms to ensure equal access for out-of-school adolescents.
- Create safe spaces for adolescents and young people in communities so that they can access services and products free of charge, drawing on pre-existing cultural gatherings where feasible.

Longer-term priorities

- Strengthen sexual and reproductive health product supply chains to prevent supply shortages and ensure contraceptive availability.

3. Strengthen access to safe abortion care:

Short-term priorities

- Integrate safe abortion care packages into adolescent sexual and reproductive health interventions, including raising awareness about the importance of seeking out trained health professionals and avoiding harmful traditional or chemical abortifacients, while being cognisant of country-specific legal restrictions.
- Include abortion care, sexual and reproductive health information, and treatment guidance in adolescent sexual and reproductive health education.
- Address moral and religious concerns surrounding abortion laws through community sensitisation.

Longer-term priorities

- Advocate for legal revisions so as to avoid the individual and public health toll of unsafe abortions.

4. Improve adolescent sexual and reproductive health service access and uptake:

Short-term priorities

- Design and scale up adolescent-friendly services, accessible to both in-school and out-of-school adolescents.
- Promote health service visits by school-based clubs and through community-based cultural gatherings in order to familiarise adolescents with available services in their communities, and to facilitate engagement between health service providers and young people.
- Ensure that sexual and reproductive health services include adolescents with disabilities to avoid gaps in access to service access, including ensuring appropriate adaptations, for example ensuring that facilities have ramps for young people with physical and visual impairments, that young people with hearing impairments have access to sign language interpretation.

- Invest in robust monitoring, evaluation and learning from adolescent service access and quality over time so as to maximise scarce resources, and to share emerging evidence of promising practices with providers in other localities.

Longer-term priorities

- Work with local champions, especially progressive traditional and religious leaders who enjoy considerable community influence, to raise awareness about available adolescent sexual and reproductive health services and to encourage uptake.
- Collaborate with health centres to train staff at scale in delivering adolescent sexual and reproductive health services, and ways to build trust between adolescents and service providers.

5. Increase awareness about girls' and women's rights, as well as about the different forms of gender-based violence - including within marriage -and support legal recourse against rape

Short-term priorities

- Work with communities to sensitise them against the normalisation of gender-based violence on the basis of gender rights and equality, to promote change over time, including with regard to domestic violence, which is perpetuating violence against women from adolescence to older age. This work needs to actively engage girls, boys, women and men (including fathers, brothers, husbands and community leaders). It may be useful to find local role models from the district (both men and women) who can talk about the importance of changing practices, through their lived experiences.
- Provide sexual and reproductive health education focused on preventing gender-based violence, especially targeting male adolescents.
- Educate parents to recognise and prevent child sexual exploitation and physical violence.
- Train teachers on safeguarding policies to reduce the incidence of sexual harassment and physical violence in schools, making them safe spaces for adolescents.
- Sexual and reproductive health education should include a focus on rape, giving the clear message that it is not a girl's fault if she is violated, no matter the circumstances.

Longer-term priorities

- Carry out more sustained work at the community level to transform the practice of gender-based violence (and particularly sexual violence) against adolescents, since despite legal recourse being available, social norms imply shame that leads to under-reporting and revictimisation of girls in particular.
- Raise awareness about girls' rights in a way that helps them understand why it is important for their development to safe, empowering them against the gender-based violence they experience in their communities. This can include sharing stories of role models from communities similar to their who have been able to overcome GBV so that they can see it does not have to be the norm.

6. Continue to work with communities to increase knowledge about the negative physical and psychological consequences of child marriage

Short-term priorities

- Promote more widespread use of contraception and implement safe abortion care to reduce adolescent pregnancies, which are a significant driver of child marriage.
- Work with men in the community (fathers, uncles, husbands, chiefs) to help understand the value of girls completing education for poverty reduction in the medium term, and the physical consequences for adolescent girls and young women of early childbearing.
- Emphasise the consequences of early marriage and early pregnancy at the community level, highlighting the risks to girls' physical and mental health of early childbearing, particularly given the number of girls who are married early, and who could, at least, be supported to continue in school and delay childbearing.
- For girls who have been married at a young age, explore programming to support their education and wellbeing, as well as their understanding of SRH given their situation of sexually active, married girls.

Longer-term priorities

- Continue engaging with girls, boys, women and men to continue pushing for change in norms that enable child marriage. The examples of Sierra Leone and other countries in the region where change has occurred which may be seen as more familiar references, can be shared highlighting gains by individuals and communities from extending the age of marriage.
- Once change starts being supported, co-develop bi laws and regulations with communities to protect adolescents from child marriage, ensuring that these laws reflect community needs and values informed by newly accepted changes in practice.
- Promote investment in education for adolescent girls and boys as a key preventive approach to child marriage, and raise awareness about the longer-term value of education, including through the linkages between education and labour market opportunities.

7. Support the enforcement of FGM bans, while increasing access to accurate information about this harmful practice

Short-term priorities

- Undertake community sensitisation through cultural gatherings (such as the Foda in Niger) and religious forums, including radio-based ones, to raise awareness about the risks of FGM and to challenge misinformation about its consequences, for males as well as females, including for example, working with men to debunk the myth that sexual intercourse is less enjoyable if a girl/woman has not been cut.
- Generate awareness about the physical and psychological consequences of FGM, which are often unknown or not discussed.

- Work to de-couple the practice of FGM from the social event or activity that encourages its continuation, so that eventually, coming-of-age ceremonies are not centred around FGM.
- In contexts where FGM is not a widespread practice, promote girls' clubs in which peer influencers can speak to other adolescents about the risks of practicing FGM and share their experiences of not having undergone FGM. In contexts where it is a majority practice, identify influential community members (such as clan or religious members) who can be persuaded to share information publicly about the harms of FGM and the importance of eliminating the practice.

Longer-term priorities

- Develop laws with community involvement to protect children and adolescents from FGM and other harmful practices.
- Advocate with ministries of health for laws and policies that forbid the practice of FGM in health centers in addition to supporting awareness raising for health professionals around its harms in cases such as some localities in Mali and Sierra Leone, where health professionals in health centers still conduct FGM.

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Annex 1: Key research questions and tools

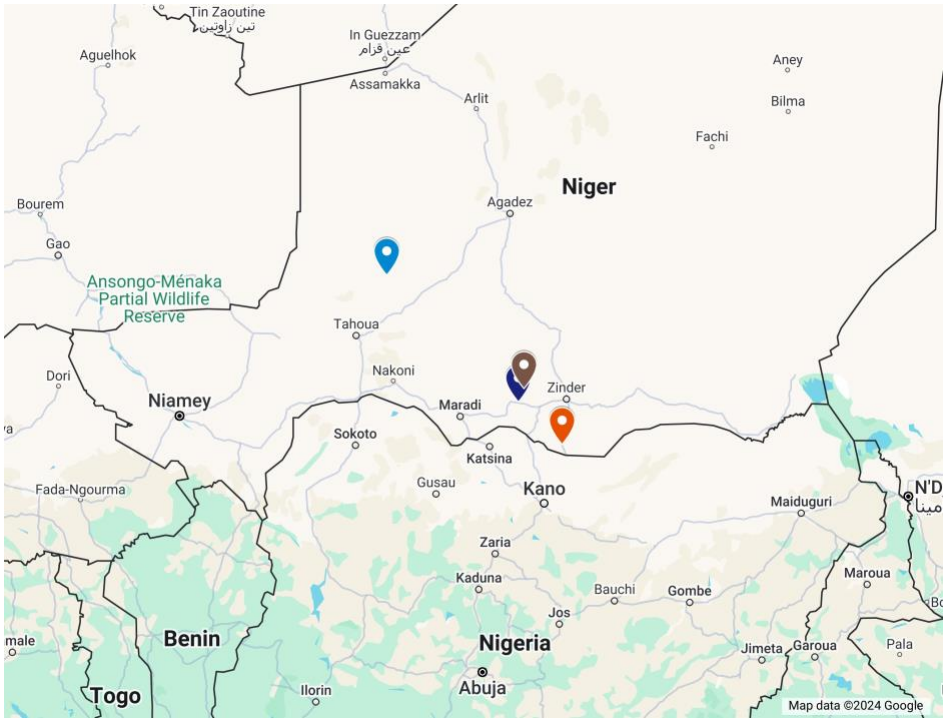
	Participants	Aim of the tool
Body mapping (FGD)	Girls 10–14 years Boys 10–14 years	Uncovering what young adolescents know about their bodies, about sexual and reproductive health (SRH), and who/what their sources of information are.
Community mapping (FGD)	Girls 11–19 years Boys 11–19 years	Learning about older adolescents' social support network, where they get information from, what they know about SRH, what they think about social norms and gender dynamics in the community.
Social norm mapping (FGD)	Community leaders Parents	Gaining insights about community perceptions on social norms, particularly regarding SRH, and whether there have been events or changes at the national, district or local levels that have triggered important shifts in these perceptions around norms.
Social hexagon (Individual adolescent interviews)	Adolescent girls (married, not married, with disabilities, without disabilities) Adolescent boys 10–19 years	Learning what older adolescents' social support networks are, how they use them, where they get information from (particularly on SRH), what they know about SRH, what they think about social norms and gender dynamics in the community.
Vignettes (Key informant interviews with service providers and community leaders)	Various key informants at the village and district level (teachers, health workers, etc.)	Gaining insights about how key informants working in different areas would react to challenging cases where their knowledge of SRH regulations and practice would be tested. Additional specific questions about the SRH context, legislation, customs and support to adolescents were also explored.

Annex 2: Study locations

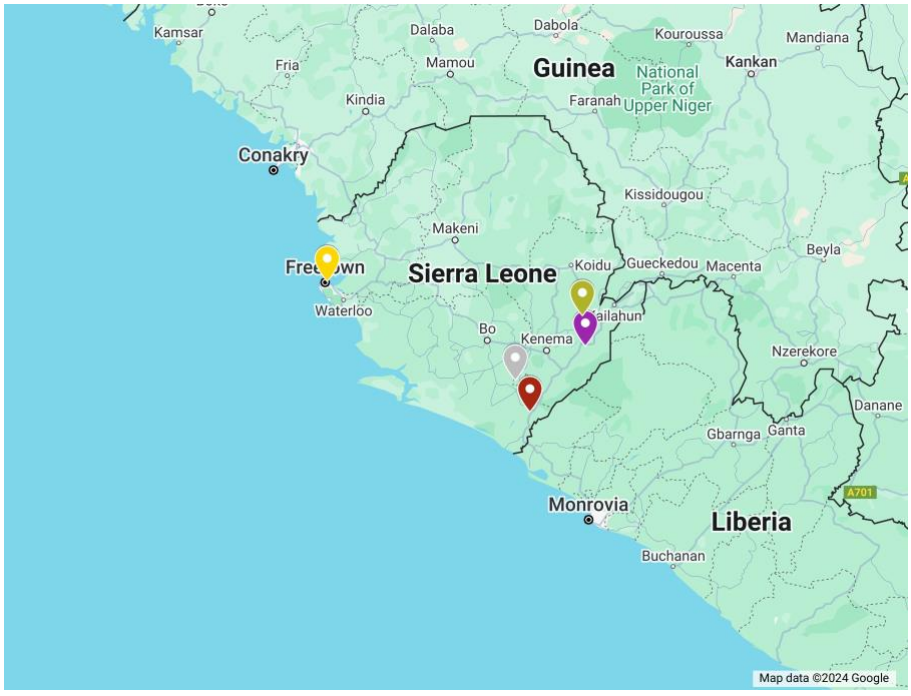
Country	Proximate programming communities		Remote programming communities		Non-programming communities
Mali	Sincina	Namposela	Mpessoba EPR	Mpessoba Zantiéla	Bougouni
Niger	Maiguijé	Ouara	Awache	Magaria	Garare
Sierra Leone	Manowa	Bunumbu	Follah	Gbahama	Woroma

Mali

Niger



Sierra Leone



Annex 3: Thematic coding approach in MAXQDA

The Foundations Research Project used the qualitative research software MAXQDA to manage and analyse the large volumes of data collected. MAXQDA facilitated the coding process, which in simple terms refers to the assignment of labels to segments of information for the purpose of categorising and organising data under relevant themes. This approach enabled a systematic and in-depth analysis of the data while ensuring consistency across the different country teams involved in the study.

To streamline the analysis, a codebook was developed based on the GAGE conceptual framework, which guided the categorisation of data into key capability domains, including: bodily integrity and freedom from violence; voice and agency; and health, nutrition and sexual and reproductive health.

In addition to these core domains, Foundation-specific codes were introduced to capture the impact of the programme's interventions. The codebook was designed to be both deductive and inductive, allowing for predefined themes (based on the GAGE framework) while also being flexible enough to incorporate emerging themes from the data.

Prior to the commencement of the coding process, all coders across the three countries received detailed training on how to use MAXQDA effectively. This training ensured that the coders were proficient in applying the codebook consistently.

To maintain quality control, the initial coded transcripts were reviewed by the research team, and feedback was provided to the coders until their work met the required standards of quality and consistency. Weekly meetings were held with the country teams to monitor the progress of the coding process, address any challenges, and ensure alignment across the teams in terms of code application and the introduction of new codes as needed.

The codebook was tested on an initial set of transcripts, and feedback from the country teams was used to assess its effectiveness. As the coding progressed, new codes were introduced to address emerging themes. For example, codes related to psychosocial well-being were added to capture adolescent experiences concerning support from family, peers, and other adults in accessing sexual and reproductive health services and knowledge.

Furthermore, intersectionality was a key consideration throughout the coding process. To capture the complexities of how various inequalities (such as age, gender, economic status, marital status, and disability) intersect and impact adolescents' experiences, 'difference codes' were employed. These codes were always double-coded with the main capability codes, enabling a nuanced analysis of intersectional differences within each theme.

Once coding was completed, thematic analysis was carried out by exporting coded segments into Excel. This step allowed the research team to explore the data in a more granular way by applying filters such as gender, age, or location to identify patterns and variations across different demographic groups. Additionally, the use of Excel facilitated informal coding, providing a space for further categorisation of data and supporting more in-depth analysis.

Annex 4: Participants per tool, per country

Method	Activities	Number of interviews carried out							
		Mali		**Niger**		**Sierra Leone**		**Total interviews**	**Total participants**
		Number of interviews	Number of participants	Number of interviews	Number of participants	Number of interviews	Number of participants		
Social norms (FGD)	Fathers	3	25	3	24	5	29	11	78
	Mothers	3	23	3	24	5	30	11	77
	Stakeholders	3	21	2	16	4	31	9	68
Body map (FGD)	Boys	3	24	3	24	5	37	11	85
	Girls	3	26	3	24	4	4	10	54
Adolescent IDI	Married/ Coupled girls	18	18	16	16	8	8	42	42
	Unmarried/Uncoupled girls	25	25	17	17	16	16	58	58
	Unmarried boys	23	23	20	20	27	27	70	70
	Married boys	NA	NA	NA	NA	1	1	2	2
Community mapping (FGD)	Unmarried girls	3	22	3	24	6	29	12	75
	Unmarried boys	3	20	3	24	6	38	12	82
	Married/ coupled girls	3	24	3	24	4	31	10	79
Key informant interview	Police	3	3	2	2	5	5	10	10
	Male teacher	4	4	6	6	6	6	16	16
	Female teacher	5	5	NA	NA	6	6	11	11
	Traditional leader	3	3	1	1	6	6	10	10
	Religious leader	3	3	1	1	5	5	9	9
	Health worker	3	3	7	7	4	4	14	14
	FGM Cutter	0	0			5	5	5	5
	Community Leader	2	2	6	6			8	8
	Protection agent	2	2	**7**	**7**	3	3		
	Women's Development Agent	1	1	2	2	2	2	5	5
Total		**116**	**277**	**108**	**269**	**133**	**323**	**346**	**858**