ADOLESCENT IN TRANSITION IN WEST AFRICA (ATWA) OUTCOME EVALUATION

2022-2023 Baseline Report



THE UCSD CENTER ON GENDER EQUITY AND HEALTH, GRADE AFRICA, AND SAVE THE CHILDREN

MARCH 2023

GRADE Africa

Save the Children

GEH Center on Gender Equity and Health • UC San Diego School of Medicine

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Recommended Citation:
Center on Gender Equity and Health. 2023. Adolescent Transitions in West Africa (ATWA) Outcome Evaluation: Year 2 Baseline Report. La Jolla, CA: University of California San Diego for Save the Children.

gehweb.ucsd.edu/adolescent-transition-west-africa-atwa/
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LIST OF ACRONYMS AND KEY PHRASES

ASRHR	Adolescent Sexual and Reproductive Health Rights
ATWA	Adolescent Transitions in West Africa
CFA	Confirmatory Factor Analysis
DHS	Demographic and Health Surveys
EPA	Exploratory Factor Analysis
FGC	Female Genital Cutting
GAGE	Gender and Adolescence Global Evidence
GEAS	Global Adolescent Study
GEM	Gender Equitable Men
LSE	Life Skill Education
MHM	Menstrual Hygiene Management
MPNS	Menstrual Practice Needs Scale
MPQ	Menstrual Practices Questionnaire
RCT	Randomized Controlled Trial
SRH	Sexual and reproductive health
SRHR	Sexual and Reproductive Health Rights
UCSD	University of California San Diego
VYAs	Very young adolescents
Y/O	Year olds

BACKGROUND

The Adolescent in Transition in West Africa (ATWA) program is funded by the Dutch Ministry of Foreign Affairs. The four-year program aims to influence and promote positive adolescent sexual and reproductive health and rights (ASRHR) outcomes by addressing some of the interrelated drivers of poor sexual and reproductive health and rights (SRHR) among very young (ages 10-14 years) and older (ages 15-19 years) adolescents in eight regions of the Liptako Gourma area of West Africa, an area that covers eastern Burkina Faso, southwestern Niger, and a small portion of southeast and central Mali.

Spanning from December 2019 until November 2023, the program will improve the sexual and reproductive health and rights of adolescents by catalyzing the provision of Life Skills Education (LSE) in school settings, and in Niger and Mali outside of school settings as well. Teachers, mentors, and peers will engage adolescent girls and boys in learning about SRHR, building critical life skills and improving attitudes, behaviors and norms towards gender and SRHR. Alongside the provision of LSE, the program will increase access to, and uptake of, quality adolescent-responsive SRH services and contraception among adolescents by improving the quality and youth-friendliness of services, including the attitudes, skills and knowledge of service providers. Overall objectives of the project include:

Impact: Improved sexual and reproductive health and rights of adolescents
Outcome 1: Improved sexual and reproductive health and rights and gender equality knowledge, intent, and behaviors among adolescents
Outcome 2: Ensure health facilities offer quality adolescent responsive SRH services that are used by adolescent girls and boys

Overall, ATWA seeks to provide SRHR information to 472,180 adolescents through 2,573 teachers in 2,148 primary schools (adolescents ages 10 to 14) and 425 secondary schools (adolescents ages 14 to 19), 48,000 out-of-school adolescents, 1,704 health workers, and 500 health centers. Additionally, 212,090 girls in 2,537 schools in Niger, Mali and Burkina Faso are to be provided with the knowledge, materials, and facilities to manage their menstruation in a hygienic and dignified fashion. ATWA also aims to provide 48,000 out-of-school adolescents in Niger and 4,368 in Mali with quality ASRHR information in small groups by mentors.

To evaluate the intervention's impact, an external outcome evaluation was carried out in each year of implementation by the program's partnering research organizations: the Center on Gender Equity and Health at the University of California San Diego (UCSD-GEH) and GRADE Africa. In each of the three countries, intervention and control groups were identified and interviewed at the start and end of each of the two intervention years. This report provides findings from the Year 2 baseline survey conducted between November 2022 and January 2023.

OUTCOME EVALUATION - STUDY DESIGN & METHODOLOGY

The overall objective of the evaluation is to evaluate the efficacy of the ATWA program in improving the knowledge, attitudes, behavioral intentions and other precursors of behavior change related to menstrual hygiene and other ASRHR outcomes. To assess ATWA's efficacy towards these outcomes, a repeated cross-sectional cluster randomized controlled trial (RCT) design is employed. Data collection occurred via administration of a quantitative survey to adolescents in both the intervention and control groups by trained enumerators. The survey is fielded among a cross-sectional sample at each of the four evaluation time points: baseline Year 1 (December 2021), endline Year 1 (June 2022), baseline Year 2 (November 2022), endline Year 2 (anticipated May 2023).

STUDY POPULATION

The ATWA intervention aims to reach male and female very young and older adolescents, ages 10 to 14 years and 15 to 19 years, respectively. The geographic focus of ATWA is eight regions of the Liptako Gourma area, an area that covers eastern Burkina Faso, southwestern Niger, and a small portion of southeast central Mali. The intervention will be implemented in: Sikasso, Gao, Mopti, and Ségou regions of Mali; Boucle de Mouhoun, Nord, and Centre-Nord regions in Burkina Faso; and Tillabery region in Niger. The situation in the Liptako Gourma area is characterized by insecurity and violence, including against schools and health centers, and conservative attitudes towards adolescents' SRHR.

Although the intervention is largely school-based, ATWA also reaches a smaller percentage of adolescents who are not enrolled in schools via community small group settings. Adolescents who are not enrolled in school may be out of school either temporarily due to political instability or COVID-related school closures, or for longer durations due to familial considerations.

SURVEY TOOL DEVELOPMENT

Prior to the Year 1 Baseline, and in coordination with Save the Children, UCSD-GEH drew upon the ATWA M&E Framework (Appendix A) and each country's curricula to develop a quantitative survey designed to assess evaluation indicators and other key intervention topics. The resulting survey tool includes 12 themes: Respondent Demographics; Puberty; Menstrual Hygiene & Management; HIV, STIs & Pregnancy Knowledge; Contraception; Personal Sexual History; Health Services; Gender Attitudes & Norms; Gender-Based Violence; Self-Efficacy; Child Marriage; and Female Genital Cutting (FGC).

The construction of indicators for each of the 12 themes was guided by the following previously-validated surveys: the 2020 edition of the Performance Monitoring for Action (PMA2020), Demographic and Health Surveys (DHS), the Johns Hopkins University's Global Early Adolescent Study (GEAS), Gender and Adolescence: Global Evidence (GAGE), Menstrual Practices Questionnaires (MPQ), and the Menstrual Practice Needs Scale (MPNS-36). The demographic indicators were defined using the PMA2020 and the GEAS, while the gender attitudes and norms were defined using the GEAS after factor analysis. Contraceptive use measures among adolescents aged 10-14 and 15-19 were also defined using the GEAS. Finally, the analysis of practices during menstruation was assessed using the MPQ. In addition, UCSD researchers in collaboration with Save the Children-Netherlands staff created new indicators reflective of the unique ATWA programmatic mandate.

After initial development in July 2021, the survey tool was circulated among Save the Children country offices in Burkina Faso, Mali, and Niger and reviewed to ensure included item topics matched the country's curricula and to ensure cultural considerations were made with respect to item wording and appropriateness of topics for adolescents, especially very young adolescents. This review process resulted in variation of the items asked in each country by adolescent sex, age, and school status (please see Appendix C for how the survey items vary by respondent type).

The final survey was used in Year 1 baseline, with minor modifications at Year 1 endline. The modifications between Year 1 baseline and endline include the addition of three questions for Malian respondents regarding whether they received SRH education from peers, teachers, or another person (Items 908A, 908B, and 908C). In Year 2, two new sections were added to the survey to assess community support for ASRHR education and services and to understand who adolescents turn to in their social support networks when they have questions or concerns about ASRHR-related matters (such as body changes during puberty, romantic relationships, and pregnancy prevention). These topics were added to the survey to respond to Output 1.4 in the ATWA Monitoring and Evaluation framework (Appendix A) that sought to assess community leaders' support for provision of LSE/SRHR information and SRH services. Given that a direct survey amongst adult community leaders was not feasible, indicators under Output 1.4 were assessed via the survey amongst adolescents. Please see report section 7 that documents adolescent perceptions of community support for provision of LSE/SRHR information and SRH services.

The final Year 2 baseline survey is presented in Appendix B. A matrix summarizing items asked by type of adolescent (e.g., among in-school Malians ages 10 to 14 versus out-of-school Nigeriens ages 15 to 19) is provided in Appendix C.

SAMPLING FRAME

In a coordinated effort, Save the Children, GRADE Africa, and UCSD-GEH identified key demographic variables within Burkina Faso, Mali, and Niger that were hypothesized to contribute to variation in intervention effectiveness. These variables included: region, province, school type (primary/secondary), and urbanicity (rural/urban). Based on these considerations, sampling frames of schools (for in-school adolescents) and communities (for out-of-school adolescents) were developed for each of the three countries (provided in Appendix D) based on demographic and geographic variables hypothesized to introduce variation into the sample, such as the country's region or urbanicity of the locations. Following the sampling frame development, intervention sites were randomly selected. For each intervention site identified (i.e., a school or community), a control site was matched based on region, province, school type, and urbanicity.

The study design required that the control sites (i.e., the comparison groups for the intervention sites) be schools and communities that: 1) had not yet been targeted by the ATWA project; and 2)

be a minimum of 5 kilometers away from an ATWA intervention site to minimize the potential for contamination effects between the control and intervention groups.

As indicated in the technical report by GRADE Africa (Appendix E), fifty schools were selected in each country, with twenty-five assigned as intervention schools and the remaining twenty-five assigned as control schools. Of the twenty-five schools in each study arm, seventeen were primary schools and eight were secondary schools. This balance between primary and secondary schools was determined based on the population targeted by ATWA (i.e., the intervention targeted more primary school students than secondary school students). Fifteen students were randomly selected at each primary school, and ten students were randomly selected at each secondary school. In total, it was planned that 670 students be selected to participate in each country.

In addition to the in-school sample, data collection was planned in eight communities in Mali (where schools are closed) and in eight communities in Niger (where adolescents were not attending school). Four of the eight communities would be selected as "intervention communities" and the remaining four communities would be selected as "control communities." Fifteen adolescents would be selected in each community, for a total of 120 out-of-school adolescents in Mali and Niger, respectively.

Thus, as summarized in Table 1, the planned sample included a total of 2,250 adolescents for inclusion in Year 2 baseline data collection (1,125 adolescents in the intervention group and 1,125 adolescents in the control group). This sample size was determined based on power calculations of outcome indicators and budget considerations. Additional detail is provided in Sections 1.4-1.5 of GRADE Africa's Baseline Technical Report (Appendix E).

Table 1. Planned sample of adolescents by country and school status

Region	School level	Sample Size
Burkina Faso		
Boucle du Mouhoun	Primary	180
	Secondary	40
	Total	**220**
Nord	Primary	210
	Secondary	80
	Total	**290**
Centre-Nord	Primary	120
	Secondary	40

	Total	**160**
	Overall Country Total	**670**
Niger		
Tillabéry	Primary	510
	Secondary	160
	Out-of-School	120
	Overall Country Total	790
Mali		
Gao	Primary	120
	Secondary	40
	Out-of-School	60
	Total	**220**
Mopti	Primary	180
	Secondary	60
	Total	**240**
Ségou	Primary	120
	Secondary	40
	Out-of-School	60
	Total	**220**
Sikasso	Primary	90
	Secondary	20
	Total	**110**
	Overall Country Total	790
	Total Planned Sample	**2,250**

Of all the schools and villages that were selected for Year 2 baseline data collection, there were only two schools in which data collection did not take place and were not replaced by a new school: a secondary school in Niger and a primary school in Burkina Faso. In lieu of selecting a new school in Niger, the data collection team interviewed 10 additional students at a nearby school in the same study arm. In Burkina Faso, the primary school was not replaced, nor was another nearby school in the same study arm oversampled; as a result, the sample size in Burkina Faso was ultimately reduced by 15 individuals. In addition, in the Gao region of Mali—an area of extreme instability—120 adolescents (75 in-school, 45 out-of-school) were initially interviewed, but were eventually excluded from analyses as they were later understood to not have been part of the intervention. In response, in March 2023 a new sample of 73 (of a planned 75) in-school adolescents were interviewed in the following schools: Ouani franco arabe, Ecole Sable, BOSSALIA P/C, FIA1, and Forgho Arma PC. Although the timing of this additional data collection did not permit the data to be included in analyses for this baseline report, the new data will permit longitudinal analysis to be conducted among these 73 adolescents to examine ATWA's impact in

the endline report. Finally, Mali no longer offers the program of out-of-school adolescents, so a new sample of out-of-school adolescents was not recruited for interviews. See Sections 2.6 through 2.9 of the Baseline Technical Report (Appendix E) for additional detail on challenges during data collection (such as security risks and limited road access), enumerators' strategies to overcome these challenges, and information on the changes to the sampling frame.

Overall, data collection in each of the three countries was successful with 98% of the pre-selected schools and villages participating in the Year 2 baseline survey. This comes as a result of the strong collaboration between GRADE Africa, Save the Children country office teams, local authorities, school directors and teachers. Final sample sizes at baseline by key demographic variables are provided in the evaluation results section (see Table 3).

Commitment to Conducting Ethical Research and Child Safe Programming

Study protocols were prepared and submitted to Ethics Committees in each of the three countries in addition to the UCSD Institutional Review Board (IRB) (IRB Determination #210928). The study is also registered on ClinicalTrials.gov, an online database by the U.S. National Library of Medicine of randomized trials (ClinicalTrials.gov Identifier: NCT05396664). Regional educational directors in each of the three countries were informed of the study by the GRADE Africa team, as were provincial and departmental directors. Save the Children country office representatives informed local school officials, as well as the administrative and customary authorities within selected communities.

Before the start of baseline data collection, enumerators completed a five-day training in which they were provided guidance and training on:

- Ethical principles of research, child advocacy policies, and data collection procedures;
- Best practices for translation of survey questions, consent and assent forms to local languages
- Safety protocols for conducting data collection in communities with heightened security risks; and
- Data collection procedures using e-tablets programmed in CommCare, the mobile data collection platform.

In addition to the 17 enumerators who completed this training and who were involved in data collection in each of the three countries, there were two additional enumerators, local to the commune of Tera in Niger, who were trained and assisted with data collection in this area due to heightened security risks.

Data Collection Procedures

Data collection teams planned to survey the same schools and villages as those included in the Year 1 sampling frame, provided they were not closed or inaccessible due to security risks. Before data collection began in November 2022, an updated list of schools and villages for each of the three countries was programmed in CommCare, and study objectives and timelines for the project were shared with local authorities and school directors. Following this key stakeholder consultation process, participant lists were obtained via school directors at each school and, for out-of-school adolescents, from local authorities in Niger and Mali. The data collection team then used a Random Number Generator application to randomly select individuals from these lists.

Informed consent was obtained via parental written consent and verbal assent in local languages. In addition, care was taken to match female adolescents with female enumerators, and male adolescents with male enumerators. The sex-matched enumerator then administered the survey using electronic tablets programmed using CommCare. A monitoring and quality control tracking system for data collection was developed and updated daily.

Year 2 baseline data collection occurred between November 8 to December 30, 2022 in Niger, between November 23 to December 15, 2022 in Burkina Faso, and between December 21, 2022 to January 16, 2023 in Mali. Additional detail about this sampling process is provided in Section 2.7 of GRADE Africa's Baseline Technical Report (Appendix E).

Outcome Evaluation Indicators

The ATWA M&E Framework (Appendix A) includes both monitoring and evaluation indicators. Table 2 provides a summary of the evaluation indicators included in the report, and the associated report sections in which they are discussed. The full table of evaluation indicators by country along with results is provided in Appendix F. Emphasis for the outcome evaluation is placed on outcome indicators; however, data were also generated on the longer-term impact indicators. As such, information on the impact indicators is also included in this report for completeness.

Table 2. List of ATWA outcome evaluation indicators by corresponding report section

IMPACT: Improved sexual and reproductive health and rights among adolescents		
Indicator	**Indicator Definition**	**Report Section**
[1] Decrease in adolescent birth rate *(NB: adolescent parity is used as a proxy as we do not assess births by year in this study)*	[1] The average number of births to female respondents ages 15-19	1. Demographic Characteristics
[2] Decrease in proportion of adolescents who have ever been pregnant or caused a pregnancy	[2] The percent of adolescent females who have ever been pregnant + the percent of adolescent males who have ever caused a pregnancy	1. Demographic Characteristics
[3] Increase in need for family planning satisfied with modern contraception	[3A] Percentage of [sexually active] adolescents age 15-19 years currently married or in union who have their need for family planning satisfied with modern contraceptive methods	5. Contraception & Sexual Activity
	[3B] Percentage of female adolescents (15-19) who are sexually active and who have their need for contraception satisfied with modern methods	5. Contraception & Sexual Activity
[4] Increase in adolescent modern contraceptive prevalence rate (CPR)	[4] The percent of sexually active adolescents (15-19) who are currently using (or whose partner is using) a modern contraceptive method. "Currently" is defined as 'at last sex'.	5. Contraception & Sexual Activity
[5] Decrease in proportion of adolescents married	[5A] Percentage of women 10-19 years old who were married or in union before age 18. *[Note: this is the percentage of the* sample *living with spouse before age 18.]*	1. Demographic Characteristics
	[5B] Percentage of women 10-19 years old who were married or in union before age 15. *[Note: this is the percentage of the* sample *living with spouse before age 15.]*	1. Demographic Characteristics
Outcome 1: Improved sexual and reproductive health and rights and gender equality knowledge, intent, and behaviors among adolescents		
Indicator	**Indicator Definition**	**Report Section**
[1.1] Proportion of adolescents with intent to use modern contraception	Number of adolescents who respond yes to planning to use modern contraception in the future [timeframe may be defined by country program], disaggregated by method	5. Contraception & Sexual Activity

[1.2] Proportion of sexually active adolescents reporting using a condom at last sex	*Numerator*: Number of adolescents who respond yes to having used a condom at last sex *Denominator*: Number of sexually active adolescents surveyed	5. Contraception & Sexual Activity
[1.3] Proportion of sexually active unmarried adolescents who use a condom consistently in the last 6 months	*Numerator:* Number of adolescents who respond yes to having used a condom every time they had sex in the last 6 months *Denominator:* Number of adolescents surveyed who are sexually active and unmarried	5. Contraception & Sexual Activity
[1.4] Proportion of adolescents with gender equitable attitudes through average score on gender equitable attitude scale	*Numerator:* Proportion of adolescents with significant increase in average score on gender equitable attitude scale *Denominator:* Number of adolescents surveyed	7. Gender Attitudes & Norms
[1.5] Average number of modern contraceptive methods known among women 10-14 and 15-19 years old	Average number of modern contraceptive methods known to female adolescents ages 10-14 and 15-19 in the survey	5. Contraception & Sexual Activity
[1.6] Proportion of adolescents with correct knowledge about body changes during puberty, the menstrual cycle, fertility and conception, pregnancy risk and prevention	Composite indicator of 9 items measuring proportion of adolescents who respond correctly to a series of questions on puberty, menstruation, pregnancy risk and prevention	2. Puberty
[1.7] Proportion of adolescents with correct knowledge about STI risk and prevention and treatment	Composite indicator measuring proportion of adolescents who responded correctly to series of 4 questions on STI prevention and treatment	4. HIV, STI, & Pregnancy Knowledge
[1.8] Proportion of adolescents with comprehensive knowledge of HIV prevention	Composite indicator measuring proportion of adolescents who responded correctly to series of 6 questions on HIV prevention	4. HIV, STI, & Pregnancy Knowledge
[1.9] Proportion of adolescents with knowledge of where to seek SRH services, including where to get tested for HIV, where to get condoms, and where to get contraceptives	*Numerator*: Proportion of adolescents that knows where to seek SRH services. *Denominator*: Number of adolescents surveyed	6. Access to Health Services
[1.10] Proportion of girls who report properly disposing of absorbent materials (sanitary napkins or menstrual cloth)	*Numerator:* Number of postmenarchal girls who report properly disposing of absorbent materials (sanitary napkins or menstrual cloth) (i.e., putting into the rubbish) *Denominator:* Number of girls who use absorbent materials (sanitary napkins or menstrual cloth)	3. Menstrual Hygiene & Management

[1.11] Proportion of girls who report hygienically washing and drying reusable menstrual cloth	*Numerator*: Number of girls who report hygienically washing and drying reusable menstrual cloth *Denominator*: Number of girls who washed and reused menstrual materials	3. Menstrual Hygiene & Management
Output 1.2: Adolescent girls in Niger, Mali and Burkina Faso, and out of school adolescent girls in Niger have the knowledge, materials, and in-school facilities to manage their menstruation in a hygienic, healthy, and dignified fashion		
Indicator	**Indicator Definition**	**Report Section**
[1.2.3] Proportion of girls and boys that can answer a basic set of four questions about menstruation	*Numerator:* Number of girls and boys that can answer a basic set of questions about menstruation correctly *Denominator:* Surveyed adolescents	2. Puberty
[1.2.4] Proportion of girls that know how to hygienically manage menses	*Numerator:* Number of girls that can answer a set of five questions correctly about how to hygienically manage menses *Denominator*: Surveyed female adolescents	3. Menstrual Hygiene & Management
[1.2.6] Proportion of girls and boys that can identify that menstruation is a normal biological function of the female body	*Numerator*: Number of girls and boys that answer a question correctly regarding that menstruation is a normal biological function of the female body *Denominator:* Surveyed adolescents	2. Puberty
**Indicators not included in this list are assessed using monitoring data and are not included in this report.*		
Output 1.4: Communities demonstrate support for LSE and SRH services for adolescents **Only adolescents were surveyed in the ATWA Outcome Evaluation. As such, indicators under Output 1.4 are assessed via adolescents' perceptions of community support.*		
Indicator	**Indicator Definition**	**Report Section**
[1.4.1] Proportion of adolescents who feel religious community leaders support the provision of LSE/SRHR information and SRH services to adolescents ages 10-14 and 15-19 years	Proportion of adolescents who feel religious community leaders support adolescents ages 10-14 and 15-19 years: ▪ learning about puberty/life skills education ▪ learning about reproductive health and contraception ▪ accessing sexual and reproductive health services	7. Community Support
[1.4.2] Proportion of adolescents who feel school leaders support the provision of LSE/SRHR information and SRH services to adolescents ages 10-14 and 15-19 years	Proportion of adolescents who feel school leaders support adolescents ages 10-14 and 15-19 years: ▪ learning about puberty/life skills education ▪ learning about reproductive health and contraception	7. Community Support

	▪ accessing sexual and reproductive health services	
[1.4.3] Proportion of adolescents who feel other community leaders support the provision of LSE/SRHR information and SRH services to adolescents ages 10-14 and 15-19 years	Proportion of adolescents who feel other <u>community leaders</u> support adolescents ages 10-14 and 15-19 years: ▪ learning about puberty/life skills education ▪ learning about reproductive health and contraception ▪ accessing sexual and reproductive health services *(Indicators are disaggregated by primary and secondary school status)*	7. Community Support

YEAR 2 OUTCOME EVALUATION – BASELINE RESULTS

Overall, a total of 2,235 adolescents participated in the Year 2 Baseline Survey, with 665 from Burkina Faso, 790 from Mali, and 790 from Niger.

1. SOCIO-DEMOGRAPHIC CHARACTERISTICS

The average age of respondents across all three countries was 13.31 years old (min=9 years, max=19 years). The number of boys and girls in the sample was similar, with 1,058 boys (50.0%) and 1,057 girls (50.0%). The vast majority (98.2%) of adolescents were unmarried. Given the very small sample of married respondents (n=40, 1.%), analyses disaggregated by marital status should be interpreted with caution. Respondent characteristics by country are provided in Table 3.

Table 3. Respondent characteristics by country

	Burkina Faso (n=655)	**Mali** (n=670)	**Niger** (n=790)	**Total** (n=2,115)
Sex				
Male	329 (50.2%)	331 (49.4%)	398 (50.4%)	**1,058 (50.0%)**
Female	326 (49.8%)	339 (50.6%)	392 (49.6%)	**1,057 (50.0%)**
Age				
10-14 years	483 (73.7%)	488 (72.8%)	556 (70.4%)	**1,527 (72.2%)**
15-19 years	172 (26.3%)	182 (27.2%)	234 (29.6%)	**588 (27.8%)**
School Status				
Primary	495 (75.6%)	435 (64.9%)	510 (64.6%)	**1,440 (68.1%)**
Secondary	160 (24.4%)	160 (23.9%)	160 (20.3%)	**480 (22.7%)**
Out-of-School	0 (0.0%)	75 (11.2%)	120 (15.2%)	**195 (9.2%)**
Marital Status				
Unmarried	655 (100.0%)	665 (99.3%)	759 (96.1%)	**2,079 (98.2%)**
Married	0 (0.0%)	6 (0.7%)	31 (3.9%)	**46 (1.7%)**
Number of respondents	665	670	790	**2,115**

Impact Indicator 1: Decrease in adolescent birth rate

The overall planned ATWA impact is improved sexual and reproductive health and rights among adolescents. Impact Indicator 1 is the decrease in adolescent birth rate among female respondents ages 15-19 years. Given that the number of births by year is not assessed in this study, we use adolescent parity among female respondents as a proxy for this indicator.

As shown in Table 4, there were a total of 12 births among 294 female respondents ages 15–19 years, with the most births reported being 2 births. The female respondents had an average of 0.05 births. Results disaggregated by school status show that there were 11 total births among the out-of-school adolescent girls (average number of births=0.23; n=57) and only one total birth among the in-school adolescent girls (average number of births=0.004; n=237). Among the married adolescent girls (n=29), a total of 11 births were reported and 1 birth was reported among the unmarried adolescent girls (n=274). These differences observed across marital status and school status were statistically significant. Results disaggregated by country show that adolescent girls in Niger had the highest number of births (n=10) and Mali and Burkina Faso had the same number of births (n=1).

Table 4. Impact Indicator 1: Decrease in adolescent birth rate

Indicator	Indicator Definition	Baseline Level	
[Impact 1] Decrease in adolescent birth rate	The average number of births to female respondents ages 15-19	Overall Sample	Avg births= 0.05 (# of births= 12 | min= 0 | max= 2 | SD= 0.24 | N= 294)
		School Status*	
		Out-of-school	Avg births= 0.23 (# of births= 11 | min= 0 | max= 2 | SD= 0.50 | N= 57)
		In-school	Avg births= 0.004 (# of births= 1 | min= 0 | max= 1 | SD= 0.06 | N= 237)
		Marital Status*	
		Unmarried	Avg births= 0.004 (# of births= 1 | min= 0 | max= 1 | SD= 0.06 | N= 265)
		Married	Avg births= 0.45 (# of births= 11 | min= 0 | max= 2 | SD= 0.63 | N= 29)
		Country*	
		Burkina Faso	Avg births= 0.01 (# of births= 1 | min= 0 | max= 1 | SD= 0.11 | N= 87)
		Mali	Avg births= 0.01 (# of births= 1 | min= 0 | max= 1 | SD= 0.10 | N= 91)
		Niger	Avg births= 0.1 (# of births= 10 | min= 0 | max= 2 | SD= 0.36 | N= 116)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Impact Indicator 2: Decrease in adolescent pregnancy

Impact Indicator 2 is the decrease in the proportion of adolescents who have ever been pregnant or caused a pregnancy. As shown in Table 5, 2.4% (n=19) of adolescents have ever been pregnant or caused a pregnancy. A lower proportion of male respondents reported having caused a pregnancy as compared to their female counterparts who reported they have ever been pregnant (1.0% of males versus 3.8% of females). Half of the married adolescents (50.0%; n=36) have ever been pregnant or caused a pregnancy, and only 0.1% of unmarried adolescents have ever been pregnant or caused a pregnancy. None of the younger adolescents reported ever causing or being pregnant (n=217), while 3.2% of older adolescents reported that they have ever been pregnant or caused a pregnancy (n=588). Results disaggregated by school status show that the reports of an adolescent causing or ever being pregnant was higher among the out-of-school adolescents (11.6%; n=147) compared to in-school adolescents (0.3%; n=658). Less than ten percent of adolescents in Burkina Faso (0.4%), Mali (0.4%) and Niger (6.1%) reported they have ever been pregnant or caused a pregnancy. All these differences observed in the disaggregated data were statistically significant.

Table 5. Impact Indicator 2: Decrease in adolescent pregnancy

Indicator	Indicator Definition	Baseline Level	
[Impact 2] Decrease in proportion of adolescents who have ever been pregnant or caused a pregnancy	The percent of adolescent females who have ever been pregnant + the percent of adolescent males who have ever caused a pregnancy	Overall Sample	2.4% (n= 19/805)
		Sex*	
		Males	1.0% (n= 4/414)
		Females	3.8% (n= 15/391)
		Age*	
		10-14	0.0% (n= 0/217)
		15-19	3.2% (n= 19/588)
		School Status*	
		Out-of-school	11.6% (n= 17/147)
		In-school	0.3% (n= 2/658)
		Marital Status*	
		Unmarried	0.1% (n= 1/769)
		Married	50.0% (n= 18/36)
		Country*	
		Burkina Faso	0.4% (n= 1/279)
		Mali	0.4% (n= 1/247)
		Niger	6.1% (n= 17/279)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Impact Indicator 5: Decrease in adolescent marriage

Impact Indicator 5 is the decrease in the proportion of women 10-19 years who were married or in union before age 18 and before age 15. As indicated Table 6, 1.6% (17/1,057) of female respondents started living with their husbands before age 18 and 0.3% (3/1,057) of female respondents began living with their husbands before age 15. A higher percentage of older and out-of-school female respondents started living with their husbands before age 15 and 18, compared to their respective counterparts. As compared to Burkina Faso and Mali, Niger had the highest level of adolescent marriage, with 3.3% (13/392) of Nigerien respondents reporting they lived with their spouse before age 18 and 0.8% (3/392) of Nigerien respondents reporting they were living with their spouse before age 15.

Table 6. Impact Indicator 5: Decrease in proportion of adolescents married

Indicator	Indicator Definition	Baseline Level	
[Impact 5] Decrease in proportion of adolescents married	[5A] Percentage of women 10-19 years old who were married or in union before age 18. *[Note: this is the percentage of the* sample *living with spouse before age 18.]*	Overall Sample	1.6% (n= 17/1057)
		Age*	
		10-14	0.1% (n= 1/762)
		15-19	5.4% (n= 16/295)
		School Status*	
		Out-of-school	16.3% (n= 16/98)
		In-school	0.1% (n= 1/959)
		Country*	
		Burkina Faso	0.0% (n= 0/326)
		Mali	1.2% (n= 4/339)
		Niger	3.3% (n= 13/392)
	[5B] Percentage of women 10-19 years old who were married or in union before age 15. *[Note: this is the percentage of the* sample *living with spouse before age 15.]*	Overall Sample	0.3% (n= 3/1057)
		Age^	
		10-14	0.1% (n= 1/762)
		15-19	0.7% (n= 2/295)
		School Status*	
		Out-of-school	3.1% (n= 3/98)
		In-school	0.0% (n= 0/959)
		Country^	
		Burkina Faso	0.0% (n= 0/326)
		Mali	0.0% (n= 0/339)
		Niger	0.8% (n= 3/392)

^No statistically significant differences between groups (i.e., p-value≥0.05).
*p<0.05

2. PUBERTY

Outcome 1 of the ATWA intervention is sexual and reproductive health and rights and gender equality knowledge, intent, and behaviors among adolescents. Output 1.2 of the ATWA intervention is that adolescent girls in Niger, Mali and Burkina Faso, and out of school adolescent girls in Niger have the knowledge, materials, and in-school facilities to manage their menstruation in a hygienic, healthy, and dignified fashion. Outcome 1 and Output 1.2 are assessed via three indicators (1.6, 1.2.3, 1.2.6) on adolescent girls' and boys' knowledge of: body changes during puberty, fertility, and menstruation.

Outcome Indicator 1.6: Knowledge about body changes during puberty, the menstrual cycle, and fertility

Outcome Indicator 1.6 is the proportion of adolescents with correct knowledge about body changes during puberty, the menstrual cycle, fertility and conception, pregnancy risk and prevention. This was assessed using a composite indicator which measured the proportion of adolescents who responded correctly to at least seven of the following nine questions:

- 401: True or false: It is normal that each adolescent boy and girl experiences changes in their body at different times as they grow up.
- 403: True or false: Only girls go through puberty, not boys.
- 404: True or false: It is normal for a young teenager to wake up and find that he has wet his underwear through ejaculation.
- 405: True or false: Boys grow hair on their face, bodies, and genital areas as they go through puberty.
- 614: True or false: A boy can get a girl pregnant before he has his first (ever) ejaculation. *(Modified for Malian respondents to read: True or false: A boy can get a girl pregnant before the start of puberty.)*
- 615: True or false: A boy can be fertile every day of the month.
- 616: True or false: It is normal for a girl to have periods that don't come at the same time each month.
- 617: When in the menstrual cycle is a girl is most likely to get pregnant if she has sex?
    - Options: During menstruation; In the first 10 days of the cycle; During ovulation; In the last 10 days of the cycle; Other; Don't know; Refused
- 618: Which of the following statements is true about pregnancy?

- Options: You cannot get pregnant or cause a pregnancy if you are not in love; You cannot get pregnant having sex standing up; Having sex for the first time cannot cause a pregnancy; All of the above are false; Other; Don't know; Refused

Only Nigeriens were asked all nine questions. Malian in-school 10-14-year-old adolescents were not asked 614,616, 617, and 618. Burkinabe in-school 10-14-year-old adolescents were not asked 617. None of the Malian respondents were asked about 618. Table 7 presents results among adolescents who responded to all nine questions (don't know and refused responses were treated as missing).

As shown in Table 7, 36.4% of adolescents (n=1,182) answered all nine questions correctly and of these, 20.1% (120/598) of younger adolescents (10-14 years) and about half of the adolescents ages 15 – 19 (53.1%; 310/584) answered all questions correctly. Results disaggregated by sex show that a similar percentage of male and female adolescents answered all the questions correctly (36.3% and 36.5%, respectively). In the school status disaggregation, the results show us that 37.4% (73/195) of out-of-school adolescents answered all nine questions correctly compared to 36.2% (357/987) of in-school adolescents. Among the married adolescents, 38.9% (14/36) answered all questions correctly, and 36.4% (416/1,146) of unmarried adolescents answered all nine questions correctly. The differences seen in the disaggregation by sex, marital status, and school status were not statistically significant.

Table 7. Outcome Indicator 1.6: Knowledge about body changes during puberty, the menstrual cycle, and fertility

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents with correct knowledge about body changes during puberty, the menstrual cycle, fertility and conception, pregnancy risk and prevention.	Composite indicator of 9 items* measuring proportion of adolescents who respond correctly to a series of questions on puberty, menstruation, pregnancy risk and prevention **Only Nigeriens were asked all 9 questions. Malian IS 10-14 y/o not asked 614, 616, 617, 618. Burkinabe IS 10-14 y/o not asked 617. None of the Malian*	Overall	36.4% (n= 430/1,182)
		Sex^	
		Males	36.3% (n= 217/598)
		Females	36.5% (n= 213/584)
		Age*	
		10-14	20.1% (n= 120/598)
		15-19	53.1% (n= 310/584)
		School Status^	
		Out-of-school	37.4% (n= 73/195)
		In-school	36.2% (n= 357/987)
		Marital Status ^	
		Unmarried	36.3% (n= 416/1,146)
		Married	38.9% (n= 14/36)

	respondents were asked 618.	Country* Burkina Faso Mali Niger	 79.1% (n= 136/172) 54.3% (n= 127/234) 21.5% (n= 167/776)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.2.3: Knowledge and beliefs about menstruation

To assess Output Indicator 1.2.3, a series of four basic questions about menstruation were posed to respondents. These included:

- 402: True or false: For most girls their monthly bleeding comes every 14 days.
- 406. True or false: If a girl bleeds from her vagina every month, it is a sign of disease.
- 407: True or false: Menstruation is dirty or impure.
- 408: True or false: Used sanitary napkins can be used to cast a spell.

As shown in Table 8, in the overall sample (n=2,115), only 2.9% (n=62) of the respondents answered all four questions correctly. Of these, the highest proportion answering all four questions correctly were adolescent boys (3.5%), belonged to the 10-14 age group (3.4%), were in-school (3.2%), were not married (2.9%) and lived in Mali (5.2%). Differences observed across age group, school status and country-level were statistically significant.

Table 8. Output Indicator 1.2.3: Knowledge and beliefs about menstruation

Indicator	Indicator Definition	Baseline Level	
Proportion of girls and boys that can answer a basic set of four questions about menstruation	*Numerator:* Number of girls and boys that can answer a basic set of questions about menstruation correctly *Denominator:* Surveyed adolescents	Overall Sex^ Male Female Age* 10-14 15-19 School Status* Out-of-school In-school Marital Status^ Unmarried Married	2.9% (n= 62/2115) 3.5% (n= 37/1058) 2.4% (n= 25/1057) 3.4% (n= 52/1527) 1.7% (n= 10/588) 0.5% (n= 1/195) 3.2% (n= 61/1920) 2.9% (n= 61/2079) 2.8% (n= 1/36)

		Country*	
		Burkina Faso	3.4% (n= 22/655)
		Mali	5.2% (n= 35/670)
		Niger	0.6% (n= 5/790)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.2.6: Menstruation a normal biological function

Output Indicator 1.2.6 is the proportion of girls and boys that can identify that menstruation is a normal biological function of the female body. To assess this indicator, respondents were asked to respond to a true/false item stating that if a girl bleeds from her vagina every month, it is a sign of disease. As shown in Table 9, about half of the respondents answered this question correctly. About three in five adolescent girls (59.0%; 623/1,056) and older adolescents (65.6%; 386/588) identified mensuration as a normal biological function. Although not statistically significant, the results disaggregated by school status show that about half of the in-school (51.8%; 995/1,919) and out-of-school adolescents (52.3%; 102/195) answered this question correctly. As compared to the other two countries, Burkina Faso had the highest proportion of adolescents answering all four questions correctly (62.6%; 410/655). The differences observed in the sex, age group, and country-level disaggregation were statistically significant.

Table 9. Output Indicator 1.2.6: Menstruation a normal biological function

Indicator	Indicator Definition	Baseline Level	
Proportion of girls and boys that can identify that menstruation is a normal biological function of the female body	*Numerator*: Number of girls and boys that answer a question correctly regarding that menstruation is a normal biological function of the female body *Denominator:* Surveyed adolescents	Overall	51.9% (n= 1,097/2,114)
		Sex*	
		Male	44.8% (n= 474/1,058)
		Female	59.0% (n= 623/1,056)
		Age*	
		10-14	46.6% (n= 711/1,526)
		15-19	65.6% (n= 386/588)
		School Status^	
		Out-of-school	52.3% (n= 102/195)
		In-school	51.8% (n= 995/1,919)
		Marital Status^	
		Unmarried	51.7% (n= 1,074/2,078)
		Married	63.9% (n= 23/36)
		Country*	
		Burkina Faso	62.6% (n= 410/655)
		Mali	48.8% (n= 327/670)

		Niger	45.6% (n= 360/789)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

3. MENSTRUAL HYGIENE & MANAGEMENT

Proper menstrual hygiene and management among adolescent girls is a key component of the ATWA intervention in each of the three countries. This aspect of the project is captured under Outcome 1 and Output 1.2 via three indicators (1.10, 1.11, and 1.2.4) that examine girls' behaviors surrounding disposal and washing of menstrual materials and hygienically managing menses.

Outcome Indicator 1.10: Proper disposal of menstrual materials

Outcome Indicator 1.10 is the proportion of girls who report properly disposing of absorbent materials (i.e., putting used sanitary napkins and/or menstrual cloth into the trash/rubbish). To assess this indicator, postmenarchal girls were asked where they often disposed of their used menstrual materials during their last menstrual period. As shown in Table 10, 7.0% (21/302) of adolescent girls properly disposed of their absorbent materials and a higher proportion of younger adolescents than older adolescents reported properly disposing of their absorbent materials (11.9% versus 5.0%). Among the out-of-school adolescents, 6.7% (3/45) reported proper disposal, and a similar percentage was reported among in-school adolescents (7.9%; 18/257). Compared to unmarried adolescents, more married adolescents reported correctly disposing of absorbent materials (8.7% versus 6.8%). Malian adolescents (14.9%; 14/94) most often reported correctly disposing of absorbent materials compared to adolescents in Burkina Faso (1.8%; 2/112) and Niger (5.2%; 5/96). These differences were significant for the results disaggregated by age group and country.

Table 10. Outcome Indicator 1.10: Proportion of girls who report properly disposing of absorbent materials (sanitary napkins or menstrual cloth)

Indicator	Indicator Definition	Baseline Level	
Proportion of girls who report properly disposing of absorbent materials (sanitary napkins or menstrual cloth)	*Numerator:* Number of postmenarchal girls who report properly disposing of absorbent materials (sanitary napkins or menstrual cloth) (i.e., putting into the rubbish)	Overall	7.0% (n= 21/302)
		Age*	
		10-14	11.9% (n= 10/84)
		15-19	5.0% (n= 11/218)
		School Status^	
		Out-of-school	6.7% (n= 3/45)

	Denominator: Number of girls who use absorbent materials (sanitary napkins or menstrual cloth)	In-school	7.0% (n= 18/257)
		Marital Status^	
		Unmarried	6.8% (n= 19/279)
		Married	8.7% (n= 2/23)
		Country*	
		Burkina Faso	1.8% (n= 2/112)
		Mali	14.9% (n= 14/94)
		Niger	5.2% (n= 5/96)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Outcome Indicator 1.11: Washing and drying of reusable materials

Outcome Indicator 1.11 is the proportion of girls who report hygienically washing and drying reusable menstrual materials. Overall, of girls who washed or reused menstrual materials, 74.6% (132/177 girls) reported that they soaked their materials (Indicator 1.11.A); and of these, 96.1% (170/177 girls) reported they used soap or detergent when soaking materials (Indicator 1.11.B). Among girls who washed menstrual materials, 24.3% (43/177 girls) reported they always exposed their washed materials to the sun (Indicator 1.11.C), 92.1% (163/177 girls) reported that the materials were always dry before their reuse (Indicator 1.11.D), and only 9.2% (18/195 girls) reported that the materials were ironed before reusing them (Indicator 1.11.E).

Table 11. Outcome Indicator 1.11: Proportion of girls who report washing and drying reusable menstrual materials

Indicator	Indicator Definition	Baseline Level	
Proportion of girls who report hygienically washing and drying reusable menstrual cloth	[1.11.A]: Percentage of girls who soaked menstrual materials *(Note: Among those who washed and reused menstrual materials)*	Overall	74.6% (n= 132/177)
		Age^	
		10-14	73.1% (n= 49/67)
		15-19	75.5% (n= 83/110)
		School Status^	
		Out-of-school	68.9% (n= 31/45)
		In-school	76.5% (n= 101/132)
		Marital Status^	
		Unmarried	76.2% (n= 122/160)
		Married	58.8% (n= 10/17)
		Country*	
		Burkina Faso	78.4% (n= 29/37)
		Mali	83.5% (n= 66/79)
		Niger	60.7% (n= 37/61)

	[1.11.B]: Percentage of girls who used soap when soaking menstrual materials *(Note: Only asked of girls who reported soaking menstrual materials)*	Overall Age^ 10-14 15-19 School Status^ Out-of-school In-school Marital Status^ Unmarried Married Country^ Burkina Faso Mali Niger	96.1% (n= 170/177) 94.0% (n= 63/67) 97.3% (n= 107/110) 100.0% (n= 45/45) 94.7% (n= 125/132) 95.6% (n= 153/160) 100.0% (n= 17/17) 91.9% (n= 34/37) 98.7% (n= 78/79) 95.1% (n= 58/61)
	[1.11.C]: Percentage of girls who exposed menstrual materials to the sun every time when drying them *(Note: Among all girls who washed menstrual materials)*	Overall Age^ 10-14 15-19 School Status* Out-of-school In-school Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	24.3% (n= 43/177) 26.9% (n= 18/67) 22.7% (n= 25/110) 13.3% (n= 6/45) 28.0% (n= 37/132) 25.6% (n= 41/160) 11.8% (n= 2/17) 40.5% (n= 15/37) 20.3% (n= 16/79) 19.7% (n= 12/61)
	[1.11.D]: Percentage of girls who reported their menstrual materials were always dry before reusing them *(Note: Among all girls who washed menstrual materials)*	Overall Age^ 10-14 15-19 School Status* Out-of-school In-school Marital Status* Unmarried Married Country*	92.1% (n= 163/177) 92.5% (n= 62/67) 91.8% (n= 101/110) 84.4% (n= 38/45) 94.7% (n= 125/132) 93.8% (n= 150/160) 76.5% (n= 13/17)

		Burkina Faso Mali Niger	91.9% (n= 34/37) 97.5% (n= 77/79) 85.2% (n= 52/61)
	[1.11.E]: Percentage of girls who reported ever using an iron on menstrual materials before re-use *(Note: Among all girls who used iron-able materials)*	Overall Age^ 10-14 15-19 School Status^ Out-of-school In-school Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	9.2% (n= 18/195) 12.9% (n= 8/62) 7.5% (n= 10/133) 3.8% (n= 2/52) 11.2% (n= 16/143) 9.9% (n= 17/171) 4.2% (n= 1/24) 22.9% (n= 8/35) 10.1% (n= 8/79) 2.5% (n= 2/81)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.2.4: Hygienically managing menses

Output Indicator 1.2.4 is the proportion of girls that know how to hygienically manage menses. This was evaluated using a composite indicator which measured the proportion of girls who responded that they agreed or strongly agreed with all of the following five questions:

- 505: Do you agree or disagree: You change the materials every 4-8 hours, or whenever needed (for example, when they are very full).
- 506: During your last menstrual period, how often did you wash your hands BEFORE changing your menstrual materials?
- 507: During your last menstrual period, how often did you wash your hands AFTER changing your menstrual materials?
- 508: How frequently did you wash your genitals during your last menstrual period?
- 509: When you washed your genitals, did you use soap?

As indicated in Table 12, 39.3% of postmenarchal girls reported that they hygienically manage menses and over three in ten postmenarchal girls between the ages of 10-14 and 15-19 hygienically

manage menses (35.9% and 40.9%, respectively). Results disaggregated by school status show significant differences, with 42.5% (141/332) of in-school adolescents compared to 23.5% (16/68) of out-of-school adolescents reporting that they hygienically manage menses. Among the unmarried postmenarchal girls, two in five reported hygienically managing menses (40.4%; 150/371) and almost a quarter of married girls reported this (24.1%; 7/29). A significantly higher proportion of postmenarchal girls in Burkina Faso (50.4%; 64/127) hygienically managed their menses compared to those in Mali (34.7%; 52/150) and Niger (33.3%; 41/123).

Table 12. Output Indicator 1.2.4: proportion of girls that know how to hygienically manage menses

Indicator	Indicator Definition	Baseline Level	
Proportion of girls aged that know how to hygienically manage menses	*Numerator:* Number of girls that answer positively to a set of five questions correctly about how to hygienically manage menses *Denominator*: Post-menarchal female adolescents	Overall	39.3% (n= 157/400)
		Age^	
		10-14	35.9% (n= 47/131)
		15-19	40.9% (n= 110/269)
		School Status*	
		Out-of-school	23.5% (n= 16/68)
		In-school	42.5% (n= 141/332)
		Marital Status^	
		Unmarried	40.4% (n= 150/371)
		Married	24.1% (n= 7/29)
		Country*	
		Burkina Faso	50.4% (n= 64/127)
		Mali	34.7% (n= 52/150)
		Niger	33.3% (n= 41/123)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

4. HIV, STI, & PREGNANCY KNOWLEDGE

The ATWA intervention aims to increase adolescents' knowledge of STI risk, prevention and treatment, as well as knowledge of HIV prevention.

Outcome Indicator 1.7: STI risk, prevention and treatment knowledge

This outcome was evaluated using a composite indicator which measured the proportion of adolescents who responded correctly to all four[1] of the following questions on STI prevention and treatment:

- 602: True or false: A boy/girl can get an STI or HIV the first time that he/she has unprotected sexual intercourse.
- 606: True or false: Using a condom can protect against STIs/HIV
- 607: True or false: For both men and women, signs of a sexually transmitted infection include redness, burning, or sores on the genitals
- 609: True or false: People can reduce their risk of contracting STIs and the HIV virus by having one sexual partner.

All adolescents in each of the three countries were asked the above-mentioned questions, with the exception of primary students in Mali who were only asked question 607 (as the other questions were deemed too sensitive). As indicated in Table 13, 60.5% (n=1,273) of adolescents who were asked all four questions, answered all of them correctly. Results disaggregated by sex show a statistically significant difference, with 64.1% of male respondents having answered all four questions correctly (n=676) while only 56.8% of female respondents answered all four questions correctly (n=597). Other statistically significant results were seen when comparing age groups, school status, and country. Of all three countries, Burkina Faso had the highest proportion of adolescents who answered all four questions correctly (77.4%, n=507) and Niger had the lowest proportion (34.4%, n=270). Results disaggregated by marital status show that 60.4% of unmarried adolescents (n=1,251) and 61.1% of married adolescents (n=22) answered all four questions correctly, yet this difference was not statistically significant.

Table 13. Outcome Indicator 1.7: Proportion of adolescents with correct knowledge about STI risk and prevention and treatment

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents with correct knowledge about STI risk and prevention and treatment.	Composite indicator measuring proportion of adolescents who responded correctly to series of 4 questions on STI prevention and treatment	Overall	60.5% (n=1,273/2,106)
		Sex*	
		Males	64.1% (n= 676/1,055)
		Females	56.8% (n= 597/1,051)
		Age*	
		10-14	58.7% (n= 893/1,522)
		15-19	65.1% (n= 380/584)

[1] Note: In-school Malian adolescents ages 10-14 years were only asked item 607 in this series. As such, for that segment of the sample, this indicator represents the proportion correctly answering item 607 only.

	**IS Malians ages 10-14 were asked only 607 (symptoms of STIs) but are included in these estimates for sake of comprehensiveness of the sample.*	School Status* Out-of-school In-school Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	 47.7% (n= 93/195) 61.7% (n= 1,180/1,911) 60.4% (n= 1251/2,070) 61.1% (n= 22/36) 77.4% (n= 507/655) 74.6% (n= 496/665) 34.4% (n= 270/786)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Outcome Indicator 1.8: HIV prevention knowledge

This outcome was evaluated using a composite indicator which measured the proportion of adolescents[1] who responded correctly to at least five of the following six questions on HIV prevention:

- 602: True or false: A boy/girl can get an STI or HIV the first time that he/she has unprotected sexual intercourse.
- 606: True or false: Using a condom can protect against STIs/HIV.
- 608: True or false: People can get HIV from mosquito bites.
- 609: True or false: People can reduce their risk of contracting STIs and the HIV virus by having one sexual partner
- 610: True or false: HIV is transmitted by sharing food.
- 612: True or false: A person can take a tablet every day to protect against HIV.

In-school Malian adolescents ages 10-14 years were not asked any of these questions as they were deemed too sensitive. Overall, 41.0% (n=687) of adolescents who were asked all six questions, answered all of them correctly. As indicated in Table 14, 37.2% (n=406) of adolescents ages 10-14 years and 48.1% (n=281) of adolescents ages 15-19 years answered all questions correctly. This difference was statistically significant, as were differences by school status and country. There was not a statistically significant difference in results disaggregated by sex or marital status.

[1] Note: In-school Malian adolescents ages 10-14 years were not asked any of these questions due to curricula requirements in Mali. As such, this indicator does not represent this sub-population of the sample.

Table 14. Outcome Indicator 1.8: Proportion of adolescents with comprehensive knowledge of HIV prevention

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents with comprehensive knowledge of HIV prevention	Composite indicator measuring proportion of adolescents who respond correctly to at least 5 questions in a series of 6 questions on HIV prevention **IS Malians ages 10-14 not asked these six questions*	Overall	41.0% (n= 687/1674)
		Sex^	
		Males	42.9% (n= 361/842)
		Females	39.2% (n= 326/832)
		Age*	
		10-14	37.2% (n= 406/1090)
		15-19	48.1% (n= 281/584)
		School Status*	
		Out-of-school	29.7% (n= 58/195)
		In-school	42.5% (n= 629/1479)
		Marital Status^	
		Unmarried	41.1% (n= 674/1638)
		Married	36.1% (n= 13/36)
		Country*	
		Burkina Faso	58.5% (n= 383/655)
		Mali	36.3% (n= 85/234)
		Niger	27.9% (n= 219/785)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

5. CONTRACEPTION & SEXUAL ACTIVITY

A large focus of the ATWA evaluation indicators centers on adolescent behaviors and knowledge surrounding contraception and sexual activity. This section provides findings on seven indicators.

Impact Indicator 3: Need for family planning satisfied with modern contraception

Impact Indicator 3.A is the proportion of sexually active adolescents ages 15-19 years who are currently married or in union and have their need for family planning satisfied with modern contraceptive methods. Impact Indicator 3.B is the proportion of all sexually active female adolescents ages 15-19 years (married or unmarried) who have their need for contraception satisfied with modern methods.

As shown in Table 15, 17.9% (n=5) of sexually active married adolescents reported having their need for family planning satisfied with modern contraceptive methods. Differences in disaggregated results by sex, school status and country were not statistically significant. Among sexually active female adolescents 15-19 years (Impact Indicator 3.B), 53.5% (n=23) reported having their needs for contraception satisfied with modern contraception. A higher proportion of in-school respondents reported having their need for contraception satisfied with modern methods (82.6%, n=19), as compared to out-of-school respondents (20.0%, n=4). Among unmarried respondents, over 95% reported having their need for modern contraception satisfied (n=19). All respondents from Burkina Faso (100%, n=15), more than half of the respondents from Mali (57.1%, n=4), and less than 20% of respondents from Niger (19.0%, n=4) reported having their need for modern contraception satisfied. Contrary to results for Impact Indicator 3.A, all these differences in disaggregated results for Impact Indicator 3.B were statistically significant.

Table 15. Impact Indicator 3: Need for family planning satisfied with modern contraception

Indicator	Indicator Definition	Baseline Level	
Increase in need for family planning satisfied with modern contraception	[3.A] Percentage of [sexually active] adolescents ages 15-19 years *currently married or in union* who have their need for family planning satisfied with modern contraceptive methods	Overall Sample	17.9% (n= 5/28)
		Sex^	
		Males	20.0% (n=1/5)
		Females	17.4% (n= 4/23)
		School Status^	
		Out-of-school	20.0% (n= 5/25)
		In-school	0.0% (n=0/3)
		Country^	
		Burkina Faso	NA – no married adolescents
		Mali	25.0% (n= 1/4)
		Niger	16.7% (n=4/24)
	[3.B] Percentage of female adolescents (15-19) who are sexually active and who have their need for contraception satisfied with modern methods	Overall Sample	53.5% (n= 23/43)
		School Status*	20.0% (n= 4/20)
		Out-of-school	82.6% (n=19/23)
		In-school	
		Marital Status*	
		Unmarried	95.0% (n= 19/20)
		Married	17.4% (n= 4/23)
		Country*	
		Burkina Faso	100% (n=15/15)
		Mali	57.1% (n= 4/7)
		Niger	19.0% (n=4/21)

^No statistically significant differences between groups (i.e., p-value≥0.05).
*p<0.05

Impact Indicator 4: Adolescent modern contraceptive prevalence rate

Impact Indicator 4 is the proportion of sexually active adolescents (15-19) who are currently using (or whose partner is using) a modern contraceptive method.

As shown in Table 16, 54.8% (n=40) of sexually active adolescents ages 15-19 years reported using a modern contraceptive method the last time they had sex. Results disaggregated by school status, marital status and country were statistically significant, while there was not a statistically significant difference by sex. Notably, 75.6% of in-school respondents (n=34) versus 21.4% of out-of-school respondents (n=6) reported using a modern contraceptive method at last sex, and 77.8% of unmarried respondents (n=35) versus 17.9% of married respondents (n=5) reported using a modern contraceptive method at last sex. Of each of the three countries, Burkina Faso had the highest proportion of respondents who reported using a modern contraceptive method at last sex (92.6%, n=25), while Niger had the lowest proportion (25.0%, n=7).

Table 16. Impact Indicator 4: Adolescent modern contraceptive prevalence rate

Indicator	Indicator Definition	Baseline Level	
Increase in adolescent modern contraceptive prevalence rate (CPR)	The percent of sexually active adolescents (15-19) who are currently using (or whose partner is using) a modern contraceptive method. "Currently" is defined as 'at last sex'.	Overall Sample	54.8% (n= 40/73)
		Sex^	
		Males	56.7% (n= 17/30)
		Females	53.5% (n= 23/43)
		School Status*	
		Out-of-school	21.4% (n= 6/28)
		In-school	75.6% (n=34/45)
		Marital Status*	
		Unmarried	77.8% (n= 35/45)
		Married	17.9% (n= 5/28)
		Country*	
		Burkina Faso	92.6% (n=25/27)
		Mali	44.4% (n= 8/18)
		Niger	25.0% (n=7/28)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Outcome Indicator 1.1: Intent to use modern contraception

Outcome Indicator 1.1 is the proportion of adolescents with the intent to use modern contraception in the future.

As indicated in Table 17, 62.2% (n=686) of adolescents reported the future intention to use modern contraception. Among respondents 10-14 years, 58.6% (n=314) reported the intent to use modern contraception, while 65.6% (n=372) of respondents between the ages of 15-19 years reported the intent to use modern contraception. By country, 62.9% of respondents from Burkina Faso (n=410), 58.7% of respondents from Mali (n=135), and 63.8% of respondents from Niger (n=141) reported the future intention to use modern contraception. Differences disaggregated by age were statistically significant, whereas disaggregated results by sex, school status, and country were not statistically significant.

Table 17. Outcome Indicator 1.1: Intent to use modern contraception

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents with intent to use modern contraception	*Numerator*: Number of adolescents who respond yes to planning to use modern contraception in the future, disaggregated by method *Denominator*: Number of adolescents surveyed **This question not asked of Malian or Nigerienne in-school adolescents ages 10-14. In Niger, out-of-school adolescents ages 10-14 are also not asked this question.*	Overall Sample Sex^ Males Females Age* 10-14 15-19 School Status^ Out-of-school In-school Country^ Burkina Faso Mali Niger	62.2% (n= 686/1103) 62.2% (n= 342/550) 62.2% (n= 344/553) 58.6% (n= 314/536) 65.6% (n= 372/567) 67.5% (n= 104/154) 61.3% (n= 582/949) 62.9% (n= 410/652) 58.7% (n= 135/230) 63.8% (n= 141/221)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

The following data show responses to the question, "Of the family planning methods we've talked about – male condoms, female condoms, oral contraceptive pills, gel/foam, rhythm method, withdrawal, emergency contraception, injectables, IUDs, and implants – what contraceptive method do you think you – or your partner – will use in the future?"

As shown in Figure 1, the method that was stated for planned future use by the most adolescents was the male condom, selected by 336 of the adolescent respondents, followed by oral contraceptive pills, selected by 238 adolescents, and injectables, selected by 205 adolescents.

Figure 1. Planned contraceptive methods for future use (combined sample)

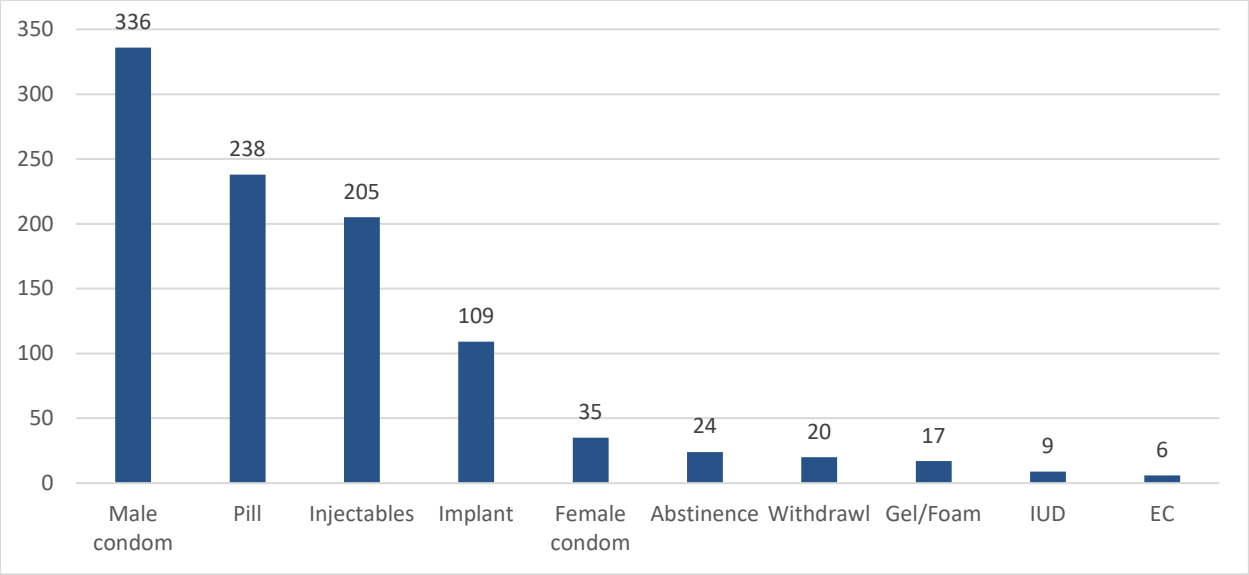
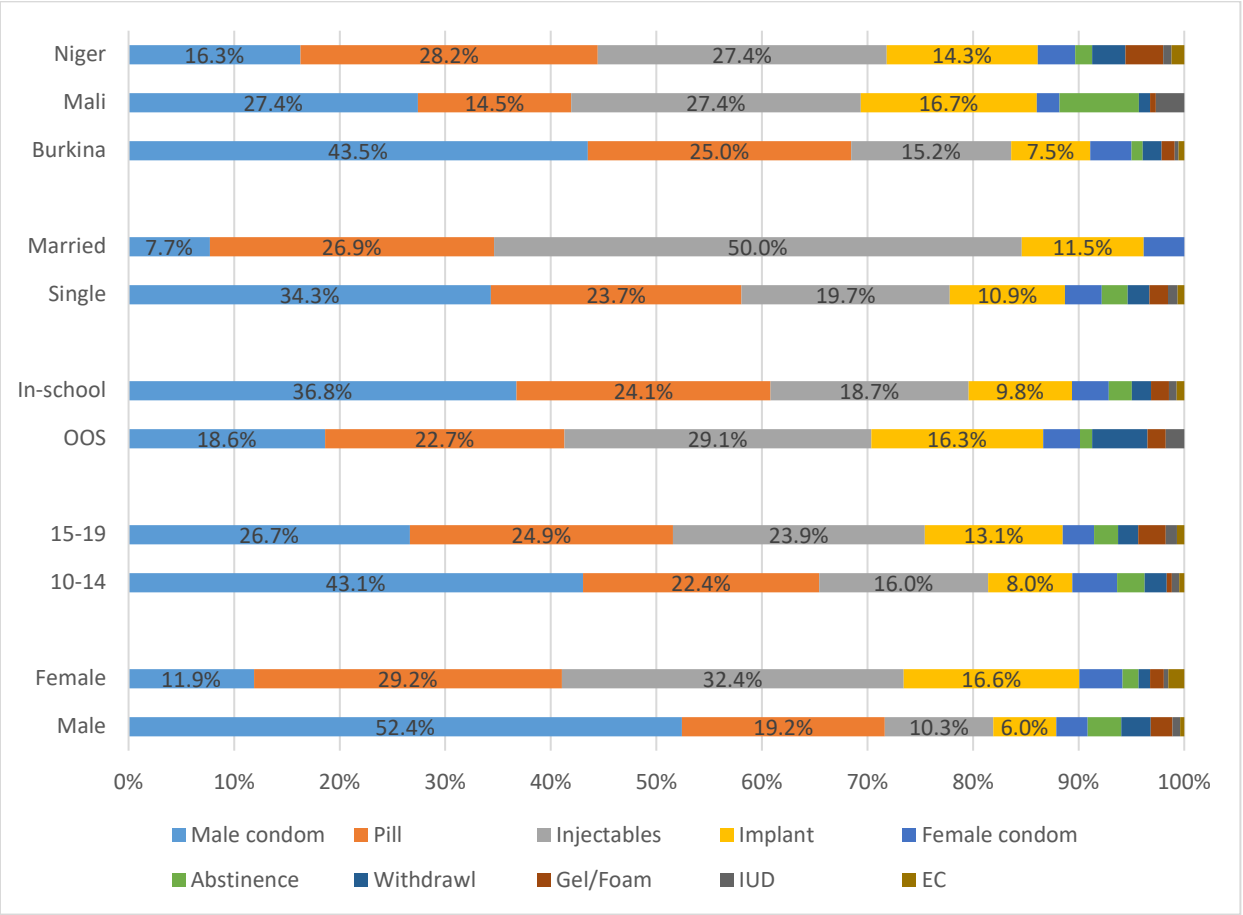


Figure 2 disaggregates the planned methods by country, marital and school status, age, and sex of the adolescent respondents. For the most part, the male condom, pill, and injectables remain the top three methods that adolescents plan to use in the future, although the proportions change by adolescent sub-group. For example, injectables—not male condoms—was the method most often selected by female, out-of-school, married and Malian adolescents for future use.

Figure 2. Planned contraceptive methods for future use, by country, marital and school status, age, and sex



Outcome Indicator 1.2: Condom use at last sex

Outcome Indicator 1.2 is the proportion of sexually active adolescents reporting using a condom at last sex. Of the 86 adolescents who reported they had had sex in the past 12 months, 44.2% (n=38) reported using a condom at last sex. Among respondents 10-14 years, 53.9% (n=7) reported having used a condom at last sex, while 42.5% (n=31) of respondents between the ages of 15-19 years reported using a condom at last sex. By country, 69.2% of respondents from Burkina Faso (n=27), 42.1% of respondents from Mali (n=8), and 10.7% of respondents from Niger (n=3) reported using a condom at last sex. Results disaggregated by school status, marital status, and country were statistically significant, while results disaggregated by sex and age were not statistically significant.

Table 18. Outcome Indicator 1.2: Condom use at last sex

Indicator	Indicator Definition	Baseline Level	
Proportion of sexually active adolescents reporting using a condom at last sex	*Numerator*: Number of adolescents who respond yes to having used a condom at last sex *Denominator*: Number of sexually active adolescents surveyed ** This question not asked of Malian or Nigerien in-school adolescents ages 10-14. In Niger, out-of-school adolescents ages 10-14 are also not asked this question.*	Overall	44.2% (n= 38/86)
		Sex^	
		Males	52.6% (n= 20/38)
		Females	37.5% (n= 18/48)
		Age^	
		10-14	53.9% (n= 7/13)
		15-19	42.5% (n= 31/73)
		School Status*	6.9% (n= 2/29)
		Out-of-school	63.2% (n= 36/57)
		In-school	
		Marital Status*	
		Unmarried	65.5% (n= 38/58)
		Married	0.0% (n= 0/28)
		Country*	
		Burkina Faso	69.2% (n= 27/39)
		Mali	42.1% (n= 8/19)
		Niger	10.7% (n= 3/28)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Outcome Indicator 1.3: Consistent condom use

Outcome Indicator 1.3 is the proportion of sexually active unmarried adolescents who reported using a condom consistently in the last six months. Adolescents were asked whether they used a condom each time they had sex in the past six months, with response options ranging from 1 – always to 5 – never. As shown in Table 19, of the 46 unmarried sexually active adolescents, 69.6% (n=32) reported always using a condom when they had sex. As compared to Mali and Niger, Burkina Faso had the highest proportion of sexually active unmarried respondents who reported using a condom consistently in the last six months (80.6%, n=25). Differences in disaggregated results by country were statistically significant, whereas differences in results disaggregated by sex, age and school status were not statistically significant.

Table 19. Outcome Indicator 1.3: Consistent condom use

Indicator	Indicator Definition	Baseline Level	
Proportion of sexually active unmarried adolescents who use a	*Numerator:* Number of adolescents who respond yes to having used a condom every	Overall Sample	69.6% (n= 32/46)
		Sex^	
		Males	64.0% (n= 16/25)

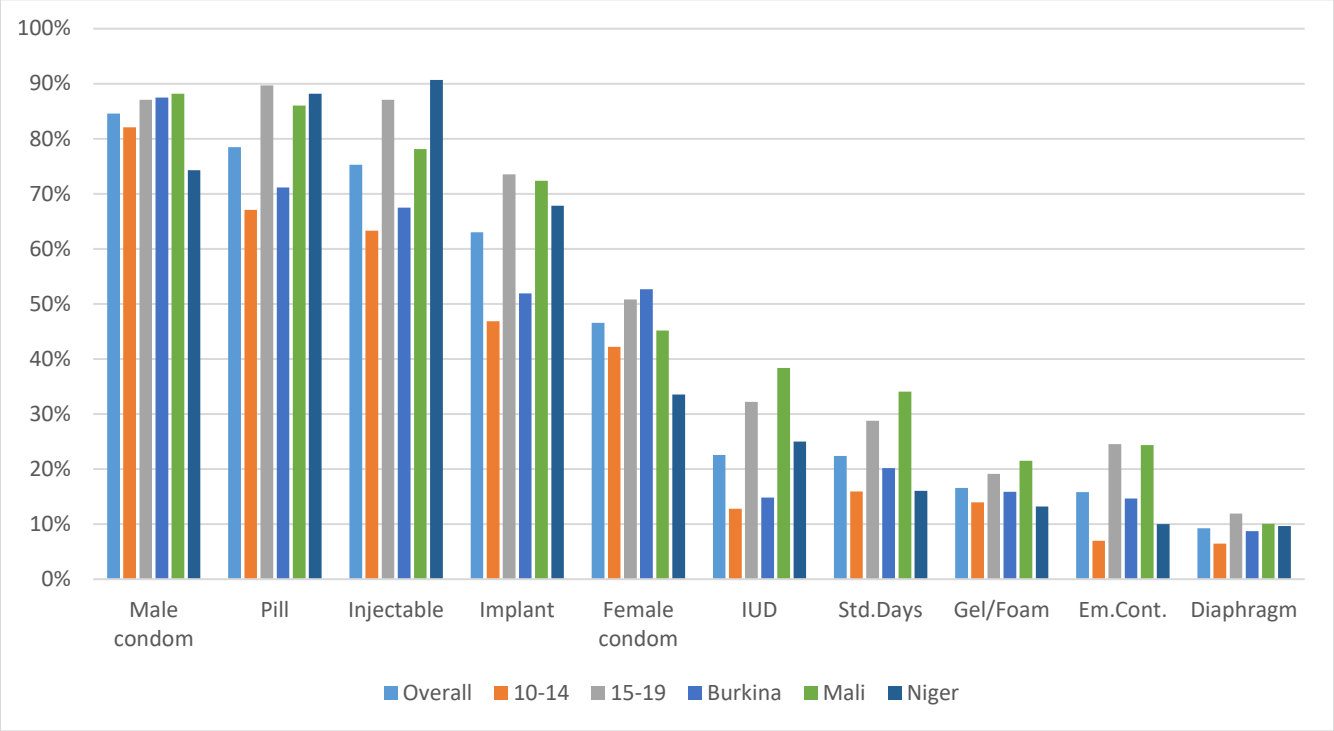
condom consistently in the last 6 months	time they had sex in the last 6 months *Denominator:* Number of adolescents surveyed who are sexually active and unmarried **This question not asked of Malian or Nigerien in-school adolescents ages 10-14. In Niger, out-of-school adolescents ages 10-14 are also not asked this question.*	Females Age^ 10-14 15-19 School Status^ Out-of-school In-school Country* Burkina Faso Mali Niger	76.2% (n= 16/21) 77.8% (n= 7/9) 67.6% (n= 25/37) 50.0% (n= 2/4) 71.4% (n= 30/42) 80.6% (n= 25/31) 41.7% (n= 5/12) 66.7% (n= 2/3)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Outcome Indicator 1.5: Known modern contraceptive methods

Outcome Indicator 1.5 is the average number of modern contraceptive methods known to female adolescents ages 10-14 and 15-19.[1] The ten possible methods included: contraceptive implant, IUD, injectables, birth control pills, emergency contraception, male and female condoms, diaphragm, foam/jelly, and the standard days method. As shown in Figure 3, the most commonly known method is the male condom, followed by the oral contraceptive pill and injectables. Overall, a higher proportion of older than younger adolescents knew about contraceptive methods. Variation in knowledge of methods exists by country.

[1] These questions were not asked of IS adolescents ages 10-14 years in Mali or Niger.

Figure 3. Knowledge of modern methods by method type (in overall sample and by age and country)



As indicated in Table 20, the average number of modern contraceptive methods known among female respondents was 4.33 (min=0, max=10). Differences in results disaggregated by age and country were statistically significant, while differences by school status and marital status were not statistically significant.

Table 20. Outcome Indicator 1.5: Average number of modern contraceptive methods known among females

Indicator	Indicator Definition	Baseline Level	
Average number of modern contraceptive methods known among women 10-14 and 15-19 years old	Average number of modern contraceptive methods known to female adolescents ages 10-14 and 15-19 in the survey	Overall	Mean # known= 4.33 | min= 0 | max= 10 | SD= 2.44 | N= 584)
		Age*	
		10-14	Mean # known= 3.47 | min= 0 | max= 10 | SD= 2.51 | N= 293)
		15-19	Mean # known= 5.2 | min= 0 | max= 10 | SD= 2.01 | N= 291)
		School Status^	
		Out-of-school	Mean # known= 4.71 | min= 0 | max= 9 | SD= 2.06 | N= 98)
		In-school	Mean # known= 4.25 | min= 0 | max= 10 | SD= 2.50 | N= 486)

		Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	 Mean # known= 4.31 | min= 0 | max= 10 | SD= 2.46 | N= 553) Mean # known= 4.71 | min= 0 | max= 9 | SD= 2.02 | N= 31) Mean # known= 3.99 | min= 0 | max= 10 | SD= 2.72 | N= 326) Mean # known= 5.40 | min= 1 | max= 10 | SD= 1.96 | N= 119) Mean # known= 4.22 | min= 0 | max= 9 | SD= 1.76 | N= 139)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

6. ACCESS TO HEALTH SERVICES

Alongside the provision of life skills education, the ATWA program seeks to increase access to quality adolescent-responsive SRH services. Outcome evaluation indicators have been included to assess the proportion of adolescents with the knowledge of where to seek SRH services.

Outcome Indicator 1.9: Knowledge of where to seek SRH services

Outcome Indicator 1.9 is the proportion of adolescents with knowledge of where to seek SRH services, including where to get tested for HIV, where to get treatment for a sexually transmitted infection (STI), where to get condoms, and where to get contraceptives[1]. This was assessed via four questions:

- 902: I know where to get condoms.
- 903: I know where to go if I needed to get contraception (birth control).
- 907: I know where to go to get treatment for a sexually transmitted infection.
- 908: I know where to go to get tested for HIV.

Results for all respondents are provided for knowledge of where to get tested for HIV, where to get treatment for STIs, and where to get condoms. A separate indicator is reported for where to get contraception (birth control), which was asked of all out-of-school girls and in-school girls ages 15-19 years.

[1] The item assessing knowledge of where to get contraceptives was asked only of girls who were out of school and in-school girls ages 15-19 years (n=358).

As indicated in Table 21, 32.2% of respondents (n=677) reported that they knew where to seek SRH services. A higher proportion of male respondents reported knowing where to access these services as compared to female respondents (34.8% of males versus 29.5% of females). A lower proportion of respondents ages 10-14 years reported knowing where to access SRH services as compared to respondents ages 15-19 years (27.9% of respondents 10–14 years versus 43.0% of respondents 15–19 years). Among married respondents, near half (44.4%, n=16) reported they knew where to access these services, while among unmarried respondents, only 31.9% (n=661) reported they knew where to access these services. Burkina Faso had the highest proportion of respondents knowing where to access SRH services (59.2%, n=388), while Niger had the lowest proportion (16.2%, n=127). Differences in disaggregated results by sex, age, and country were statistically significant, whereas differences by school status and marital status were not statistically significant.

Of 337 female adolescents 15-19 years, 76.6% of respondents (n=258) reported that they knew where to access birth control. While differences by country were statistically significant, differences disaggregated by age, school status and marital status were not statistically significant.

Table 21. Outcome Indicator 1.9: Knowledge of where to seek SRH services

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents with knowledge of where to seek SRH services, including where to get tested for HIV, treatment for STIs, and condoms	*Numerator*: Proportion of adolescents that know where to seek SRH services. *Denominator*: Number of adolescents surveyed	Overall	32.2% (n= 677/2106)
		Sex*	
		Males	34.8% (n= 367/1055)
		Females	29.5% (n= 310/1051)
		Age*	
		10-14	27.9% (n= 424/1518)
		15-19	43.0% (n= 253/588)
		School Status ^	
		Out-of-school	29.2% (n= 57/195)
		In-school	32.4% (n= 620/1911)
		Marital Status^	
		Unmarried	31.9% (n= 661/2070)
		Married	44.4% (n= 16/36)
		Country*	
		Burkina Faso	59.2% (n= 388/655)
		Mali	24.2% (n= 162/669)
		Niger	16.2% (n= 127/782)
Proportion of girls ages 15-19 who know where to access contraceptives	*NA – not an indicator, but included for completeness*	Overall	76.6% (n= 258/337)
		Age^	
		10-14	74.1% (n= 40/54)
		15-19	77.0% (n= 218/283)
		School Status^	
		Out-of-school	79.4% (n= 77/97)
		In-school	75.4% (n= 181/240)
		Marital Status^	
		Unmarried	76.1% (n= 233/306)
		Married	80.6% (n= 25/31)
		Country*	
		Burkina Faso	87.5% (n= 70/80)
		Mali	68.9% (n= 82/119)
		Niger	76.8% (n= 106/138)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

7. COMMUNITY SUPPORT

Community support for LSE and SRH services for adolescents is essential for creating an enabling environment for adolescents to engage in ATWA programming. The original ATWA Monitoring

and Evaluation framework (Appendix A) sought to assess community leaders' support for provision of LSE/SRHR information and SRH services (Output 1.4). Given that a direct survey amongst adult community leaders was not feasible, these indicators were assessed in each of the three countries via adolescent self-report of perceived community support.

As shown in the final survey tool (Appendix B), survey respondents were asked to respond to a series of questions, with distinction made between: 1) the type of community leader (i.e., religious, school, and other community leaders); 2) the type of support (i.e., providing adolescents with information about puberty/life skills education; information about contraception; adolescents' access to SRH services); and 3) the age group of children receiving the information/services (i.e., those in upper primary versus those in secondary school). The survey questions posed to adolescents are summarized below.

- How supportive do you think [religious/school/other community] leaders are in general about adolescents in [upper primary/secondary] school learning about puberty/life skills education?
- When you think about [religious/school/other community] leaders in your community, how supportive do you think they are in general about adolescents in [upper primary/secondary] school learning about reproductive health and contraception to prevent early pregnancy?
- When you think about [religious/school/other community] leaders in your community, how supportive do you think they are in general about adolescents in [upper primary/secondary] school accessing sexual and reproductive health services?

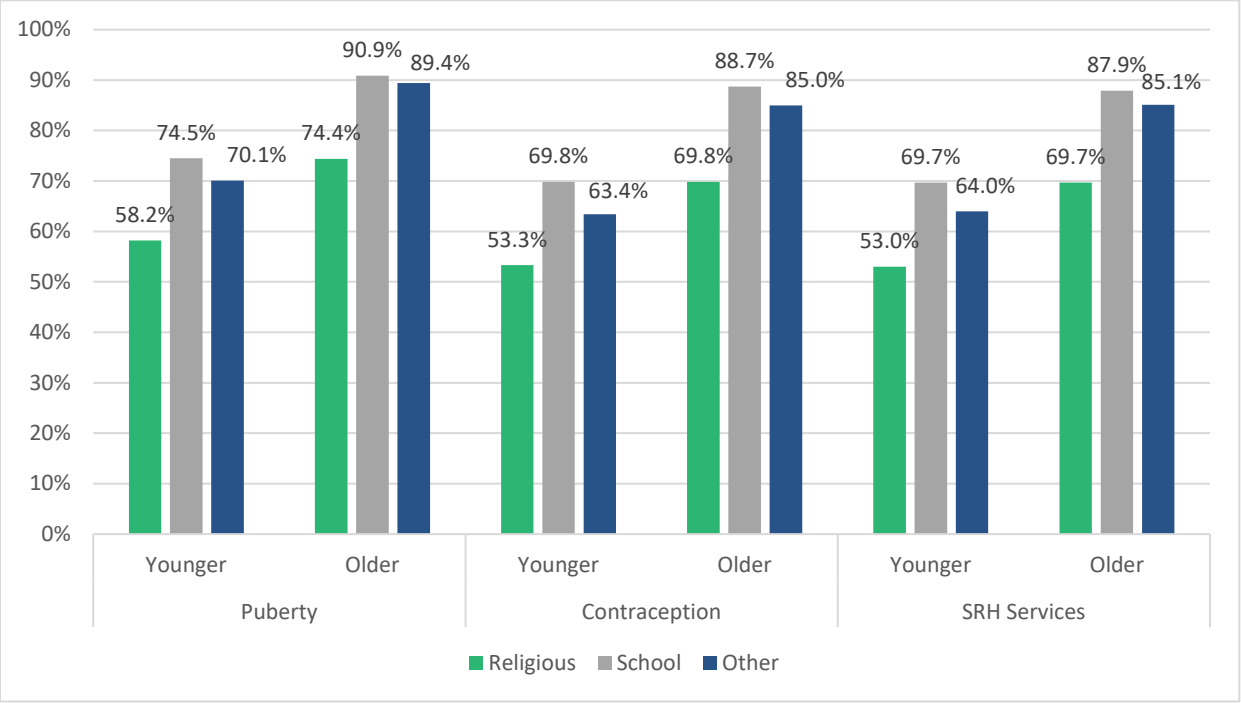
Note that none of the out-of-school adolescents were asked their perceptions of school leaders' support for these types of LSE/SRHR information and SRH services.

Response options were on a 5-point Likert scale (5=extremely supportive, 4=somewhat supportive, 3=neutral (neither supportive nor unsupportive), 2=somewhat unsupportive, 1=not supportive at all). To align these responses with the original indicator in the M&E Framework, we merged the five categories to create a binary option indicating that community members were either 'supportive' or 'unsupportive' of the provision of LSE/SRHR information and SRH services to adolescents. Responses of 'extremely supportive and 'somewhat supportive' were considered 'supportive', and reports of neutral and/or unsupportive as 'unsupportive'.

Each section below details these responses by type of community leader and type of support. In summary, however, as shown in Figure 4, we can see that in general there is more perceived

community support for provision of SRHR information and services to older than younger adolescents. By type of community leader, religious leaders are assumed by adolescents to be the least supportive of all community leaders (as compared to school and other types of community leaders such as civic or local cultural leaders). Finally, across all three types of community leaders—adolescents feel that there is more community support for learning about puberty than for accessing SRH services.

Figure 4. Community support for adolescents learning about LSE/SRHR and accessing SRH services (by age group and type of leader)



Output Indicator 1.4.1: Proportion of adolescents who feel religious community leaders support the provision of LSE/SRHR information and SRH services to adolescents ages 10-14 and 15-19 years

Output Indicator 1.4.1 centers on religious leaders' support of adolescents receiving LSE/SRHR information and SRH services. As shown in the subsequent sections, support for LSE/SHRH information and SRH services was assessed via three topics: a) learning about puberty and life skills education; b) learning about contraception; and c) accessing sexual and reproductive health services.

Output Indicator 1.4.1.a examines religious leaders' support for adolescents learning about puberty. As shown in Table 22, overall, 58.2% of the respondents felt that religious leaders

support younger adolescents learning about puberty, as compared to 74.4% of respondents feeling that religious leaders support older adolescents doing so. Statistically significant differences were seen between males and females, out-of-school and in-school adolescents and by country.

Table 22. Outcome Indicator 1.4.1.a: Adolescents who feel religious community leaders support adolescent girls and boys learning about puberty

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents who feel religious community leaders support younger adolescents learning about puberty	*Numerator:* Number of adolescents who feel religious community leaders are supportive of adolescents in upper primary school learning about puberty *Denominator*: Number of adolescents surveyed	Overall	58.2% (n= 1153/1980)
		Sex*	
		Males	50.8% (n= 497/979)
		Females	65.5% (n= 656/1001)
		Age^	
		10-14	57.9% (n= 827/1428)
		15-19	59.1% (n= 326/552)
		School Status*	
		Out-of-school	49.2% (n= 87/177)
		In-school	59.1% (n= 1066/1803)
		Marital Status^	
		Unmarried	58.0% (n= 1129/1946)
		Married	70.6% (n= 24/34)
		Country*	
		Burkina Faso	69.4% (n= 453/653)
		Mali	74.0% (n= 455/615)
		Niger	34.4% (n= 245/712)
Proportion of adolescents who feel religious community leaders support older adolescents learning about puberty		Overall	74.4% (n= 1446/1944)
		Sex*	
		Males	68.7% (n= 672/978)
		Females	80.1% (n= 774/966)
		Age*	
		10-14	73.0% (n= 1016/1392)
		15-19	77.9% (n= 430/552)
		School Status*	
		Out-of-school	65.5% (n= 114/174)
		In-school	75.3% (n= 1332/1770)
		Marital Status^	
		Unmarried	74.2% (n= 1420/1913)
		Married	83.9% (n= 26/31)
		Country*	

		Burkina Faso Mali Niger	84.4% (n= 551/653) 74.7% (n= 460/616) 64.4% (n= 435/675)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.4.1.b is the proportion of adolescents who feel religious community leaders support adolescents learning about contraception. In contrast to the indicator above that examined support for learning about puberty, a smaller proportion of adolescents felt that religious leaders would support younger adolescents (only 53.3%) learning about contraception and only 69.8% of respondents felt that religious leaders would support older adolescents learning about contraception. As above, we see statistically significant differences by sex, school status, and country.

Table 23. Outcome Indicator 1.4.1.b: Adolescents who feel religious community leaders support adolescent girls and boys learning about contraception

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents who feel religious community leaders support younger adolescents learning about contraception	*Numerator:* Number of adolescents who feel religious community leaders are supportive of adolescents learning about contraception *Denominator*: Number of adolescents surveyed	Overall Sex* Males Females Age^ 10-14 15-19 School Status* Out-of-school In-school Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	53.3% (n= 1049/1969) 45.7% (n= 448/980) 60.8% (n= 601/989) 52.9% (n= 752/1422) 54.3% (n= 297/547) 35.6% (n= 62/174) 55.0% (n= 987/1795) 53.5% (n= 1035/1936) 42.4% (n= 14/33) 68.0% (n= 444/653) 71.3% (n= 437/613) 23.9% (n= 168/703)
Proportion of adolescents who feel religious community leaders support older		Overall Sex* Males Females	69.8% (n= 1355/1941) 65.6% (n= 641/977) 74.1% (n= 714/964)

adolescents learning about contraception		Age* 10-14 15-19 School Status* Out-of-school In-school Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	 68.1% (n= 946/1390) 74.2% (n= 409/551) 58.4% (n= 101/173) 70.9% (n= 1254/1768) 70.0% (n= 1337/1911) 60.0% (n= 18/30) 81.9% (n= 535/653) 71.0% (n= 435/613) 57.0% (n= 385/675)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.4.1.c is the proportion of adolescents who feel religious community leaders support adolescents accessing sexual and reproductive health services. The proportion of adolescents who felt religious leaders would support younger and older adolescents accessing SRH services was roughly the same as those who felt religious leaders would support adolescents of both age groups learning about contraception: 53.0% of respondents felt religious leaders would support younger adolescents accessing SRH services (53.3% felt religious leaders would support younger adolescents learning about contraception). For older adolescents, 69.7% of respondents felt religious leaders would support access to SRH services (69.8% felt religious leaders would support older adolescents learning about contraception).

Table 24. Outcome Indicator 1.4.1.c: Adolescents who feel religious community leaders support adolescent girls and boys accessing sexual and reproductive health services

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents who feel religious community leaders support younger adolescents accessing sexual and reproductive health services	*Numerator:* Number of adolescents who feel religious community leaders are supportive of adolescents accessing sexual and reproductive health services *Denominator*: Number of adolescents surveyed	Overall Sex* Males Females Age^ 10-14 15-19 School Status*	53.0% (n= 1043/1969) 48.0% (n= 471/982) 58.0% (n= 572/987) 52.5% (n= 746/1422) 54.3% (n= 297/547)

		Out-of-school In-school Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	34.5% (n= 60/174) 54.8% (n= 983/1795) 53.0% (n= 1026/1936) 51.5% (n= 17/33) 66.8% (n= 437/654) 69.8% (n= 427/612) 25.5% (n= 179/703)
Proportion of adolescents who feel religious community leaders support <u>older</u> adolescents accessing sexual and reproductive health services		Overall Sex^ Males Females Age* 10-14 15-19 School Status* Out-of-school In-school Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	69.7% (n= 1353/1940) 68.2% (n= 668/980) 71.4% (n= 685/960) 68.1% (n= 945/1387) 73.8% (n= 408/553) 53.2% (n= 91/171) 71.3% (n= 1262/1769) 69.9% (n= 1336/1910) 56.7% (n= 17/30) 82.7% (n= 542/655) 70.2% (n= 429/611) 56.7% (n= 382/674)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.4.2: Proportion of adolescents who feel <u>school leaders</u> support the provision of LSE/SRHR information and SRH services to adolescents ages 10-14 and 15-19 years

Output Indicator 1.4.2.a is the proportion of adolescents who feel school leaders support adolescents ages 10-14 and 15-19 years learning about puberty. In contrast to religious leaders, adolescents indicated that school leaders in their communities would be overall more supportive of adolescents of both age groups learning about puberty, contraception, and accessing SRH services. Overall, when asked about school leaders' support of younger adolescents learning about and accessing SRH services, 74.5% of respondents felt that school leaders would support younger

adolescents learning about puberty (Table 25), 69.8% felt school leaders would support younger adolescents learning about contraception (Table 26), 69.7% felt school leaders would support younger adolescents accessing SRH services (Table 27).

When asked about school leaders' support of older adolescents learning about and accessing SRH services, 91.0% of respondents felt that school leaders would support older adolescents learning about puberty (Table 25), 88.7% felt school leaders would support older adolescents learning about contraception (Table 26), 87.9% felt school leaders would support older adolescents accessing SRH services (Table 27).

Table 25. Outcome Indicator 1.4.2.a: Adolescents who feel school leaders support adolescent girls and boys learning about puberty

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents who feel school leaders support younger adolescents learning about puberty	*Numerator*: Number of adolescents who feel school leaders are supportive of adolescents learning about puberty *Denominator*: Number of adolescents surveyed	Overall	74.5% (n= 1374/1844)
		Sex^	
		Males	74.4% (n= 682/917)
		Females	74.6% (n= 692/927)
		Age^	
		10-14	74.3% (n= 1030/1386)
		15-19	75.1% (n= 344/458)
		Marital Status^	
		Unmarried	74.6% (n= 1372/1840)
		Married	50.0% (n= 2/4)
		Country*	
		Burkina Faso	80.8% (n= 527/652)
		Mali	95.0% (n= 537/565)
		Niger	49.4% (n= 310/627)
Proportion of adolescents who feel school leaders support older adolescents learning about puberty		Overall	91.0% (n= 1640/1805)
		Sex^	
		Males	91.1% (n= 834/915)
		Females	90.6% (n= 806/890)
		Age*	
		10-14	89.8% (n= 1207/1344)
		15-19	93.9% (n= 433/461)
		Marital Status^	
		Unmarried	90.8% (n= 1636/1801)
		Married	100.0% (n= 4/4)

		Country* Burkina Faso Mali Niger	 95.8% (n= 623/650) 94.8% (n= 534/563) 81.6% (n= 483/592)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.4.2.b is the proportion of adolescents who feel school leaders support adolescents ages 10-14 and 15-19 years learning about contraception.

Table 26. Outcome Indicator 1.4.2.b: Adolescents who feel school leaders support adolescent girls and boys learning about contraception

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents who feel school leaders support younger adolescents learning about contraception	*Numerator*: Number of adolescents who feel school leaders are supportive of adolescents learning about contraception *Denominator*: Number of adolescents surveyed	Overall Sex^ Males Females Age^ 10-14 15-19 Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	69.8% (n= 1282/1837) 69.9% (n= 639/914) 69.7% (n= 643/923) 68.9% (n= 952/1381) 72.4% (n= 330/456) 69.8% (n= 1280/1833) 50.0% (n= 2/4) 80.4% (n= 524/652) 93.4% (n= 525/562) 37.4% (n= 233/623)
Proportion of adolescents who feel school leaders support older adolescents learning about contraception		Overall Sex* Males Females Age* 10-14 15-19 Marital Status^ Unmarried Married Country* Burkina Faso	88.7% (n= 1595/1799) 90.6% (n= 826/912) 86.7% (n= 769/887) 87.2% (n= 1170/1341) 92.8% (n= 425/458) 88.6% (n= 1591/1795) 100.0% (n= 4/4) 95.9% (n= 625/652)

		Mali Niger	93.9% (n= 527/561) 75.6% (n= 443/586)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.4.2.c is the proportion of adolescents who feel school leaders support adolescents ages 10-14 and 15-19 years accessing sexual and reproductive services.

Table 27. Outcome Indicator 1.4.2.c: Adolescents who feel school leaders support adolescent girls and boys accessing sexual and reproductive health services

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents who feel school leaders support younger adolescents accessing sexual and reproductive health services	*Numerator*: Number of adolescents who feel school leaders are supportive of adolescents accessing sexual and reproductive health services *Denominator*: Number of adolescents surveyed	Overall Sex^ Males Females Age^ 10-14 15-19 Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	69.7% (n= 1276/1830) 70.5% (n= 646/916) 68.9% (n= 630/914) 69.4% (n= 954/1374) 70.6% (n= 322/456) 69.8% (n= 1275/1826) 25.0% (n= 1/4) 81.3% (n= 531/653) 93.6% (n= 525/561) 35.7% (n= 220/616)
Proportion of adolescents who feel school leaders support older adolescents accessing sexual and reproductive health services		Overall Sex* Males Females Age* 10-14 15-19 Marital Status* Unmarried Married Country* Burkina Faso Mali Niger	87.9% (n= 1575/1791) 91.1% (n= 827/908) 84.7% (n= 748/883) 86.3% (n= 1149/1331) 92.6% (n= 426/460) 88.0% (n= 1573/1787) 50.0% (n= 2/4) 95.7% (n= 624/652) 95.0% (n= 530/558) 72.5% (n= 421/581)

^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.4.3: Proportion of adolescents who feel other community leaders support the provision of LSE/SRHR information and SRH services to adolescents ages 10-14 and 15-19 years

Output Indicator 1.4.3.a is the proportion of adolescents who feel other community leaders supported adolescents ages 10-14 and 15-19 years learning about puberty. As shown in Tables 28-30, when asked about other community leaders (i.e., leaders in communities who were not considered religious or school leaders, but may include other civic or local leaders), we see similar rates of support as with the religious leaders. For younger adolescents, 70.1% of respondents felt that these other community leaders would support learning about puberty, 63.4% felt other community leaders would support learning about contraception, and 64.0% of respondents felt that other community leaders would support younger adolescents accessing SRH services.

For older adolescents, 89.4% of respondents felt that these other community leaders would support learning about puberty, 85.0% felt other community leaders would support learning about contraception, and 85.1% of respondents felt that other community leaders would support older adolescents accessing SRH services.

Table 28. Outcome Indicator 1.4.3.a: Adolescents who feel other community leaders support adolescent girls and boys learning about puberty

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents who feel other community leaders support younger adolescents learning about puberty	*Numerator*: Number of adolescents who feel other community leaders are supportive of adolescents learning about puberty *Denominator*: Number of adolescents surveyed	Overall	70.1% (n= 632/902)
		Sex*	
		Males	67.1% (n= 343/511)
		Females	73.9% (n= 289/391)
		Age^	
		10-14	69.9% (n= 438/627)
		15-19	70.5% (n= 194/275)
		School Status^	
		Out-of-school	64.7% (n= 55/85)
		In-school	70.6% (n= 577/817)
		Marital Status^	
		Unmarried	69.6% (n= 615/883)
		Married	89.5% (n= 17/19)

		Country* Burkina Faso Mali Niger	 91.7% (n= 276/301) 92.2% (n= 154/167) 46.5% (n= 202/434)
Proportion of adolescents who feel other community leaders support older adolescents learning about puberty		Overall Sex^ Males Females Age* 10-14 15-19 School Status^ Out-of-school In-school Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	89.4% (n= 806/902) 88.4% (n= 456/516) 90.7% (n= 350/386) 87.8% (n= 547/623) 92.8% (n= 259/279) 83.3% (n= 70/84) 90.0% (n= 736/818) 89.2% (n= 789/885) 100.0% (n= 17/17) 98.7% (n= 297/301) 93.4% (n= 155/166) 81.4% (n= 354/435)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.4.3.b is the proportion of adolescents who feel other community leaders support adolescents ages 10-14 and 15-19 years learning about contraception.

Table 29. Outcome Indicator 1.4.3.b: Adolescents who feel other community leaders support adolescent girls and boys learning about contraception

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents who feel other community leaders support younger adolescents learning about contraception	*Numerator*: Number of adolescents who feel other community leaders are supportive of adolescents learning about contraception *Denominator*: Number of adolescents surveyed	Overall Sex^ Males Females Age^ 10-14 15-19 School Status^	63.4% (n= 572/902) 63.1% (n= 323/512) 63.8% (n= 249/390) 62.6% (n= 391/625) 65.3% (n= 181/277)

		Out-of-school	53.6% (n= 45/84)
		In-school	64.4% (n= 527/818)
		Marital Status^	
		Unmarried	63.4% (n= 560/883)
		Married	63.2% (n= 12/19)
		Country*	
		Burkina Faso	92.4% (n= 278/301)
		Mali	89.8% (n= 150/167)
		Niger	33.2% (n= 144/434)
Proportion of adolescents who feel other community leaders support <u>older</u> adolescents learning about contraception		Overall	85.0% (n= 760/894)
		Sex*	
		Males	88.1% (n= 453/514)
		Females	80.8% (n= 307/380)
		Age*	
		10-14	82.1% (n= 505/615)
		15-19	91.4% (n= 255/279)
		School Status^	
		Out-of-school	80.5% (n= 66/82)
		In-school	85.5% (n= 694/812)
		Marital Status^	
		Unmarried	85.2% (n= 747/877)
		Married	76.5% (n= 13/17)
		Country*	
		Burkina Faso	98.3% (n= 296/301)
		Mali	89.2% (n= 148/166)
		Niger	74.0% (n= 316/427)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Output Indicator 1.4.3.c is the proportion of adolescents who feel other community leaders support adolescents ages 10-14 and 15-19 years accessing sexual and reproductive health services.

Table 30. Outcome Indicator 1.4.3.c: Adolescents who feel other community leaders support adolescent girls and boys accessing sexual and reproductive health services

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents who feel other community leaders support <u>younger</u> adolescents	*Numerator*: Number of adolescents who feel other community leaders are supportive of adolescents accessing	Overall	64.0% (n= 577/902)
		Sex^	
		Males	65.4% (n= 334/511)
		Females	62.1% (n= 243/391)

accessing sexual and reproductive health services	sexual and reproductive health services *Denominator*: Number of adolescents surveyed	Age^ 10-14 15-19 School Status* Out-of-school In-school Marital Status^ Unmarried Married Country* Burkina Faso Mali Niger	 64.2% (n= 402/626) 63.4% (n= 175/276) 51.8% (n= 43/83) 65.2% (n= 534/819) 64.2% (n= 567/883) 52.6% (n= 10/19) 90.4% (n= 272/301) 90.4% (n= 151/167) 35.5% (n= 154/434)
Proportion of adolescents who feel other community leaders support <u>older</u> adolescents accessing sexual and reproductive health services		Overall Sex* Males Females Age* 10-14 15-19 School Status* Out-of-school In-school Marital Status* Unmarried Married Country* Burkina Faso Mali Niger	85.1% (n= 764/898) 88.2% (n= 454/515) 80.9% (n= 310/383) 83.0% (n= 514/619) 89.6% (n= 250/279) 75.9% (n= 63/83) 86.0% (n= 701/815) 85.5% (n= 753/881) 64.7% (n= 11/17) 99.3% (n= 299/301) 91.6% (n= 152/166) 72.6% (n= 313/431)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

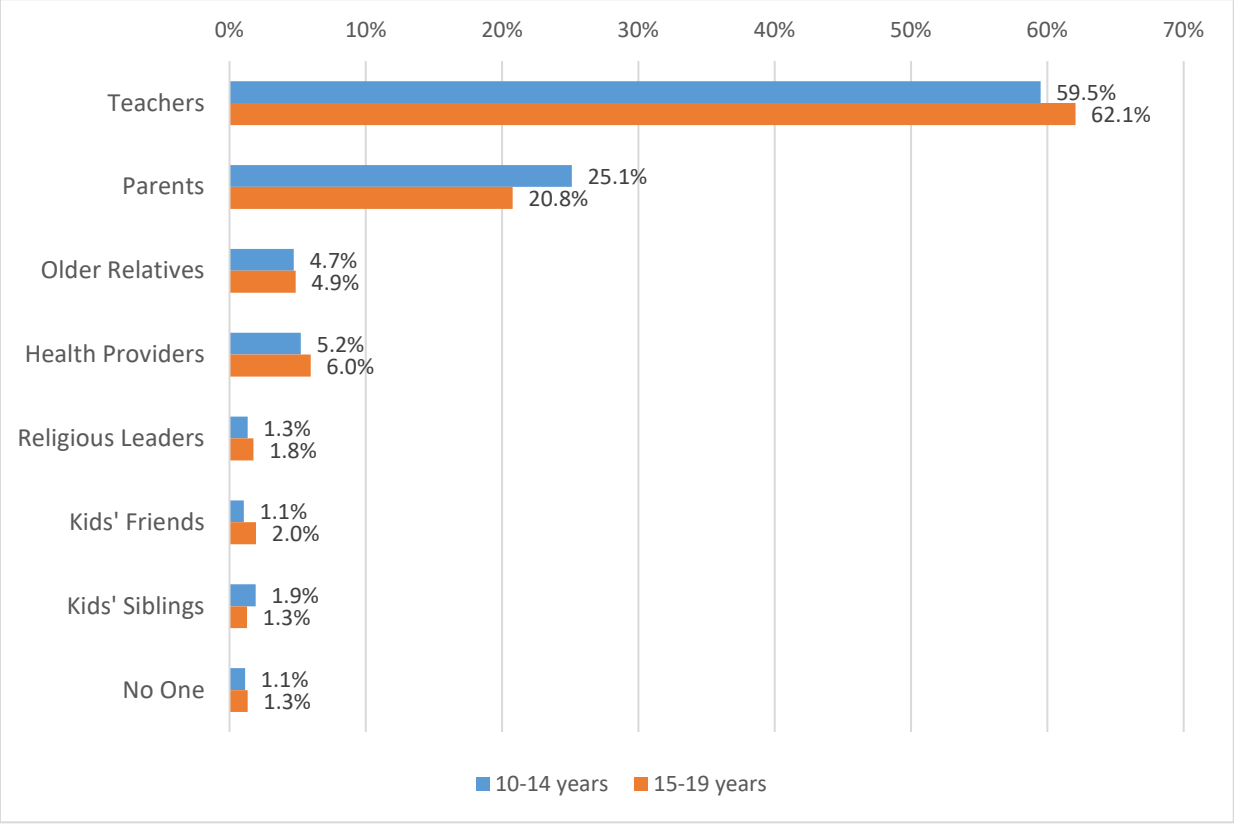
Adolescent beliefs about appropriate people to teach them about puberty

In the Year 2 Baseline survey, we asked adolescents who they thought were the most appropriate people to teach adolescents of upper primary and secondary school age (10-14 years and 15-19

years, respectively) about puberty and reproductive health. Respondents were asked to select the *most* appropriate, and so were forced to choose only one option.

As shown in the graph below (Figure 5), of all of the options and for both age categories of adolescents (both younger and older adolescents) most of our survey respondents felt that ***teachers were best-positioned to teach adolescents about puberty and reproductive health***: 59.5% of respondents felt teachers were the best people to teach younger adolescents and 62.1% of respondents felt this was true for older adolescents. The next most-selected type of person was parents, with 25.1% of respondents choosing parents as most appropriate for teaching younger adolescents and a slightly smaller proportion (20.8%) of all respondents choosing parents as being the most appropriate to teach older adolescents about puberty and reproductive health. The remaining options—older relatives, health providers, religious leaders, kids' friends, and kids' siblings—were selected by less than a fifth of respondents. Notably, only a very small proportion of respondents (roughly 1.0%) of adolescents felt that no one should teach adolescents about puberty and reproductive health.

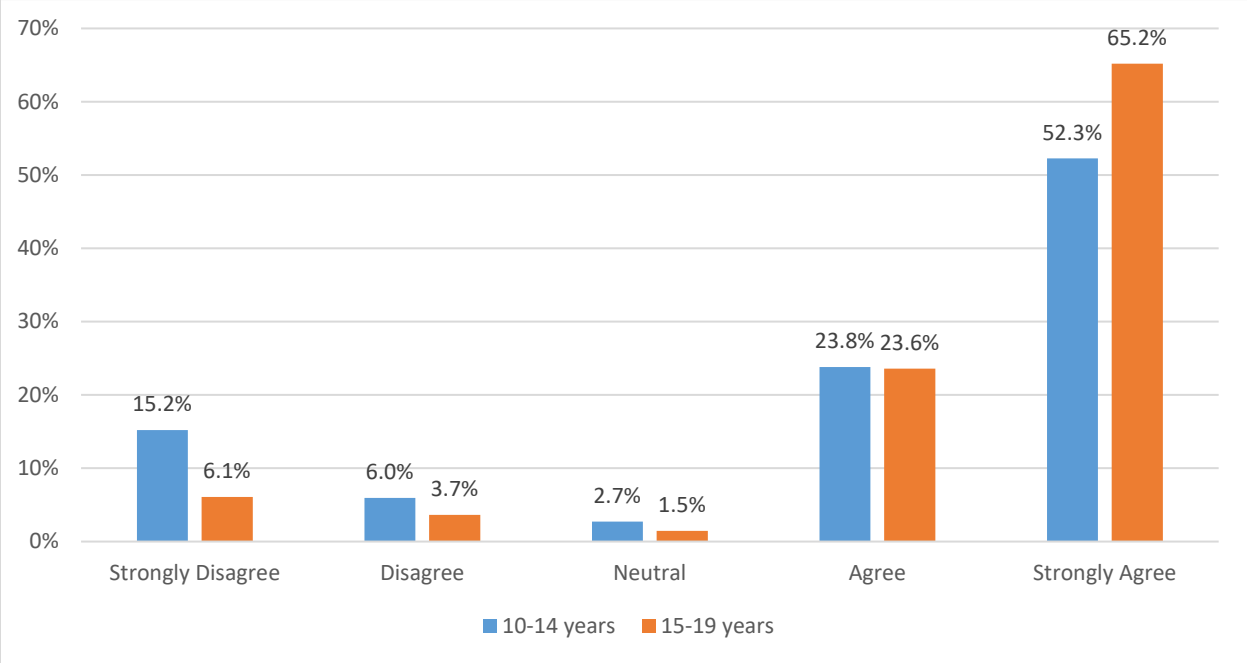
Figure 5. Perceived appropriate people to teach adolescents about puberty (by ages of adolescents taught about puberty)



Adolescent perceptions of community support for SRH education in schools

As indicated in Figure 6, the majority of respondents strongly agreed that most people in their community believed that adolescents should learn about puberty and reproductive health. This varied slightly by age, with a larger proportion (15.4% versus 6.7%) of adolescents strongly disagreeing that community members support younger (versus older) adolescents learning about puberty and reproductive health in school.

Figure 6. Community members believe that adolescents should learn about puberty & RH in school (by ages of adolescents)



8. GENDER ATTITUDES & NORMS

One of the core elements of the ATWA program is to support the formation of positive gender attitudes and norms. Outcome evaluation indicators have been designed to assess this area.

Outcome Indicator 1.4: Gender Equitable Attitudes

Outcome Indicator 1.4 is the proportion of adolescents with gender equitable attitudes, which are evaluated based on the Gender Equitable Attitudes scale. This scale has a maximum score of 5, indicating the most gender-equitable attitudes, with a score of 1 representing the least gender-

equitable attitudes. The scale was created from the following five variables that were answered using a 5-point Likert scale ranging from 1 – do not agree at all to 5 – strongly agree[1]:

- 1001: Boys and girls should be equally responsible for household chores. Do you agree or disagree?
- 1002: It is acceptable for boys to get more education than girls. Do you agree or disagree? (reverse-coded)
- 1008: A man should have the final word about decisions in the home. Do you agree or disagree? (reverse-coded)
- 1009: A woman should obey her husband in all matters. Do you agree or disagree? (reverse-coded)
- 1011: It is the responsibility of girls/women AND boys/men to prevent pregnancy if they are having sex. Do you agree or disagree?

As indicated in Table 31, the average score on the gender equitable attitudes scale was 3.11 (min= 1 | max= 5 | SD= 1.25| N= 2107) among all respondents. Female respondents (average score= 3.28), respondents between the ages of 10-14 years (average score=3.20), as well as in-school respondents (average score= 3.17) and respondents who were not married (average score=3.11) had higher average scores than their respondent counterparts. Of the three countries, respondents from Mali had the highest average score (3.43), while respondents from Burkina Faso had the lowest average score (2.91). All these differences observed in the disaggregated data were statistically significant.

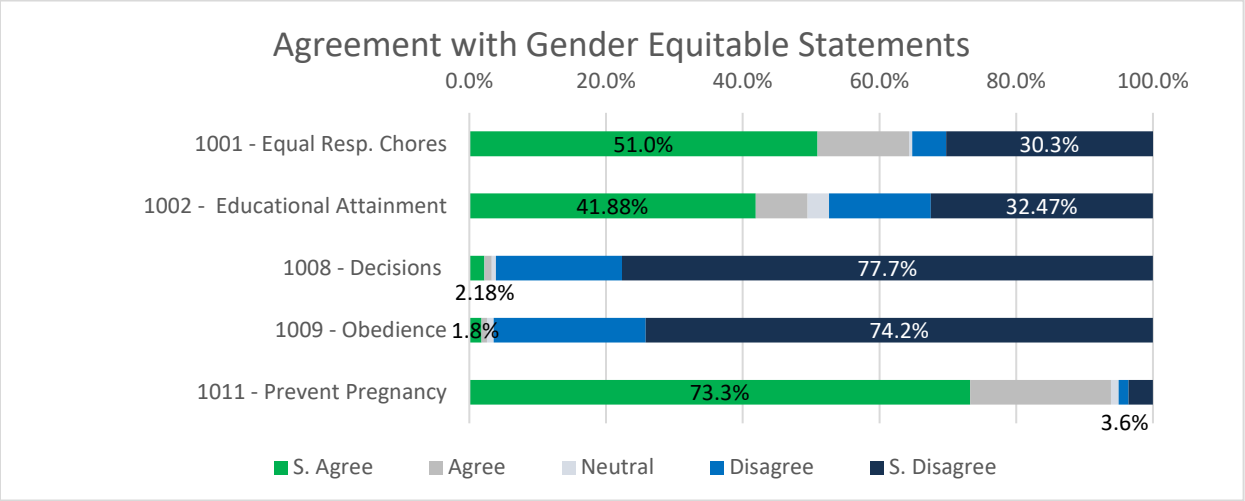
As shown in Figure 7, a greater proportion of adolescents agreed that there should be gender equity in household chore sharing, educational attainment, and pregnancy prevention efforts. At the same time, the majority of adolescents agreed that men should have the final say in decisions and women should obey their husbands in all matters.

[1] 1001 was asked of all adolescents; 1002 was not asked of Malian IS adolescents; 1008, 1009, and 1011 were not asked of Malian IS adolescents nor Nigerienne IS adolescents ages 10-14. As such, the scores on this scale for these sub-populations represent the average score across only the items they were asked. For example, for Malian IS adolescents, the score represents only their responses to 1001 (views about household chores).

Table 31. Outcome Indicator 1.4: Gender equitable attitudes

Indicator	Indicator Definition	Baseline Level	
Proportion of adolescents with gender equit able attitudes through average score on gender equitable attitude scale	*Numerator:* Proportion of adolescents with significant increase* in average score on gender equitable attitude scale *Denominator:* Number of adolescents surveyed **Increase will be determined at endline. For now, average score is provided. 1 = lowest possible score (least gender-equitable); 5 = highest possible score (most gender-equitable)*	Overall Sample	Avg score= 3.11 (min= 1 | max= 5 | SD= 1.25| N= 2107)
		Sex*	
		Males	Avg score= 2.91 (min= 1 | max= 5 | SD= 1.25| N= 1050)
		Females	Avg score= 3.28 (min= 1 | max= 5 | SD= 1.22| N= 1057)
		Age*	
		10-14	Avg score= 3.20 (min= 1 | max= 5 | SD= 1.27| N= 1519)
		15-19	Avg score= 2.82 (min= 1 | max= 5 | SD= 1.15| N= 588)
		School Status*	
		Out-of-school	Avg score= 2.38 (min= 1 | max= 3.8 | SD= 0.72| N= 194)
		In-school	Avg score= 3.17 (min= 1 | max= 5 | SD= 1.27| N= 1913)
		Marital Status*	
		Unmarried	Avg score= 3.11 (min= 1 | max= 5 | SD= 1.26| N= 2071)
		Married	Avg score= 2.38 (min= 1 | max= 3.6 | SD= 0.55| N= 36)
		Country*	
		Burkina Faso	Avg score= 2.91 (min= 1.2 | max= 5 | SD= 0.53| N= 655)
		Mali	Avg score= 3.43 (min= 1 | max= 5 | SD= 1.73| N= 665)
		Niger	Avg score= 2.96 (min= 1 | max= 5 | SD= 1.13| N= 787)
^No statistically significant differences between groups (i.e., p-value≥0.05). *p<0.05			

Figure 7. Agreement with Gender Equitable Statements



9. GENDER-BASED VIOLENCE

Although not included in the overall indicators in the M&E Framework, five survey items were included to assess adolescent views on gender-based violence (GBV). Country offices in Mali and Niger suggested these items not be asked of in-school adolescents. As such, the responses to these questions represent out-of-school adolescents ages 10-19 in Mali and Niger, and all Burkinabe adolescents (n=910). The five items were worded as follows:

- 1101: No one has the right to force another person to engage in sexual activity. Do you agree or disagree?
- 1102: If a girl refuses to have sexual intercourse with her boyfriend, it is acceptable for him to try and persuade her by using some force or pressure. Do you agree or disagree? (reverse-coded)
- 1103: There are times when a woman deserves to be beaten by her husband.[1] Do you agree or disagree? (reverse-coded)
- 1104. A woman should tolerate violence for the sake of her family. Do you agree or disagree? (reverse-coded)

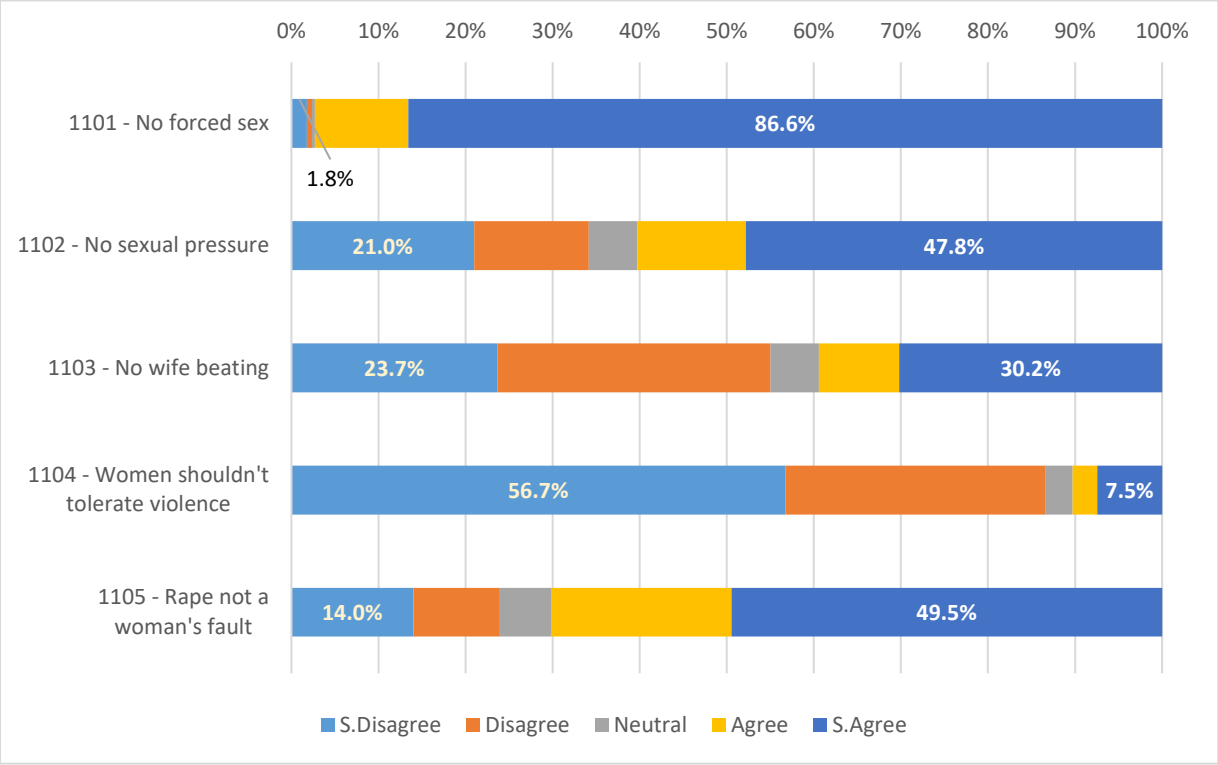
1 This item was modified from the Year 1 survey which stated, "It is acceptable for a man to slap or kick his wife if she does not follow his orders." The reason for this change was to align the wording with the Gender-Equitable Men (GEM) Scale (Pulerwitz & Barker, 2008), a validated and globally-recognized and used measure, which is also more open-ended and not as behaviorally-specific as the previous wording.

Pulerwitz, J., & Barker, G. (2008). Measuring Attitudes toward Gender Norms among Young Men in Brazil: Development and Psychometric Evaluation of the GEM Scale. *Men and Masculinities*, *10*(3), 322–338.

- 1105. If a woman is raped, it was not her fault for putting herself in that situation.[1] Do you agree or disagree?

As shown in Figure 8, there was large variation in responses to these statements that assessed adolescent views on forms of GBV. Most adolescents (86.6%) strongly agreed that no one has the right to force another person to engage in sexual activity. By comparison less than half of the respondents (47.8%) strongly agreed that it is unacceptable for a boyfriend to persuade his girlfriend to have sex by using some force or pressure and that it's not a woman's fault if she's raped (49.5%). An even smaller proportion of respondents strongly agreed that there are no instances in which a woman deserves to be beaten by her husband (30.2%). Less than one in ten (7.5%) of respondents felt that women shouldn't tolerate violence for the sake of her family, with a majority (56.7%) responding that women *should* tolerate violence for the sake of her family.

Figure 8. Attitudes against gender-based violence

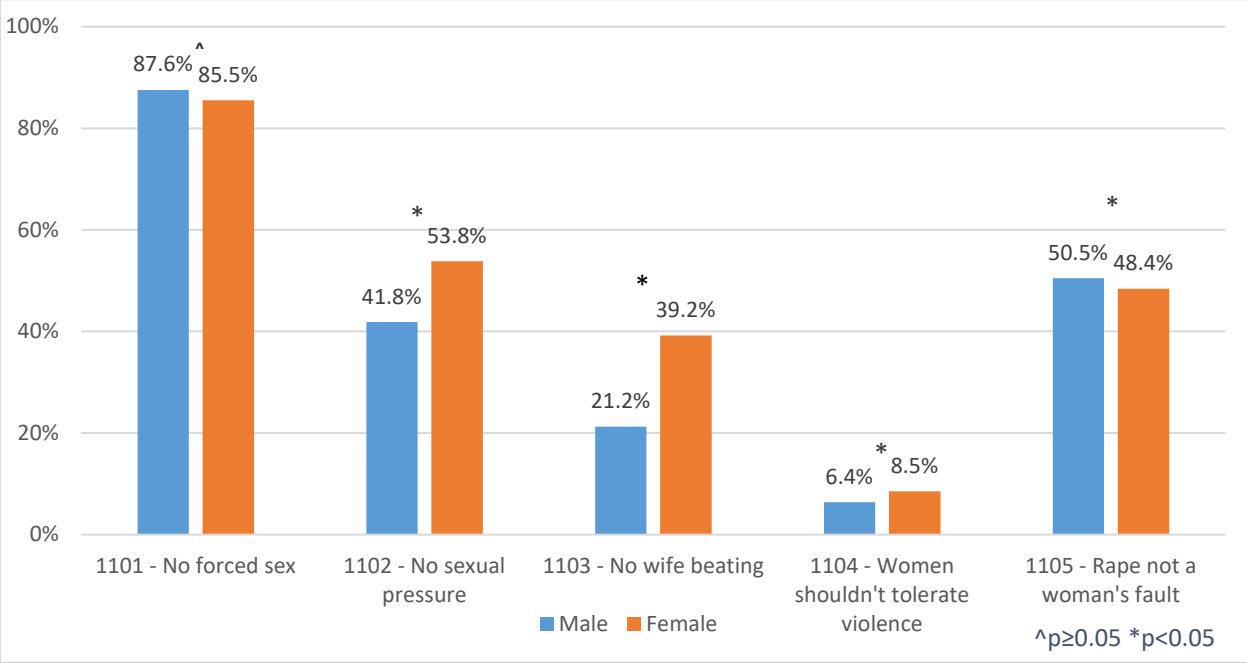


As shown in Figure 9, for four out of five of the GBV statements, there are statistically significant differences between boys and girls in the levels of strong agreement with these statements. For

1 This item was modified from the Year 1 survey which stated, "If a woman is raped, she is usually at fault for putting herself in that situation."

both boys and girls, there is strong agreement that no one has the right to force another person to engage in sexual activity. A statistically significantly greater proportion of girls than boys strongly agree that a girl shouldn't be pressured into have sex, that there is no justification for wife beating, and that women should not tolerate violence for the sake of her family. Surprisingly, however, more boys than girls strongly agreed that it is not a woman's fault if she is raped.

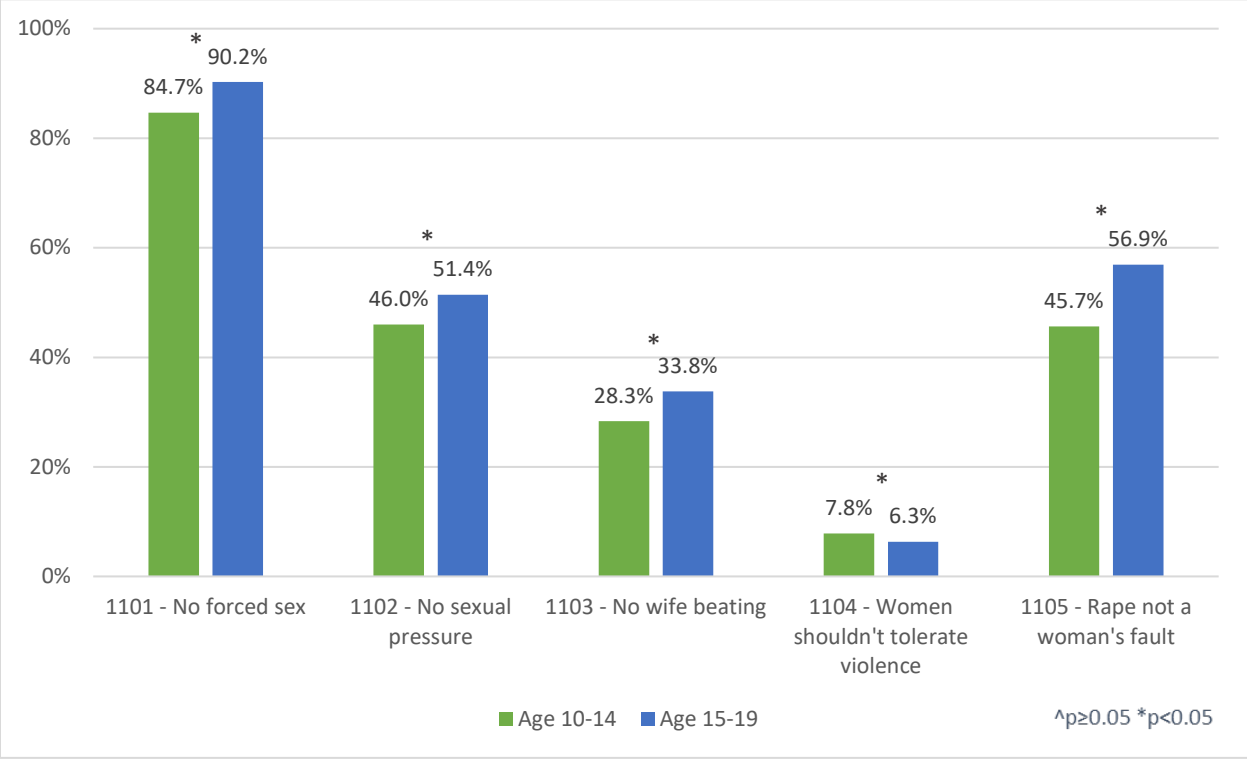
Figure 9. Sex differences in strong agreement with statements against gender-based violence



As shown in Figure 10, there is also variation in levels of strong agreement with statements against GBV by age group of adolescents; in general, there is a larger proportion of adolescents in the older age group (ages 15-19) than in the younger age group (ages 10-14) who strongly

agree that there is no rationale for GBV. This finding that norms about violence differ by age group suggests that attitudes about GBV are not stable over the lifecourse, and can be modified.

Figure 10. Age differences in strong agreement with statements against gender-based violence



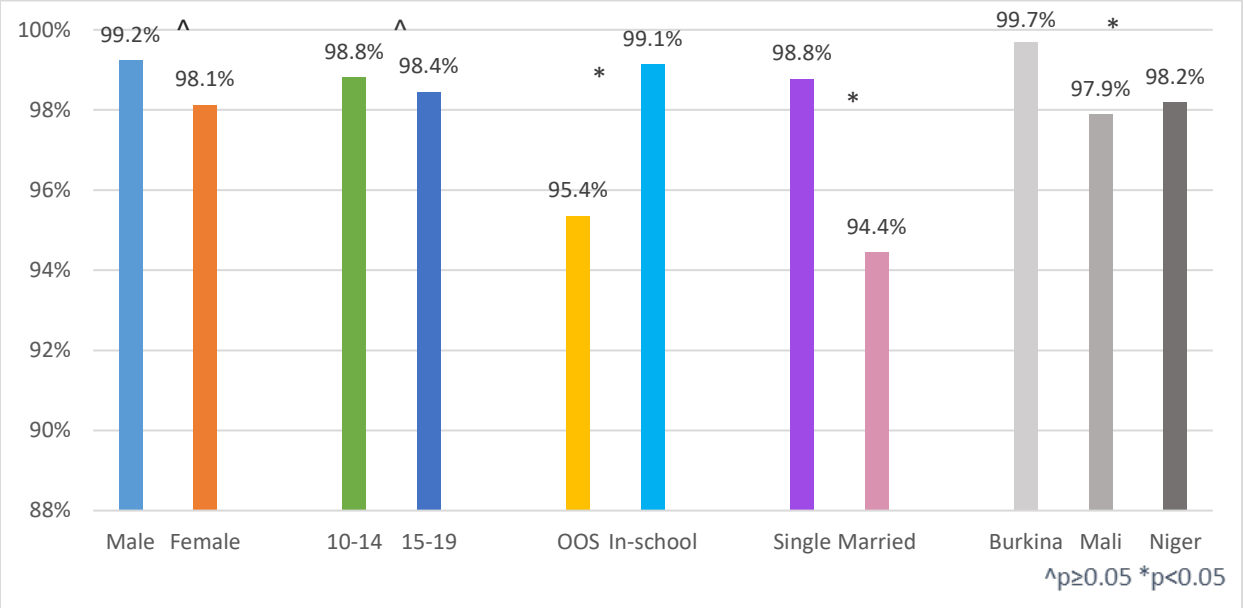
10. SELF-EFFICACY

Although not included in the overall indicators in the M&E Framework, a number of survey items were included to assess adolescent self-efficacy with respect to general self-efficacy, self-efficacy surrounding puberty/change, self-efficacy surrounding unwanted sexual attention, self-efficacy in practicing safe sex, and ability to resist peer pressure. Response options for all items were a 5-point Likert scale where 5 is strongly agree, and 1 is strongly disagree.

Self-efficacy in future attainment

The first question assessed general levels of self-efficacy and asked, "If you try hard, you can improve your situation in life." This question was not asked of Nigerienne in-school (IS) adolescents ages 10-14 years. Of the remaining adolescents who answered this question, nearly all (98.7%) agreed or strongly agreed that—if they tried hard—they could improve their life situation. As shown in Figure 11, there are statistically significant differences in perceived self-efficacy in ability to improve one's situation in life by school status, marital status, and country.

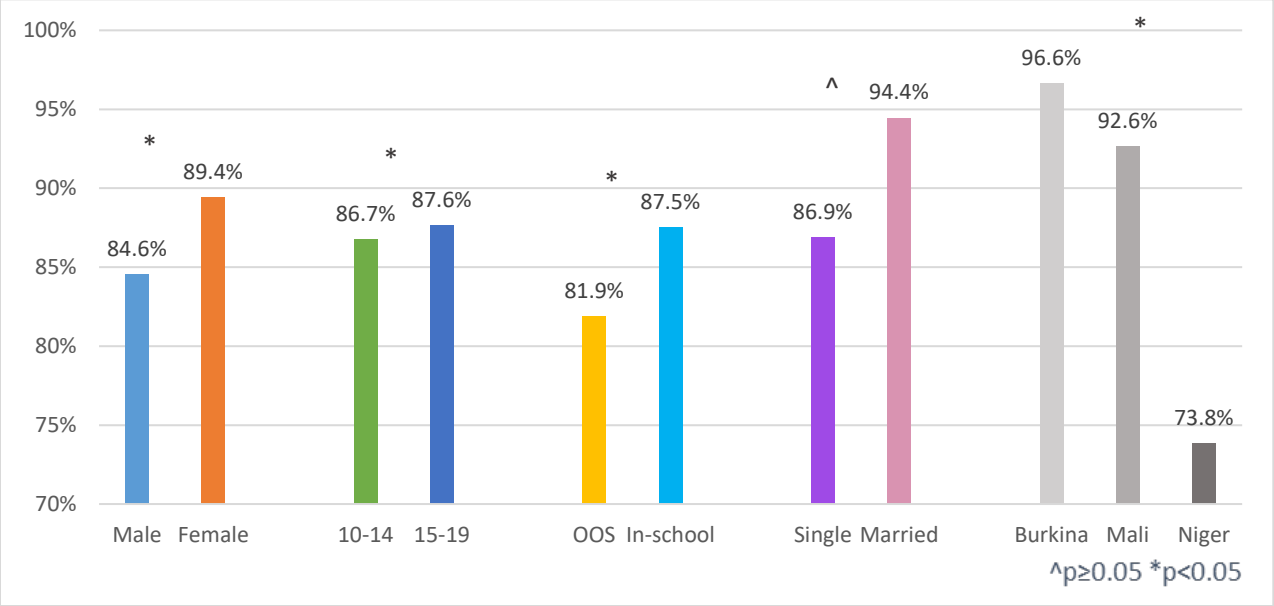
Figure 11. Perceived self-efficacy in ability to improve one's life situation (by sex, age, school and marital status, country)



Self-efficacy in puberty

All respondents were asked for their agreement about whether they are able to ask questions about puberty to a trusted adult. Most (87.0%) respondents agreed or strongly agreed that they could do so. As shown in Figure 12, there are statistically significant differences in perceived self-efficacy in ability to improve one's situation in life by sex, school status, and country. Note that although there is a 7.6 percentage point difference between single and married adolescents' self-efficacy, this difference is not statistically significant (due to the small sample size of married adolescents).

Figure 12. Perceived self-efficacy in asking questions about puberty to a trusted adult (by sex, age, school and marital status, country)



Self-efficacy related to unwanted sexual attention

All respondents were asked three questions related to agreement about their self-efficacy related to unwanted sexual attention. These three items asked whether respondents agreed or disagreed with the following statements:

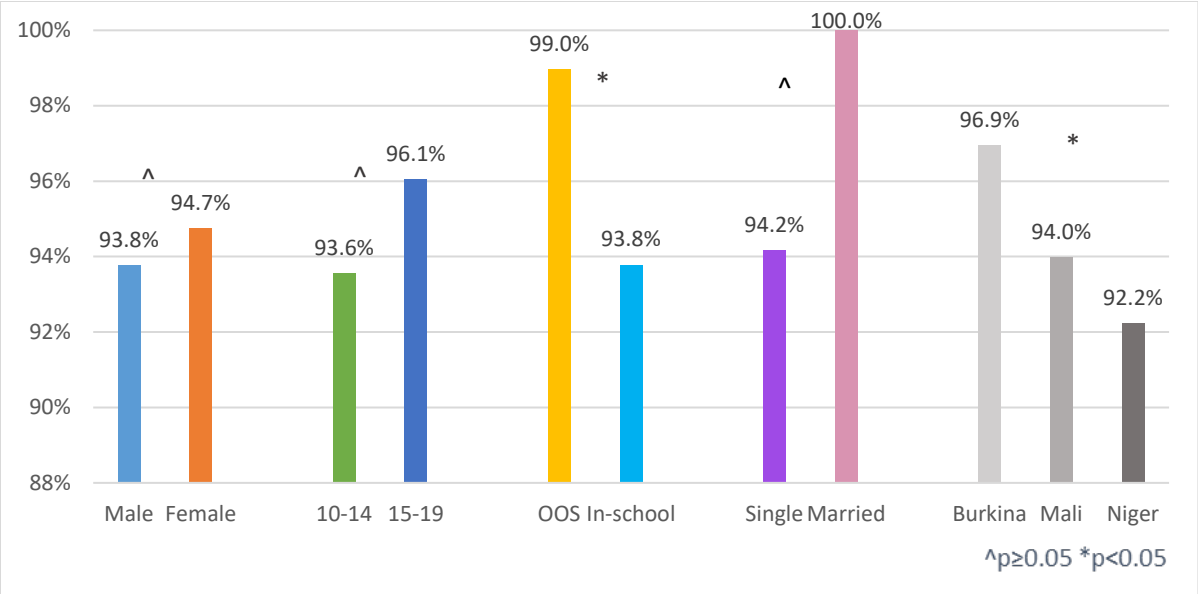
- 1203: You are able to refuse unwanted sexual attention from a stranger.
- 1204: If it happened, you could refuse unwanted sexual attention from a relative or someone else you know.
- 1205: You could tell a trusted adult about any unwanted sexual attention you may have experienced.

Most respondents (94.3%) agreed or strongly agreed that they could refuse unwanted sexual attention from a stranger. As shown in Figure 13, there are statistically significant differences in levels of agreement by school status and country.

A slightly smaller majority (92.5%) of respondents agreed or strongly agreed that they could refuse unwanted sexual attention from a relative or someone else they know. This proportion was slightly higher among girls than boys (92.2% for girls compared to 92.7% for boys, p=0.011 – no graph), and among in-school as compared to out-of-school adolescents (92.7% for in-school and 90.6% for out-of-school, p=0.001). There were no statistically significant differences between younger and older adolescents or between single and married adolescents. Finally, Malian

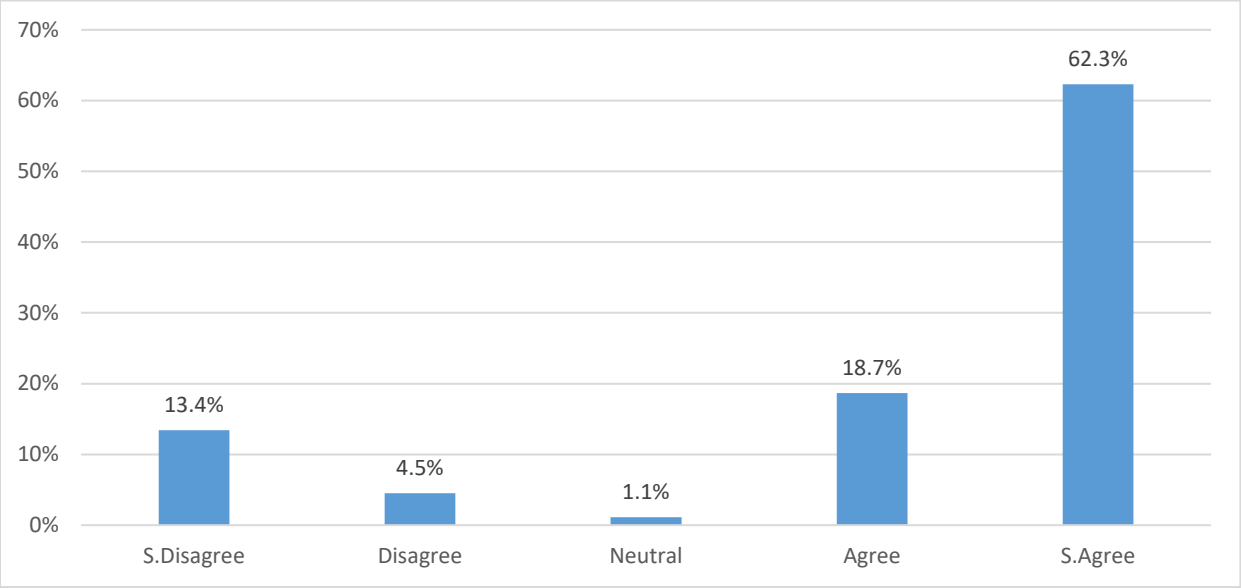
adolescents had the lowest proportion of adolescents who agreed or strongly agreed that they could refuse unwanted sexual attention from a relative or someone else they know (88.9% for Mali, 92.2% for Niger, 96.5% for Burkina Faso, p<0.001).

Figure 13. Proportion of adolescents agreeing or strongly agreeing they could refuse unwanted sexual attention from a stranger (by sex, age, school and marital status, country)



Finally, when asked whether they could tell a trusted adult about any unwanted sexual attention they may have experienced, most (81.0%) respondents had perceived self-efficacy (i.e., they responded that they agreed or strongly agreed with this statement). As shown in Figure 14 below, roughly one in five (17.9%) of respondents disagreed or strongly disagreed that they could tell a trusted adult about unwanted sexual attention. There were no statistically significant differences by sex, age group, or marital status in these findings, however statistically significant differences were seen by school status: only 76.3% of out of school adolescents compared to 81.4% of in-school adolescents (p=0.001) felt they could tell an adult about unwanted sexual attention. By country, less than three-quarters (72.8%) of Nigerien respondents as compared to 80.2% of Malian and 91.4% of Burkinabe respondents (p<0.001) felt they could tell an adult about unwanted sexual attention.

Figure 14. Perceived self-efficacy in ability to tell an adult about unwanted sexual attention



Self-efficacy in safe and consensual sex

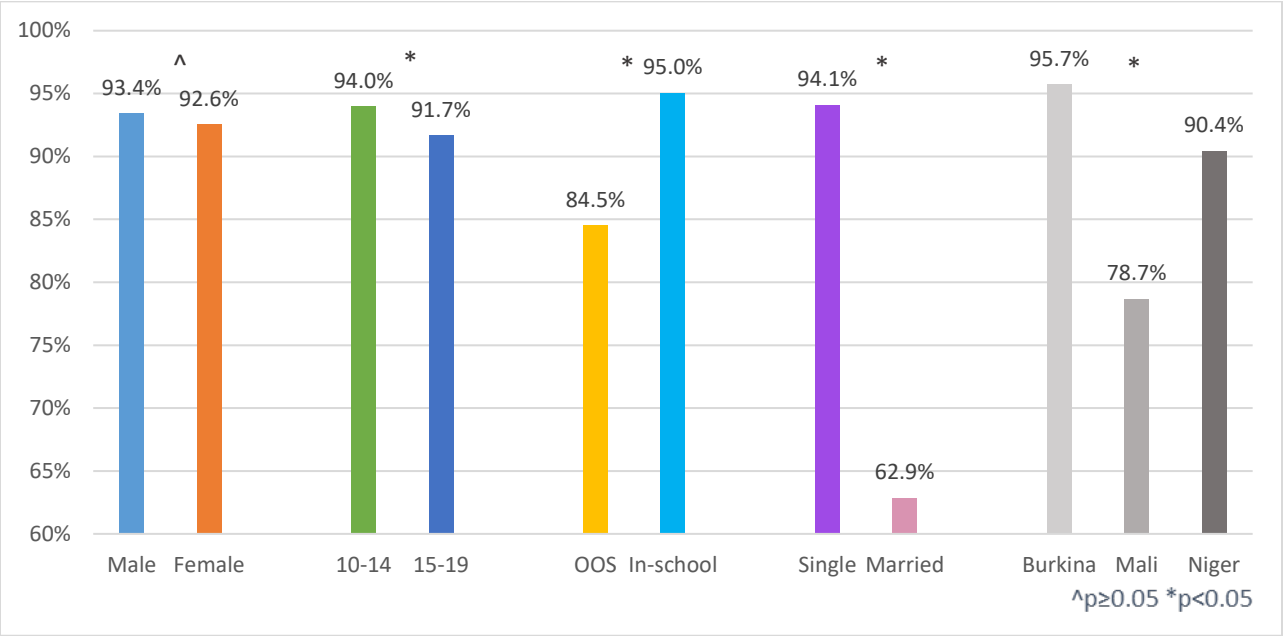
Three survey items were designed to assess adolescents' perceived self-efficacy surrounding safe and consensual sexual activity. These included:

- 1206: You could refuse sexual intercourse with a boyfriend / girlfriend even if he/she wanted to have it? Do you agree or disagree?
- 1207: If you needed to, you would feel confident in your ability to insist on using condoms with a sexual partner. Do you agree or disagree?
- 1208: If you needed to, you would feel confident in your ability to use contraception. Do you agree or disagree?

Question 1206 was not asked of in-school Malian adolescents of any age nor of the youngest in-school Nigerien adolescents ages 10-14 years. Question 1207 was asked of everyone aside from the youngest in-school Nigerien adolescents ages 10-14 years. Question 1208 was asked to all girls aside from the youngest in-school Nigerien adolescent girls ages 10-14 years.

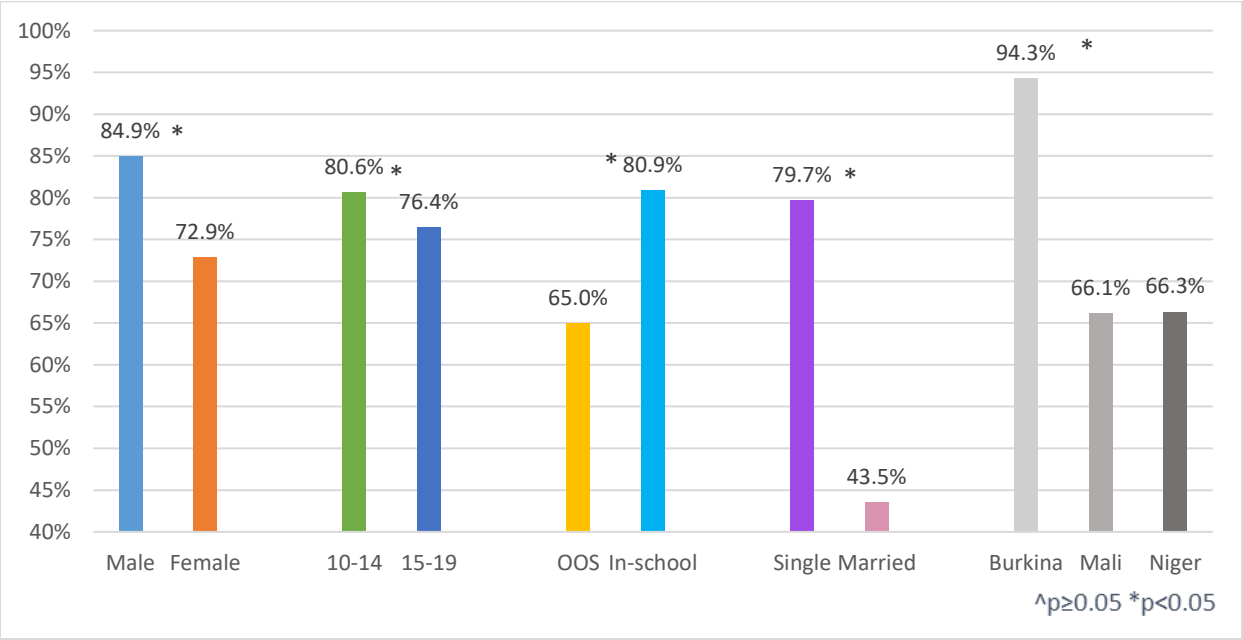
Most adolescents (93.0%) had strong perceived self-efficacy in their ability to refuse sexual intercourse with a boyfriend / girlfriend even if he/she wanted to have it. As shown in Figure 15, statistically significant differences were seen by all sub-categories of adolescents aside from sex.

Figure 15. Proportion of adolescents who agree or strongly agree that they could refuse sex even if a partner wanted it (by sex, age group, school and marital status, country)



Regarding question 1207, we found that nearly four out of five (79.1%) respondents agreed or strongly agreed that they could insist on condom use with a partner. As shown in Figure 16, there was statistically significant differences between all sub-groups of adolescents, with a higher proportion of boys than girls agreeing or strongly agreeing that they could insist on condom use, a higher proportion of younger than older adolescents, a higher proportion of in-school than out-of-school adolescents and much higher proportions of single and Burkinabe respondents as compared to married and Malian or Nigerien respondents agreeing or strongly agreeing that they could insist on condom use with a partner.

Figure 16. Proportion of adolescents who agree or strongly agree that they could insist on condom use with a partner (by sex, age, school and marital status, country)

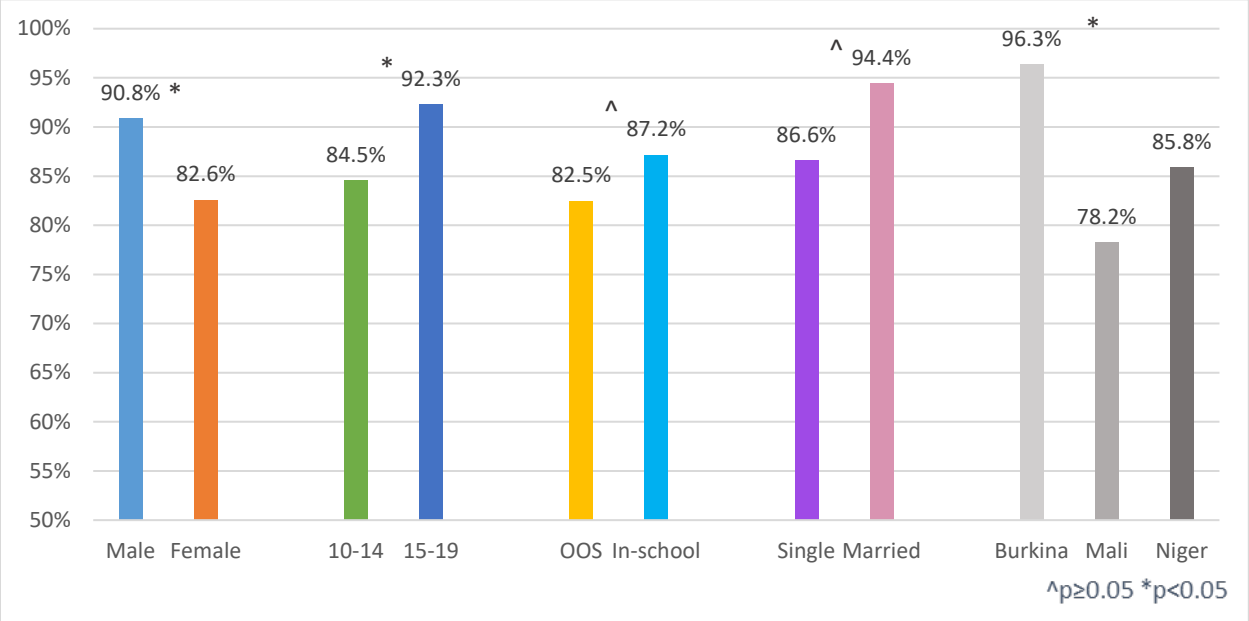


Finally, adolescent girls were asked about their perceived confidence in ability to use contraception. Nearly four out of five (79.1%) female respondents agreed or strongly agreed that—if they needed to—they would feel confident in their ability to use contraception. This proportion varied in statistically significant differences by age and country. By age, a greater proportion of *younger* adolescents (79.9%) than older adolescents (77.6%) felt confident in their ability to use contraception if/when needed (p=0.002). By country, 96.0% Burkinabe, 68.5% Malian, and 54.9% of Nigerien female respondents agreed or strongly agreed that they felt confident in their ability to use contraception (p<0.001) (no graph).

Self-efficacy in bodily autonomy

All adolescents were asked whether they agreed or disagreed with the following statement about bodily autonomy: "You feel you can make your own decisions about your body." As with the previous self-efficacy measures, most adolescents (86.7%) felt they could make their own decisions about their body. As shown in Figure 17, statistically significant variation was seen by sex (a higher proportion of boys than girls agreed with this), age group (a higher proportion of older as compared to younger adolescents agreed with this), and by country, with 96.3% of Burkinabe adolescents agreeing or strongly agreeing with this statement about bodily autonomy.

Figure 17. Agreement and strong agreement regarding bodily autonomy (by sex, age category, school and marital status, country)



Self-efficacy & peer pressure

To assess knowledge of peer pressure, adolescents were asked the following question:

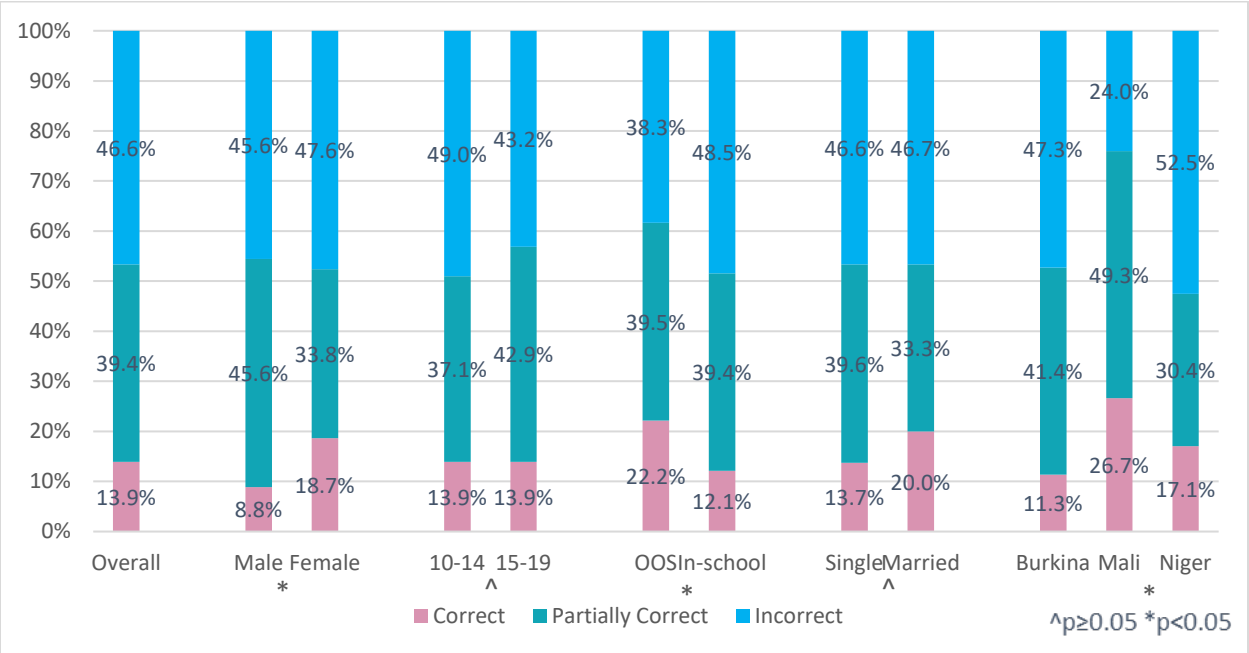
- 1210: Which of the following statements about peer pressure are true?
  - *Peer pressure is when friends influence your attitudes, values and behavior.
  - *You are influenced by peers because you want to be accepted.
  - Peer pressure is always negative.

Respondents who selected both of the starred responses (i.e., the correct responses) were coded as 'correct'; respondents who selected only one of the correct responses were coded as partially correct; all others were coded as incorrect. This question was not asked of any in-school Malian adolescents or in-school Nigeriens ages 10-14 years.

Overall, there was low correct knowledge of peer pressure's mechanisms, with only 13.6% of adolescents in the overall sample correctly selecting both of the correct response options. As shown in Figure 18, more female than male; younger than older, out-of-school than in-school; and Malian than Nigerien and Burkinabe adolescents answered this question correctly.

statistically significant variation was seen by sex (a higher proportion of girls than boys selected both correct responses), school status (a higher proportion of out-of-school as compared to in-school adolescents selected both correct responses), and by country, with Mali having the highest proportion of adolescents who correctly selected both responses.

Figure 18. Knowledge of peer pressure's mechanisms

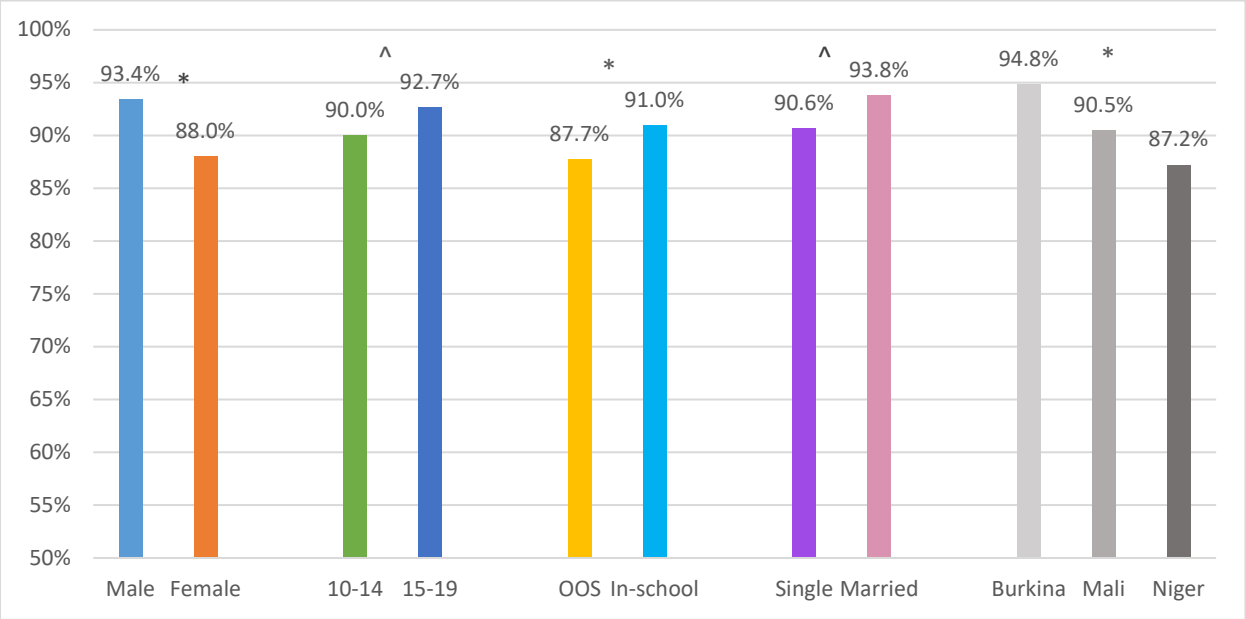


Finally, one item assessed adolescents' ability to resist negative peer pressure:

- 1211: If it happens, you are able to resist negative peer pressure. Do you agree or disagree? (strongly agree – strongly disagree)

Most adolescents (90.7%) agreed or strongly agreed that they could do so resist negative peer pressure. As shown in Figure 19, this proportion was higher among: boys than girls (93.4% of males versus 88.5% of females ($p<0.001$)); in-school than out-of-school adolescents (91.0% of in-school versus 87.7% of out-of-school adolescents ($p=0.005$); and Burkinabe adolescents relative to the other countries' adolescents (94.8% in Burkina; 90.5% in Mali; 87.2% in Niger ($p<0.001$)). There were no statistically significant differences by age or marital status.

Figure 19. Agreement with self-efficacy in resisting peer pressure



11. CHILD MARRIAGE

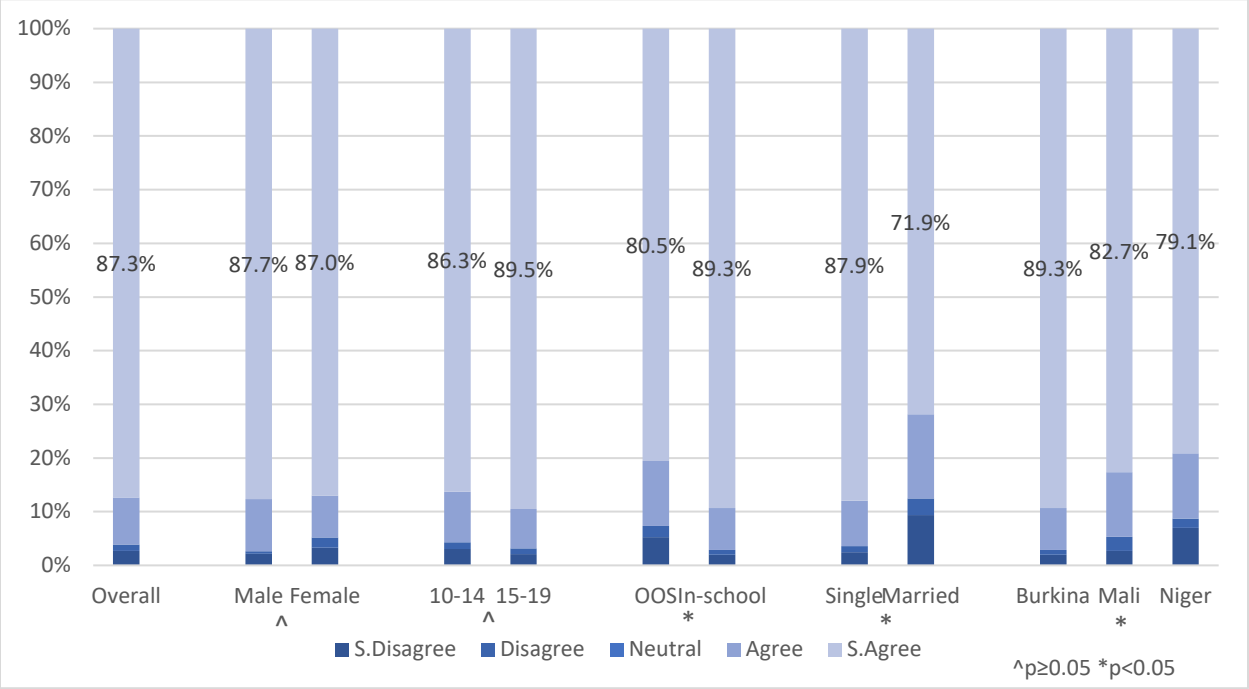
Two survey items assessed adolescent views on the appropriateness of child marriage, and three survey items assessed adolescents' perceptions on their ability to choose when and with whom to marry. The five items were worded as follows:

- 1301: Early marriage often has harmful consequences for a girl's health, psychological wellbeing and education. Do you agree or disagree?
- 1302: Early pregnancies carry high health risks for a young woman/girl and her baby. Do you agree or disagree?
- 1303: You have the right to choose whether, when and with whom you want to marry. Do you agree or disagree?
- 1304: If your mother/father want to marry you off, but you do not want to, would you be able to refuse?
- 1305: If your mother/father want to marry you off, but you do not want to, would you be able to seek help from a trusted adult to prevent your marriage?

Question 1301 was not asked of any in-school adolescents in Mali or Niger; Question 1302 was not asked of any in-school Malian adolescents nor Nigerien in-school adolescents ages 10-14 years. The other three questions (1303-1305) were asked of all adolescents.

As shown in Figure 20, overall 87.3% of the adolescents who answered this question (i.e., out-of-school adolescents in Mali and Niger and all adolescents in Burkina Faso) strongly agreed that early marriage often has harmful consequences for a girl's health, psychological wellbeing, and education. Less than 4% of the respondents disagreed or strongly disagreed with this statement. No statistically significant differences in agreement with this statement were seen by sex or age, however, a larger proportion of in-school, single, and Burkinabe adolescents strongly agreed that early marriage has harmful consequences for a girl's health and wellbeing as compared to the out-of-school, married, and Malian and Nigerien respondents.

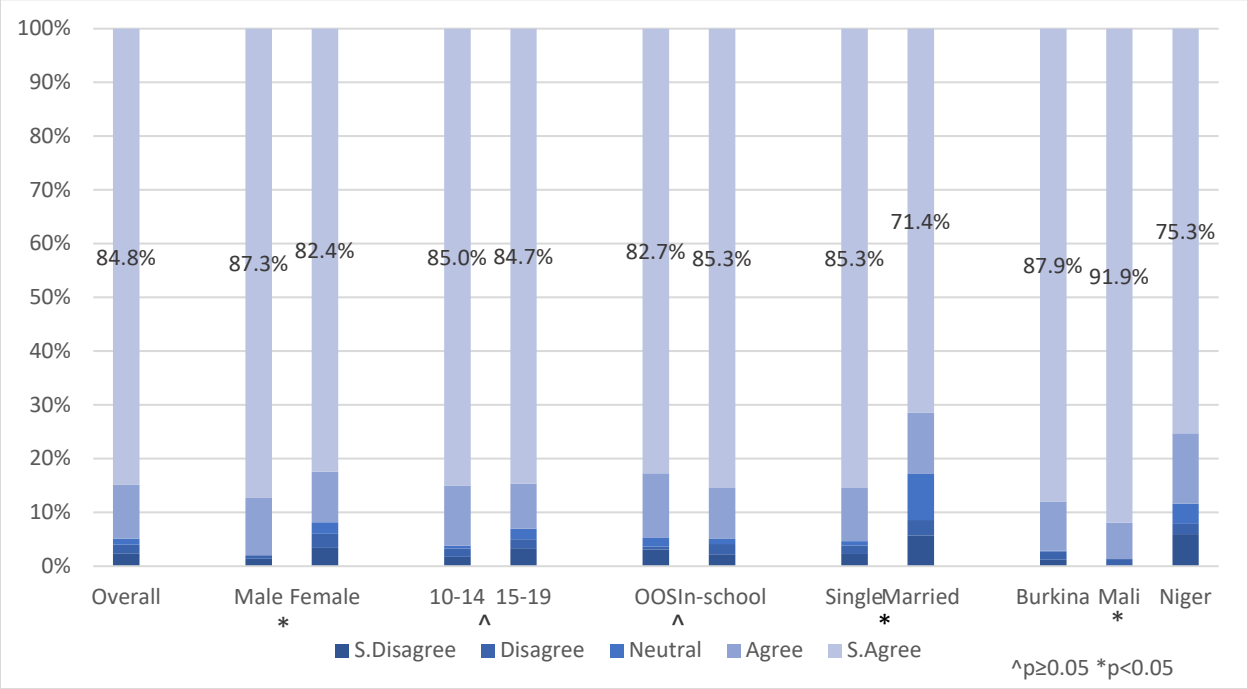
Figure 20. Agreement with statement that early marriage has harmful consequences for girls



Among adolescents who were asked whether they agreed that early pregnancies carry high health risks for young women and their babies, 84.8% responded that they strongly agreed. As shown in Figure 21, this proportion was higher among boys and girls, and higher among unmarried than married adolescents. By country, there was a larger proportion of adolescents who strongly agreed that early pregnancies carry high health risks for young women and their babies among Malian

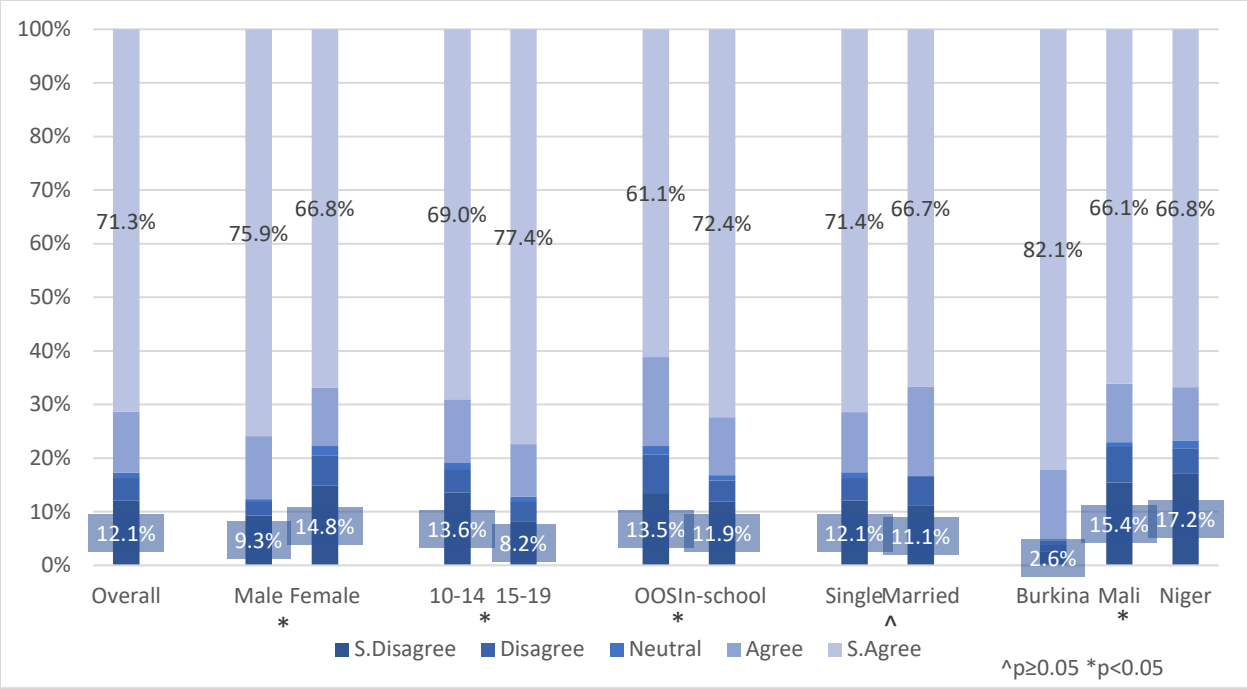
respondents versus Burkinabe and Nigerien respondents. No statistically significant differences were seen by age or school-status in levels of agreement with this statement.

Figure 21. Agreement with statement that early pregnancy carries health risks for young women and their babies



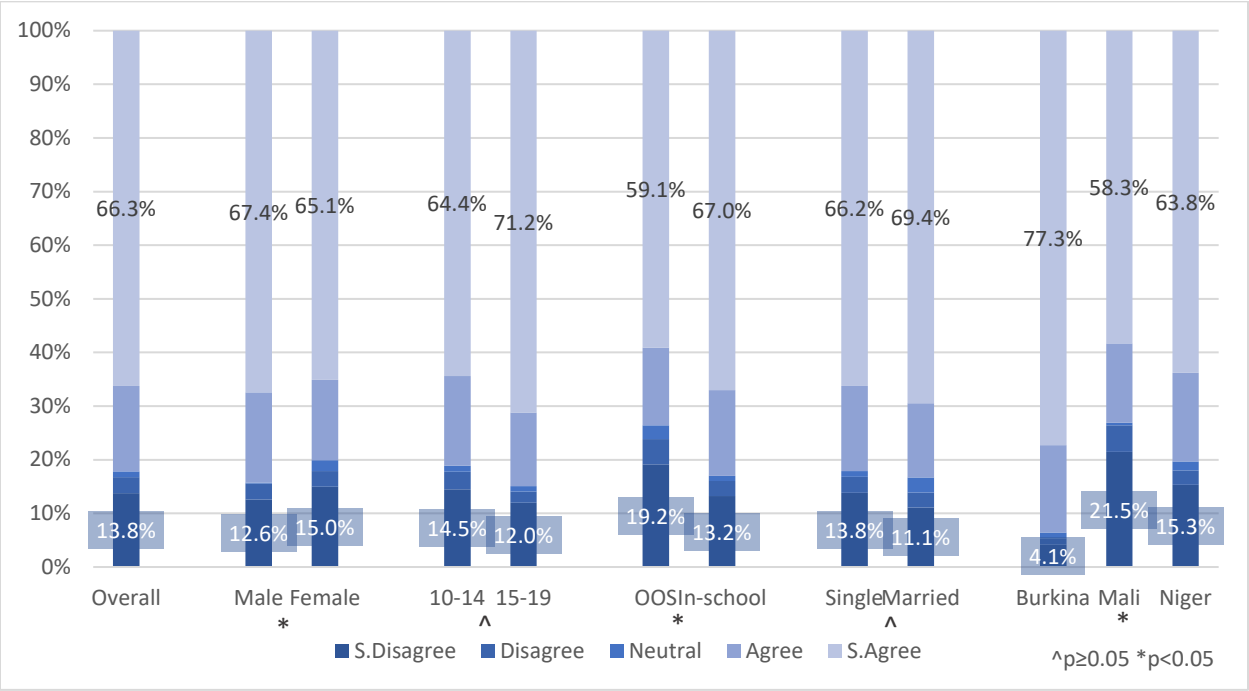
All adolescents were asked whether they agreed that they have the right to choose whether, when and with whom to marry. As shown in Figure 22, less than three quarters of respondents (71.3%) strongly agreed with this statement. No statistically significant differences were seen by marital status, however, fewer girls than boys, fewer of the younger (10-14-year-old) adolescents than older adolescents, and fewer out-of-school than in-school adolescents strongly agreed that they had the right to choose the conditions of their marriage. Finally, Niger had the smallest proportion of adolescents stating that they strongly agreed they could choose the conditions of their marriage as compared to Burkina Faso and Mali.

Figure 22. Agreement with statement about having a right to choose conditions of marriage



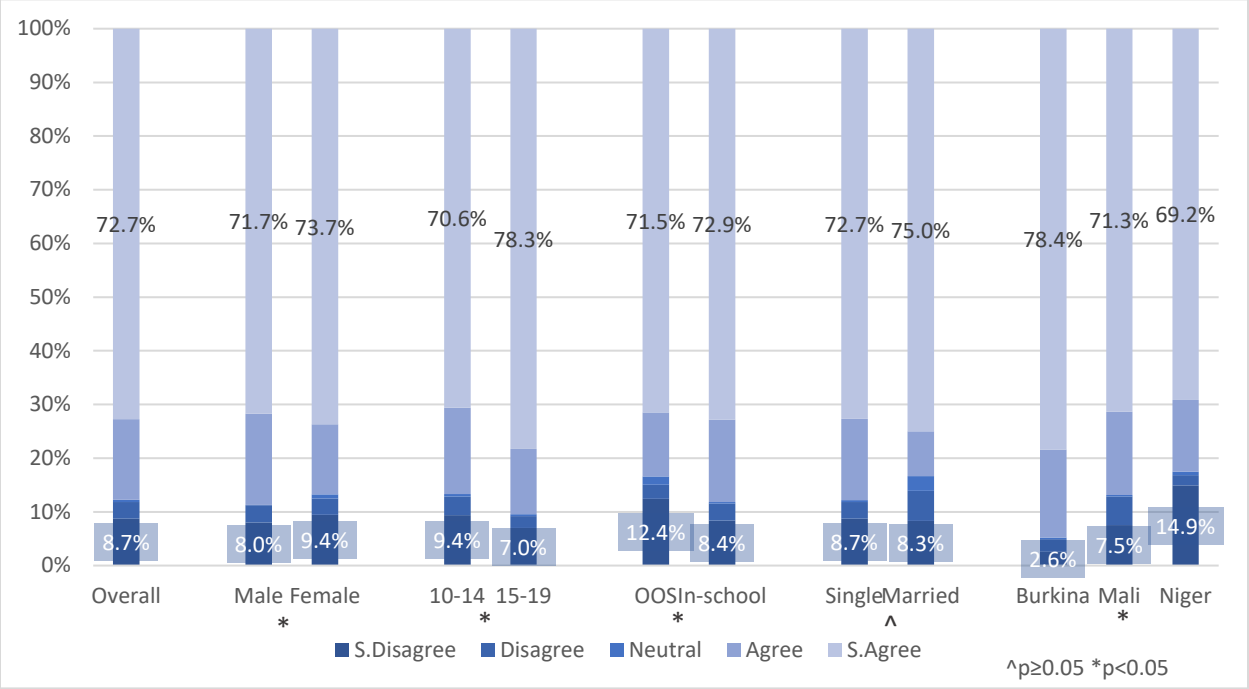
All adolescents were asked whether they agreed that they could refuse an unwanted marriage proposed by their parents/guardians. As shown in Figure 23, 66.3% of the overall sample strongly agreed that they could go against their parents' wishes regarding marriage arrangements. No statistically significant differences were seen by age or marital status, however, fewer girls than boys and fewer out-of-school than in-school adolescents strongly agreed that they could go against their parents' wishes regarding marriage arrangements. Finally, Mali had the smallest proportion of adolescents stating that they strongly agreed they could refuse their parents' wishes about marriage.

Figure 23. Proportion of adolescents agreeing they could refuse if their parents wanted them to get married



The last indicator on child marriage assessed whether adolescents felt they could seek help from a trusted adult in order to prevent an arranged marriage. As shown in Figure 24, roughly three-quarters of the respondents (72.7%) strongly agreed they could get help. There were small but statistically significant differences among all sub-groups of adolescents, except by marital status.

Figure 24. Agreement with statement that adolescent could seek help from a trusted adult about an unwanted marriage



12. FEMALE GENITAL CUTTING

Finally, four survey items about female genital cutting (FGC) were included for Burkinabe respondents. These included:

- 1401E: Have you ever heard of female circumcision - a practice in which a girl may have part of her genitals cut?
- 1402E: A girl should be circumcised. Yes or no?
- 1403E: FGC causes serious physical and mental health complications for girls and women.
- 1404E: Do you think that this practice should be continued?

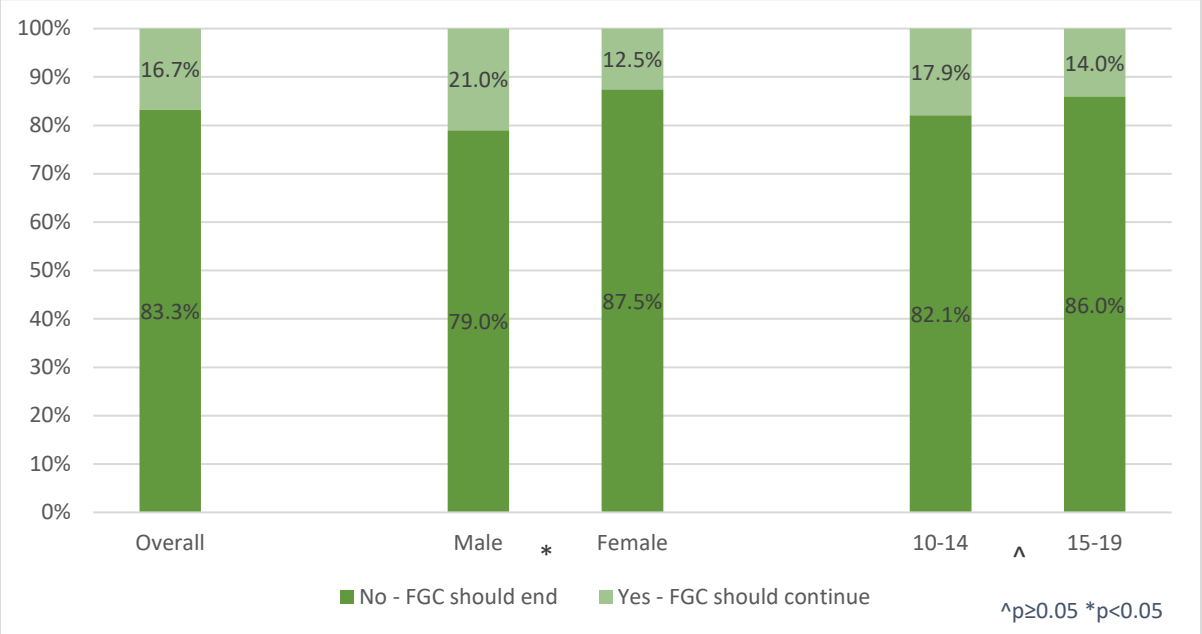
Among the 655 Burkinabe respondents, 87.0% stated they had ever heard of FGC. No differences were seen by sex in knowledge of FGC, but a statistically significant difference between age categories was seen with 82.4% of 10-14 year-olds and 100% of 15-19 year-olds reporting they had heard of FGC ($p<0.001$).

Of the 570 respondents who had heard of FGC, most (87.9%) stated girls should not be circumcised. There were no differences by sex, but a larger proportion of the older adolescents than the younger adolescents felt that girls should not be circumcised (85.7% 10-14 year-olds; 93.0% 15-19 year-olds, p=0.014).

When asked whether FGC causes serious health complications for girls and women, 94.6% of the respondents agreed, with no differences seen by sex but with a higher proportion of older than younger adolescents agreeing (93.2% 10-14 year-olds; 97.7% 15-19 year-olds, p=0.031).

Finally, respondents were asked whether FGC should be continued. As shown in Figure 25, overall 83.3% of respondents felt that the practice of FGC should end. Unlike the previous three questions about FGC, for this measure we saw statistically significant differences by sex but not age, with a higher proportion of girls than boys stating FGC should end (87.5% of girls felt FGC should end as compared to 79.0% of boys, p=0.007).

Figure 25. Proportion of Burkinabe adolescents stating FGC should not be continued (in overall sample, and by sex and age)



APPENDICES

Appendix A. ATWA M&E Framework

[please find attached]

Appendix B. ATWA Survey Instrument

[please find attached]

Appendix C. Survey Items by Respondent Type

[please find attached]

Appendix D. Sampling Frame by Country

[please find attached]

Appendix E. Data Collection Technical Report (GRADE Africa)

[please find attached]

Appendix F. Baseline Findings by Country

[please find attached]