

ADOLESCENT TRANSITION IN WEST AFRICA

Reaching Adolescents with Culturally-Adapted Life Skills and Sexual and Reproductive Health Education:
End of Project Evaluation Summary Brief

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GRADE Africa

Save the Children

UC San Diego
CENTER ON GENDER EQUITY AND HEALTH

Project Description

The Adolescent in Transition in West Africa (ATWA) program was a four-year program (2019-2023) that aimed to influence and promote positive adolescent sexual and reproductive health and rights (SRHR) outcomes by addressing interrelated drivers of poor SRHR among very young (10-14 years) and older (15-19 years) adolescents in eight regions of the Liptako Gourma area, an area covering eastern Burkina Faso, southwestern Niger, and a portion of southeast central Mali. Liptako Gourma is characterized by insecurity and violence, including violence against schools and health centers, as well as conservative attitudes towards adolescents' SRHR. This often means that puberty and emergent sexuality is shrouded in secrecy for many adolescents. In this context, the ATWA intervention is both necessary from an adolescent SRHR perspective, but also challenging from an implementation perspective.

ATWA worked with Ministries of Education in Burkina Faso, Niger, and Mali to catalyze the provision of culturally-adapted life skills and sexual and reproductive health (SRH) education for adolescents in school and out-of-school settings across the three countries. Save the Children developed and shared SRH education content with ministry partners, who drew upon their existing Life Skills Education (LSE) curricula to incorporate, tailor, and adapt SRH elements to develop the ATWA curricula for each country context. In adapting the curricula to these country contexts, the ministries opted to use different terms to describe the type of curriculum used in ATWA. In Burkina Faso, it is known as *Sexual and Reproductive Health Education*; in Mali *Reproductive Health Education*; and in Niger *Life Skills Education*. The out-of-school material was adapted and expanded by Save the Children from existing tools from the Gender Roles, Equality and Transformation (GREAT) project.

In each of the three countries, teachers, mentors, and peers engaged adolescent girls and boys on SRHR topics to improve their attitudes, behaviors, and norms towards gender and SRHR and building critical life skills. Alongside the provision of LSE, ATWA additionally aimed to increase access to, and uptake of quality adolescent-responsive SRH services among adolescents by working with service providers to improve the quality and youth-friendliness of services.

ATWA's overall objectives 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:	Health facilities offer quality adolescent responsive SRH services that are used by adolescent girls and boys

Formative Research – Social Norms Examination

Before the start of the ATWA intervention, the project team conducted qualitative research using the Social Norms Exploration Tool (SNET)[1]—a participatory learning and action tool developed with support from USAID and the Gates Foundation. This qualitative research sought to understand the views and norms held by the ATWA intervention communities surrounding adolescent SRHR.

The results from the Social Norms Exploration highlighted the many beliefs and social norms surrounding gender, sexuality, and age-appropriate behaviors that create barriers to healthy adolescent SRHR outcomes. In qualitative interviews, the team heard frequently that teaching adolescents about puberty and sexuality would lead to promiscuity. As young boy described, « *Quand on évoque le sujet de la sexualité avec un adolescent ça le pousse à croire qu'il est assez grand pour avoir une vie sexuelle active.* » ("When you bring up the subject of sexuality with a teenager it makes them think they're old enough to have an active sex life.") Parents and adults in the communities often chose not speak to adolescents about puberty and emergent sexuality for reasons of embarrassment. One community leader noted: « *Les parents ont honte de parler de sexualité aux enfants. Il y a une gêne pour ces questions. Donc les adolescents sont laissés à eux-mêmes sur ce sujet.* » ("Parents are

1 Institute for Reproductive Health. 2020. Social Norms Exploration Tool. Washington, DC: Georgetown University. https://irh.org/wp-content/uploads/2020/04/Social_Norms_Exploration_Tool_SNET-1.pdf

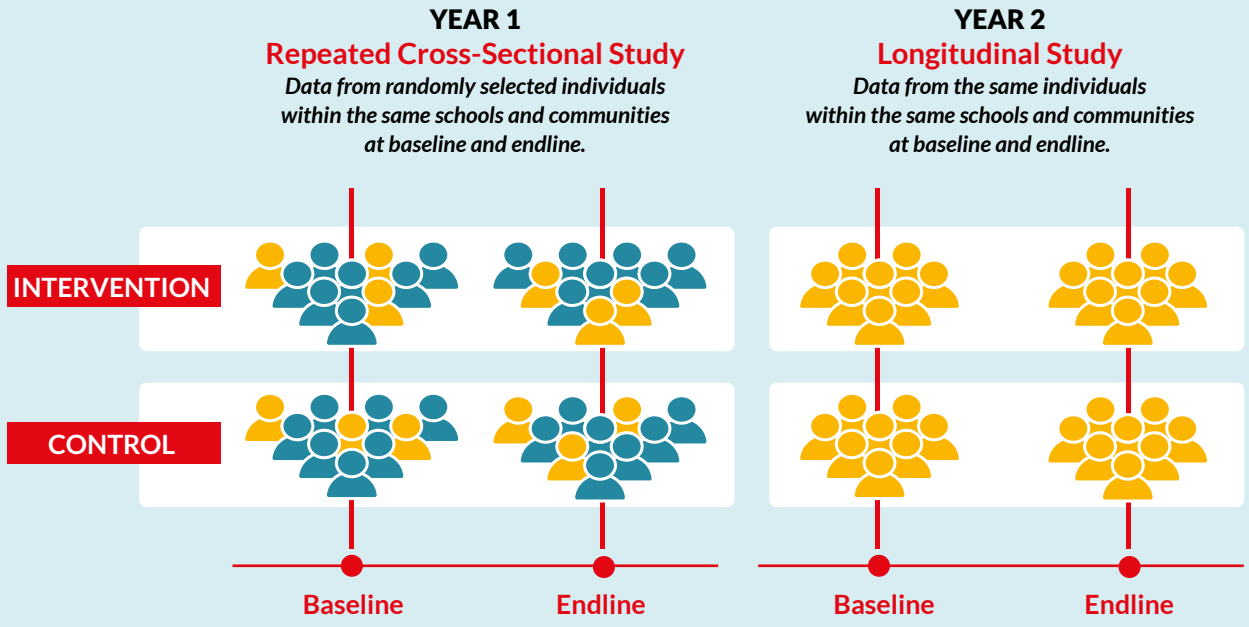
ashamed to talk to children about topics related to sexuality. There is an embarrassment about these issues. So, teenagers are left to their own devices.") Compounding these beliefs that talking to adolescents about puberty and sexual and reproductive health would lead to promiscuity or embarrassment, health educators also noted that parents frequently didn't have accurate information: « *Les parents eux-mêmes ne savent pas, ils manquent de connaissances sur le sujet. Ils ne sont pas éduqués sur ces questions, donc il sera difficile de transmettre aux adolescents ce qu'on ne connait pas soi-même.* » ("Parents themselves don't know, they lack knowledge on the subject. They're not educated about these issues, so it will be difficult to pass on to teenagers what you don't know yourself.") This formative research highlighted the importance of sensitizing community leaders and parents to the ATWA intervention and generating support for it in advance of implementation. Please see the community support section below for additional information.

Outcome Evaluation Study Design

Research partners at the Center on Gender Equity and Health at the University of California San Diego (UCSD-GEH) and GRADE Africa implemented rigorous evaluation designs to assess the ATWA intervention's impact on Outcome 1: ASRHR knowledge, intent, and behaviors among adolescents. Outcome 2 on health facilities was assessed separately in close collaboration with Health authorities.

For Year 1 of the intervention, the research team used a repeated cross-sectional cluster randomized trial with a comparison group. This study design gathers data from adolescents in the same communities at baseline and endline from both the intervention and control groups. Endline data are used to contrast differences between the control and intervention groups, after accounting for cluster-level baseline levels of outcome indicators. In Year 2, the research team determined that it would be possible to follow adolescents longitudinally (i.e., to reach the same adolescents at baseline and endline), and implemented a longitudinal cluster randomized controlled trial (C-RCT). This study design is one of the strongest available to assess intervention impact.

Research Design



Sample & Data Collection

Before the start of the Year 1 intervention, intervention and control schools were selected in each of the three countries, and from these, a random sample of approximately 2,200 adolescents were selected to complete the survey at each time point. In Year 1, this random sample occurred at both baseline and endline, and in Year 2, the random sample occurred at baseline with the same adolescents re-interviewed at endline.

- **Year 1** baseline data collection occurred in December 2021 with 2,244 adolescents; endline data collection occurred at the end of program implementation in May and June 2022 among 2,069 adolescents.
- **Year 2** baseline data collection occurred in November-December of 2022 (n=2,113 adolescents) and endline data collection occurred in May-June of 2023 (endline, n=1,998). The Year 2 evaluation had a high follow-up rate from baseline to endline (94.6%), with most, but not all, adolescents followed over time.

2 Items were either drawn or adapted from 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).

Survey Tool Development

UCSD-GEH worked with Save the Children to review and adapt items from existing validated survey tools[2], to ensure complete linkages between the survey items, the ATWA M&E Framework, and the country-specific ATWA curricula. The ATWA survey tool covers 12 topics: 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). In the Year 2 evaluation, a new section on Community Support for CSE was added to adolescents' perceptions of their community leaders' support for LSE and SRH services.

Statistical Analyses

For the Year 1 analyses with the repeated cross-sectional data (i.e., different individuals interviewed at baseline and endline, but within the same communities), UCSD-GEH fit a series of regression models to the individual-level data, using robust standard errors to account similarities between adolescents in the same schools or communities (i.e., intracluster correlation). Regression models also include cluster-level baseline values of each indicator to account for any differences at baseline between the intervention and control groups.





For the Year 2 analyses with the longitudinal data (i.e., the same individuals interviewed at baseline and endline), UCSD-GEH used a difference-in-differences statistical approach within hierarchical mixed effects regression models. UCSD-GEH also conducted omnibus chi-square tests ($\chi 2$) with endline data to examine outcomes that were not included in the M&E Framework: gender-based violence, self-efficacy, and female genital cutting.

UCSD-GEH additionally ran chi-square tests among adolescents in the ATWA intervention to assess whether adolescents who received peer education (available only in Year 2) and those that did not had different outcomes. We highlight findings where peer education positively impacted an ASRHR outcome with a peer education icon (shown at left). For all analyses, statistical significance is assessed as p-values less than 0.05. Additional methodological detail can be found in the Year 1[3] and 2[4] endline reports.

ATWA Outcome Evaluation Results in Brief

Demographics

At endline in both Years 1 and 2, the average age of respondents was 13.3 years (min= 9 years, max 19 years), with 74% of respondents between the ages of 10-14 years and 26% between the ages of 15-19 years. This oversample of younger adolescents was in line with the ATWA program design to intentionally reach more younger than older adolescents. There was an even balance of boys and girls in the sample (49% boys, 51% girls). The vast majority (98%) of adolescents were unmarried. Among married adolescents, only one was between the ages of 10 and 14 years. Finally, a relatively small proportion (12%) of adolescents ages 15-19 years old reported being sexually active in the past 12 months (younger adolescents were not asked about sexual activity due to the sensitive nature of this question in this study setting).

Puberty

Adolescents were asked a series of nine questions to assess knowledge about body changes during puberty, the menstrual cycle, fertility and conception, pregnancy risk and prevention. Questions ranged from "it's normal that boys and girls experience changes in their bodies as they grow up" to "a boy can get a girl pregnant before he has had his first ever ejaculation."

In Year 1 (cross-sectional data), only 7.7% of adolescents in the control group and 10.4% in ATWA answered all nine questions correctly. This higher proportion among ATWA adolescents was not, however, statistically significant from the control group (2.7 percentage point difference (p=0.610)).

In Year 2 (longitudinal data), there was a 10.1 percentage point increase in correct knowledge among control group adolescents (34.5% of adolescents answering all nine questions correctly at baseline compared to 44.6% at endline) and a 22.1 percentage point increase from baseline to endline among intervention group adolescents (27.9% t o 50.0%). This difference in change between the two study arms over time was statistically significant, indicating that **participation in the ATWA intervention was associated with adolescents being 2.6 times more likely to have accurate knowledge about puberty (OR=2.63, p<0.001).**

3 Center on Gender Equity and Health. 2022. Adolescent Transitions in West Africa (ATWA) Outcome Evaluation: Year 1 Endline Report. La Jolla, CA: University of California San Diego for Save the Children.

4 Center on Gender Equity and Health. 2024. Adolescent Transition in West Africa (ATWA) Outcome Evaluation: Year 2 (2022-2023) Endline Report. La Jolla, CA: University of California San Diego for Save the Children.



Menstruation

Before the start of ATWA, accurate knowledge and beliefs about menstruation were low among all adolescents, with only around 15% of boys and 19% of girls correctly answering at least two of three of the following true or false questions: girls' menstrual cycles are typically 14 days long; menstruation is dirty/impure; used sanitary napkins can be used to cast magic spells.

At endline in Year 1, 16.9% of adolescents in the control group compared to 20.6% of ATWA adolescents correctly answered at least two of the three menstruation knowledge questions. This higher proportion among ATWA adolescents was not, however, statistically significant from the control group (3.7 percentage point difference (p=0.195)).

In Year 2, significant increases were seen among the intervention group, with 46% of ATWA adolescents (compared to 25% of control adolescents – a 21 percentage point increase) answering at least 2 of the 3 questions correctly—corresponding to **a 2.6 times greater likelihood among ATWA participants in having accurate knowledge about menstruation (OR=2.62, p<0.001)**. This intervention impact was *especially strong for boys*; boys on average had lower correct knowledge at baseline relative to girls, but boys in ATWA essentially caught up to girls in ATWA by endline. Compared to boys in the control group, **boys in ATWA were 3.7 times more likely to have accurate knowledge about menstruation (OR=3.71, p<0.001)**.

The ATWA intervention also showed positive impacts on the proportion of adolescents who knew that menstruation was a normal biological function (and that monthly bleeding is not a sign of disease).

At endline in Year 1, 50.2% of control adolescents compared to 58.5% of ATWA adolescents correctly identified menstruation as a normal biological function (p=0.058).

This intervention effect was even stronger in Year 2. Among control adolescents, 47.9% of the participants had the correct knowledge at baseline and this increased to 58.6% at endline, a 10.7 percentage point increase. Among ATWA adolescents, 56.9% of the participants had the correct knowledge at baseline and this increased to 83.6% at endline, a 26.7 percentage point increase. This corresponded to **ATWA adolescents being 2.8 times more likely to know that menstruation was a normal biological function** than adolescents in the control group (OR=2.82, p<0.001).

Peer education (PE) also had positive impacts on this indicator; 82.4% of adolescents in the intervention group who did not receive PE know that menstruation is a normal biological function of the female body as compared to 89.5% of adolescents who did receive PE ($\chi 2$ p=0.039).

STI and HIV Prevention and Treatment

To assess whether ATWA impacted adolescents' knowledge of STI risk, prevention and treatment, boys and girls were asked the following four true/false questions: people can get an STI or HIV the first time they have unprotected sex; using a condom can protect against STIs/HIV; symptoms of STIs include redness, burning or sores on the genitals; people can reduce risk by having one sexual partner.

By endline of Year 1, more ATWA than control adolescents had correction knowledge of STI and HIV prevention (47.2% of controls versus 56.2% of ATWA adolescents), however this intervention effect was only marginally statistically significant (p=0.083). In Year 2, however, **ATWA adolescents were 2.6 times more likely to have correct knowledge of STI risk, prevention and treatment** than adolescents in the control group (OR=2.63, p<0.001). (Controls saw a 1.6 percentage point increase in correct knowledge, from 55.5% at baseline to 57.1% at endline; ATWA adolescents saw a 16.6 percentage point increase, from 53.9% at baseline to 70.5% at endline.)

Adolescents were also assessed whether the ATWA intervention was associated with improved knowledge of where to go to get tested for HIV, for STI treatment, and where to get contraception and condoms. By endline of Year 1, 36.9% of adolescents in the control group and 38.7% of adolescents in the intervention group reported correct knowledge of where to seek SRH services. However, this difference was not statistically significant (p=0.512).

In Year 2, there was a 24.2 percentage point increase in knowledge of where to seek SRH services among ATWA adolescents, from 37.2% at baseline to 61.4% at endline. By comparison, adolescents in the control group saw a 7.8 percentage point increase in knowledge, from 26.7% at baseline to 34.5% at endline. The longitudinal evaluation findings show that **ATWA adolescents were 2.4 times more likely to know where to seek SRH services**, compared to adolescents in the control group (OR=2.44, p<0.001).

This effect was stronger for ATWA adolescents who received peer education, with 47.9% of adolescents in the intervention group who did not receive PE reported knowledge of where to seek SRH services as compared to 69.0% of adolescents who did receive PE ($\chi 2$ p<0.001).

When asked specifically about HIV prevention, ATWA adolescents showed greater increases in correct knowledge on HIV prevention compared to adolescents in the control group. By endline of Year 1, 11.9% of the adolescents in the intervention group displayed correct knowledge on HIV prevention compared to 8.4% of the adolescents in the control group. However, this increase in knowledge was not statistically significant (p=0.125).

Between baseline and endline of Year 2, ATWA adolescents saw a 25.5 percentage point increase, from 42.5% at baseline to 68.0% at endline as compared to adolescents in the control group who saw a 9.8 percentage point increase in correct HIV prevention knowledge, from 40.3% at baseline to 50.1% at endline. This corresponds to **ATWA adolescents being 2.7 times more likely to report correct knowledge about HIV prevention**, as compared to adolescents in the control group (OR=2.66, p<0.001).

Peer education (PE) also had positive impacts on this indicator; 54.8% of adolescents in the intervention group who did not receive PE responded correctly to the six questions on HIV prevention as compared to 74.8% of adolescents who did receive PE (p=0.029).

Contraceptive methods

Adolescents were asked whether they planned to use modern contraceptive methods such as condoms, oral contraceptive pills, and intrauterine devices. By endline of Year 1, 64.0% of the adolescents in the control group and 68.3% of the adolescents in the intervention group planned to use modern contraception methods but this difference was not statistically significant (p=0.937).

In Year 2, we saw a 12.6 percentage point increase from baseline to endline in the control group (from 45.3% at baseline to 57.9% at endline), compared to a 19.3 percentage point increase in the intervention group (51.4% to 70.7%). This difference in change between the study arms over time was statistically significant, indicating that **participation in the ATWA intervention was associated with adolescents being 1.7 times more likely to intend to use modern contraception (OR=1.68, p=0.041)**.

Female adolescents were asked whether they knew about 10 different contraceptive methods (e.g., oral contraceptive pills, condoms, etc.). By endline of Year 1, adolescent girls ages 10-14 years in the control group knew 3.4 out of a possible 10 modern contraceptive methods on average. Conversely, adolescent girls of similar ages in the intervention group knew 4.5 out of a possible 10 modern contraceptive methods on average. However, this difference in knowledge between groups was not statistically significant (p=0.211). Older adolescent girls (ages 15-19) on average knew more contraceptive methods than the younger adolescents (6.0 methods in the control group and 6.2 methods in the intervention group), but this difference between control and intervention groups was not statistically significant (p=0.502).

At baseline of Year 2, the average number of modern methods known to all girls ages 10-14 in the overall sample was 3.3 methods out of a possible 10, and among all girls ages 15-19, 5.1 known methods. By endline of Year 2, ATWA girls in both age groups had a larger increase in known methods as compared to girls in the control group (ATWA: 8.9 methods vs. 6.0 methods known among controls among girls ages 10-14 years ($p<0.001$) and 8.1 among ATWA girls versus 6.8 methods known among controls within the 15-19 year old age group ($p<0.001$)). This demonstrates ATWA's strong positive impact on knowledge of contraceptive methods among both younger and older female adolescents.

Adolescent marriage & views on child marriage

At endline of Year 1 and Year 2, a large majority (87.8% and 94.2% respectively) of respondents strongly agreed that early marriage often has harmful consequences for a girl's health, psychological wellbeing and education. In Year 1, more adolescents in the ATWA intervention strongly agreed that child marriage had harmful consequences for a girl's health than adolescents in the control group, but the difference was not statistically significant (88.5% versus 87.0% of controls ($\chi 2$ $p=0.093$)). In Year 2, more adolescents in the ATWA intervention strongly agreed that child marriage had harmful consequences on a girl's health than adolescents in the control group (96.8% versus 92.0% of controls ($\chi 2$ $p=0.005$)), an effect that was highly statistically significant.

At endline of Year 1 and Year 2, a majority (72.1% and 71.9% respectively) of adolescents strongly agreed that they have the right to choose whether, when and with whom they want to marry. In Year 1, 74.1% of the ATWA adolescents strongly agreed compared to only 70.1% in the control group ($\chi 2$ $p=0.006$), indicating positive intervention effects on this



indicator. Similarly in Year 2, more ATWA adolescents than control group adolescents held this view (78.6% versus 65.5% of controls) (χ2 p<0.001)), indicating positive intervention effects.

Peer education (PE) also had positive impacts on this indicator; 65.0% of adolescents in the intervention group who did not receive PE strongly agreed that they had the right to choose the conditions of their marriage as compared to adolescents who *did* receive PE (84.5%) (χ2 p<0.001).

In Year 1, 67.0% of ATWA adolescents compared to 59.6% of adolescents in the control group strongly agreed that they could refuse an unwanted marriage as arranged by their parents (χ2 p=0.004), with a statistically significant intervention effect. At endline of Year 2, more ATWA adolescents than control group adolescents strongly agreed they could refuse if their mother/father wanted to marry them off, with 53.1% of controls stating they strongly agreed versus 70.3% among ATWA adolescents strongly agreeing they could do so (χ2 p<0.001).

Peer education also had positive impacts on this indicator, with 55.2% of ATWA adolescents who did not receive PE strongly agreeing they could refuse an unwanted marriage as compared to 74.9% of ATWA adolescents who *did* receive PE strongly agreeing they could refuse if their parents wanted them to get married (χ2 p=0.001).

By endline of Year 1, more ATWA adolescents strongly agreed that they could seek help from a trusted adult to prevent being married (74.1% versus 69.4% of controls) (χ2 p=0.005)), indicating positive intervention effects. In Year 2, ATWA adolescents were also more likely to strongly agree at endline that they could seek help from a trusted adult to prevent being married (76.0% of ATWA adolescents as compared to 63.4% of adolescents in the control group (χ2 p<0.001)).

Peer education also had a positive impact on this indicator, with 57.0% of ATWA adolescents who *did not* receive PE strongly agreeing that they could seek help from a trusted adult to prevent an unwanted arranged marriage as compared to ATWA adolescents who *did* receive PE (82.9%) (χ2 p<0.001).

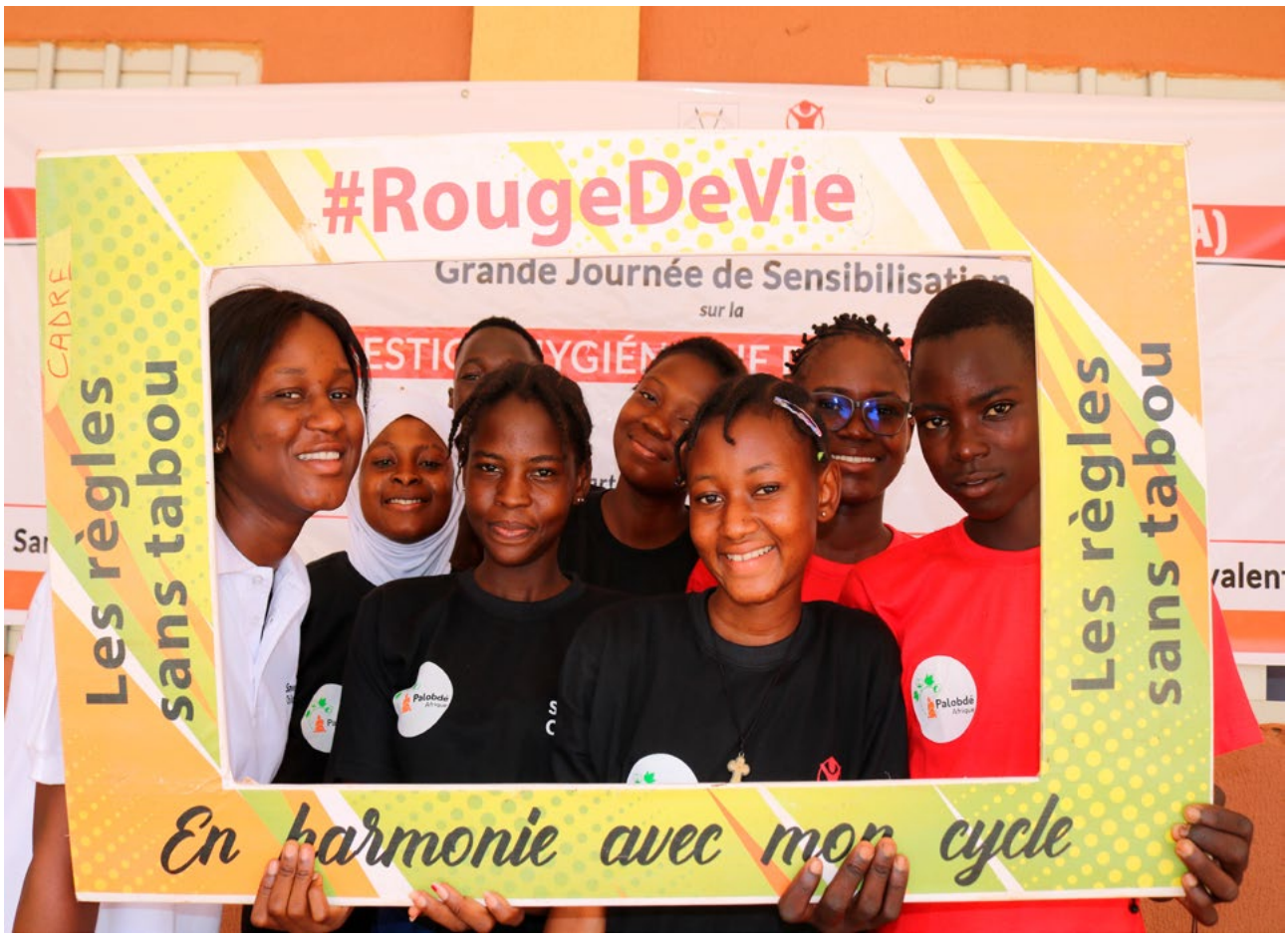


Gender attitudes and norms

The proportion of adolescents with gender equitable attitudes was evaluated based on the Gender Equitable Attitude scale, a composite measure of six items assessing the degree of positive attitudes surrounding gender equity in domains such as household chores, education, and males having the final say in household decision-making.

At endline of Year 1, the average score of all respondents on the Gender Equitable Attitude Scale was 3.1 out of 5 (the average of responses across all items on 5-point Likert scales). Moreover, the average score for adolescents in the control group and the ATWA intervention group was 3.1 (p=0.903), indicating no intervention effect in Year 1.

At endline of Year 2, ATWA adolescents had higher average scores than adolescents in the control group (3.9 versus 3.1 among controls (p<0.001)). This intervention effect was particularly strong for boys who had lower agreement than girls at baseline, but who matched ATWA girls' levels by endline (ATWA boys' scores at endline: 3.9, girls' scores: 4.0). Boys' average scores in the control group stayed the same over time (2.9 at baseline and 2.8 at endline) as compared to ATWA boys' average scores who increased an entire point on the 5-point scale (3.0 at baseline to 3.9 at endline (p<0.001). This indicates that the ATWA intervention was particularly useful in impacting boys' attitudes towards gender equitable behaviors and decisions.



Attitudes on Gender-Based Violence (GBV)

At endline of Year 1 and Year 2, the majority of respondents[5] agreed that no one has the right to force another person to engage in sexual activity (85.0% and 93.4% respectively). In Year 1, 87.6% of the adolescents in the ATWA intervention agreed to this statement compared to 82.4% of the adolescents in the control group ($\chi 2$ p=0.158). In Year 2, more adolescents in the ATWA intervention agreed with this statement as compared to to adolescents in the control group (95.9% versus 91.2%), and this difference was statistically significant ($\chi 2$ p=0.043).

Although a large majority of adolescents agreed that no one has the right to force another person to engage in sexual activity, somewhat contradictorily, fewer adolescents strongly agreed that it is unacceptable to use pressure or force to persuade a *girlfriend* to have sex if she didn't want to. Year 1 analysis showed that 61.7% of adolescents in both the intervention and control group strongly agreed with this statement (no intervention effect). In Year 2, results showed a positive intervention effect, with a larger proportion of adolescents in ATWA agreeing that it is unacceptable to pressure or force a girlfriend to have sex (68.7% among ATWA participants versus 62.4% among controls ($\chi 2$ p<0.001)).

Adolescents were also asked about whether it is okay for a man to beat his wife for disobeying his order. At endline of Year 1, 57.6% of the adolescents in the intervention group strongly disagreed with this statement compared to the 54.7% of respondents in the control group, however this difference between the two groups was not statistically significant ($\chi 2$ p<0.106). At endline of Year 2, only 34.9% of adolescents in the control group strongly disagreed that it's ok for a man to beat his wife, whereas 62.7% of ATWA adolescents strongly disagreed ($\chi 2$ p<0.001). This indicates a strong intervention effect on attitudes towards GBV.

5 Country offices in Mali and Niger suggested GBV-related questions not be asked of in-school adolescents. As such, responses to these questions represent Burkinabe adolescents and out-of-school adolescents ages 10-19 in Niger. This also means that peer education was not provided on topics surrounding gender-based violence and no supplemental analyses on peer education effects are included in this section.

Self-efficacy

A number of survey items were included to assess 11 different types of adolescents' self-efficacy: from self-efficacy more generally to self-efficacy surrounding puberty/change, unwanted sexual attention, practicing safe sex, and ability to resist peer pressure. By endline of Year 1, positive intervention effects were found in several self-efficacy measures. Notably, when asked if they could refuse unwanted sexual attention from a stranger, 82.9% of the ATWA adolescents strongly agreed compared to 77.5% of the adolescents in the control group ($\chi 2$ $p<0.025$). When asked about the ability to insist on condom use, 63.2% of the ATWA adolescents strongly agreed while only 54.2% of the adolescents in the control group strongly agreed that they could do so ($\chi 2$ $p<0.001$). Intervention effects were also seen in self-efficacy to use contraception, with 66.5% of ATWA adolescents and 56.3% of adolescents in the control group strongly agreeing they could use contraception ($\chi 2$ $p<0.019$). Year 1 results also showed intervention effects on adolescents' ability to resist negative peer pressure; 73.5% of ATWA adolescents strongly agreed they could do so compared to 67.9% of adolescents in the control group ($\chi 2$ $p<0.018$).

In Year 2, we found positive intervention effects in adolescent self-efficacy on all of the self-efficacy measures. For example, 95.6% of the ATWA adolescents strongly agreed that trying hard can improve one's situation in life compared to 86.9% of the adolescents in the control group ($\chi 2$ $p<0.001$). Regarding puberty, 81.6% of ATWA adolescents compared to 66.4% of adolescents in the control group stated they felt confident in asking questions about puberty to a trusted adult ($\chi 2$ $p<0.001$). A higher proportion of ATWA adolescents than controls said they could tell a trusted adult about any unwanted sexual attention they had experienced (75.2% versus 62.0% in the control group, ($\chi 2$ $p<0.001$)). More ATWA adolescents also expressed confidence in being able to refuse unwanted sexual intercourse with a partner (89.3% versus 79.6% in the control group ($\chi 2$ $p<0.001$)), and to insist on using condoms with a sexual partner (72.4% versus 56.0% in the control group ($\chi 2$ $p<0.001$)). Additionally, there was a greater proportion of ATWA adolescents compared to adolescents in the control group who felt they can make their own decision about their body (76.8% versus 65.1% respectively strongly agreed, ($\chi 2$ $p<0.001$)). Lastly, ATWA adolescents reported greater resistance to negative peer pressure with 80.0% strongly agreed compared to 70.2% in the control group ($\chi 2$ $p<0.001$).

Community support for ASRHR

Community support is essential for creating an enabling environment for adolescents to engage in CSE programming, especially in conservative settings such as the Liptako Gourma region of West Africa. In the Year 2 evaluation, the survey was expanded to include questions assessing community support for life skills education and sexual and reproductive health services for adolescents. Survey items distinguished between: 1) the type of community leader (i.e., religious, school, and other community leaders such as chiefs, mayors, or city council members); 2) the type and topic of CSE (i.e., puberty/LSE information; information about contraception; and adolescents' access to SRH services); and 3) the age group of adolescents receiving the SRHR information/services (i.e., upper primary (ages 10-14) versus secondary school (ages 15-19)).

Overall, adolescent respondents felt that their community leaders supported all three types of LSE/SRHR information and SRH services, though school leaders were viewed as being more supportive of LSE/SRHR than religious leaders, and puberty information was viewed as less controversial than access to SRH services. All adolescent respondents (regardless of their age or sex) felt that their school and religious leaders were more supportive of older adolescents (ages 15-19) than younger adolescents (10-14) receiving LSE/SRHR information and SRH services. For example, only 59% of adolescents felt that religious leaders in their communities were supportive of adolescents ages 10-14 years accessing SRH services. This is compared to 92% of adolescents who felt that school leaders were supportive of older adolescents (ages 15-19 years) learning about puberty and receiving LSE.





Conclusion

Across both years, ATWA's outcome evaluation findings showed many significant improvements in SRHR-related knowledge and attitudes among both very young (10-14 years) and older adolescents (15-19 years). Findings demonstrate that participation in this school- and community-based intervention was associated with adolescents being more likely to:

- have accurate knowledge about puberty, menstruation, and STI/HIV prevention and treatment
- know where to seek SRH services
- plan on using modern contraception in the future
- agree with statements reflecting their confidence in being able to handle SRH-related issues (e.g., practicing safe sex, refusing unwanted sexual attention, and asking questions about puberty to a trusted adult)
- have self-efficacy in being able to refuse an unwanted early marriage,
- agree that gender-based violence was unacceptable, and
- hold gender equitable attitudes.

The addition of peer education further strengthened ATWA's impact on SRHR knowledge and attitudes. We also found stronger intervention effects in Year 2 than in Year 1. This is likely because most of the teachers and mentors were involved in ATWA in both years of implementation. The teachers and mentors gained experience with the ATWA curricula in Year 1 which then translated into improved quality of teaching and small group facilitation in Year 2. Teachers and mentors were able to more effectively implement ATWA, resulting in an increased 'dose' of the program. In addition to these facilitator-level changes, school leadership and education officials were already familiar with the ATWA curricula in Year 2, having been sensitized on the program in Year 1, and increased their engagement.

ATWA responds to the need for culturally-adapted SRH education in Mali, Niger, and Burkina Faso. It is an evidence-based program linked to improvements in adolescents' SRHR knowledge and attitudes, both critical pathways to positive SRHR outcomes across the life course.

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