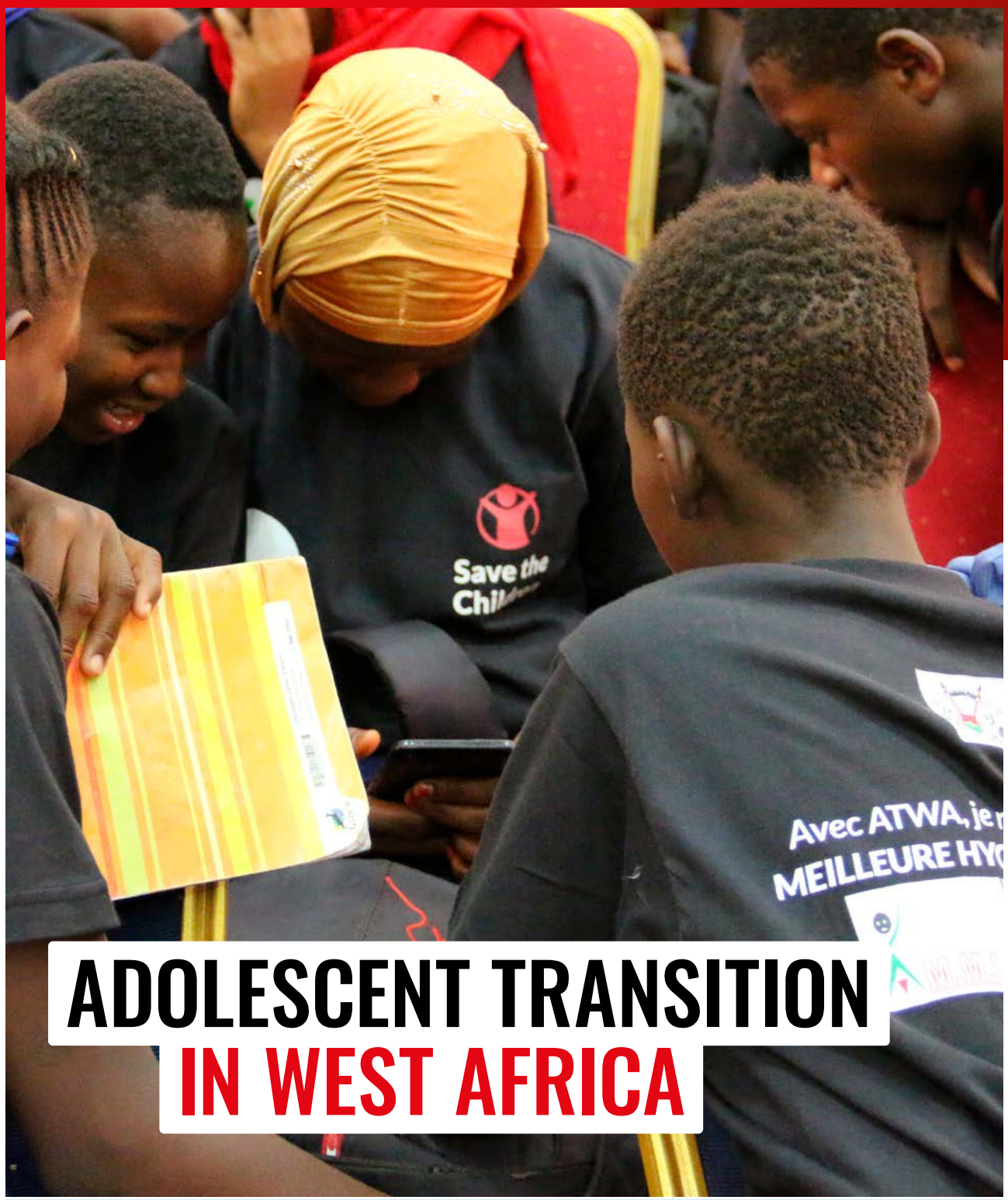


ADOLESCENT TRANSITION IN WEST AFRICA

Reaching Adolescents with Culturally-Adapted Life Skills and Sexual and Reproductive Health Education

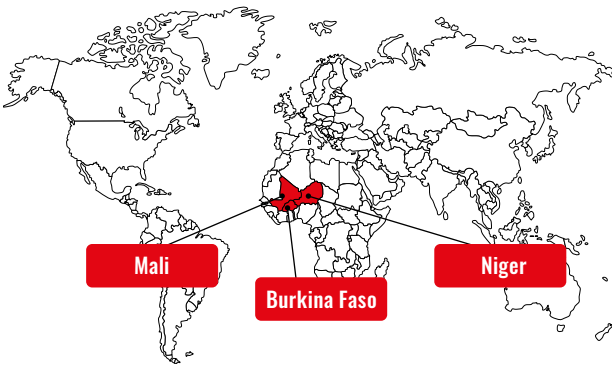
May 2024

GRADE Africa
Save the Children
GEH
Center on Gender Equity and Health • UC San Diego School of Medicine

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 Sexual and Reproductive Health and Rights (ASRHR) perspective, but also challenging from an implementation perspective.

ATWA worked with ministries of education to catalyze the provision of Life Skills Education (LSE) and Sexual and Reproductive Health (SRH) education for adolescents in school and out-of-school settings. The ATWA in-school LSE curricula were tailored and adapted for each country context by the Ministries of Education in Burkina Faso, Niger, and Mali in collaboration with various agencies and further adapted in collaboration with Save the Children. 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

Impact Evaluation

Research partners at the Center on Gender Equity and Health at the University of California San Diego (UCSD-GEH) and GRADE Africa implemented a longitudinal cluster randomized trial with a comparison group, with the aim of assessing all indicators under Outcome 1. (Outcome 2 was assessed separately in close collaboration with Health authorities). This study design gathers data from the same adolescents at baseline and endline from both the intervention and control groups. This study design is one of the strongest available to assess ATWA's impact on ASRHR knowledge, attitudes, intent, and behaviors among adolescents.

Data collection for the Year 2 ATWA evaluation occurred in November-December of 2022 (baseline, n=2,113 adolescents) and in May-June of 2023 (endline, n=1,998). The evaluation had a high follow-up rate from baseline to endline (94.6%), with most, but not all, adolescents followed over time.

Survey Tool Development

UCSD-GEH worked with Save the Children to review and adapt items from existing validated survey tools[1], 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;
- Female Genital Cutting (FGC).

Analyses

UCSD-GEH used a difference-in-differences statistical approach within hierarchical mixed effects regression models to account for intracluster correlation, or the similarities on outcome measures within individuals and schools/communities over time.

UCSD-GEH also conducted omnibus chi-square tests ($\chi 2$) with endline data among adolescents in the ATWA intervention to test for statistically significant differences in outcomes between adolescents who received peer education and those that did not.

We highlight findings where peer education positively impacted an ASRHR outcome with a peer education icon (shown at left). **Additional methodological detail can be found in the final report[2] here.**

Year 2 Results in Brief

Demographics

The average age of respondents across the three intervention countries (Burkina Faso, Mali, Niger) at the time of the endline survey was 13.3 years (min 9 years, max 19 years), with 73.9% (n=1,477) of respondents between the ages of 10-14 years and 26.1% (n=521) between the ages of 15-19 years. This oversample of younger adolescents was in line with the ATWA program design of reaching more younger than older adolescents. There was an even balance of boys and girls in the sample, with 981 boys (49.1% of the total sample) and 1,017 girls (50.9%). The vast majority (98.5%) of adolescents were unmarried. Among married adolescents, only one was between the ages of 10 and 14 years. Finally, a relatively small proportion of adolescents in the sample reported being sexually active in the past 12 months: among the 508 adolescents ages 15-19 included in the survey sample at endline, 12.4% (n=63) stated they had been sexually active in the past 12 months.

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." 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% to 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).**

1 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).

2 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.
- atwa-y2-baseline-report_final.pdf (ucsd.edu)
- https://resourcecentre.savethechildren.net/pdf/ATWA-Evaluation-Report.pdf/



Menstruation

Accurate knowledge and beliefs about menstruation were low among all adolescents (control and intervention) at baseline, with only around 15% of boys and 19% of girls correctly answering at least two of three 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. 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). Among the 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 2.82 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 STI risk, prevention and treatment, boys and girls were asked the following 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. There was a significant increase in knowledge among adolescents in ATWA, relative to those in the control group. Adolescents in the control group saw a 1.6 percentage point increase in correct knowledge, from 55.5% at baseline to 57.1% at endline. On the other hand, ATWA adolescents saw a 16.6 percentage point increase, from 53.9% at baseline to 70.5% at endline. This corresponded to **ATWA adolescents being 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).

Participation in the ATWA intervention was also associated with improved knowledge of where to go to get tested for HIV, for STI treatment, and where to get contraception (birth control) and condoms. 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. ATWA adolescents who 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 ($\chi 2$ p=0.029).

Contraceptive methods

When asked whether they planned to use modern contraceptive method options in the future, 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).**

Adolescents' views on child marriage

At endline, a large majority (94.2%) of respondents strongly agreed that early marriage often has harmful consequences for a girls' health, psychological wellbeing and education. More adolescents in the ATWA intervention strongly agreed that child marriage had harmful consequences than adolescents in the control group (96.8% versus 92.0% of controls ($\chi 2$ p=0.005)), indicating positive intervention effects on this indicator.

At endline, a majority (71.9%) of all adolescents strongly agreed that they have the right to choose the conditions of their marriage (in other words, whether, when and with whom they want to marry), and more ATWA adolescents than control group adolescents held this view (78.6% versus 65.5% of controls) ($\chi 2$ 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%) ($\chi 2$ p<0.001).



At endline, 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 that they could refuse their parents about an unwanted marriage versus 70.3% among ATWA adolescents strongly agreeing they could do so ($\chi 2$ 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 their parents 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 ($\chi 2$ p=0.001).

ATWA adolescents were also more likely at endline to strongly agree 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 ($\chi 2$ 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%) ($\chi 2$ 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 of six items assessing degree of acceptance surrounding gender equity in domains such as household chores, education, and males having the final say in household decision-making. At endline, the average score of all respondents on the Gender Equitable Attitude Scale was 3.5 out of 5 (the average of responses across all items on 5-point Likert scales). At endline, 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 at baseline, but saw greater increases in scores on gender equity by endline. 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, the vast majority of all respondents[3] agreed that no one has the right to force another person to engage in sexual activity (93.4%). More adolescents in the ATWA intervention agreed with this relative to adolescents in the control group (95.9% versus 91.2% in the control group ($\chi 2$ p=0.043)). Interestingly, a smaller proportion of adolescents strongly agreed (65.4% in the overall sample) that it is unacceptable to use pressure or force to persuade a girlfriend to have sex if she didn't want to, with ATWA having a positive intervention effect on levels of agreement that it is unacceptable to pressure or force a girlfriend to have sex (68.7% versus 62.4% (p<0.001)).

At endline, a majority of all respondents (52.0%) felt it was sometimes ok for a man to beat his wife for disobeying his orders, though there was a strong intervention effect on this indicator. 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 adolescents in the intervention group strongly disagreed ($\chi 2$ p<0.001).

Self-efficacy

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. We found positive intervention effects in adolescent self-efficacy on all 11 of the self-efficacy measures. For example, 95.6% of the ATWA adolescents strongly agreed that trying hard can improve your 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 for life skills education and sexual and reproductive health services for adolescents was essential for creating an enabling environment for adolescents to engage in ATWA programming. Survey items were included to assess adolescents' perceptions of their community leaders' support for LSE and SRH services. We 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 of support for adolescents (i.e., puberty/LSE information; information about contraception; and adolescents' access to SRH services); and
3. the age group of children receiving the information/services (i.e., those in upper primary school versus those in secondary school).

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

3 Country offices in Mali and Niger suggested GBV-related questions not be asked of in-school adolescents. As such, the responses to these questions only represent the 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.

Implications for Programs/Research

Overall ATWA's Year 2 outcome evaluation findings show many significant improvements in SRHR-related attitudes and knowledge among adolescents of all age groups. These changes may be harbingers of future shifts in ATWA long-term outcome measures as adolescents progress in their pubertal development and grow into young adults. Additional rounds of data collection could examine this longitudinal connection between attitudes and knowledge in adolescence on behavior and SRHR outcomes into young adulthood. Further rounds of data collection could also provide insights into whether ATWA's immediate intervention effects on knowledge and behavior are sustained over time.



GRADE Africa

Save the Children

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