Co-creating gender-transformative interventions for adolescent mental, sexual, and reproductive health and rights: Influence of context and actors on process and content in Niger, Ghana, and Burkina Faso

Running title: Co-creation of gender transformative interventions

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Abstract

This paper explores how context and actors influence processes and content efforts to co-design gender transformative primary health care systems for adolescents in West Africa and draws out lessons for co-creation of effective adolescent mental, sexual, and reproductive health and rights (AMSRHR) interventions in low and middle income countries. The study design was a multi-country case study with the case defined as "processes, context, actors and content of co-creation of gender-transformative adolescent mental, sexual, and reproductive health interventions". Data are from mixed qualitative sources in two research phases: a situational/context analysis and co-creation/data validation workshops. Findings reveal that while national AMSRHR policies promote gender-sensitive approaches, actual programmes remain largely gender-neutral or gender-blind. Important considerations in co-creating AMSRHR interventions include how to effectively engage powerful stakeholders with diverse positions, pay attention to gendered power imbalances in co-creation processes, and raise critical consciousness of complex AMSRHR issues through non-threatening, participatory approaches.

Keywords: West Africa; Gender Transformative; Sexual and Reproductive Health; Mental Health; Co-Creation; Adolescents

Introduction

Adolescence is a critical period marked by physical, cognitive, emotional, and social development and role transitions.[1,2] Globally, more young people are experiencing puberty and initiating sex at an early age, and rates of early pregnancy remain high.[3,4]

This especially poses health risks for adolescent girls, such as complications during pregnancy and childbirth, exposure to sexually transmitted infections, and unsafe abortions, while also leading to higher rates of school dropout, reduced economic opportunities, and a cycle of poverty and gender inequality that adversely affects girls' education and future prospects.[5,6] Additionally, mental health conditions, including anxiety, depression, stress, and suicidal behaviour, are also well-documented problems for adolescents globally. This can be partly attributed to the fact that adolescence is a period of social transition accompanied by new stressors. If left unaddressed, these conditions can greatly impact the physical health and overall wellbeing of adolescents in later years.[7] Recent studies have found the intersections between adolescent mental, sexual, and reproductive health and rights (AMSRHR) to be profound and that these intersections can adversely affect adolescent wellbeing.[8,9]

In West Africa, adolescent mental health (AMH) remains marginalized, and most adolescent health programming is focused on adolescent sexual and reproductive health and rights (ASRHR). Moreover, despite numerous policies, programmes, and interventions aimed at addressing AMSRHR challenges, adverse AMSRHR outcomes for adolescents remain.[10,11] Many of the AMSRHR challenges faced in West Africa are linked with gendered norms that are produced and practiced through socialisation.[12-19] Research increasingly suggests that evidence-based, gender-transformative approaches to the design and implementation of interventions can lead to improvements in AMSRHR outcomes. [20-22] Gender transformative approaches have been conceptualised as approaches that "*address the root causes of gender-based health inequities through interventions that challenge and redress harmful and unequal gender norms, roles, and unequal power relations that privilege men over women*."[23] Despite the fact that gender transformative interventions for adolescent wellbeing do exist, many of these interventions do not engage youth in co-creation processes. This results in a lack of adolescent perspective and voice in the design of interventions pertaining to their wellbeing.[24,25]

Co-creation, a participatory approach that actively involves end-users like adolescents in the design of health interventions, has gained recognition as a promising approach to addressing intractable health challenges.[26] Vargas et al.[27] make the distinction between co-production and co-design, which they situate within the overarching concept of co-creation, with co-creation referring to using the most participatory process in all project stages. Many authors agree that co-creation, co-design, and co-production processes have the potential to result in solutions that are more likely to reflect the lived experiences and needs of end users and their communities, thus improving the effectiveness and sustainability of interventions.[28,27]

Both co-creation processes and gender transformative approaches are inherently complex and require careful navigation of larger sociocultural, economic, and political issues, as well as stakeholder positions. A clear understanding of the context within which co-creation processes and interventions are being implemented and the actors involved is therefore essential in order to design relevant interventions that improve adolescent health.

There have been studies in Nigeria, Malawi, South Africa, and India that have examined researchers' experiences in using specific co-creation approaches with adolescents to improve access to SRHR, such as action learning and human-centred design.[29,30,31,32] The impact of cultural, situational, structural, and environmental

contexts and actors on co-creation processes to design gender-transformative adolescent AMSRHR interventions in West Africa and the content of resulting interventions remains an underreported area.

Research questions and objectives

Our overall research question is: how have context and actors influenced processes and content of efforts to co-create gender transformative Adolescent Mental, Sexual, and Reproductive Health and Rights (AMSRHR) Interventions in West Africa? Within the framework of this overall research question, our specific research questions were: What are the contexts within which AMSRHR interventions are embedded in West Africa (Niger, Burkina Faso, and Ghana), and to what extent are they gender transformative? Who are the actors and stakeholders in AMSRHR, and what are their positions in relation to gender and gender transformative programmes and interventions? How do these contexts and actors influence the processes for engaging adolescents and other key stakeholders (actors) in the co-creation of potentially gender transformative AMSRHR interventions? How have the interactions between context, actors, and processes influenced the type(s)/content of the co-created interventions? Ultimately, we aim to draw out lessons about the co-creation of gender transformative adolescent health interventions within the context of low and middle income countries.

Theoretical and Conceptual Framing

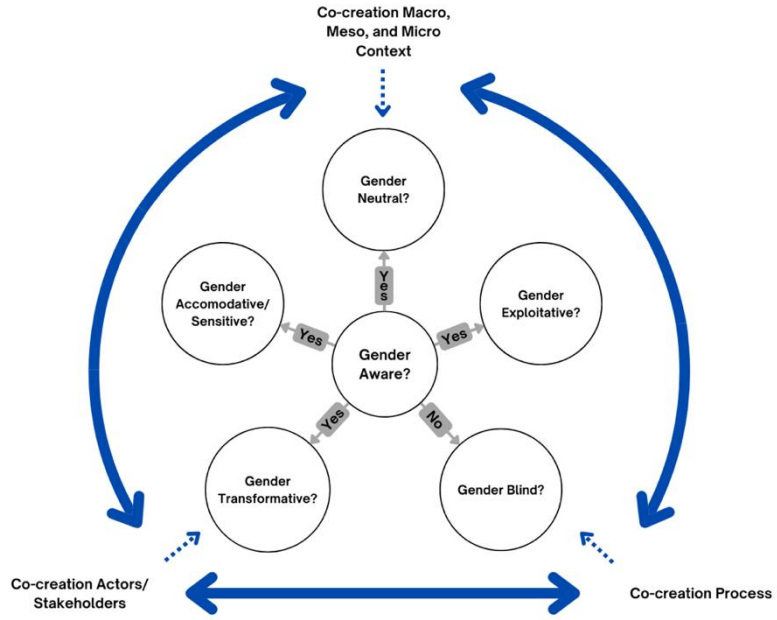

Figure 1 Conceptual Framework guiding the analysis

To help structure our exploration and analysis, we drew on and adapted two already existing theoretical concepts and frameworks in the literature. Specifically, we drew on ideas in Rolleri's [33] gender and sexual health series and Walt and Gilson's health policy analysis triangle of context, actors, processes, and content. Our modification of the

framework described by Caro and Rolleri and the integration of this framework and the policy analysis triangle is summarised as Figure 1 and explained below.

Drawing on Caro's [34] continuum of gender programming, Rolleri describes four categories of gender programming labelled as gender exploitative, gender blind, gender accommodating, and gender transformative. Gender exploitative programmes and interventions recognise, but do not try to question or transform systems, norms, and practices in relation to gender; but rather, take advantage of the status quo in terms of existing roles, norms, and systems. Even where existing systems are harmful, gender exploitative programmes and interventions will use and reinforce them to achieve desired programme goals. Gender blind or neutral programmes and interventions ignore the issue of gender, whether intentionally or unintentionally, and may or may not necessarily do harm. Gender accommodating or sensitive programmes and interventions recognise existing gender norms and respond by trying to limit harmful impact without necessarily transforming norms and underlying drivers of the norms. Gender transformative programmes and interventions recognise gender norms, raise awareness about unhealthy norms, question the costs of adhering to these norms, and try to replace them with more equitable and healthy norms.

In Caro's framework, these four categories are described as a continuum. We, however, think they are more of categories with a range of possibilities within each category. Thus, health systems, programmes, and interventions can have varying degrees of being gender-blind, neutral, exploitative, or transformative. We also felt there is a category of gender awareness, the opposite of which is gender blindness. In gender awareness, the issues of gender, to varying degrees, are recognised and known. In gender blindness, they are not recognised and known.

We also felt gender blind and gender neutral, which are combined in Caro's framework, are each a unique category. It is possible to be aware of gender issues (gender aware) but choose to be non-mobilised or neutral in the application of this awareness. It is a bit akin to a powerful stakeholder who knows about and could react to and engage with an issue but chooses to be non-mobilised and does not engage or support any particular direction in a policy process.

We also felt that co-creation is akin to the policy and programmes formulation design stage of the public policy process. We therefore drew on Walt and Gilson's [35] health policy analysis triangle framework of actors, context, processes, content, and their interaction as contributing to explain the evolution as well as the outcome of policy processes. In our case study, the processes and outcome of interest that actors, context, processes, and content potentially influence is the how and why of co-creation processes and the extent to which the outcome of these processes is fostered towards more gender transformative health system design. Thus, in looking at gender transformation and co-creation processes, it is important to explore the extent to which context, actors, and processes are gender aware, blind, neutral, or transformative and how these influence content and vice versa.

We defined context as any macro (national and global), meso (sub-national), or micro (community, household, and individual) influences on adolescent mental, sexual, and reproductive health and rights (AMSRHR) in Niger, Ghana, and Burkina Faso. We interpret context as acting across these three interlinked levels. The macro level includes consideration of national and international policies and agreements and a country's economic base, political institutions, and demographic structures. The meso-

level includes institutional/organisational policies, culture, and practices. Individual and interpersonal contexts are covered under the 'micro-level' which considers values, perspectives, knowledge, and behaviour. The micro level reflects how overarching macro and meso-level contexts affect ASRHR and AMH, and adolescents' and other stakeholders' (including frontline providers', parents', etc.) own practices and experiences within the dynamics of the larger social worlds that they are embedded within.

Methods

Study design

The study design was a multiple case study of three West African countries – Niger, Ghana, and Burkina Faso. The case definition was "the processes, context, actors, and content of co-creation of gender-transformative adolescent mental, sexual, and reproductive health interventions."

Study sites

In all three countries, the study sites were purposively selected for convenience and accessibility as regions and districts where the research group was already involved in research exploring primary health care policies and systems and efficiency in the production of adolescent mental, sexual, and reproductive primary health care. The study sites in Burkina Faso were the Hauts-Bassins and Centre-West regions; in Ghana, they were La-Nkwantanang Madina, Ningo Prampram, Ga East, and Shai Osudoku districts of the Greater Accra region; in Niger, they were Niamey, Maradi and Dakoro.

Study population /participants and sources of data

Data were from mixed qualitative sources in two research phases with an overlap between the phases. Phase 1 was a situational and context analysis involving the collection and analysis of data to study the context and existing situation of adolescent mental, sexual, and reproductive health and rights actors, policies, and programmes in the study setting. Phase 2 consisted of multiple workshops to share research findings and co-create interventions with stakeholders.

Data collection methods

Phase 1 – Situational and contextual analysis

The contextual analysis involved mapping stakeholders and documenting adolescent sexual and reproductive health issues, values, social norms, power, practices, and perspectives of stakeholders, as well as facilitators and barriers to adolescent and community engagement. Data was collected between 2021 and 2023 using desk reviews of legislative, policy, and administrative documents relevant to adolescent health policy, key informant interviews, focus group discussions, rich pictures, and observations with adolescents and other key national and sub-national stakeholders.

Rich pictures are drawings of the way people see a given issue or situation.[36] They were used because visual methods can sometimes capture perspectives and issues better than traditional qualitative methods where issues are not always easily verbalized. Each country team conducted primary data collection with key stakeholder groups using slightly different methods adapted to their unique context.

Co-creation workshops

The second phase (co-creation) involved organising workshops with key stakeholder groups to disseminate and validate preliminary findings and to collectively reflect on the development and formulation of intervention projects. The early co-creation workshops were organised, and data collected between April 2022 and February 2024. The methods used in co-creation and the stakeholders involved in co-creation forums were unique to each context. In both Niger and Burkina Faso, researchers facilitated co-creation by organising a forum attended by adolescent girls and boys, along with parents, education workers, civil society organisations, and health workers. In Ghana, co-creation was done using separate forums of adolescent boys, adolescent girls, and a mixed group of professionals from the health, education, and social services sectors who were focal persons engaged in adolescent health at the district levels. The specific methods used in the co-creation workshops, including the number of workshops, the composition of adolescent and other adult participants, and the methods used to jointly rank and prioritise interventions, are described in Table 1.

Data analysis

To analyse the data, each country research team, led by the Principal Investigator (LW, AD, and MY), re-read their field diaries and reports to immerse themselves in the data they had collected on the situational and contextual analysis and the co-creation process. A common Excel-based data collection template was developed by the lead and second authors (LW and ND) and then shared with each country team to facilitate the grouping of relevant data under each research question. Following this process, members of a core cross-country team met through several in-person and online meetings to re-analyse the data to identify specific themes emerging under each research question.

Ethical approval

Ethical approvals were obtained from the Ghana Health Service Ethics Review Committee No. GHS-ERC 011/04/22, Comite D'Ethique pour la Recherche en sante No. 2022-08-176 (Burkina Faso) and Le Comite National D'Ethique pour la Recherche en sante Reuni a Niamey (Niger) No 14/2022/CNERS.

Results

We structure our presentation of results by research question starting with an exploration of macro, meso, and micro context and the extent of its gender-transformativeness and actors and stakeholders and their positions in relation to gender

transformative ASRMH programmes and interventions. Since actors and stakeholders and their positions are embedded in and interlinked with our description of the macro-meso and micro contexts, we integrate our discussion of context and stakeholders together to avoid duplication and overlap. Next, we describe strategies used to engage adolescents and other key stakeholders and the impact on co-creation processes in their context. We end with a description of the early output of the co-creation process and how and why context, actors, and processes have influenced the type of intervention being co-created.

Macro, meso and micro contexts and stakeholder positions

Macro-level

At the macro level, in all three contexts, the wording of national-level health policies and strategic plans suggests a commitment to gender-sensitive or gender-accommodating AMSRHR programmes. However, in practice, most programmes remain gender-neutral, at best. Sexual and Reproductive Health and Rights (SRHR) programmes and interventions primarily target adolescent girls, often neglecting the specific needs of adolescent boys. Compared to SRHR, Mental Health (MH) is marginalised in both policy formulation and implementation of programmes and interventions. There is limited recognition within policy and programming of the ways gender influences adolescent mental health experiences and care-seeking behaviours. Adolescent boys and girls and their communities in Niger, Ghana, and Burkina Faso play an inadequate role in AMSRHR policy agenda setting, formulation and implementation, despite the fact that they are the end users of these initiatives.

Meso-level

Health systems across all three countries operate in low-resource contexts, where multiple powerful actors, each with varying levels of influence and differing positions, shape adolescent health policy and implementation. These dynamics often weaken efforts to effectively implement adolescent health programmes, particularly those related to SRHR. Across the board, conservative sociocultural norms around adolescent SRHR have led to conflicting institutional policies and practices surrounding SRHR, particularly between development partners, health agencies, educational actors, and religious and traditional leaders. Suspicion of global SRHR agendas among powerful local stakeholders often results in resistance to externally driven SRHR interventions.

Micro-level

At the micro level, boys and girls face unique AMSRHR needs. Yet, social norms related to SRHR impose more burden on women and girls than men and boys. Adolescent sexuality is discouraged, and communities often use social control mechanisms to discourage unmarried adolescents, especially girls, from being sexually active and using family planning. A summary of the contexts within which AMSRHR are embedded in Niger, Burkina Faso, and Ghana, and the extent to which they are gender transformative is provided in Table 2.

Processes for engaging adolescents and other key actors in co-creation

We reflected on our multileveled analysis of the contexts, actor positions, and their extent of gender transformativeness across the three settings when planning our approaches to co-creation of AMSRHR interventions. Against this background, important considerations in organising co-creation forums included how to effectively engage powerful stakeholders with diverse positions on AMSRHR-related issues, build rapport and trust between these stakeholders and researchers, and between adolescents and adults, and pay attention to gendered power imbalances in co-creation processes.

Differences in values, interests, and positions of stakeholders

In Niger and Burkina Faso, the religious context had a particular influence on approaches to co-creation. In Niger, religious leaders were initially identified as stakeholders in the process. However, the team eventually decided not to involve them, as they had not identified a religious leader who supported or was at least in favor of relatively open dialogue on adolescent sexual and reproductive health (SRHR). There was concern that the potential for varying perspectives to be expressed productively would not be possible. The team deliberately focused on working with allies in the co-creation process, avoiding the presence of opponents who might compromise the creation of a safe space for constructive exchanges with adolescents on sensitive issues. In Burkina Faso, religious leaders took part in co-creation forums; this did not appear to pose any threat of excluding participants with contrasting opinions from the discussions.

The positions of the National Educational Service in Niger and Ghana influenced the engagements between in-school adolescents and researchers in these contexts. In Niger, the implementation of any interventions co-created by stakeholders in schools was not possible due to the ban on sexual and reproductive health activities. In Ghana, the research team held separate co-creation forums for adolescents and adult stakeholders to ensure safe spaces for discussion. In the beginning, the School Health Education Programme's (SHEP) coordinators insisted on accompanying researchers to the adolescent focus groups. Initially, their presence sometimes led to disruptions and uncomfortable moments for the adolescents, especially for girls, who wanted to discuss issues such as abortion and contraceptive use. The request that SHEP coordinators accompany researchers to the adolescent FGD was related to some mistrust about possible conflicting agendas of the research team in relation to ASRHR and school health positionality on ASRHR. The researchers addressed this issue by consistently making it clear there was no intent to push particular value systems or agendas but rather to work together to co-create contextually relevant interventions. The research team focused on building trust and encouraging the SHEP coordinators to observe the research activities quietly (without pushing any agenda) so that in school adolescents could have voice. The coordinators complied with the request to observe quietly and unobtrusively, and this resulted in more candid conversations between researchers and adolescents.

Power imbalances between adolescent girls and boys

In Ghana, co-creation was done with boys and girls separately; this approach was adopted after observing that during a pilot co-creation session with in-school adolescents, the boys primarily dominated the discussions. Separate sessions for boys and girls allowed girls to discuss their perspectives more candidly than would be the case in mixed-gender groups.

In Niger and Burkina Faso, the co-creation forums brought together mixed groups of girls and boys. Aware of the imbalance of power between the sexes in Niger during the field surveys, the researchers identified girl and boy 'leaders' capable of expressing themselves in public and defending their ideas. In addition, prior to the workshop, separate sessions were organised with adolescents of both sexes to explain the nature of their contribution and to help them gain confidence in their role. This prior support, particularly for the girls, boosted their self-confidence and helped to reduce the power gap between the sexes during the co-creation.

In Burkina Faso, researchers carefully selected facilitators who were experienced educational professionals who could effectively guide the discussions between girls and boys.

Using rich pictures to explore adolescent wellbeing

In Niger and Ghana, rich pictures were used as a data collection method with adolescents as a way to gain in-depth information on the situations, challenges, and opportunities in relation to their MSRHR. Rich pictures enabled adolescents to share their perspectives on sensitive topics such as suicide, drug use, child marriage, and abortion and to highlight connections between SRHR and MH issues. Adolescent rich pictures also illuminate the inter-relationships between gendered power relations and poor AMSRHR outcomes, particularly for girls. We provide one example of a rich picture from Niger in Figure 2 below:

Figure 2. Rich picture diagram from adolescents in Niger depicting a father who forces his daughter to marry an older man

Scene 1: The father decides to marry off his daughter to a friend and "doesn't listen to anyone". "But the daughter wants to study for a better life".
Scene 2: The friend says: "Hello, I would like you to give me your daughter in marriage. Here's 5 million". The father replies: "Oh all right my friend, no problem."
Scene3: "The daughter would rather kill herself than live with a man the same age as her father."
Scene 4: "The family cries."
The girl ends her drawing with this slogan: "No to forced marriage!

In Niger, the rich pictures drawn by adolescents were also an important tool for intergenerational dialogue, helping to reduce the power imbalances between adults and adolescents. Prior to the joint co-creation forum organised with both adults and adolescents, the adolescents were brought together in a separate group to discuss the results of the research with the researchers and to draw rich pictures in order to agree on their priorities in terms of AMSRHR. During the joint forum, the teachers reported that the teenagers were disrespectful and were taking drugs on school premises. The teenagers presented rich pictures showing how drugs were sold in front of their school and how they were encouraged by their peers to use them. The discussion around these images enabled the adults to gain a better understanding of the difficulties faced by the teenagers, which led to a more effective co-creation forum.

Interactions and influence between context, actors, processes, and co-creation

The types and content of the areas of intervention that can be co-produced are profoundly influenced by the socio-cultural and institutional contexts in which they take place. Our approach to co-creating interventions in such a context has been to recognise that issues of AMSRHR are complex and highly value-laden. While personal attitudes are easier to change in a short time, shifting gendered ideologies and cultural taboos (which operate on a more sub-conscious level and are embedded within not only individuals but communities and institutions) is a social process that takes time.[37]

Following review of the analysis and observations from the phase 1 as well as the phase 2 data and initial co-creation forums, it appeared that it was critical to find some innovative approaches to enable dialogue, and raise critical consciousness [38] as an initial step in what was clearly going to require long rather than short term effort. Arts-based interventions with youth and their communities effectively engage youth in ways that can promote social consciousness raising and dialogue on complex issues.[39,40] Theatre-based interventions are a compelling tool for engaging populations like youth in a non-threatening manner.

With this in mind, in Ghana and Niger, a Theatre for Development (TfD) based intervention approach was finally settled upon as the approach to address the gendered AMSRHR issues of concern in each context. The playful and imaginative approach of TfD can act to break down stereotypes and subvert the status quo. While we are still in the process of completing co-creation and conducting a process evaluation of our intervention, we envision the intervention to involve the following: Recruit adolescents, health workers, and opinion leaders and raise their understanding of TfD and their critical consciousness of gender norms and AMSRHR issues in their communities; Adolescents and their communities collaboratively develop a script; Performance of the

play in different locations in the community to engage audiences on gender norms and AMSRHR issues.

In Burkina Faso, findings also suggested that awareness raising among adolescents and other stakeholders related to disparities in status between girls and boys, and gendered norms unfavourable to young girls, as well as training professionals to deliver care that meets the needs expressed by both adolescent boys and girls, is needed as an initial step towards more gender transformative primary health care. However, rather than TfD, the team has opted for an intervention focusing on awareness-raising using communication channels adapted to the categories of people targeted as the preferred intervention in context.

Table 1: Summary of methods used and participants in co-creation forums in Niger, Ghana and Burkina Faso

Location	No. of Forums	Methods of Engagement	Type of Participants
Niger	1	Presentation to validate and amend the results, group work by adults and adolescents. Creation of rich pictures by adolescents.	Teenage girls (7) and boys (5) at school Adults: teachers (2), health professionals (12), national associations (2) and NGOs (2) community players (2)
Ghana	8	Validation of findings in a focus group discussion format. Use of rich pictures, policy briefs	Out-of-school adolescent girls (24) Out-of-school adolescent boys (30)
	8	Validation and co-creation survey with close and open-ended questions. Use of rich pictures and policy briefs	In-school adolescent girls (146) In-school adolescent boys (126)
	4	Validation of findings in a focus group discussion format. Use of policy briefs.	Front-line service providers: (education (6) health (18) social services (11)) Parents (15) Community/Religious Leaders (6)
Burkina Faso	1	PowerPoint presentation, policy briefs, focus group discussion, summary, final report	In-school adolescent girls (25) In school adolescent boys (35) Out of school adolescent girls (20) Out of school adolescent boys (10) Parents (18) CSO representatives (20) Health workers (20) Education workers (26)

Table 2: Macro, meso and micro level contexts and stakeholder positions related to adolescent mental, sexual and reproductive health and the extent of their gender transformativeness in Niger, Ghana and Burkina Faso

Level	To what extent are the contexts and positions of key stakeholders' gender transformative?	Examples
Macro (National / International Policies & Political Institutions)	The wording of national level health policies and strategic plans in Ghana and Niger suggests a commitment to gender-sensitive or gender-accommodating adolescent MSRHR programmes. In Burkina Faso, national policies and plans are entirely gender blind. In all three countries, SRHR programmes and interventions primarily target adolescent girls, often neglecting the specific needs of adolescent boys and their roles in the reproductive health of women and girls.	In Ghana, the Adolescent Health Services Policy and Strategy (2016-2020) (AHSPS) describes "gender sensitivity and equity" as one of its guiding principles.[41] In Niger, the Multisectoral National Strategic Plan for Adolescent and Youth Health promotes gender equality.[42] Particular attention is paid to combating gender-based violence, early marriage and teenage pregnancy, in order to guarantee a better future for young girls.[43] In Burkina Faso, national policies and plans such as The Reproductive Health Plan of Adolescents' and Young People do not mention gender,[44] however, Article 8 of the Reproductive Health Act states that all individuals have equal rights and dignity with regard to reproductive health.[45]
	In all three countries, AMH remains marginalised in policy and programmatic efforts, despite institutional support in policy fora. Compared to adolescent SRHR, which receives more policy prioritisation and funding, MH lacks sufficient resources and gender-responsive interventions. In all three contexts, the emotional and psychological stresses associated with early pregnancy, early and forced marriage and gender-based violence are neglected for adolescent girls, despite the fact that these issues have an outsize negative impact on adolescent girls as compared to boys.	For example, in Burkina Faso, there were fifteen (15) national policies/strategies related to adolescent SRHR published during the period 1990-2024. Only four (4) policies/strategies focused on mental health were published over the same thirty-year period. In Ghana and Niger the ratio of national ASRHR policies/strategies: mental health policies/strategies over the same period was 9:2 and 11:2 respectively. In Niger and Burkina Faso, programs addressing girls' mental health problems

		resulting from forced and early marriages and reproductive health complications, are poorly implemented by national adolescent health programmes, although they are prioritised by non-state actors such as NGOs and Development Partners with the support of international funding.
Meso (Institutional Policies, Positions, Culture & Practices)	Conflicts between positions on promotion of adolescent sexual health between education, health and religious institutions	In Ghana, there are conflicts between the Ghana Education Service and Ghana Health Service, particularly related to the provision of education on family planning. In Niger, there is a complete ban on SRHR education in schools. These conflicts arise from the condemnation of sexual activity before marriage. These policies have an outsize effect on girls since they bear the social and reproductive consequences of inadequate access to family planning, including early pregnancy. This resistance to sexual health agendas for adolescents across all 3 countries stems from the views of powerful stakeholders, such as religious and traditional leaders, that sexual health education for adolescents is driven by ideologies and actors promoting LGBTQI+ rights.
Micro (Individual & Interpersonal Contexts- Gender Norms related to ASRHR and AMH)	Both boys and girls with mental health conditions experience stigma, however, adolescent boys and girls have differing experiences of specific mental health conditions.	In all three settings, more boys reported betting and substance abuse as mental health concerns than girls. Substance abuse often serves as a coping mechanism for boys to manage the mental and physical pressures of gendered norms, particularly the expectation to be breadwinners. In contrast, girls' mental health concerns are often linked to their reproductive health, particularly the burden of navigating pregnancies without adequate social support.

	Social and religious norms condemn premarital sex for young women, however, for young men these societal rules are more lenient. While boys' virility is valued, girls face greater social pressure to maintain chastity.	For example, multiple sexual partners are a practice that is normalized for boys and men, while the practice is often considered less acceptable for girls and women and can result in stigma. This stigma can discourage girls from accessing SRHR services, while boys may avoid health-seeking behavior due to societal expectations of masculinity.
	Girls and women are socialised to perceive themselves as inferior to boys and men and to be submissive and responsive to their perspectives.	The lesser financial power held by girls, combined with gendered norms that support men's dominance over women, can limit girls' agency in important decisions related to their SRHR. In Ghana, this is exemplified through the practice of transactional sex and in Burkina Faso and Niger, through the high prevalence of early/forced marriage.

Discussion

This paper presents insights into how contexts and actors and the extent of their gender-transformativeness influence co-creation processes and the content of potentially gender transformative Adolescent Mental, Sexual, and Reproductive Health and Rights interventions in Niger, Ghana, and Burkina Faso. An important lesson for co-creation is the need to understand context and engage as relevant in context rather than with a fixed approach. This is especially so in a highly value-laden issue like adolescent mental, sexual, and reproductive health and rights.

Despite the need for the engagement of powerful stakeholders and the ideal of engaging all relevant stakeholders in co-creation, this is not necessarily always possible, depending on the context. In all three countries – Niger, Ghana, and Burkina Faso – the researchers found that it was difficult, or in a few cases unfortunately impossible, to involve and engage stakeholders with different alignments and viewpoints. The situation and extent of difficulty can vary with the same category of stakeholder group in different contextual circumstances, and it is important to understand stakeholder groups and their positions in context. Sometimes, to make progress, powerful stakeholders who are unwilling to allow the perspectives of other stakeholders to be heard may need to be engaged separately over time rather than as part of mixed groups (as happened in the Nigerien context in this study).

The literature on adolescent SRHR in diverse contexts from high to low and middle income such as the Netherlands,[46] South Africa,[47] India,[31] and Nigeria [29] also highlights how societal norms around premarital sex and taboos around discussions of

sex and family planning are persistent barriers to effective adolescent SRHR programmes.[31,47,46,48] Mbachu et al.,[29] in particular, explain how misalignments between education and health authorities can create significant challenges for the implementation of SRHR interventions in schools. The literature on co-creation and participatory approaches to health research more generally also stress the importance of carefully selecting stakeholders to avoid disruptive conflict and promote productive dialogue and collaboration.[49, 30]

Another lesson we learned is the need to find creative ways of engaging adolescents and giving them the voice and space to express their experiences and perspectives. Researchers in Niger and Ghana found that using the construction of rich pictures by adolescents as a participatory method of situational analysis and expression enabled adolescents to engage positively in the co-creation process and enabled researchers and other adult participants to deepen their understandings of adolescent girls' and boys' AMSRHR perspectives and experiences. Adolescent rich pictures (such as those in Fig 2) highlight girls' and boys' unique AMSRHR concerns and also illuminate the inter-relationships between gendered power relations and poor AMSRHR outcomes, particularly for girls. Similar to the findings of this research, the literature suggests that rich pictures and arts-based methods, more generally, encourage community engagement by providing a space for the negotiation of ideas[50] and helping stakeholders interact with complexity[51] and sensitive issues.[52]

This article also highlights the power dynamics between boys and girls during the co-creation process. Gender dynamics in participatory processes are also a well-documented challenge in the co-creation literature.[32,31] Other studies also point out that gender dynamics often manifest themselves in mixed gender group discussions, where boys tend to dominate, leaving girls reluctant to participate.[53] To counteract these power imbalances, separate gender-specific forums, such as those used in Ghana, are recommended in the literature on gender-sensitive participatory methods.[31] In contrast, efforts to build girls' confidence through pre-engagement activities in Niger and Burkina Faso align with the findings of Longworth and colleagues,[49,] who suggest that empowering girls prior to group interactions can reduce power disparities in participatory research. Yet, despite researchers' efforts to mitigate power imbalances between adults and adolescents, the strategies adopted during co-creation were more gender-specific than gender-transformative. Moving the structure of the forums beyond a simple validation, discussion, and prioritisation exercise could have shifted co-creation activities towards an approach which is more likely to translate into a critical awareness of gender and power and the transformation of unequal relationships and harmful social norms.

Local dynamics, social norms and the specific issues at stake for each stakeholder must shape not only the definition of topical priorities but also the approaches adopted to construct the content of an intervention. Integral to the process of shifting harmful gender norms is moving beyond typical approaches to health education and health promotion[54] to raise critical consciousness of how gendered social structures shape individual and collective well-being.

As the research team analysed the context, actors and processes in the co-creation forums, it became clear that any transformation would require interventions that could enable societal dialogue in ways that are acceptable and that could engage even stakeholders with whom direct dialogue has been difficult. A potential way

forward seems to be the use of Theatre for Development, which is the intervention currently being co-produced in Ghana and Niger.

Theatre for Development can act as more than just a communication tool; it is regarded as a catalyst for social transformation because it combines reflection with action (*praxis).*[55] While we are still in the process of developing and conducting a process evaluation of our TfD-based intervention in Ghana and Niger, we think that such an approach could engage both adolescents and duty bearers to challenge deeply entrenched norms and ultimately foster a more gender-responsive health system.

Study strengths and limitations

The refining and piloting of the TfD intervention that emerged from the analysis presented in this paper is still ongoing. Therefore, the conclusions we draw about the relationships between the contexts, co-creation processes and the content of the interventions and the extent of their gender-transformativeness are confined to the experiences of intervention co-creation only. The research teams are yet to complete the planned six-month pilot and process evaluation of the co-created interventions. Moreover, within the short term time frames of the current research, we will not be able to evaluate impact of the co-designed intervention on AMSRHR and gendered power dynamics across our three country contexts. However, this study has several strengths. First, it adds to the limited literature on co-creation in West Africa; providing insights from one Anglophone (Ghana) and two Francophone (Niger and Burkina Faso) countries. Second, the use of a multiple case study design that includes three West African countries strengthens the generalizability of findings across different socio-economic, socio-cultural and socio-political contexts. Third, each country case analysis triangulates findings from multiple qualitative data sources, improving the validity of the results and conclusions in each context.

Policy and Practice Implications

The lessons learned from our study lead us to make several specific recommendations for improving AMSRHR policy and for efforts to co-create potentially gender transformative interventions for adolescent AMSRHR:

1. There are considerable interactions between adolescent mental health and sexual and reproductive health and rights issues. These interactions are driven by specific gendered norms and expectations. Using synergistic approaches to policies, programs and implementation that avoid fragmenting services and interventions, consider the needs of and involvement of both boys and girls, and pay attention to the interlinkages between adolescent MH and SRHR are critical.
2. Strategies aimed at balancing the participation of adolescents and adults, as well as those that mitigate power differentials between girls and boys, should be considered and integrated into all stages of research and intervention co-creation.
3. The use of arts-based tools and approaches, such as rich pictures in co-creation processes with adolescents, can facilitate communication between generations. In addition, it can also increase young people's openness about sensitive MSRHR issues. These tools and approaches can also be used to explore the links between MSRHR

issues and gendered power relations and can be used to facilitate adolescents' deeper involvement in co-creation processes.

4. It is important to find co-creation and intervention approaches that enable social dialogue and stakeholder engagement to find contextually relevant ways forward to transform systems over the medium to long term rather than using confrontational approaches. Theatre for Development is one such approach we are currently exploring.

Conclusion

A dissonance persists between the contextual realities of gender norms and the ambitions of gender transformative policies, programmes, interventions and research programmes in the West African context (Niger, Ghana, Burkina Faso). To be truly transformative, interventions and co-creation processes need to be tailored to local health systems' contexts and adopt progressive strategies for change that move beyond gender sensitivity, while at the same time working strategically to understand the positions of and build trust and rapport with stakeholders and strengthen adolescent voice and engagement in context.

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