A COMIC, A CARD GAME, AND REAL TALK:

how MSI Mali's peer educators are breaking taboos about adolescent sexuality

OVERVIEW

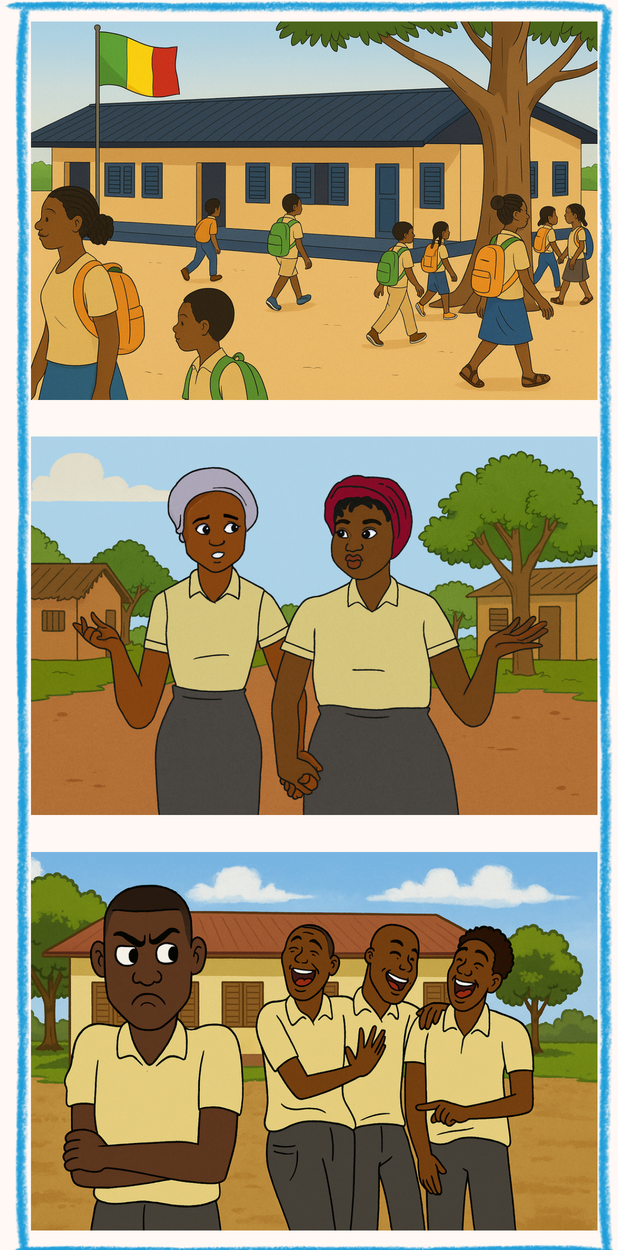
The Dogoli Taala ("no taboos" in Bambara) approach in Mali is a toolkit designed for and by peer educators to support their work in breaking taboos around adolescent sexuality. Combining a comic strip, and Truth Game, and a digital tool, the package offers simple, engaging tools to spark open discussions on sensitive topics in sexual reproductive health and rights (SRHR) such as contraception, consent, sexually transmitted infections (STIs), and peer pressure. By equipping peer educators with accessible, practical resources, the approach helps them confidently challenge myths, improve knowledge, and create safer spaces for dialogue in a context where stigma and misinformation often limit adolescents' access to accurate information.

Piloted successfully in 2024, peer educators using Dogoli Taala showed strong improvements in knowledge, attitudes, and confidence, all while identifying areas for continued support. For example, topics such as consent and peer pressure proved more difficult for peer educators to internalise and deliver than information on contraceptive methods, highlighting the need for more targeted support to address deeper social and relational dynamics. Building on these results, the approach has been refined and scaled up under the FCDO-funded WISH2 programme, involving 40 new peer educators and working with expert partner WiLDAF to strengthen support on broader SRHR topics such as gender and consent. As such, a strong pilot has evolved into a more comprehensive, real-world model, keeping what worked, improving what did not, and scaling up to have even greater impact.

THE CHALLENGE

More than half of sexually active adolescent girls and young women in Mali who want to avoid pregnancy are not using modern contraception. This stark reflection of the gap between need and access unfolds in a context where 42% of girls are already married during adolescence, often to men more than ten years older, and where only 2.7% report having decision-making power over their SRHR. While many interventions understandably focus on married adolescents, they risk overlooking the 15% of sexually active young people who are unmarried and face equally significant, if not greater, barriers to information and care. Despite relatively high awareness of modern contraceptive methods, fear of side effects and pervasive myths remain strong deterrents to use. Strict social norms around adolescent sexuality compound these challenges. Young people rarely feel safe asking questions: doing so can lead to gossip, stigma, and reputational damage for themselves and their families. For girls especially, limited access to reliable knowledge undermines their ability to make informed, autonomous choices about their bodies and futures.

As a result, adolescents often turn to their peers for guidance. Yet these peers frequently lack accurate information themselves, perpetuating misinformation. In schools, where many unmarried adolescents spend much of their time, peer dynamics can both increase pressure to engage in early sex and create opportunities for open dialogue and positive change. Leveraging this influence is essential.



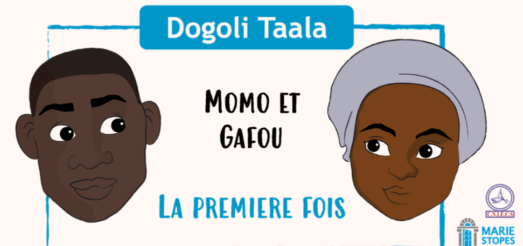
MSI Mali trained a cohort of peer educators to help address these challenges and reach adolescents with accurate, relatable information. While the peer educator approach has shown strong potential, these young leaders continued to face important barriers in their work. Many lacked the depth of technical knowledge needed to confidently debunk persistent myths around contraception and sexual health, and accessing more advanced training is often costly or time-intensive. Beyond knowledge gaps, peer educators are also navigating the realities of discussing highly sensitive topics within a restrictive social environment. As young people themselves, they may feel uncomfortable initiating conversations about sexuality, particularly with boys, or when addressing sex outside of marriage, which remains highly stigmatized. Without tailored tools or practical guidance to facilitate these discussions, peer educators can struggle to move beyond basic messaging and create the open, trust-based dialogue that is essential for meaningful behaviour change.

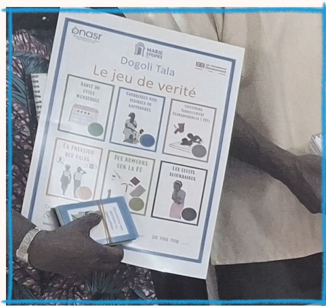
WHAT WE DID

As part of a project funded by the Dutch government (Bangué Kolossi Nyeta), MSI Mali used human-centred design (HCD) to develop and implement a toolkit for peer educators called “Dogoli Taala” (meaning “no taboos” in Bambara). All tools were co-created with peer educators themselves, and rapid-tested and refined with young people, benefiting from adolescents’ own innovative ideas.
The Dogoli Taala kit includes three tools designed to support peer educators:

The Momo and Gafou comic strip:

A simple visual story about a young couple navigating their sexuality, to encourage free and open discussions about sex, contraception, STIs, and consent. The comic strip takes the form of a flipchart, to make it easier for peer educators to use in groups.



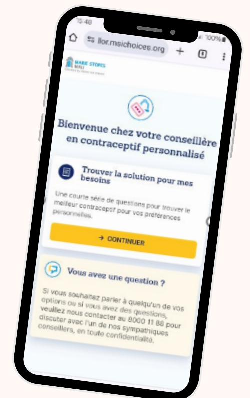


The Truth Game:

A Trivial Pursuit-inspired card game answering common questions and myths about adolescents' sexual health and encourage young people to seek further information and services from MSI Mali. Used by peer educators during group activities, the card game aims to generate discussion as well as share correct information. The card game includes topics such as contraception and STIs, but also consent and peer pressure.

The Choice App:

A digital tool (accessible as an offline app or website) that young people can use themselves to better understand the FP method options available to them and what might be best for them. The peer educators can also use this during their activities with young people, or share the link for adolescents to use it individually. While Mali’s internet penetration rate is only at 36% across the country, internet usage is higher among the younger, more urban population segments, which matches the target audience of the activity. With a median age of 16, 79% of internet users in Mali are under the age of 35.[1] During the research to inform the activity, it was felt that a digital tool would be a low-cost amplifier of information as the app already existed, offering technical information about contraception in an accessible way.



Together, these tools are designed to spark open discussions among adolescents on sensitive SRHR topics, improve knowledge and acceptance of contraception, and strengthen peer educators’ confidence and capacity to engage effectively with their peers. The tools go beyond contraception alone, covering a broader range of issues including menstruation, STIs, consent, and peer pressure. Importantly, the tools are intentionally simple and practical, allowing them to be used with minimal training. Content such as myth-busting guidance is presented in a clear, accessible way, enabling peer educators not only to address misconceptions with others, but also to continuously reinforce and update their own knowledge.
The Dogoli Taala toolkit was piloted in late 2024 with the project’s 90 peer educators, across 13 public health facilities supported by MSI in 8 districts (Niena, Djenné, Bla, Kati, Kalabancoro, Fana, Dioila, Ouelessebougou).

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[1] Konatech. (2024, January 15). Les chiffres clés du digital au Mali en 2024. https://www.konatech.org/les-chiffres-cles-du-digital-au-mali-en-2024/

WHAT WE LEARNED

At the end of the 4-month pilot, a mixed-methods evaluation combined pre- and post-pilot surveys of peer educators with analysis of routine service data from service delivery sites. It assessed the reception of the toolkit, peer educator knowledge and confidence, and trends in adolescent service use across the 13 sites.

The toolkit shows strong early impact on knowledge, attitudes and service uptake, but sustained behaviour change will likely take more time to materialise. The Dogoli Taala toolkit demonstrates clear promise in shifting adolescents' knowledge and attitudes around SRHR. Peer educators reported strong perceived improvements, with those "strongly agreeing" that adolescents are aware of the consequences of unintended pregnancy increasing from 28% to 64% (+128%), alongside gains in acceptance of family planning (+60%) and consent within relationships (+71%). These findings suggest the tools are effective at opening up dialogue on sensitive topics and improving awareness and social acceptance, as critical precursors to behaviour change. However, translating these shifts into sustained behaviour change and service uptake appears to require more time. Peer educators expressed lower confidence in the tools' ability to generate referrals to service delivery sites (e.g. only 45% for the Choice Tool, compared to 55–58% for the other tools), and service data shows only modest and uneven gains: adolescent client share increased slightly from 26% to 30%, with mixed results across the 13 sites. Taken together, this highlights that while the toolkit is effective for influencing knowledge and attitudes in the short term, additional time is likely needed to convert these gains into consistent service use. Other barriers not addressed directly by the toolkit also continue to play a role, such as parental control or physical access to health facilities.

The co-creation approach resulted in tools that peer educators actively used and valued. The Human-Centred Design process contributed to the development of tools that peer educators were actively excited to use in practice. Across the pilot, peer educators reported strong uptake of the tools overall, particularly the Momo and Gafou comic strip (66% indicating that they used it often) and the truth game (55%). This suggests that involving users in the design process helped ensure relevance, usability and acceptability. At the same time, the Choice Tool was used a lot less, and was not used at all by 23% of peer educators. As such, simpler, more visual and interactive tools might be easier to adopt, while digital tools may require additional support or adaptation, or work better in contexts where internet penetration is higher.

The tools effectively built peer educators' confidence and knowledge on core SRHR topics such as contraception, but highlight the need to go further on more complex, related issues like consent. The tools strengthened peer educators' knowledge and confidence overall, with clear improvements in core SRHR areas (contraceptive methods, STIs). Their overall reported confidence across all topics rose from 2.8 to 3.5 out of 4, and the proportion of peer educators answering all questions in the survey correctly increased from 9% to 35%. Yet, this leaves an important segment of peer educators not answering all questions correctly.

Across both knowledge and confidence questions, the clearest gaps remained around more sensitive and socially nuanced topics, such as consent, peer pressure, and navigating relationships. This divergence reinforces both the value, and the challenge, of intentionally expanding the toolkits' content beyond traditional contraceptive-related content. While ideas on these more challenging topics are harder to shift, the pilot confirms they are essential to include, as they address key social drivers of behaviour that are often left unaddressed.

Finally, peer educators expressed high levels of satisfaction with their role, with the vast majority (70%) saying they recommend working with MSI Mali. They valued the opportunity to build their own knowledge and support their peers. At the same time, they highlighted the need for ongoing support, particularly in light of uncertainties around funding continuity.

WHAT THIS MEANS

Co-creation can drive real-world adoption. The pilot reinforces that involving peer educators themselves in design leads to tools they actually use, particularly when formats are simple, engaging and adaptable in low-resource settings. However, variation in uptake (e.g. lower use of the digital tool) shows that co-creation must be paired with strong attention to usability and context, not just relevance.

Expanding beyond "classic" SRHR topics is both necessary and harder. The pilot validates the decision to include broader themes such as consent and peer pressure, as these are critical drivers of adolescents' behaviour. At the same time, these topics proved more difficult for peer educators to internalise and deliver, highlighting the need for more targeted support to address deeper social and relational dynamics.

Shifts in knowledge and attitudes can happen quickly, but behaviour change takes longer. Within just four months, the tools contributed to meaningful improvements in knowledge, confidence, and perceived shifts in adolescents' attitudes. However, the more complex step of translating these shifts into service uptake and sustained behaviour change requires more time. Addressing other barriers affecting adolescent contraceptive use, such as social norms not addressed by the toolkit, also continue to play a role. Ensuring these are addressed in complementary interventions, for example by engaging key gatekeepers such as parents, is important to ensure holistic impact.

In a constrained funding environment, meaningful youth engagement requires investing in what peer educators gain, not just what they deliver. The pilot highlights a critical tension: while peer educators are highly motivated and deeply engaged, especially through the specific Dogoli Taala toolkit's approach, sustaining this model becomes more challenging in the context of broader funding constraints in the SRHR sector. Without sufficient investment in peer educators' own development, stability, and support systems in their work, there is a risk that engagement becomes extractive, relying on their time, trust, and social capital without delivering proportional benefits to them. Ensuring that peer educators meaningfully gain from their involvement is therefore not just an operational consideration, but a core condition for ethical, sustainable, and impactful programming.

The lessons from the pilot evaluation directly informed the scale-up of Dogoli Taala under WISH2 to 40 peer educators, assuring both continuity and improvement of a successful approach. Based on peer educator feedback, the toolkit was slightly adapted, such as improving the illustrations in the comic strip, to make it more engaging and accessible for young people. At the same time, the evaluation identified a gap in addressing broader SRHR topics beyond contraception, particularly around consent and gender dynamics. In response, the WISH2 model introduces a complementary training approach including gender-based violence, consent and inter-partner dynamics. The improved Dogoli Taala model now continues across 9 districts in Mali, equipping peer educators with a more holistic understanding of SRHR that combines service-oriented knowledge with critical social- and protection issues. SBC approaches in the same areas, such as husband schools and other types of community mobilisation, work in tandem to address other barriers to adolescent contraceptive use, for example through engagement of key gatekeepers and providers. Together, these strategies are driving meaningful change in adolescent access to SRH care in Mali.

MSI REPRODUCTIVE CHOICES