WOMEN'S REFUGEE COMMISSION

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Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings:

An In-depth Look at Family Planning Services

December 2012

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Save the Children is the leading independent organization for children, with programs in more than 120 countries around the world. Our mission is to inspire breakthroughs in the way the world treats children, and achieve immediate and lasting change in their lives.

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Contents

Acronyms and Abbreviations

ARC	American Refugee Committee
CBO	Community-based organization
EC	Emergency contraception
FGC/M	Female genital cutting/mutilation
FGD	Focus group discussion
FHOK	Family Health Options Kenya
GBV	Gender-based violence
HAGN	Haiti Adolescent Girls Network
IASC	Inter-Agency Standing Committee
IAWG on RH in Crises	Inter-agency Working Group on Reproductive Health in Crises
IDP	Internally Displaced Person
IEC	Information, education and communication
IUD	Intrauterine device
LAM	Lactational amenorrhea method
NGO	Nongovernmental organization
PEP	Post-exposure prophylaxis
RHRC	Reproductive Health Response in Crises Consortium
SEA	Sexual exploitation and abuse
STF	Straight Talk Foundation
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WRC	Women's Refugee Commission

Executive Summary

Globally, 16 million adolescent girls aged 15-19 years and two million girls under age 15 give birth every year. In the poorest regions of the world, this translates to roughly one in three girls bearing children by the age of 18. Adolescent girls are at the highest risk of maternal mortality: the risk of pregnancy-related death is twice as high for girls aged 15-19 and five times higher for girls aged 10-14 compared to women in their twenties. Further, pregnant adolescents are more likely than adults to pursue unsafe abortions; an estimated three million unsafe abortions occur every year among girls aged 15-19.

In humanitarian settings, child-bearing risks are compounded for adolescents, due to increased exposure to forced sex, increased risk taking and reduced availability of and sensitivity to adolescent sexual and reproductive health (ASRH) services. During conflict or a natural disaster, family and social structures are often disrupted, and educational and social services are discontinued. Adolescents can become sexually active when few protective services are available, and girls especially are vulnerable to sexual assault and exploitation. Such risks increase their vulnerability to sexually transmitted infections, unwanted pregnancies and unsafe abortion. At the same time, adolescents in crisis settings will have similar needs and desire for SRH information and services as their peers in non-crisis settings. Investing in ASRH may delay first pregnancy, reduce maternal mortality, improve health outcomes, contribute to broad development goals and reduce poverty.

To address the specific SRH needs of adolescents in humanitarian settings, the Inter-agency Working Group on Reproductive Health in Crises has developed a chapter on ASRH in the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (IAFM).[1] Save the Children and the United Nations Population Fund have developed a complementary *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*[2] to provide guidance and tools for program implementation.

Although ASRH is receiving increased attention in both development and humanitarian contexts, there is little documentation of progress to date in humanitarian settings, or of programs that effectively integrate SRH services, including family planning, for this population. To address this gap, the Women's Refugee Commission and Save the Children undertook a year-long exercise to map existing ASRH programs that have been implemented since 2009 and document good practices, in order to inform ASRH service provision in humanitarian settings. This was accomplished through a practitioner survey and humanitarian funding analyses; key informant interviews; and a collection of good practice case studies.

Key Findings

The survey reached 1,200 individuals through various related listservs. Based on the more than 200 responses, a mere 37 programs focused on the SRH needs of 10- to 19-year-olds in crisis-affected settings since 2009. Only 21 of these programs offered at least two methods of contraception, and none were in acute onset emergency settings. Since 2009, proposals for ASRH through Flash and Consolidated Appeals[3] have constituted less than 3.5 percent of all health proposals per year, and the majority of them have gone unfunded. Also, very few program evaluations and research studies in humanitarian settings have looked at the impact of ASRH interventions at the population level.

Despite this lack of programming, notable practices for ASRH in humanitarian settings exist. Three programs among the 21 programs were identified to be "effective" in their delivery of SRH services by demonstrating enhanced contraceptive uptake: Profamilia in Colombia, the Adolescent Repro-ductive Health Network in Thailand and Straight Talk Foundation in northern Uganda.

Additionally, several programs show promising approaches, including utilizing a consortium model to address the needs of this population; providing ASRH services within school-based programs; working with urban displaced populations; and incorporating ASRH into disaster risk reduction activities.

A closer examination of notable programs found that:

- **Successful programs have ensured stakeholder involvement to build community trust and secure adult support**.
- **Adolescent participation and engagement, beyond tokenistic participation and from the onset of an emergency is critical to building adolescent buy-in and increasing demand for services**.
- **Successful ASRH programs are responsive to the different needs of adolescent sub-populations**, including married/unmarried adolescents; in-school/out-of-school adolescents; and adolescents with disabilities.
- **Qualified and dedicated ASRH staff, including clinical staff, are crucial to good quality service provision.** Stronger programs place heavy emphasis on identifying and recruiting staff with appropriate backgrounds, as well as investing in staff awareness, ongoing training and support.
- **The provision of comprehensive SRH services for adolescents at a single site can increase service utilization**. Adolescents are best served by interventions that address multiple needs. Integration of SRH services, including sexuality education, skills building to negotiate safe sexual practices, family planning, HIV and comprehensive abortion care where legal, improves use among this critical population for whom the completion of referrals can be challenging.
- **Stronger programs take a holistic, multi-sectoral approach to ASRH programming that moves beyond facility-based health services and a siloed SRH focus**. Through network models, strong referral mechanisms or comprehensive programming, stronger ASRH programs offer adolescents more than pure clinical SRH services. These include protection, life skills, literacy, numeracy, vocational training and livelihood skills, among other relevant services.
- **Stronger programs provide refresher trainings, structured supervision, recognition and ongoing mentorship to peer educators to address motivation and retention challenges.**
- **Flexible outreach strategies, as well as the inclusion of transportation budgets, are necessary to reaching adolescents in insecure environments and otherwise hard-to-reach areas.**
- **Addressing ASRH during emergency preparedness can help to ensure that the critical needs of this population are not overlooked at the onset of emergencies.** Involving adolescents in preparedness efforts is an important initial step. Additionally, the pre-positioning of supplies; readily available information, education and communication materials; and trained peer educators will better ensure the SRH needs of adolescents in the early stages of an emergency.

By examining the state of ASRH programming in humanitarian settings, it is possible to better understand the accomplishments made to date, as well as the growth that is still needed within this field. The gap in the number of ASRH programs, as well as definitively effective ASRH programs, will leave adolescents unable to control their own SRH. Despite good practices, challenges and gaps remain, such as **limited SRH supplies, especially contraceptives**, as well as **donor-influenced shifts in program priorities** that impact provision of vital SRH services, such as family planning. The case study programs clearly show the impact of funding and donor shifts on uptake of adolescent family planning services.

Recommendations

Based on these findings, the following recommendations have been developed to address and mitigate the SRH risks for adolescents in crises.

Donors and governments should:

- **Urgently fund programs addressing ASRH within the context of the Minimum Initial Service Package (MISP) for reproductive health** to meet life-saving needs in acute emergencies.
- **Increase support for holistic, comprehensive, flexible ASRH programming** through protracted crises and recovery, taking into account good practices and the flexibility and creativity required to overcome challenges faced in meeting the needs of this population.
- **Commit to multi-year funding** to support iterative and reflective processes of program development that engage adolescents.
- **Strengthen the capacity of development programs to address the SRH needs of adolescents at risk of displacement, during emergency preparedness and response**.

The **health sector/cluster** in crisis settings should:

- **Advocate, prioritize and approve ASRH-inclusive projects in humanitarian funding appeals** to ensure ASRH is addressed in emergency response.
- **Mainstream ASRH among health sector/cluster partners for a coordinated response**.

Humanitarian organizations providing SRH or child-friendly services in crisis settings should:

- **Integrate the diverse population of adolescents into existing SRH, child protection and education programming through adopting adolescent-friendly approaches and outreach strategies**. SRH, child protection and education staff should be trained in adolescent-friendly service provision to reduce provider biases and build trust. Additionally, programs should be tailored to meet the unique needs of this diverse population (very young adolescents, in/out-of-school adolescents, married/unmarried adolescents and adolescents with disabilities, among other marginalized sub-groups).
- **Monitor service usage through collection of sex- and age-disaggregated data.** This disaggregation should include 10-14, 15-19 and 20-24 years.

Humanitarian health organizations interested in providing ASRH services in crisis settings should:

- **Advocate and adopt an adolescent lens to MISP responses in acute emergencies**. The inclusion of ASRH into emergency SRH, gender-based violence (GBV), child protection and education proposals would widen the scope of programming possibilities and permit more integrated efforts.
- **Provide integrated ASRH services according to existing guidance,** such as that outlined in the IAFM *Adolescent Reproductive Health* chapter and other tools and guidelines.
- **Involve relevant stakeholders (parents, community leaders, health practitioners and teachers) and adolescent girls and boys themselves as full partners** in the design, implementation, monitoring and evaluation of ASRH programs. Programs should meaningfully engage younger adolescents, not simply older youth in their twenties.
- **Strengthen program linkages and referral pathways, and coordinate with related sectors,** including protection, education and livelihoods, for a holistic, multi-sectoral response.
- **Engage in initiatives that evaluate and document ASRH programming.** Invest in measuring the impact of interventions at the population level, examining cross-sectoral outcomes and ASRH programming across the relief to development continuum (crisis, post-crisis and recovery).

Development organizations providing SRH services and working in crisis-prone settings should:

- **Play a stronger role in emergency preparedness efforts** to respond to urgent SRH needs of the population when crises occur, including for adolescents.
- **Coordinate with humanitarian actors** at the onset of an emergency for a multi-sectoral response adopting good practices in ASRH programming in humanitarian settings.

I. Introduction

The Inter-agency Working Group (IAWG) on Reproductive Health in Crises' Adolescent Sexual and Reproductive Health (ASRH) sub-working group identified that although the term "adolescent-friendly services" has been well defined, and checklists and tools—such as the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (IAFM)[4] and the complementary *Adolescent Sexual and Reproductive Health Toolkit* (ASRH Toolkit)[5]—exist to guide program implementation, there has been little documentation of how frequently ASRH programs are implemented, and to what extent they have been effective. Such documentation supports program managers and other service providers to better cater to adolescent SRH needs. The Women's Refugee Commission (WRC) and Save the Children—two of the co-chairs of the IAWG ASRH sub-working group—embarked on an initiative to identify effective[6] practices for the delivery of ASRH services, inclusive of family planning components. This outcome document is designed to highlight current strengths and gaps in ASRH programming within humanitarian response for those working on ASRH in crises. It is further intended as a resource for SRH managers who are considering expanding their services to adolescents and seeking more "how-to" guidance for implementation.

I.I Background

"Adolescence (10-19 years of age) is one of life's most fascinating and complex life stages."[7] It is a continuum of physical, cognitive, behavioral and psychosocial change that is characterized by increasing levels of individual autonomy, a growing sense of identity, self-esteem and progressive independence from adults.[8] At one end of the continuum is early adolescence, from 10 to 14 years of age, characterized by initial physical changes and rapid brain development. During this phase, some adolescents may be physically, cognitively, emotionally and behaviorally closer to children than adults. Middle adolescence, 15-16 years, is a time when sexual orientation progressively develops, and peers become an important source of influence. In older adolescence, aged 17-19 years, adolescents may look and act like adults, but may not have reached cognitive, behavioral and emotional maturity.[9]

Investing in adolescent sexual and reproductive health (ASRH) may delay first pregnancy, reduce maternal mortality, improve health outcomes of women and their children, contribute to broad development goals and reduce poverty.

Ensuring that adolescents can protect their health during each phase of development is a critical global public health priority. Such investments may delay first pregnancy, reduce maternal mortality, improve health outcomes for women and their children, contribute to development goals and reduce poverty.

Globally, adolescent girls aged 15-19 account for roughly one-fifth of all girls and women of reproductive age.[10] An estimated 16 million girls aged 15-19 and two million girls under age 15 give birth every year.[11] In the poorest regions of the world, this translates to roughly one in three girls bearing children by the age of 18.[12] These adolescents are at higher risk of maternal death than any other sub-population. The risk of pregnancy-related death is twice as high for girls aged 15-19 and five times higher for girls aged 10-14 compared to women aged 20-29.[13] In low- and middle-income countries, complications from pregnancy and childbirth are the leading cause of death among girls 15-19.[14] Pregnant adolescents are more likely than adults to pursue unsafe abortions; an estimated three million unsafe abortions occur every year among girls 15-19.[15] Adolescents and youth aged 15-24 account for just under half (40 percent) of all unsafe abortions worldwide.[16] The adverse effects of adolescent childbearing extend to their infants. Stillbirths and newborn deaths are 50 percent higher among infants of adolescent mothers than among infants of women aged 20-29 years.[17] Newborns of adolescent mothers are more likely to have low birth weight, with the risk of long-term effects.[18]

A 2006 study by Magadi et al. of demographic and health survey data from 21 Sub-Saharan African countries found maternal health services were generally underused by 15- to 19-year-olds compared to women aged 20-34 and 35-49. Adolescents with premarital, unintended pregnancies were more likely to receive poorer maternal health care, particularly in countries with relatively high levels of premarital adolescent pregnancies, such as Côte d'Ivoire and Kenya, where more than one third of all adolescent births are outside of marriage.[19]

Access to family planning services for adolescents could significantly reduce maternal death and improve family health outcomes. However, unmet need for family planning is highest among those 15-19 years old for both married and unmarried adolescents.[20] A United Nations Population Fund (UNFPA) report documents that contraceptive prevalence among married adolescents (15-19 year olds) is only 22 percent in developing countries, and even lower in South Asia (15 percent) and Sub-Saharan Africa (16 percent).[21] Unmarried adolescents face additional barriers to accessing contraception. In most parts of the developing world, unmarried, sexually active adolescents face stigma and social disapproval. The 2012 *State of the World's Population Report* notes that "social norms and practices can limit individual access [to family planning]. The subordination of the rights of young people…can limit access to information…services and the capacity to act."[22] The report also notes that despite gaps in access, the initiation of sexual relations is increasingly occurring outside of marriage for adolescent girls.[23]

As adolescents transition from childhood to adulthood, they typically benefit from the influences of adult role models, social structures and community groups.[24] However, during conflict or a natural disaster, family and social structures are often disrupted and educational and social services are discontinued.[25] In such settings, adolescents may become sexually active when few protective services are available. Adolescents, especially girls, are vulnerable to sexual assault and exploitation.[26] Such risks increase their vulnerability to sexually transmitted infections (STIs), unwanted pregnancies and unsafe abortion. At the same time, adolescents will have similar needs and desire for SRH information and services as their peers in non-crisis settings.[27]

Although sparse, a few studies have documented the specific SRH needs of adolescents in humanitarian settings. A 2003 study of adolescent pregnancies in Congolese refugee camps in Tanzania found that almost 30 percent of all births were by girls between the ages of 14 and 18.[28] A 2000 survey by the Colombian NGO Profamilia found that displaced girls aged 13 to 19 had higher rates of pregnancy and childbearing than their non-displaced counterparts, documented at 30 percent versus 19 percent, respectively.[29] A 2003 survey of adolescent Bhutanese refugees in Nepal revealed that a surprising 22 percent of boys and 46 percent of girls "did not know anything" about sexual contact, while only 41 percent of all respondents knew that condom usage prevented STIs.[30] Cross-sectional qualitative assessments undertaken by the WRC and partners have also shown increased SRH risks for adolescents, particularly adolescent girls, as they pertain to sexual exploitation and abuse (SEA) in contexts such as Kenya after the post-election violence[31] and Haiti after the 2010 earthquake.[32]

Adolescent girls in Haiti after the earthquake.
© *Lauren Heller, WRC*

In humanitarian settings, child-bearing risks are compounded for adolescents due to increased exposure to forced sex, increased risk taking and reduced availability and sensitivity to ASRH services. The IAWG ASRH sub-working group has recognized that there is little documentation of effective ASRH programs in humanitarian settings. Such

documentation would aid program managers and other service providers.

Much has been learned regarding effective practices for ASRH programming globally. For example, it is accepted that ASRH programs that effectively influence knowledge and attitudes among youth do not necessarily lead to effective change in behaviors.[33] [34] Behavior change, especially among this population, is more complicated and may require multi-faceted interventions, tailored to local contexts and specific age groups, as noted by Bearinger et al. As part of a 2007 *Lancet* series on ASRH, Bearinger et al. concluded that a combination of youth-friendly services, implemented by clinicians trained to work with this population, as well as sex education and skills building for negotiating sexual behaviors, are crucial to effective ASRH programming.[35] In terms of what constitutes "good" approaches to ASRH, some projects have looked to assess various components of ASRH programs, including youth centers,[36] youth-friendly clinics, peer outreach or peer educator approaches and mobile brigades. More generalizable is recent WHO guidance: A 2012 policy brief from WHO recommends the following program actions to improve program success:

- Engage adolescents as full partners in the design, implementation and monitoring of family planning programs.
- Target different outlets for distribution.
- Incorporate both traditional and innovative methods of communication to reach boys and girls with information.
- Link family planning services with other ASRH services.
- Support providers to be respectful and sensitive when providing contraceptives to adolescents both in and out of union.[37]

Investments in ASRH programs that target vulnerable adolescents will help girls stay in school, marry later, delay childbearing, have healthier children and earn a better income that benefits themselves, their families and their communities.[38] Such investments must include family planning in order to address high pregnancy-related mortality rates within this population.

In humanitarian settings, investments in ASRH from the onset of an emergency can reduce vulnerabilities to unwanted pregnancy, unsafe abortion and STIs/HIV that result from the lack of access to SRH information, the disruption or inaccessibility of SRH services, the increased risk of SEA, as well as high-risk sexual behaviors.[39]

Adolescent girls in Afghanistan.
© Jeff Holt, Save the Children

In humanitarian contexts, published data on effective models targeting adolescents are virtually non-existent. Published program evaluations mention adolescents as clients; however, data are not available or not disaggregated to discern the impact on adolescent SRH specifically.[40]

II. Methodology

The WRC, in collaboration with Save the Children, and with support from the United Nations High Commissioner for Refugees (UNHCR) undertook a review of existing ASRH programs in humanitarian settings. Although the initial objective of the exercise was to identify and document effective practices for the delivery of SRH services, inclusive of family planning, the research question and sub-questions were expanded through the process in response to gaps in available programs. Due to the general absence of ASRH programming in acute emergencies, a more complete examination of programs in humanitarian settings at large was conducted, and a review of funding streams was added. The research undertaken ultimately includes:

1) a mapping of ASRH programs in humanitarian settings, and 2) a collection of good practice case studies.

The mapping of ASRH programs was conducted through:

- Circulating an online survey in English and French to professional networks working on adolescent programs in the humanitarian and development communities. The survey was open from March through August 2012.
- Reviewing health sector Flash and Consolidated Appeals Process (CAP) appeals from 2009 through October 2012 to identify proposed and funded ASRH projects.

Qualifying programs for the mapping exercise were those that had been:

- Implemented in crisis-affected settings at large, including post-conflict settings.
  - For programs implemented in post-conflict or protracted contexts, additional criteria were applied. The program must have contained a family planning component—defined as providing at least two modern methods of contraception—and this component must have been initiated during or immediately after the crisis and the program continues to exist.
- Targets the age group between 10 and 19 years.
- If not a dedicated ASRH program, targets adolescents as part of broader SRH programming.

All qualifying programs are listed in the program mapping matrix in Annex 5 (http://wrc.ms/Vu9btu). Consent was sought to list key contacts.

To contextualize the program mapping, the WRC and Save the Children further conducted 13 key informant interviews with humanitarian SRH practitioners for an understanding of what makes ASRH programs successful.

From the identified ASRH programs, case studies were sought among those that offered at least two methods of modern contraception. Three programs were selected to illustrate service delivery models that demonstrated effectiveness in reaching adolescents and improving contraceptive uptake through their outreach, communications or service delivery approaches. Contraceptive uptake was used as a marker of effective ASRH programs, given the importance of pregnancy prevention in adolescent lives. The good practices were collected between July and September 2012 and primarily examined:

- What are "effective" models and practices for delivering adolescent family planning services?
- How have programs reached adolescents with family planning services, especially the most vulnerable?
- Have programs conducted specific outreach to very young adolescents, and have these efforts been successful?
- What communication strategies were employed?
- What measurable change was observed in uptake over the course of the program?
- What systems are in place to examine, re-examine and adjust existing programs?
- What are the perspectives of adolescents of these services?

See Annex 1, page 29, for the detailed study methodology.

For this research, a humanitarian setting was defined as a setting affected by a conflict or disaster that overwhelmed existing in-country capacity since 2009. The 2009 cut-off year was selected based on known funding cycles in emergencies and the likelihood that information would be available.

III. Findings

III.I Mapping of existing ASRH programs in humanitarian settings

From the approximately 1,200 initial contacts made, 15 additional contacts were recommended, and another 12 identified through the analysis of Flash and CAP appeals. A total of 185 survey responses were received, and 37 programs were ultimately

included in the mapping of ASRH programs in humanitarian settings (see Annex 5). Most of the programs ineligible for inclusion were a result of their targeting only youth above age 20 or due to their implementation in a post-crisis context where their family planning component was not initiated in the early days of the crisis that preceded 2009.

The majority of eligible programs (19 of 37) came from Sub-Saharan Africa, with the single largest number coming from the Democratic Republic of the Congo (DRC). Although some ASRH programs were identified from settings responding to natural disasters, they were far fewer (8) ASRH programs compared to those responding to conflicts (29). Six were based in Asia, one in Europe, seven in the Middle East and North Africa, 19 in Sub-Saharan Africa and four in the Americas.

Some programs targeted a wide age range for their ASRH interventions, beyond a strict definition of 10- to 19-year-olds. For example, 78 percent of the 37 programs included those 20 years and older within their target population. As might be expected, those aged 15-17 and 18-19 were most commonly targeted (86 percent of programs targeted 15- to 17-year-olds and 89 percent targeted 18- to 19-year-olds). Very young adolescents (10-14 years) were less frequently targeted, although over half the programs reported including this age group (62 percent) in their ASRH programming.

Program components varied greatly. All but two provided education and awareness around health, sexuality, gender norms and HIV to adolescents. Common communication/outreach elements included information, education and communication/behavior change communication (IEC/BCC); peers; youth centers; plays; theater; and involvement of parents and religious leaders from the community.

Commonly reported challenges to providing ASRH services included adolescent knowledge of services, community attitudes, adolescent use of services, funding, provider attitude and skills, availability of supplies and methods, and level of insecurity in the setting.

ASRH programs offering at least two methods of modern contraception

A further analysis was conducted to examine the number of programs that provided at least two methods of modern contraception, given the importance of pregnancy prevention among the adolescent cohort. Findings showed that roughly 57 percent (n=21) of programs included in this mapping provided at least two modern contraceptive methods. These programs were implemented in response to conflicts in Central African Republic (CAR), Chad, DRC, Colombia and South Sudan, as well as among refugee, internally displaced persons (IDP) or other crisis-affected populations in Lebanon (Palestinian), Kenya (Somali), Pakistan (Afghan), Rwanda (DRC), Sierra Leone (post-conflict), Thailand (Burmese), Tunisia (crisis-affected), Uganda (post-conflict) and Ethiopia (Somali). They were also implemented in response to the floods in Albania and the 2010 earthquake in Haiti. Annexes 3 and 4 summarize findings from these programs.

Adolescent boys demonstrate a dance at Straight Talk Foundation's Gulu Youth Center during the conflict in northern Uganda.

All 21 programs offered general health education and varying degrees of HIV, sexuality and fertility education. Fourteen offered life skills training, six offered vocational training and/or livelihoods support and 12 reported providing youth empowerment initiatives. Seven programs targeted young mothers, and nine addressed prevention of transactional sex.

Among the 21 programs, organizations provided an average of 4.4 modern contraceptive methods (male and female condoms were counted as one method in this calculation). Pills and injectables were commonly available methods, offered within 20 and 18 programs, respectively. Emergency contraception and female condoms were provided by 15 programs each. Long-acting methods, such as the intrauterine device (IUD) and implants, were less available to adolescents: the IUD was provided by 11 programs and the implant by 10. Appropriate method mix (defined here as at least one-short acting and one long-acting family planning method) was available in 13 of the 21 programs. The majority (n=18, 86 percent) of the programs also provided family planning counseling on site. Interestingly, natural methods appeared to be provided as part of a broad method mix within more comprehensive family planning programs, rather than as an alternative to modern family planning methods. All programs offering natural methods (n=10) also provided hormonal methods, and all but two programs offered an appropriate method mix. Eleven programs offered post-abortion family planning.

Further, among the 21 programs, all but two provided family planning within a broader health service for adolescents, such as STI care and treatment, antenatal, delivery and post-natal care. Twelve programs provided HIV care and treatment. Fourteen programs provided post-rape injury treatment, while 12 programs offered emergency contraception in the context of post-rape care. Three of the 12 programs provided emergency contraception only for this purpose and not as a method of contraception. Few generalizations can be made, however, regarding what program interventions had the closest relationship to the seeming success of family planning uptake.

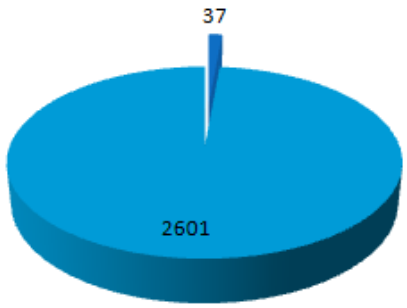
Funding analysis for all health appeals, 2009-2012

Between 2009 and 2012, there were a total of 2,638 health proposals included in 101 total appeals. Thirty-seven included some element of ASRH. While several agencies appeared to apply for the same project through both Flash and CAP appeals,[41] analysis could not account for duplicate proposals, due to complications in verifying duplicates. Hence, there are in fact fewer than 37 unique ASRH proposals across the four years, but also fewer than 2,638 unique health proposals. It is therefore assumed that, in general, less than 3.5 percent of all health proposals in any given year included a component of ASRH. Also noticeable is that despite the growing awareness around ASRH and the number of crises in recent years, a decreasing trend in the number of ASRH proposals is observed. The breakdown of appeals and the proportion of ASRH proposals among all health proposals are illustrated in Table 1 and Figure 1 (see page 10). The appeals were issued for refugee and internal displacement settings.

To better understand the content of the 37 proposals, they were divided into five categories:

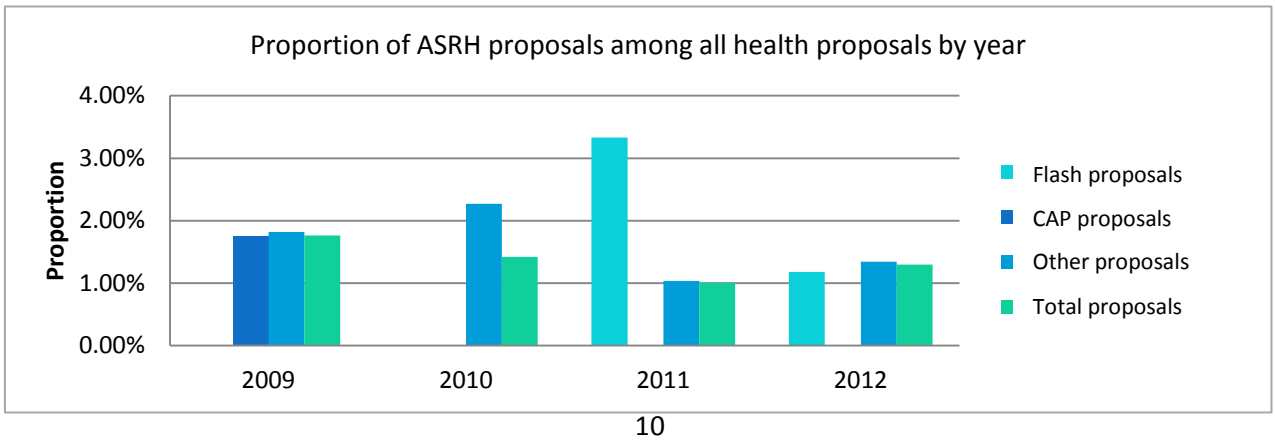
A. Programs include adolescents in MISP activities or provide family planning services (more than condoms) within longer-term response.
B. Programs specifically target adolescents for family planning, but methods unclear.
C. Programs target adolescents (among others) for provision of condoms, frequently as part of an HIV and AIDS focused intervention.
D. Programs mention adolescents as a population within SRH programs, but details unclear.
E. Programs target adolescents with behavior change campaigns, but services not provided.

Table 1: ASRH proposals among all health proposals, 2009-2012



# of emergencies triggering appeals process			Health and ASRH proposals			
2009						
Flash Appeals	8		Flash Health Proposals	57	Flash ASRH Proposals	1
CAP Appeals	15		CAP Health Proposals	715	CAP ASRH Proposals	13
Other Appeals	4		Other Health Proposals	23	Other ASRH Proposals	0
Total Appeals	**27**		**Total Health Proposals**	**795**	**Total ASRH Proposals**	**14**
2010						
Flash Appeals	4		Flash Health Proposals	165	Flash ASRH Proposals	0
CAP Appeals	15		CAP Health Proposals	441	CAP ASRH Proposals	10
Other Appeals	6		Other Health Proposals	99	Other ASRH Proposals	0
Total Appeals	**25**		**Total Health Proposals**	**705**	**Total ASRH Proposals**	**10**
2011						
Flash Appeals	6		Flash Health Proposals	85	Flash ASRH Proposals	0
CAP Appeals	15		CAP Health Proposals	483	CAP ASRH Proposals	5
Other Appeals	3		Other Health Proposals	30	Other ASRH Proposals	1
Total Appeals	**24**		**Total Health Proposals**	**598**	**Total ASRH Proposals**	**6**
2012						
Flash Appeals	1		Flash Health Proposals	8	Flash ASRH Proposals	0
CAP Appeals	20		CAP Health Proposals	447	CAP ASRH Proposals	6
Other Appeals	4		Other Proposals	85	Other ASRH Proposals	1
Total Appeals	**25**		**Total Health Proposals**	**540**	**Total ASRH Proposals**	**7**
2009-2012						
Total Appeals	**101**		**Total Health Proposals**	**2638**	**Total ASRH Proposals**	**37**

Figure 1: ASRH Proposals 2009-2012



Unfortunately, the two programs within category A (see Table 2), one from CAR (2012) and one from Zimbabwe (2010), were never funded. Among all 37 proposals, only 32 percent received any funding (n=12): seven programs were fully funded and five were partially funded. Among the fully or partially funded programs, seven could be verified and were therefore included in the program mapping.

Table 2: Funding categories

Category	Total number of proposals, 2009-2012
A	2
B	6
C	7
D	13
E	9

III.II Case studies demonstrating good practices

Among the 21 programs that offered family planning, three were identified as most closely meeting case study criteria and could be visited. Four programs demonstrated promising elements. Programs that were not selected for case studies were: limited in their data collection; weak targeting of adolescents to warrant focused attention on successes; ability to enhance contraceptive uptake; or communications to gather more information.

The three programs visited for case studies were: Profamilia's program in the pacific coast of Colombia, Straight Talk Foundation's (STF) Gulu Youth Center in northern Uganda and the Adolescent Reproductive Health Network (ARHN) in Mae Sot, Thailand.

The three case study programs have a well-established presence and positive reputation in their respective countries. Profamilia is an established SRH provider that provides ASRH services across Colombia. In 1998, the organization expanded its programs to crisis-affected regions, successfully adapting its model to meet this vulnerable group. STF began catering to crisis-affected adolescents in 2004 when active conflict prevailed in northern Uganda. STF has documented its learning on how to effectively reach crisis-affected adolescents through Kintu et al's 2007 publication.[42] ARHN—also established to specifically meet the needs of migrant communities displaced from and within Burma (Myanmar)—has been functioning for nearly 10 years. When comparing each program against the IAFM's checklist of adolescent-friendly services, they all demonstrate elements of recommended practice (see Table 3). The case studies are presented in detail below, to provide the opportunity to further understand each program, specific challenges and solutions attempted.

Table 3: Adolescent-friendly checklist

	ARHN	Profamilia	STF
Health facility			
Convenient hours	✓	✓	✓
Convenient location	✓	✓	✓
Adequate space and sufficient privacy	✓	✓	✓
Comfortable surroundings	✓	✓	✓
Provider			
Respect for adolescents	✓	✓	✓
Nonjudgmental attitude	✓	✓	✓
Privacy and confidentiality honored	✓	✓	✓
Peer counseling available	✓	✓	✓
Same-sex providers when possible	✓		counselors ✓
Strict confidentiality maintained	✓	✓	✓
Staff trained in youth-friendly health service characteristics	✓	✓	✓
Administrative			
Adolescent involvement	✓	✓	✓
Boys and young men welcome	✓	✓	✓
Necessary referrals available	✓	✓	✓
Affordable fees	✓	✓	✓
Drop-in clients welcome	✓	✓	✓
Publicity and recruitment that inform and reassure youth		✓	✓

Program: Adolescent Reproductive Health Network (ARHN)

Location: Mae Sot, Thailand
Type of program: Network-operated youth center
Target age group: 15-24 years
Setting: Peri-urban setting near Burma border, where clients are primarily migrant workers.
Crisis: With frequent arrests and insecurity for undocumented Burmese in Thailand, site mirrors conflict setting for clients.

Burmese adolescents in Mae Sot.

Program background

Established in 2003 in Mae Sot, Thailand, ARHN consists of eight community-based organizations (CBOs) that collaborate to address the SRH needs of migrant adolescents from ethnic communities in Burma. Since 2008 ARHN members have collectively operated a youth center, where workshops for adolescents are held to cover the reproductive anatomy; physical and emotional changes during adolescence; family planning; sex and gender; HIV/STI transmission and prevention; and consequences of unsafe abortion.

The most popular contraceptive methods requested are injectables and pills. The rainy season in the summer months affects client flow. If not seeking a method, clients come to the center to watch films or participate in facilitated discussions on topics including fertility awareness, HIV and family planning.

Program model

Services provided: Counseling, short-term family planning methods and referrals for long-term and permanent methods; recreational activities such as karaoke, movies, badminton and reading; and group discussions on gender and sex, decision-making, HIV/STIs, family planning and GBV. The youth center further refers clients, as appropriate, for additional health services, protection, psychosocial support, livelihoods, vocational training and educational opportunities.

Program hours: The youth center is open from 10:00 to 18:00, seven days/week. Referrals from the youth center manager (who resides on site) are available during evening hours (in emergencies) to Mae Tao Clinic (MTC), a comprehensive health facility dedicated to the Burmese community.

Staffing: ARHN employs 7-10 voluntary peer educators; one or two from each CBO. The peers rotate on a monthly basis to assist the center and facilitate group discussions. The ARHN coordinator supervises their activities. Peers have been trained in counseling, communication and facilitation skills, family planning and adolescence. Most are older and are not adolescents themselves. Only the youth center manager and the ARHN coordinator provide injections (depo) to clients.

Involvement of adolescents: The youth center was established through an SRH needs assessment that ARHN conducted among Burmese migrant adolescents.

We want to hear from more people, especially about menstruation and how girls can get pregnant. Also, when hormones change and what to do about pimples. (FGD with adolescent girls)

Privacy: The youth center is located in a quiet, accessible location. There is one counseling room offering privacy where family planning counseling is provided.

Data: ARHN collects routine data through a logbook, and uses reporting forms introduced by the MTC. ARHN submits monthly reports to MTC on activities conducted and contraceptives provided.

Challenges faced and solutions developed

Insecurity and distance: Clients who have no documentation are afraid of arrests; those who live far away also fear the police. Transportation can be costly for those traveling long distances.

- While police arrests continue to be a risk, the youth center is located in a private, safe location. In addition, it operates an emergency fund to facilitate referrals to MTC.

Adult objection to ASRH: In a conservative environment, ARHN initially experienced objection from adults and community members for its work to promote ASRH activities.

- Migrant schools are now requesting health programs and information on pregnancy prevention, since teachers are concerned that students are exposed to sex through the Internet. With time, and through winning the trust of communities in peers' ability to maintain confidentiality, the youth center has received requests from adults, communities and even other CBOs to conduct ASRH trainings.

Limited funding: When more funds were available in 2007, peers could work in the IDP settlements in Burma to provide information, condoms, pills and emergency contraception. Community outreach and provision of menstrual hygiene supplies have been limited due to funding constraints.

- ARHN has recently received additional funding to enhance the youth center's work.

Peer turnover: As peers work on a part-time basis, the youth center is not the exclusive focus of each member organization. Not all CBOs can offer two peers. Peer retention has also been challenging, since all have other jobs within their own organizations.

- ARHN is still addressing this issue, through instituting minimum time for peers to work at the center, as well as considering incentives. Some senior peers have worked with ARHN since its inception, and are experienced and serve as mentors to younger and newer peers.

Stock-outs of emergency contraception (EC): EC as a dedicated product has been in short supply, both for ARHN and MTC. The youth center's contraceptive supply chain comes through the MTC.

- ARHN recently hired a new youth center manager and a coordinator. They are learning how to provide EC through combining oral contraceptive pills in the absence of a dedicated product.

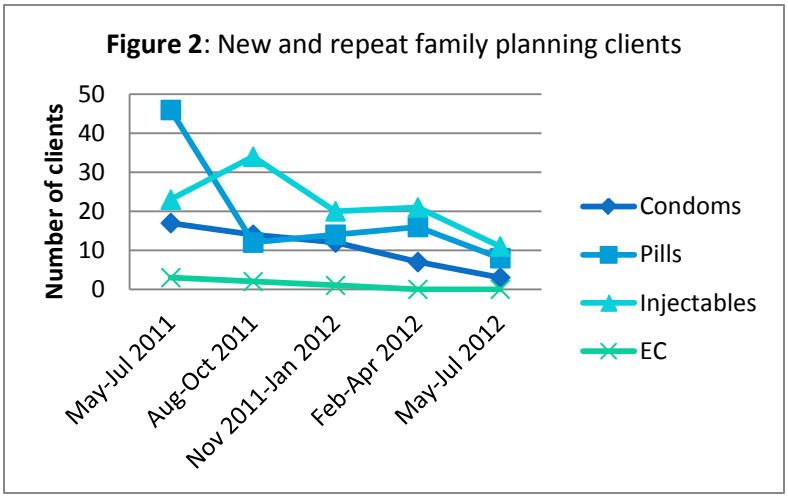
Tracking of defaulters: While data systems are in place and monthly reports are sent to MTC, the center has been unable to track defaulters of family planning methods, unless clients come for new methods.

- This area is yet to be addressed. Tracking defaulters is particularly challenging due to the constant movement of community members. However, records are kept of repeat clients, in addition to those that change methods.

Factors leading to success

Strengths of a network: As the youth center is operated by a CBO network, it can refer clients both internally and externally for comprehensive support. The youth center is more than the sum of its parts; together, the member CBOs serve a broad community, individually through their own agency activities and

The network is very strong and makes the program community based. Everyone knows someone, and they all fit together like a puzzle. This helps with referrals to make sure that clients are not lost. (ARHN staff)



collectively through the youth center. MTC, for example, provides teacher training on ASRH in schools, and the Social Action for Women works with migrant workers in factories. ARHN's strength appears to lie in its network model.

Safe, recreational space for all ages: ARHN offers space for adolescents to relax, read books, watch films, sing karaoke, talk or play table tennis. This, and the fact that the youth center is servicing a wide age range, has increased anonymity and reduced stigma among adolescents who may fear that others would assume they have a problem if they visited a health center solely for adolescents. While many of its clients are over 20 years of age, even small children come to play games or watch films, making it a friendly environment for all. The youth center staff are always present when clients are at the center, and engage with clients of all ages to ensure they receive the support they require.

Discreet: The youth center is located away from the main highway, far from where Thai police often arrest undocumented Burmese. Given the precarious security situation for the Burmese, visible promotion of the center and mass campaigns to draw public attention cannot be conducted. Community members learn about the youth center through word of mouth and reputation. Staff attribute face-to-face trainings as effective outreach strategies in conveying information to community members.

Older peers: ARHN peer educators are older and more skilled than the typical "peer" educator. Staff note that their experience, confidence and knowledge of SRH issues have allowed for trust-building with clients. The peers are able to address both emotional and physical concerns.

As a result of ARHN's work, a similar network also exists in Chiang Mai, Thailand, to provide ASRH information and services to migrants. The Adolescent Reproductive Health Zone's (ARHZ) work is based on ARHN's successful model.

Newer adolescent peer educators at the ARHN youth center.

****Data collection activities**

Case study data (program staff interviews; exit interviews; facility observation; outreach worker focus group discussion (FGD); adolescent FGD) were collected on July 17-18, 2012 in Mae Sot. The outreach worker FGD comprised six female and three male peer educators. Separate adolescent FGDs were conducted among 10 boys aged 13-18, and 10 girls aged 12-17. Informed consent was sought from all participants prior to the data gathering activity. The FGD data are not representative, given that saturation was not sought for this exercise.

Program: Raise Project Colombia

Location: Pacific Coast, Colombia
Type of program: Mobile outreach and youth-led peer education
Target age group: 10-24 years
Setting: Semi-rural, Pacific Coast Region
Crisis: Four decades of armed conflict and human rights abuses by armed groups have caused massive internal displacement within Colombia. With an estimated 2-5 million people internally displaced within Colombia, the country currently hosts one of the largest IDP populations globally.

Program Background: In Colombia, Profamilia has worked for over 25 years to deliver comprehensive SRH services for all persons, and specifically youth. Programs directed towards IDPs within Colombia started in 1995 with the national government's creation of the *National Program for Comprehensive Attention to the Population Displaced by Violence.* In the late 1990s Profamilia, with support from the Reproductive Health Response in Crises (RHRC) Consortium (then Reproductive Health for Refugees Consortium), launched programs directed towards promoting SRH services among IDPs. In the early 2000s, the SRH program began targeting IDP adolescents and youth. Profamilia pooled knowledge of best practices from its 22 years of experience working with this age group to develop a health outreach and youth-led peer education model for this crisis-affected region.

Program model: Profamilia's program delivered youth-friendly SRH care and education to crisis-affected adolescents through clinics, mobile health brigades and community education.

Clinics: Six health clinics located within the coastal region most affected by conflict and displacement, were supported to provide comprehensive SRH services: Buenaventura, Cali (including Aguablanca), Pasto, Quibdo, Popayan and Tumaco. Services included, but were not limited to, family planning, STI counseling and treatment, deliveries and antenatal care. Appointments were not necessary to receive care, and, when possible, transportation was arranged to bring patients to and from the clinic for procedures. Transportation was provided through Profamilia's services or community networks and support systems developed by Profamilia.

Mobile health brigade: Each clinic deployed no more than one mobile health brigade that could deliver the full range of SRH services to all Colombians. The outreach worker, who was hired and trained by Profamilia from within the communities reached by the brigades, first identified the needs of the community and then coordinated with the Profamilia clinic to deliver these services. The outreach worker collaborated with the community to identify available space for the health personnel to use: ideally a church, school or health facility. The mobile health brigade consisted of one doctor, one nurse and one outreach worker. They traveled to the communities by public transportation, transportation provided by the community they were going to or by renting transportation. The brigades also carried with them all materials necessary, including surgical equipment needed to perform operations when a surgical unit is donated.

Community education: Youth educators provided education and sensitization on ASRH to their peers. Profamilia recruited youth who were already living in the communities they wanted to serve. Parents and youth were informed of the training content and requirements for peer educators. Adolescents and youth between the ages of 13 and 25 who were perceived to have leadership skills were recruited from schools and other community settings. They attended a 120-hour training, which was broken into three-hour training sessions a day over the course of two months. Trainings included content on SRH; development of presentation and facilitation skills through theater and recreational activities; and follow-up training and supervision. Adolescents actively participated in the development of educational and training materials. After completing their training requirement, peer educators identified opportunities for outreach and education within their communities. Profamilia provided adolescents with their own set of educational materials which included a packet of informational brochures covering a broad range of ASRH topics. While no formal compensation was provided, peer educators received organizational T-shirts and hats.

Program hours: Clinics were open daily from 8:00 to 19:00 in order ensure after-school hours. Mobile clinics and community outreach had no set hours or schedules, as outreach was determined by community needs and interest.

Monitoring and evaluation: National standards and Profamilia's institutional protocols were applied to the clinics, mobile units and community outreach. Baseline data was collected at the start of the program and each clinic had established committees that handled monthly evaluations and feedback. Yearly evaluation surveys were administered by the national office in Bogota.

Challenges faced and solutions developed

Retention of peer educators: School, work and family commitments prohibited some peer educators from continuing to participate in the peer education program.

- Peer educator trainings were reduced from four hours a day to three hours a day to better accommodate youth attention spans and their daily responsibilities. A flexible outreach schedule allowed peer educators to balance their educational activities with work, school and home life. There was no weekly or monthly requirement of hours for peer educators to complete, allowing peer educators to identify opportunities and schedule events based on the needs of their communities. Peer educators led educational activities by themselves or with others depending on the needs of the community and mobility of the peer educators.

Adult objection to ASRH: Adults feared that introducing SRH knowledge would cause adolescents to initiate sexual relationships at a younger age.

- Profamilia established ties with community leaders and schools to educate adults on the importance of family planning education for adolescents. Adults recognized the need for these services in their communities and showed little resistance to the actual implementation of program activities.

Unpredictability of working in active conflict zones: Medical providers and outreach staff encountered problems reaching their target population, following up with patients and following through with their planned outreach activities due to insecurity.

- Neutral zones, such as schools and community centers, were identified to provide security for adolescents traveling between conflict zones.

- A number of communication strategies (peer education, word of mouth, liaisons with community leaders, radio announcements and brochures) were used to ensure that the maximum number of people was informed of their rights.
- Staff understood the importance of and implemented new outreach plans when met with obstacles such as finding a new population to reach or providing services that do not require the use of electricity.
- Program teams said that they placed a high value on flexibility when recruiting new staff, stating that "you have to have the capacity and capability to adapt while implementing." This was especially important for doctors who were brought on to join the program. Rather than focusing on the situation being stable, they ensured that their teams were comfortable with the lack of predictability when implementing.
- The creation of personal ties within the community enabled an informal follow-up process to occur between Profamilia and the clients they served.

Lack of medical personnel: Regions affected by conflict frequently struggle with human resource challenges. In the Pacific Coast region, clinics did not always have adequate medical staff to sufficiently staff the mobile units.

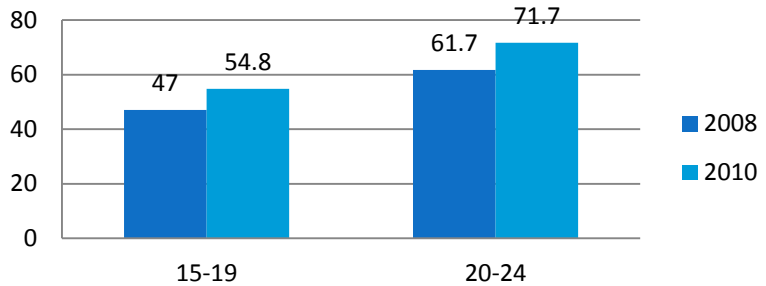
- Because Profamilia is such a large health service organization, it has been able to leverage staff from its other sites nearby to support clinics and mobile units.
- Profamilia provided referrals to other community health centers that had the specialized services sought by community members.
- Established transportation ties also facilitated client transport to and from the main Profamilia health clinic in the event that medical personnel were unable to travel to the community.

Vast distances require budget considerations: Significant budgetary commitments may be needed if a project aims to provide transportation to clients and outreach workers in an attempt to improve access.

- Working with communities and creating linkages with partners help create local transportation options for clients to travel to and from health clinics.
- Profamilia was careful to allow for and prioritize the costs of this activity. However, it recognizes that this may not be a possibility for many programs.

Factors leading to success

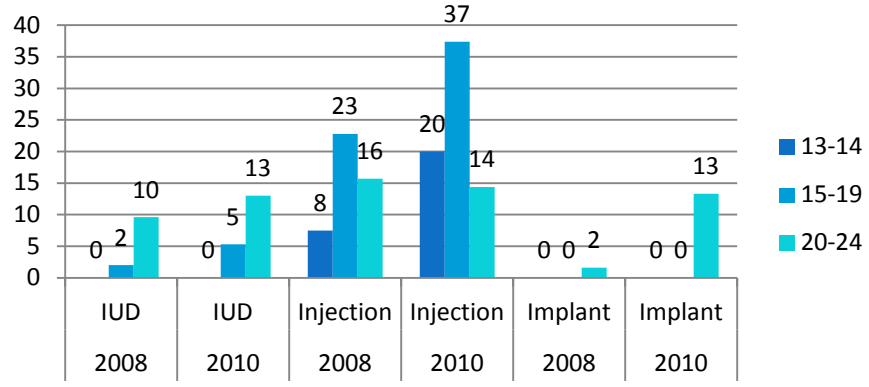
Figure 3: Percentage of adolescents and young women in a relationship who are using a modern contraceptive method



Staff training and sensitivity: Profamilia invested heavily in staff recruitment and staff sensitivity training, as well as comprehensive initial and annual update trainings to peer educators. This investment was believed to be an important factor contributing to quality, staff adaptability and community sensitivities.

Confidentiality: Clinics and mobile units were marketed as providing general family medicine to reduce anxiety and stigma for youth wanting to receive services from Profamilia. Youth, regardless of age, did not need parental consent for family planning services.

Figure 4: Percentage of sexually active adolescents and young women not in a relationship who are using a method



Community trust: With 25-plus years working in the field, Profamilia has created a name that people trust and respect. It hires outreach workers and trains peer educators from within the communities they wish to serve, which further reinforces their commitment to representing and serving community members. Limited paperwork and autonomy of youth to consent to services reduced barriers to health care access and allowed clients to easily reach the services they wish to receive.

Adolescent-centered approach: Adolescents are not just beneficiaries of the program; they contributed to the design and implementation. Adolescents were consulted during the peer education training about what lessons and approaches to teaching appear most useful and sensitive for their peers. Additionally, the varying needs of adolescents, by age group and other sub-populations were acknowledged and specific attempts were made to address their differing needs.

****Data collection activities**

A total of seven in-depth interviews were conducted with program staff in Cali and Aguablanca (the national director, four program staff and two clients). Two focus groups were conducted: one with the peer educators and another with clients who received services. Interviews were conducted by an outside consultant who also provided direct observations from the program. Interviews and FGDs took place between August 19 and September 25, 2012.

Program: Gulu Youth Center (GYC)

Location: Gulu District, Uganda
Type of program: Youth center
Target age group: 10-24 years
Setting: Peri-urban setting in Gulu, where clients were internally displaced; currently primarily returnees.
Crisis: Conflict transitioned to post-conflict setting.

Adolescents in Gulu.
©Straight Talk Foundation

Program background

The Straight Talk Foundation (STF), a national NGO, established the GYC in 2004 to provide SRH information and services to adolescents amidst the conflict in northern Uganda. GYC in Gulu town receives roughly 70,000 clients annually, including referrals from many CBOs and government institutions such as Gulu prisons. 50,000 of the clients are reached by health dialogues, and 20,000 receive SRH information and services, including HIV counseling and testing (HCT), family planning, STI diagnosis and treatment, male circumcision, post-rape care and post-exposure prophylaxis (PEP) for HIV. While initially, the target group was 10-24 years, parents of adolescents and children of adolescents also seek services at GYC.

Program model

Services provided: GYC provides integrated SRH information and services through a comprehensive prevention approach that combines "Talk + Services + Livelihoods." In addition to consultations at the youth center, GYC organizes health dialogues through community outreach to selected sites; visits to schools for health talks; home visits; support groups, such as for young mothers and adolescents living with HIV; Straight Talk clubs (in- and out-of-school); radio programs; and "infotainment/edutainment" in the form of films and sports competitions on SRH-related topics. STF further issues its own "Young Talk" newspaper targeting 10- to 14–year-olds and "Straight Talk" targeting 15- to 19-year-olds. These are made available through GYC, as well as in schools and other locations where GYC extends outreach. For services requiring specialized expertise beyond what GYC is able to provide, referrals are made to the government hospitals/health facilities, Comboni Samaritans and The Aids Support Organization for HIV care and adherence follow-up. Referral completion is followed up in circumstances of particular interest (couples with different HIV status or recurrent STIs). In cases of sexual assault, GYC refers to the hospital or private clinic for additional medical care and for post-abortion care, including additional psychosocial support. GYC also collaborates with CBOs such as Flama Medical Center for referral purposes. In Gulu District, GYC has thriving relations with the local government. GYC is a member of several district working groups on health and education within the district.

A male adolescent returned a few days after he had received counseling about peer pressure he was experiencing to have sex. The adolescent said to the outreach worker, "Thank you, you saved my life." Such positive feedback is motivating. (GYC peer educator)

Program hours: GYC is open from 8:30-17:00 during the week, and also on Saturdays. Sexual assault survivors can seek services from 8:30-17:00 seven days/week. A hotline is available 24/7.

Staffing: GYC is overseen by a center coordinator. Other staff include clinical, counseling, laboratory and finance/administration staff. Additional management support is provided through the STF head office in Kampala. GYC provides internship opportunities to students interested in gaining experience in youth-

friendly service delivery. All clinical and counseling staff have been trained in adolescent-friendly service provision and prevention of GBV, including clinical management of sexual assault survivors. GYC also works with roughly 30 peer educators from the community.

Involvement of adolescents: Adolescents report that they participate in GYC program design through taking part in drama, volleyball and football competitions. They share ideas through such fora.

Privacy: Staff are trained to maintain confidentiality, and GYC is situated in a private location.

Data: Routine data on HIV counseling and testing, IEC materials distributed and uptake of family planning and STI services are recorded by the clinician/counselor/laboratory technician on designated forms. The data manager then transfers the information to a database for analysis by STF-Kampala. Monthly reports are sent to the district headquarters. STF also uses data from GYC to inform decisions on programming.

Challenges faced and solutions developed

Funding and changing donor priorities: GYC has been supported by donors with short-term programs. Donor changes have led to priority shifts, affecting GYC activities. The number of family planning clients peaked in 2008 as a resulted of a targeted grant; the current major donor is focused on HIV/AIDS.

- STF addresses the issue of changing donors and priorities by approaching funders that share STF's goals and vision. It is also looking to diversify the donor base with those that have broader interests. To enable seamless services, family planning services are integrated into HIV programming. GYC addresses ASRH holistically.

Commodity security: GYC frequently faces stock-outs of RH supplies, as government procurement channels are used. EC, implants, injectables and female condoms are often in short supply. This is disappointing for adolescents and limits uptake. Antibiotics to treat STIs, especially ciprofloxacin and clotrimazole pessaries, have also been unavailable.

- When EC is out of stock, higher doses of combined oral contraceptive pills are used. GYC has tried to source contraceptives from other partners; when another organization provided Implanon, uptake increased between June and July 2012 among 17- to 29-year-olds.

Community resistance to ASRH: When GYC first opened in 2004, demand from adolescents for SRH services was high as there was a lack of alternative service points during the conflict. However, GYC experienced resistance from the broader community. Adults felt that GYC was "teaching young people to have sex" rather than offering sexuality education to teach adolescents what it means to transition into adulthood.

- Positive attitudes have developed over time. GYC managed to gain community acceptance through its radio programs, as well as through collaborating with cultural and religious leaders. It convened adolescents in conversations to think critically; the talks attracted them and "Straight Talk" became a label for what it was. GYC continues to sensitize adolescents both in- and out-of-school, as well as parents.

Reduced clientele in a changing environment: During the conflict, when adolescents were living in camps, more came to GYC. Fewer have come as IDPs return home. Follow-up with adolescents who have returned home post-conflict has been similarly difficult due to challenges in locating them.

- In order to continue reaching adolescents despite population movements, STF organizes mini outreach activities to different divisions of the municipality and rural areas. It also conducts home visits to those with disabilities, many of whom were injured during the conflict. STF has learned that innovation is necessary to target out-of-school adolescents, adolescents with children or those in commercial sex work. Outreach outside regular youth center hours have been a helpful strategy. Active outreach has enabled GYC to maintain contraceptive uptake.

Low female attendance: At one point, GYC experienced low female attendance.

- STF addressed the gender imbalance through initiating gender-structured dialogues and other girl-friendly approaches, such as the use of female counselors to meet female clients. The dialogues offered open fora for girls to discuss their concerns, particularly related to the conflict. With time, such spaces presented opportunities for SRH discussions. STF additionally targets men and boys to change their attitudes towards women and girls through providing them with knowledge about the important role men play in the use of contraception by their partners. Additionally, female clients are encouraged to seek services with their male partners.

I heard announcements on the radio that young people can gather together, play and get information at GYC so I decided to come here. (Female adolescent client)

Factors leading to success

Combining prevention approaches: STF's combination prevention approach within free and comprehensive services has been critical to GYC's success. The addition of livelihoods plus skills-building for SRH has been effective at empowering adolescents and creating cohesive communities for vulnerable groups, such as young mothers and the HIV positive. Counseling is further integrated for family planning and HIV/AIDS. GYC providers strive to be non-intimidating, non-judgmental, friendly and patient for adolescents to feel comfortable in discussing their concerns.

Figure 5: Method accepted among family planning clients

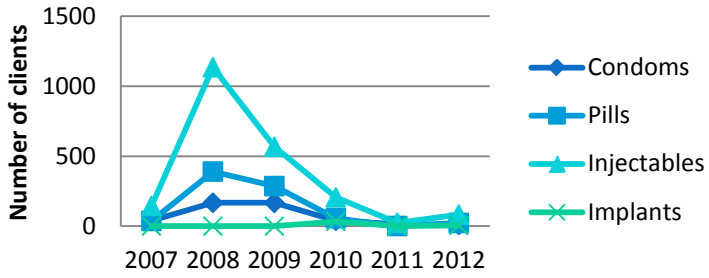
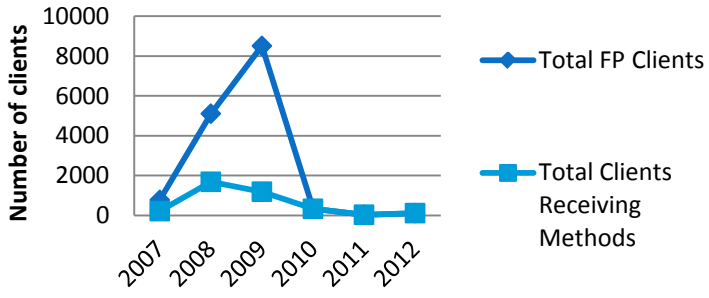


Figure 6: Clients accepting contraceptives among total family planning clients



Infotainment/edutainment and outreach: GYC's infotainment/edutainment activities are attractive to adolescents. In addition to facilitated discussions through film and entertainment, GYC embarks on major communications initiatives where print messages are available in four languages; STF radio for adolescents in 13 languages; STF radio for parents in nine languages; and free SMS texting services for family planning and SRH information through a partnership with Google and a local cell phone network. Face-to-face communications, interactions with peers and the Straight Talk Clubs also offer avenues for

in-person support. Such outreach has enabled even younger adolescents, many of whom laugh and giggle when family planning is discussed, to ask for contraceptives. GYC has created demand beyond condoms, including injectables among younger adolescents, and implants among older adolescents.

Motivated peers: While some peers reported the lack of a reliable salary as a challenge, GYC peers receive a stipend, cell phone airtime and mobilization funds when they facilitate field activities, which reportedly motivate them in their work. GYC also makes peers feel important through recognizing and praising their work in public. STF has learned that peer educators may not be as effective at improving knowledge, attitudes and behaviors at the community level if too much time is spent on training, if retention becomes a challenge or if donors set unreasonable targets. However, peers can be effective if they can sustain programs, and they serve as role models in the community. GYC makes an effort to address motivation and provides refresher trainings, structured supervision and ongoing mentorship.

Catering to diverse needs: GYC targets all categories of adolescents, including those in-school/out-of-school, married/unmarried, disabled or living with HIV.

Institutional capacity strengthening: Similar to its work with peers, STF provides refresher courses to staff and promotions within. It further has strong finance and human resource systems to enable program staff to concentrate on their work. STF offers upward mobility, whereby many of the regular staff were previously peer educators. Two senior staff at GYC have worked at the center since its inception; this has helped with program continuity and institutional memory.

After establishing the GYC, STF opened a similar youth center in Kitgum in 2007 to offer ASRH services. It has also opened an office in the Karamoja region, where the current focus is on awareness raising.

****Data collection activities**

Case study data (staff interviews, exit interviews, facility observation, outreach worker FGD; adolescent FGD) were collected on July 19, 2012 in Kampala and August 1-2, 2012 in Gulu. The outreach worker FGD comprised one female and three male peer educators, 22-26 years of age. Separate adolescent FGDs were conducted among 10 boys aged 16-22 (two above 19 years), and 10 girls aged 15-22 years (two above 19 years). Informed consent was sought from all participants prior to the data-gathering activity. The FGD data are not representative, given that saturation was not sought for this exercise.

IV. Bringing the Learning Together

Despite the limited number of existing ASRH programs in humanitarian settings, the three case studies, as well as several other programs that demonstrate promising approaches, offer lessons and innovative strategies to addressing often similar challenges for ASRH in humanitarian settings.

Across the board, **successful programs have ensured stakeholder involvement to build community trust and secure adult support**. All three case study programs reported adult objection or community resistance to ASRH during the early days of programming. However, by thoughtfully engaging community and religious leaders, parents and other stakeholders in program design, implementation and outreach, the programs gradually won the community's trust and respect. The hiring and training of outreach workers and peer educators, especially from vulnerable groups in the community, appear to contribute to building support to ASRH programs. The American Refugee Committee's (ARC) school-based ASRH program in Gihembe refugee camp in Rwanda has additionally recruited peer educators from trusted counselors already engaged in its HIV program, which improved the community's comfort and acceptance of the ASRH component (see page 24). Working from what the community is ready to accept is an opportune place to begin.

Adolescent participation and engagement, beyond token participation and from the onset of an emergency, is critical to building adolescent buy-in and increasing demand for services. Many organizations through the ASRH program mapping survey reported adolescent perceptions as barriers to increased use, or only engaged youth above 20 years of age, rather than

Highlight 1: Holistic programming to address adolescent girls' needs in emergencies
Haiti Adolescent Girls Network

Program

The Haiti Adolescent Girls Network (HAGN) is an innovative model of holistic programming for adolescent girls in emergencies. The network comprises a number of local and international NGOs working on adolescent programming in education, protection, GBV and health. Member agencies decided to come together to address the critical surge in vulnerability of adolescent girls aged 10-19 following the earthquake that devastated Haiti in 2010, and it continues to address and empower girls living in the departments of Ouest, Nippes, Centre, Sud-est, Artibonite and Sud.

Method of Providing Services

HAGN created girl-only safe spaces to encourage adolescent girls to access an environment that enabled them to learn, communicate and foster healthy relationships with their peers. As many girls faced the threat of violence and transactional sex due to poor living conditions, HAGN promoted a model of economic empowerment to improve health outcomes. This included life-skills, literacy, numeracy and vocational training to empower young girls with opportunities for alternative sources of income. Additionally, comprehensive sexuality education was offered to sensitize adolescent girls on age-appropriate SRH and GBV information, and referrals were made to adolescent-friendly health services provided by a partner organization, *Profamil*. Adolescents were able to access a range of SRH services at *Profamil*, including contraception; STI/HIV testing and treatment; antenatal, delivery and postnatal care; and clinical care for sexual assault survivors. *Profamil* also relied on a peer education model for information sharing and counseling, encouraging adolescents to access the adolescent-friendly facility.

Points of learning

Effective coordination and collaboration of humanitarian agencies can have a tremendous impact on ensuring information and services are provided in a holistic way to all affected in an emergency, but particularly for vulnerable individuals such as adolescents. Positive ASRH outcomes can be achieved when its multiple influences, such as prevention and treatment of GBV; reducing gender and economic inequalities; and promoting education are recognized and addressed, even in fragile settings. Additionally, during an emergency, coordination mechanisms are recognized and appreciated by donor agencies, the UN and the national government as a source of cohesive information and a system to maximize limited resources.

Highlight 2: Using schools to maximize reach and retention of adolescents within health services
American Refugee Committee, Gihembe camp, Rwanda

Program

The American Refugee Committee (ARC) has worked in Gihembe camp in Rwanda since 1997 to address the needs of refugees from North Kivu, DRC. In 2006, the program expanded to reach adolescents through specific school-based efforts. The aim was to go where youth are located, and provide a positive health experience through the provision of information and referrals for family planning and HIV voluntary counseling and testing (VCT) at the health center. The proximity of the health center to the school was of benefit for this model, as it was located across from the school.

Method of providing services

At least once a week, an activity is implemented by ARC's *Youth Program on Reproductive Health* at the primary and secondary school in Gihembe camp. Health educators lead ASRH sensitization activities with adolescents in each class. The staff move systematically through the school classrooms, shifting the focus each week to ensure the entire school is covered by the end of the year. The program incorporates nurses from the health facility as a way to engage in-school adolescents in the health care system. Based on need, adolescents are then escorted to the health center for family planning services. VCT referrals occur on specific youth testing and counseling days.

Although the core of this intervention is a school-based program, ARC's program has addressed one of the key criticisms of school-based programs by establishing parallel mobile outreach to out-of-school adolescents. ARC organizes drama programs with clear messages targeting this group and similarly assists with referrals for family planning, premarital consultations and VCT services at the health center. The program has also established a team of peer educators for sensitization activities and condom distribution.

Points of learning

Addressing SRH among adolescents is a challenge in many communities, and working with refugees from North Kivu is no exception. Although the stigma around family planning remains, sensitization was a core element of the program from its point of inception. Before the program, community members, religious leaders and groups of women and youth were convened for education activities related to the planned program. Program implementers acknowledge that the beginning was tough, "Because it was even taboo to talk about family planning for youth, even with adults." However, albeit slow, progress has been made. Sensitization was notably not a short-term activity.

Educators and providers were selected from the community in a manner that built support for the program. Peer educators were selected from different beneficiary populations, ensuring representation from both genders and from vulnerable populations targeted by this intervention. Additionally, many of the family planning providers were identified from the VCT program, since they had previously been working as VCT counselors. Expanding their role to counsel adolescents on family planning improved the communities' comfort and acceptance of the program. Working from what the community was ready to accept was one of the key points of learning from this program.

the 10-19 age group. Profamilia and STF's programs, in particular, have succeeded in actively engaging adolescents in the design, implementation, monitoring and evaluation of their programs. Ensuring that program improvements are based on adolescent input—including those of younger adolescents and other adolescent sub-groups—appears a critical component to iterative processes that guide good practice programming.

Successful ASRH programs are responsive to the different needs of adolescent sub-populations. Despite the reported lack of acknowledgment of the unique needs and vulnerabilities of adolescents in humanitarian settings, effective programs accept adolescents as a distinct population with specific needs and understand the heterogeneity of this group. The IAFM ASRH chapter lists a series of vulnerable groups among adolescents. These include very young adolescents 10-14 years; girl mothers; orphans and vulnerable children; child heads of households; young married girls; HIV-positive adolescents; child soldiers and other children associated with fighting forces; adolescents engaged in transactional sex; adolescent survivors of GBV; and adolescents engaging in same-sex intercourse.[43] Indeed, STF convenes support groups for vulnerable groups, such as young mothers and adolescents living with AIDS, and further reaches out to those in- and out-of-school, the married and unmarried and adolescents with disabilities. Acknowledgment of unique and distinct needs also allows programs to identify who is not being served and strengthen weaker areas, such as limited attendance of girls or younger adolescents in program activities.

Qualified and dedicated ASRH staff, including clinical staff, are crucial to good quality service provision. A frequently reported challenge to ASRH programming through the mapping exercise was non-adolescent friendly provider attitudes and provider biases. Stronger programs, however, recognize that adolescents have specific health needs and require care by providers that understand these needs, can communicate effectively with this age group and can maintain confidentiality. Such programs place heavy emphasis on identifying and recruiting staff—including female providers—with this background, as well as investing in staff awareness training, ongoing training and the provision of additional support. The Save the Children/UNFPA ASRH Toolkit is a useful tool for staff training in this regard.

The provision of comprehensive SRH services for adolescents at a single site can increase service utilization. Weaker ASRH programs offer limited components of SRH services, such as condom distribution primarily for HIV prevention purposes rather than for dual protection, or provide contraceptives without adequate sexuality education or counseling. Stronger programs offer multiple entry points to SRH services for adolescents. STF's model is a good example, where the agency has integrated family planning and HIV counseling. Integration of services, including sexuality education, skills building, family planning, HIV and comprehensive abortion care where legal, improves use among this critical population for whom referral completion can be challenging.

Highlight 3: Reaching refugee and IDP adolescents in urban centers
Family Health Options, Kenya - Nairobi, Kenya

Program

Family Health Options, Kenya (FHOK), an International Planned Parenthood Federation member association, has been running a youth center in Eastleigh, Nairobi, since 1986. Eastleigh, located in East Nairobi, is a predominantly Somali neighborhood. Only a fraction of residents are formally recognized as refugees or asylum seekers, meaning access to vital health services is compromised for many. FHOK's youth center was established to respond to the SRH needs of adolescents in this underserved community, through appropriate youth-friendly strategies. Adolescents from the Somali community, as well as other parts of the city, openly use the youth services that have been made available.

Method of providing services

FHOK's youth center serves adolescents and youth 10-24 years of age. The center provides SRH and general health services, life skills, entrepreneurial training, business skills and vocational training (hair dressing, fashion and design) for nearly 150 youth each day. The program reports that it is currently unable to meet the demand of the youth that it serves. Health services, available onsite, are non-stigmatizing and easily accessed from within the youth center. The health clinic provides a wide variety of long- and short-term methods of contraception, as well as other SRH services. Adolescents coming to the clinic are counseled by a trained nurse, and provided with an appropriate family planning method, as needed. The majority of clients served by this program are continuing users of family planning.

Points of learning

This youth center demonstrates a project that has successfully attracted adolescents to a multi-service center. Health programming in urban centers demands service provision to both the host and migrant communities. Migrants do not live in isolation, but rather in diverse communities, and their health status has an impact on the community at large. By providing services to a broader community, the acceptance and long-term sustainability of these urban programs is improved.

However, FHOK points out that it has not been as successful as it needs to be. Although the center has embraced this strategy, and is widely accepted by the host community, family planning services are not successfully reaching the refugee and migrant youth whom the program was initially intended to serve. The director notes that the program has been wildly successful as a youth center, and even pulls youth from other areas of Nairobi. However, the cultural barriers to family planning within the Somali community have not been adequately overcome. If more staff and funding were available, FHOK believes that they could invest in better catering to the population for which the program was initially designed. Although many Somali youth attend the center, few to none have accepted family planning, which has been disheartening.

Highlight 4: Emergency preparedness in ASRH UNFPA Humanitarian Consortium, Philippines

Program

Initiated by UNFPA Philippines, this pilot program is intended to train and prepare key partner agencies to respond to SRH, GBV and ASRH concerns in emergencies. The Humanitarian Consortium was created in July 2012 in the aftermath of Typhoon Washi (December 2011) as a platform to prioritize SRH, GBV and ASRH in forthcoming emergencies to sensitize communities and local government authorities to help mitigate these risks.

Method of providing services

The Humanitarian Consortium comprises key local and international NGOs working on SRH, GBV and ASRH programming in the Philippines. The ASRH partners of the Humanitarian Consortium include Family Planning Organization of the Philippines (FPOP), Save the Children and Zone One Tondo Organization (ZOTO). Identified program staff from these organizations, many who work in disaster-prone sites in Metro Manila and Mindanao, attended a training of trainers (TOT) workshops on the MISP for RH and the ASRH Toolkit in Humanitarian Settings. They in turn held internal trainings for their health and emergency teams and external trainings with representatives from the City Health Offices and local partner organizations. Additional activities of the Consortium included pre-positioning RH kits in Manila and Mindanao, standardizing information, education and communication (IEC)/behavior change communication (BCC) materials and advocacy messages, forming youth committees and training peer educators on how to conduct age-appropriate and culturally sensitive health information sessions. In addition, a concerted effort has been made to include ASRH-specific questions in emergency assessment tools such as the disaster tracking matrix and Multi-cluster Rapid Assessment (MIRA).

Points of learning

ASRH remains a largely overlooked programming area in emergency response as it is argued that sensitive issues of gender norms and sexual practices cannot be addressed in the midst of a humanitarian crisis. However, in fragile states and emergency-prone countries, these issues can be proactively addressed through the lens of emergency preparedness and disaster risk reduction. Government officials, health workers, religious leaders, parents and communities can be convinced of the risks that adolescents face during an emergency, the importance of having essential information and taking precautions to mitigate these risks. Simultaneously, adolescents are empowered with information they may not routinely access and made aware of youth-friendly services that they may not have known existed. Pre-positioning supplies, having IEC/ BCC materials and a pool of trained peer educators propels ASRH programming to take effect from the initial stages of an emergency.

Stronger ASRH programs take a holistic, multi-sectoral approach to ASRH programming that moves beyond facility-based health services and a siloed SRH focus. Through network models, strong referral mechanisms and/or provision of comprehensive programming, stronger ASRH programs offer adolescents more than just clinical SRH services. Serving the "whole person" has been found to be a critical approach, especially where programs are trying to increase demand for less frequently sought services, such as family planning. ARHN's youth center offers GBV protection services to adolescents through members and partners, including access to safe houses and psychosocial care. The Haiti Adolescent Girls' Network (HAGN) builds demand for ASRH services by offering life skills, literacy and numeracy education for economic empowerment (see page 23). With its cutting-edge combination of prevention approaches, "Talk + Services + Livelihoods," STF has been a critical contributor to empowering and building social networks among vulnerable adolescents (see page 19). Family Health Options Kenya offers life skills, business skills and vocational training at its urban youth center in Eastleigh, Nairobi; a safe space that also uses recreational activities such as drama, a gymnasium, a TV lounge and an Internet café to attract adolescents (see page 25). Profamilia in Colombia has found the inclusion of leadership skills as a key component to facilitating adolescents' active and meaningful participation in society (see page 15). Hence, using varying models of ASRH programming, stronger programs provide or adopt holistic, integrated approaches.

Stronger programs provide refresher trainings, structured supervision, recognition and ongoing mentorship to peer educators to address motivation and retention challenges. All three case study

programs reported peer retention as a challenge, given the crisis-affected nature of the setting and other commitments for adolescents. Profamilia addressed this by reducing training hours, enabling flexible outreach schedules and not instituting quotas on the number of hours to serve. STF supports peers to serve as role models in their communities, recognizing and praising their work in public venues. ARHN enables experienced peers to mentor younger and newer peers. The provision of supervision and mentorship by qualified staff through a system of consistent feedback and guidance appears central to addressing peer retention, sustaining program quality and supporting the development of adolescents.

Flexible outreach strategies, as well as the inclusion of transportation budgets, are necessary to reach adolescents in insecure environments and otherwise hard-to-reach areas. While different crisis-related circumstances prompt varying communications strategies and visibility efforts, learning from the three case studies show that creative and flexible strategies can in fact enhance adolescent access to SRH services. Profamilia dispatched mobile health brigades that brought services to crisis-affected communities, and the organization leveraged ties with the communities to enable informal follow-up with clients. The inclusion of travel support in program budgets also appears imperative, especially as humanitarian settings are compounded by the lack of medical and other human resources. A conscious prioritization is necessary if access to services is to be improved for adolescents. Engaging adolescents as community-based distributors is an additional a way to improve access.

Addressing ASRH during emergency preparedness can help to ensure that the critical needs of this population are not overlooked at the onset of emergencies. Some of the most promising examples of ASRH programs able to implement services in an emergency were those that existed before the crisis. These programs have had the benefit of time in-country to build community trust, such as the examples from Colombia and Uganda where a country program was expanded to reach crisis-affected adolescents. UNFPA in the Philippines has also attempted emergency preparedness in ASRH, where the pre-positioning of supplies, readily available IEC/BCC materials and trained peer educators can better ensure that the SRH needs of adolescents are addressed in the early stages of an emergency (see page 26).

Despite the good practices in humanitarian settings, however, challenges and gaps still remain. Limited **commodity security raises expectations, only to result in disappointment where demand has been created**. While stronger programs provide emergency contraception through combining oral contraceptive pills where a dedicated pill is not available, for example, the lack of SRH supplies is problematic and remains a continued challenge for organizations.

Adolescents in action during the Typhoon Washi (Sendong) response in Cagayan de Oro, Mindanao, Philippines.
© UNFPA Philippines

While most identified ASRH programs did not collect enough information for in-depth analysis, even the case study examples demonstrated fluctuations in uptake of contraceptive methods among adolescents over the years. The commonly reported cause of dips was a **result of shifts in funding and donor priorities**. This shows the strong role donors play in the provision and uptake of ASRH services.

Furthermore, the lack of program evaluations at large that measure impact at the population level, as well as attempts to disaggregate data by age and sex where SRH data are collected, make definitive

conclusions on effective programming impossible. More information would be helpful to addressing the needs of the diverse sub-populations that comprise adolescents, as well as the "how" to implement certain components for effective outcomes where good practice is emerging. These include examining:

- the unique SRH needs of very young adolescents, and their preferences for having their needs met;
- the unique SRH needs and outreach strategies for married and unmarried adolescents;
- the unique SRH needs and threats for male adolescents in humanitarian settings;
- how to make peer education programs effective in humanitarian settings;
- how to advocate and effectively provide long-term family planning methods to adolescents living in humanitarian settings;
- holistic, multi-sectoral models for health, protection, education and livelihoods that impact ASRH outcomes at the population level;
- ASRH program models across the relief to development continuum from crisis, post-crisis through recovery.

Disabled adolescents also have SRH needs that should not be overlooked.
© *T. Falise, UNHCR, Thailand*

V. Conclusion

Although ASRH is receiving increased attention in both development and humanitarian contexts, there is a paucity of programs that address the SRH needs of adolescents in humanitarian settings and data that show their effectiveness. The mapping activity that the WRC and Save the Children conducted between March and August 2012 demonstrates that ASRH programs in humanitarian settings remain rare, with a mere 37 programs addressing the SRH needs of adolescents since 2009. Only 21 programs among the 37 provided at least two methods of family planning.

Notable practices are emerging in ASRH in humanitarian settings, however, especially those that have successfully involved stakeholders to build community trust and realized adolescent participation and engagement—including that of vulnerable sub-groups—in program design, implementation, monitoring and evaluation. Stronger programs also appear to integrate clinical SRH services, as well as adopt a holistic, multi-sectoral approach to ASRH programming to provide or include life skills, literacy, numeracy, vocational training and livelihood skills, among other relevant services. Further, such programs have also developed creative strategies to address inherent crisis-related challenges, such as insecurity and staffing shortages.

Despite good practices, challenges and gaps remain in terms of limited commodity security, as well as donor-influenced shifts in program priorities. For improved access to ASRH services for crisis-affected adolescents, donors, governments, humanitarian organizations and development agencies need to urgently address ASRH from the onset of an emergency through protracted crisis and recovery. Investments in ASRH programs that target vulnerable adolescents will help girls stay in school, marry later, delay childbearing, have healthier children and earn a better income that benefits themselves, their families and their communities.[44] In humanitarian settings, investments in ASRH from the onset of an emergency are expected to mitigate the compounded vulnerabilities of adolescents to unwanted pregnancy, unsafe abortion and STI/HIV infection that result from the lack of access to SRH information, high sexual risk-taking, the increased risk of SEA and the disruption or inaccessibility of much needed SRH services.

VI. Annexes

- Annex 1: Methodology
- Annex 2: Limitations
- Annex 3: Roster of ASRH Programs Providing at Least Two Methods of Family Planning
- Annex 4: ASRH Program Mapping: Summary of Key Findings
- Annex 5: Mapping of all ASRH Programs (online at http://wrc.ms/Vu9btu)
- Annex 6: Online survey tool (online at http://wrc.ms/14qFolN)
- Annex 7: Case study tools (online at http://wrc.ms/X6qpYb)

Annex 1: Detailed Methodology

The research undertaken includes a mapping of ASRH programs and collection of good practice case studies. For this research, a humanitarian setting was defined as a setting affected by a conflict or disaster that overwhelmed existing in-country capacity since 2009.

Mapping of existing ASRH programs

The WRC and Save the Children undertook a mapping of existing programs implemented since 2009. This cut-off year was selected based on known funding cycles in emergencies and the likelihood that information would be available. The mapping identified and examined ASRH programs through:

- circulating an online survey in English and French to professional networks working on adolescent programs in humanitarian and development communities, and identifying key contacts through Internet-based resources and published literature on ASRH programs;
- reviewing health sector Flash and Consolidated Appeals Process (CAP) appeals to identify proposed and funded projects;
- conducting outreach to identified referrals and networks to capture less-visible programs.

Online survey for practitioners

An online survey for practitioners was developed on SurveyMonkey to scope available programs and to obtain detailed information about identified programs. A piloted questionnaire comprising 16 close-ended and four semi-structured open-ended questions was administered to each respondent per program. Using a snowball sampling approach, contact was made with approximately 1,200 IAWG members representing some 450 NGOs, UN agencies, academics institutions that form the IAWG on RH in Crises listserv. Additional outreach was made through the adolescent working group within the CORE group.[45] All respondents were asked whether they were aware of any ASRH programs in humanitarian settings, and possible contacts that might have more information. If respondents indicated that they were positioned to discuss an ASRH program, program-related questions were asked.

The majority of participants completed the survey on SurveyMonkey, although a handful shared responses in hard copy. The survey was open from March through August 2012. All relevant programs are listed in the program mapping matrix (see Annex 5); consent was sought to list key contacts.

Funding analyses

The Flash appeal is a tool for structuring a coordinated humanitarian response for the first three to six months of an emergency, with the goal of providing funding to urgent life-saving services.[46] If the emergency continues beyond six months, the Flash Appeal may be developed into a Consolidated Appeal for 12 months.[47] The UN Office for the Coordination of Humanitarian Affairs (OCHA) coordinates the appeals process and manages the Financial Tracking System (FTS), a global, real-time

database that records all reported international aid from UN agencies, NGOs and the Red Cross/Red Crescent Movement to crises where appeals have been launched.[48] All proposals are accompanied by a 1- to 2-page narrative description; thus, it is possible to review relevant appeals to assess commitments to ASRH.

Appeals for new emergencies that were made between 2009 and October 2012 were included in the analysis. All proposals listed under the health sector were scanned for ASRH-related programs, using key words such as "youth," "young" and "adolescen(t/ce)," or specified an age range that included between 10 and 19 years. Proposals were assessed for the degree to which they targeted adolescents and which SRH-related activities were considered. From among the identified proposals, relevant programs that were at least partially funded were contacted to ensure inclusion within the program mapping. Programs were excluded if they did not provide any direct services to the affected population.

Compilation of the program mapping

The following elements were inclusion criteria for the ASRH program mapping:

- Implemented in crisis-affected settings at large, including post-conflict settings.
  - For programs implemented in post-conflict or protracted contexts, additional criteria were applied. The program must have contained a family planning component—defined as providing at least two modern methods of contraception—and this component must have been initiated during or immediately after the crisis and the program continues to exist.
- Targets the age group between 10 and 19 years.
- If not a dedicated ASRH program, targets adolescents as part of broader SRH programming.

To contextualize the program mapping, the WRC and Save the Children further conducted 13 key informant interviews with humanitarian SRH practitioners for an understanding of what makes ASRH programs successful.

Good practice documentation through case studies

From among the programs identified through the mapping exercise that provided at least two modern methods of contraception, three were selected to illustrate service delivery models that demonstrated effectiveness in reaching adolescents and improving contraceptive uptake through their outreach, communications or service delivery approaches. Contraceptive uptake was used as a marker of effective ASRH programs, given the importance of pregnancy prevention in adolescent lives.

Through examining the programs in depth, the study team aimed to understand the following:

- What are "effective" models and practices for delivering adolescent family planning services?
- How have programs reached adolescents with family planning services, especially the most vulnerable?
- Have programs conducted specific outreach to very young adolescents, and have these efforts been successful?
- What communication strategies were employed?
- What measurable change was observed in uptake over the course of the program?
- What systems are in place to examine, re-examine and adjust existing programs?
- What are the perspectives of adolescents of these services?

The data collection activities conducted between July and September 2012, for each case study were:

- Key informant interviews among program and clinical staff to learn about iterative processes.
- Exit interviews with adolescents using ASRH services, particularly family planning services, to learn about positive aspects of the program.
- Facility observation to examine the level of adolescent-friendliness.
- Focus group discussions with community adolescents and outreach workers to gain their perspectives.
- Analysis of program indicators to observe trends on service use and contraceptive uptake.

Annex 2: Limitations

This assessment of the state of the field in ASRH in humanitarian settings faced a number of limitations. One of the most significant is the ability to truly gather data from every ASRH program that existed since 2009. The study team hopes that the snowball sampling approach (including outreach to regional coordinating bodies for ASRH), inclusion of humanitarian appeals analyses and long data collection period minimized the possibility that programs went undetected. However, the team acknowledges that such oversight is possible. Additionally, all information gained through the mapping exercise was self-reported, and although verified with each program, selective exclusion or misreporting of information may be possible.

Programs where no contacts could be identified, or where no communication could be established, were excluded from the final mapping matrix and analysis. A similar limitation was experienced with regard to the case studies. While five programs were initially identified to serve as possible case studies, two could not be visited due to limited communications with the program and other constraints.

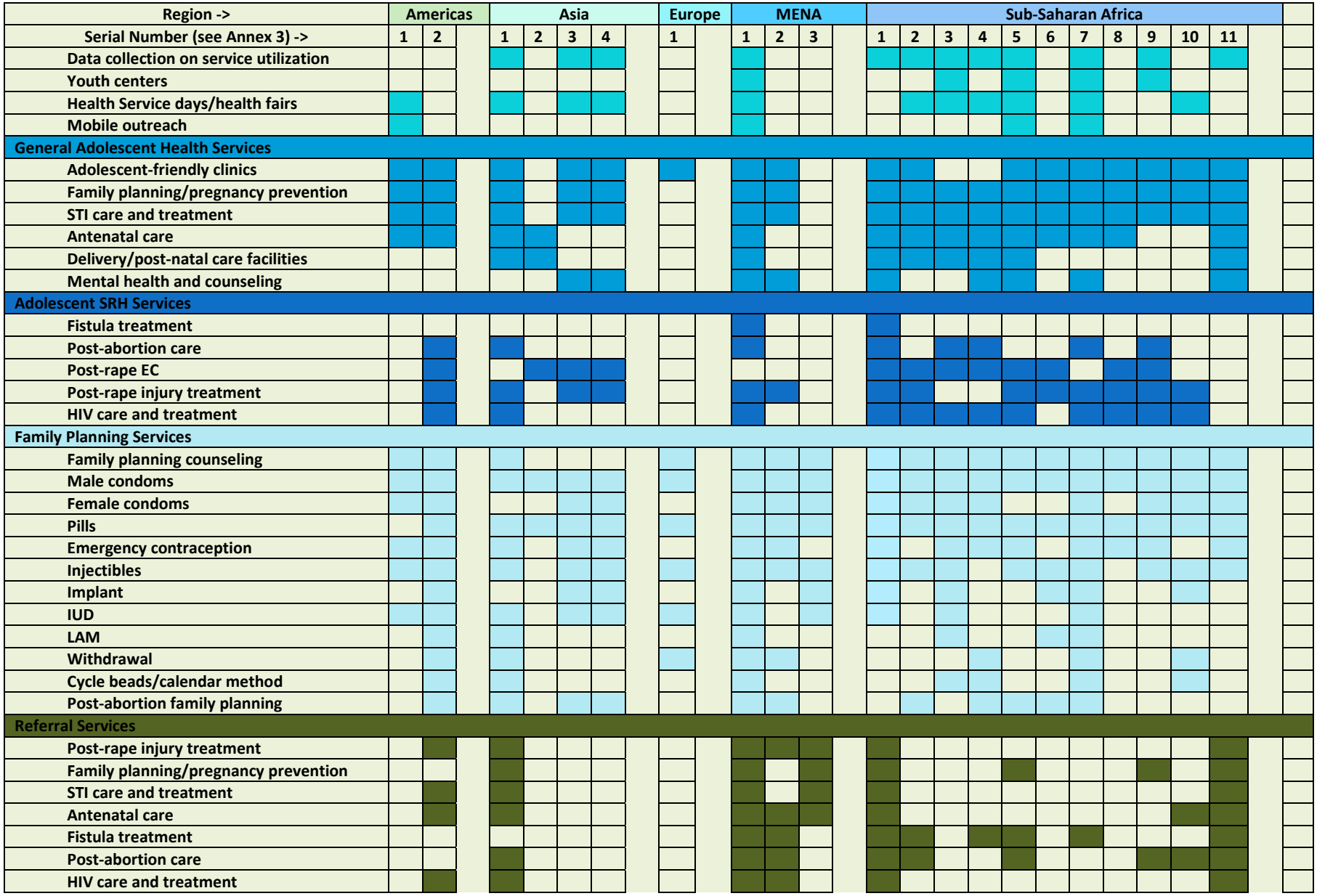
The collection of case study information was limited for the Profamilia site in Colombia. Due to funding challenges in 2011, this was the only project that was not functioning at the time of the visit. Nonetheless, given the longstanding presence in the region, clients, outreach workers, prior medical providers and others were available to reflect on the program.

Annex 3: Roster of ASRH Programs Providing at Least Two Methods of Family Planning

Region	No.	Country	Program
AMERICAS	1	Colombia	Health services for the displaced and other vulnerable groups in the Colombian Pacific Region
	2	Haiti	Profamil ASRH program
ASIA	1	Pakistan	Community-based comprehensive health services and livelihoods opportunities
	2	Thailand	Primary health care and GBV capacity strengthening for Burmese and ethnic minority refugees on the Thai-Burmese border
	3	Thailand	Adolescent Reproductive Health Zone
	4	Thailand	Adolescent Reproductive Health Program
EUROPE	1	Albania	ASRH Program by UNFPA Albania
MENA	1	Lebanon	Save the Children ARSH Program- Lebanon
	2	South Sudan	ASRH (PEARL)
	3	Tunisia	Youth Peer Education in Humanitarian Settings, UNFPA
SUB SAHARAN AFRICA	1	Central African Republic	UNFPA Program for Women and Adolescent Girls
	2	Chad	Promotion of behavioral changes for preventing HIV/AIDS and improvement of medical/psychosocial care in Dar Sila region
	3	Democratic Republic of Congo	2011 UNHCR South Kivu Project
	4	Democratic Republic of Congo	Humanitarian assistance to affected populations in Sud Ubangi region during the "Enyele conflict"/DRC
	5	Democratic Republic of Congo	STAREC project 2011, International Medical Corps (IMC) in DRC
	6	Ethiopia	Responding to SRH and GBV in Dollo Ado refugee camps in the Somali region of Ethiopia
	7	Kenya	Family Health Options Kenya-Nairobi Youth Center
	8	Rwanda	Provision of multi-sectoral services to Congolese refugees in Gihembe, Kiziba and Nyabiheke refugee camps, Rwanda
	9	Sierra Leone	Reproductive Health for War-affected Youth (RH-WAY)
	10	Sierra Leone	Gender Equality and Sexual Reproductive Health Rights und CPAP 2008-2010
	11	Uganda	Reducing the risks and vulnerability to sexual and reproductive health problems among adolescents

Annex 4: ASRH Program Mapping: Summary of Key Findings

Region ->	Americas			Asia					Europe		MENA				Sub-Saharan Africa												
Serial Number (see Annex 3) ->	1	2		1	2	3	4		1		1	2	3		1	2	3	4	5	6	7	8	9	10	11		
Program Development Components																											
A needs assessment																											
Community involvement																											
Parent involvement																											
Adolescent participation																											
Available tools or guidance materials																											
Training																											
Communication and Outreach																											
Peer workers																											
Plays or theater																											
*IEC/**BCC																											
Radio programming																											
Television programming																											
Cell-phone texting																											
Helpline																											
Computer literacy																											
Youth centers																											
Parent involvement																											
Community leader/religious leader outreach																											
Awareness and Other Education																											
General health																											
HIV																											
Sexuality																											
Fertility																											
Gender norms																											
Health provider training																											
Parent training																											
General ASRH Services																											
School support																											
Life-skills training																											
Vocational training/livelihoods																											
Youth empowerment																											
Young mothers' programs																											
Prevention of transactional sex																											
Health service delivery																											


Region ->
Americas
Asia
Europe
MENA
Sub-Saharan Africa
Serial Number (see Annex 3) ->
1 2 1 2 3 4 1 1 2 3 1 2 3 4 5 6 7 8 9 10 11
Data collection on service utilization
Youth centers
Health Service days/health fairs
Mobile outreach
General Adolescent Health Services
Adolescent-friendly clinics
Family planning/pregnancy prevention
STI care and treatment
Antenatal care
Delivery/post-natal care facilities
Mental health and counseling
Adolescent SRH Services
Fistula treatment
Post-abortion care
Post-rape EC
Post-rape injury treatment
HIV care and treatment
Family Planning Services
Family planning counseling
Male condoms
Female condoms
Pills
Emergency contraception
Injectibles
Implant
IUD
LAM
Withdrawal
Cycle beads/calendar method
Post-abortion family planning
Referral Services
Post-rape injury treatment
Family planning/pregnancy prevention
STI care and treatment
Antenatal care
Fistula treatment
Post-abortion care
HIV care and treatment

Region ->	Americas			Asia					Europe		MENA				Sub-Saharan Africa												
Serial Number (see Annex 3) ->	1	2		1	2	3	4		1		1	2	3		1	2	3	4	5	6	7	8	9	10	11		
Delivery/post-natal care facilities																											
Mental health and counseling																											
Post-rape EC																											
Implementation Challenges																											
Use of services by youth																											
Knowledge of these services																											
Adolescent perception of these services																											
Availability of supplies or method																											
Provider attitudes or skills																											
Level of security in the setting																											
Community attitudes																											
Policy																											
Funding																											

Endnotes

[1] IAWG on RH in Crises, "Chapter 4: Adolescent Reproductive Health," *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (New York. 2010).
[2] Save the Children and UNFPA, *Adolescent Sexual and Reproductive Health Toolkit in Humanitarian Settings* (New York. UNFPA, 2009).
[3] The Flash and Consolidated Appeals are tools for structuring a coordinated humanitarian response in an emergency. They can be issued for both refugee and IDP situations.
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