WOMEN'S REFUGEE COMMISSION

Save the Children

UNHCR
The UN Refugee Agency

CASE STUDY:

Adolescent Sexual and Reproductive Health Programming in Goma, Democratic Republic of the Congo

December 2013

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Photographs © Isabelle Modigell, Save the Children. Cover photo: mural painted by adolescents with sexual and reproductive health messages, by Isabelle Modigell.

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Contents

Acronyms and Abbreviations

ANC	Antenatal Care
BCC	Behavior change communication
CHW	Community Health Worker
DRC	Democratic Republic of the Congo
EC	Emergency contraception
FGD	Focus group discussion
GBV	Gender-based violence
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
MoH	Ministry of Health
NGO	Nongovernmental organization
PAC	Post-abortion care
PEP	Post-exposure prophylaxis
PNC	Post-natal care
SEA	Sexual exploitation and abuse
SRC	Survey Research Center (University of Michigan)
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

In 2012, the Women's Refugee Commission (WRC) and Save the Children, in partnership with the United Nations High Commissioner for Refugees (UNHCR) and the UN Population Fund (UNFPA), undertook a year-long, global exercise to map existing adolescent sexual and reproductive health (ASRH) programs that have been implemented since 2009 in humanitarian settings and to document good practices. Despite an overall lack of SRH programming with a family planning component for adolescents 10-19 years of age, notable practices for ASRH in humanitarian settings existed. Successful programs secured community and adolescent involvement, were responsive to the different needs of adolescent sub-populations and provided holistic and multi-sectoral services.

To operationalize the learning from the ASRH study, the WRC and Save the Children embarked on a pilot project in Goma, Democratic Republic of the Congo (DRC). The project aimed to improve adolescent (10-19 years) knowledge, attitudes and behaviors around select sexual and reproductive health (SRH) issues. It achieved this objective by demonstrating key principles that:

1. addressed **adolescent involvement** in program design, monitoring and evaluation;
2. improved the **quality** of facility-based ASRH services;
3. enhanced **accessibility** for adolescents to ASRH services;
4. conducted outreach and strengthened **linkages and referrals** to existing programs; and
5. involved **community stakeholders**.

The project focused on improving the capacity of Murara Health Center to provide high quality SRH services to adolescents and enhancing adolescent knowledge and positive attitudes towards ASRH issues and healthy SRH behaviors. It targeted two groups of adolescents**:** one composed of pregnant adolescents and adolescent mothers through support group sessions; and the other, in-school adolescents in their first and second years of secondary school through peer education. Although the short project timeline restricted the ability to evaluate behavioral outcomes, program results documented improvements in knowledge and attitudes, including confidence in demonstrating correct condom use and confidence in seeking SRH information and services when needed, particularly among in-school adolescents aged 12-14 years.

Key Learning

- **Organizations—humanitarian and development alike—must invest time and staff in the development of a conducive, adolescent-friendly environment.** As found in prior research on this topic, a considerable institutional investment in time and human resources is necessary to build the environment needed to promote ASRH. Despite cost and sustainability considerations, the introduction of a solid project management team in Goma accelerated implementation. The project further reinforced that training was required at two levels: internal training for project staff, as well as external training for service providers, teachers and peer educators.
- **ASRH programs in emergencies must target achievable outcomes within short implementation timelines**. Where longer-term funding may be available, insecurity and volatility may still result in delays and unintended adaptations to programming. Results show that knowledge and attitudes are

more feasibly influenced, while behavior change is more challenging to monitor, especially in situations of instability. Further, structural and systemic barriers—for example, the inability for adolescents to attend school due to limited parental income—require programs to tailor activities to extend reach and balance the achievement of short-term success with longer-term sustainable solutions for adolescents that will remain beyond time-bound programs. Ideally, ASRH interventions should be built into every SRH proposal, as funding and sustainability can only be ensured if ASRH is seen as an essential part of SRH programming.

- **New, vulnerable groups emerge during conflict.** Conflict upends adolescents' routines and roles. As a result, specific vulnerabilities and SRH needs materialize in emergency contexts. Survivors of conflict-related sexual violence are one such group; such adolescents need to be better targeted in programming. It is imperative for protection/gender-based violence (GBV) programming to work very closely with health programming to provide holistic care for survivors that take into account their age-specific protection, psychosocial and health needs.
- **Creative strategies should be employed to reach adolescents**. Adolescents may be best reached through mediums that appeal to their interests—art and theater are such examples. The mural of SRH messages that was painted at Murara Health Center was found to be a durable approach to effectively communicate health messages, as were theater groups. Support groups were popular among pregnant adolescents/new mothers; participants reported feeling supported despite their circumstances.
- **Peer education activities should be integrated into adolescent schedules, such as routine recess hours**. As students are often required to return home immediately after school to complete chores, after-school hours for peer activities were not ideal. Based on this experience, peer education activities should be integrated into the school's recess hours or during sessions such as "life education" classes whenever possible. This is particularly feasible in the DRC where a "life education" curriculum already exists for secondary school students, which would benefit from an update, attractive adolescent-friendly resources and more participatory methods of learning.
- **Community buy-in is essential for project sustainability**. The importance of community buy-in cannot be overstated. Murara Health Center staff and school teachers were committed to addressing ASRH; once trained, these stakeholders often spearheaded problem-solving amidst tight budgets with their resourcefulness and creativity. Such resourcefulness and commitment can extend beyond a project's duration for full integration of attitudes that promote adolescent-friendly SRH services.

Based on the learning, points reinforced in this pilot are:

Donors and governments should:

- **Commit to multi-year funding for ASRH programs** so that they have time to make improvements, overcome challenges and plan for program sustainability.

Humanitarian organizations providing SRH services should:

- **Build ASRH interventions into every SRH proposal** as an essential part of SRH programming to ensure funding and sustainability of ASRH components.

- **Plan for project sustainability through selecting critical, priority interventions to sustain** where multi-year, robust funding is not available for holistic programming. Such interventions can include the continued removal of user fees, and other major barriers for adolescent access to SRH services.
- **Intentionally target specific sub-populations of uniquely vulnerable adolescents**, including, but not limited to, girls who assume risky livelihood strategies that compromise their SRH or who are survivors of conflict-related sexual violence.

Photo: Peer educators pose for a photo.

I. Introduction

Although new research shows that pregnancy during adolescence in many developed and developing countries carries a higher risk of mortality than does pregnancy for a woman in her twenties, child-bearing risks are compounded for adolescents in humanitarian settings.[1] This is due to increased exposure to forced sex, increased risk taking and reduced availability of and sensitivity to adolescent sexual and reproductive health (ASRH) services. At the same time, adolescents in humanitarian settings will have similar needs and desire for SRH information and services as their peers in non-crisis settings.[2]

To address an identified gap in documentation of programs that effectively integrate SRH services for adolescents, the Women's Refugee Commission (WRC) and Save the Children undertook a year-long exercise in 2012 to map existing ASRH programs that have been implemented since 2009 in humanitarian settings and document good practices. Findings and recommendations were summarized in: *Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services* (hereafter *ASRH Report*, http://wrc.ms/X2XF3l), that was developed in partnership with the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Population Fund (UNFPA). Findings showed that a mere 37 programs focused on the SRH needs of 10- to 19-year-olds in humanitarian settings since 2009. Only 21 of these programs offered at least two methods of contraception, and none were in acute onset emergency settings. Despite this lack of programming, notable practices for ASRH in humanitarian settings existed, and several programs showed promising approaches.[3]

While no prescriptive conclusions could be drawn on effective ASRH programming due to the limited number of programs, the WRC and Save the Children embarked on a small-scale pilot project to operationalize the learning from the ASRH study through applying some of the good practice principles that were employed by notable programs. The selected site for the case study was Goma, Democratic Republic of the Congo (DRC).

I.I Background

Due to decades of conflict and displacement resulting in severe destruction of infrastructure and social services, Save the Children in its 2013 *State of the World's Mother's Report* rated the DRC as the worst place to be a mother among 176 countries.[4] The maternal mortality ratio is 540 per 100,000 live births (2010),[5]

[1] Andrea Nove, Zoë Matthews, Sarah Neal, Alma Virginia Camacho. "Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries." *The Lancet Global Health*. 21 January 2014.(Article in Press DOI: 10.1016/S2214-109X(13)70179-7).
[2] Save the Children and UNFPA, *Adolescent Sexual and Reproductive Health Toolkit in Humanitarian Settings*, 2009.
[3] WRC, Save the Children, et al., *Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services*. (New York: WRC, 2012). http://wrc.ms/X2XF3l.
[4] Save the Children, *State of the World's Mothers: Surviving the First Day*, 2013. http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/SOWM-MOTHERS-INDEX-2013.PDF.
[5] UNFPA, *State of the World Population 2013,* 2013. http://www.unfpa.org/webdav/site/global/shared/swp2013/EN-SWOP2013-final.pdf.

and contraceptive prevalence for modern methods is a mere 5 percent.[6] The adolescent fertility rate stands at 135 per 1,000 girls aged 15-19 years at the national level.[7]

DRC adopted a National Reproductive Health Programme, or *le Programme National de Santé de la Reproduction* (PNSR) in 2008, in which SRH, including family planning services, was officially integrated into Ministry of Health's (MoH) general package of health services.[8] However, in practice, few structures prioritize RH services, especially in the country's east, including North Kivu. According to the 2010 Multi-Indicator Cluster Survey (MICS), the adolescent fertility rate is 132 per 1,000 girls aged 15-19 years in North Kivu. Among women 15-49 years of age, 44 percent were first married or in union by the age of 15. Further, of the 27 percent of women 15-24 years who have had sex with casual partners, only 9 percent reported using a condom the last time they had sexual intercourse with casual partners.[9]

Goma, located in North Kivu, has an estimated population of 767,600 persons.[10] According to the Goma Mayor's Office, there are approximately 66,900 adolescents between the ages of 10 and 14, and 60,500 between the ages of 15 and 19.[11] Among the existing public health facilities, the General Reference Hospital of Virunga and four smaller health centers in Karisimbi offer free family planning and post-abortion care services. The UNFPA-supported Murara Health Center—which offered adolescent-friendly SRH services until 2008, when the support ceased—provides a full range of family planning methods with a small consultation fee. None of the facilities offered adolescent-friendly SRH services at the time of project initiation.

Although adolescents can in theory access all health services through the health centers, a rapid assessment conducted by Save the Children in December 2012 found that this is seldom the case. Specific barriers to improved access and uptake of ASRH services include a lack of outlets for SRH information and services, including in schools; provider biases and health facilities requiring spousal "permission" for married girls or parental permission for unmarried girls; family, religious or societal beliefs and pressures around sexual initiation and discouragement over the use of contraception or other RH services; the value placed on fertility once pregnant; and the reality of sexual violence, exploitation and abuse—including by teachers in exchange for school fees and books—that prevail.[12] The prevalence of sexual violence has also led to an increased acceptance of sexual violence within communities and in the home.[13]

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[6] Democratic Republic of the Congo Multi-Indicator Cluster Survey MICS-2010: Monitoring the Situation of Women and Children. Ministère du Plan and the Institut National de la Statistique, UNICEF. May 2010. http://reliefweb.int/sites/reliefweb.int/files/resources/MICS-RDC_2010_Summary_Report_EN.pdf

[7] UNFPA, *State of the World Population 2013,* 2013. http://www.unfpa.org/webdav/site/global/shared/swp2013/EN-SWOP2013-final.pdf.

[8] Democratic Republic of the Congo Ministry of Public Health, *Programme National de Santé de la Reproduction*, July 2008. http://familyplanning-drc.net/docs/5_PolitiqueNationaleDeSanteDeLaReproduction_Juillet_2008.pdf.

[9] Democratic Republic of the Congo Multi-Indicator Cluster Survey MICS-2010: Monitoring the Situation of Women and Children. Ministère du Plan and the Institut National de la Statistique, UNICEF. May 2010. http://reliefweb.int/sites/reliefweb.int/files/resources/MICS-RDC_2010_Summary_Report_EN.pdf.

[10] Ministry of Health data, 2012. Obtained by Save the Children.

[11] Goma Mayor's Office, population data for 2011, 2012. Obtained by Save the Children.

[12] Save the Children, *Rapid Needs Assessment of Adolescent Sexual and Reproductive Health in Goma, Democratic Republic of the Congo*, internal report (Goma. 2012).

[13] Jocelyn Kelly, Justin Kabanga, Will Cragin, Lys Alcayna-Stevens, Sadia Haider Michael J. Vanrooyen. 'If your husband doesn't humiliate you, other people won't': Gendered attitudes towards sexual violence in eastern Democratic Republic of Congo. Global Public Health: An International Journal for Research, Policy and Practice Volume 7, Issue 3, 2012.

Additional risks that arise in the context of violence and displacement include family separation, loss of access to livelihoods and family income, school drop-outs and limited access to food, shelter or other basic needs.[14] These risks increase their vulnerabilities to sexual violence, sexual exploitation and abuse, early and/or unwanted pregnancy and sexually transmitted infections (STIs), including HIV, making it all the more important that health care, including SRH services, are available and accessible to this group.[15]

To apply the learning from the *ASRH Report* in a small-scale case-study, Goma was selected by Save the Children and the WRC based on:

- existing SRH service delivery and data collection mechanisms through the Murara Health Center, with referrals to Virunga Hospital;
- availability of a youth center affiliated with Murara Health Center that offered recreational spaces for adolescents;
- availability of providers, program staff and relevant sector staff that could be trained on ASRH;
- possibility for conscious targeting of vulnerable sub-groups of adolescents;
- volatility of Goma as a town that mimics other humanitarian contexts.

The intention was to demonstrate the integration of adolescent-friendly services into existing SRH services, rather than establish an entirely new SRH program from its inception.

II. Project Model

The project aimed to improve adolescent (10-19 years) knowledge, attitudes and behaviors around select SRH issues. It achieved this objective by demonstrating key principles that:

1. addressed **adolescent involvement** in program design, monitoring and evaluation;
2. improved the **quality** of facility-based ASRH services;
3. enhanced **accessibility** for adolescents to ASRH services;
4. conducted outreach and strengthened **linkages and referrals** to existing programs; and
5. involved **community stakeholders**.

These principles were selected from among the good practice principles documented in the *ASRH Report*, taking into consideration the existing infrastructure, budget, cycle of violence and feasible interventions, as well as other available resources.

The project primarily focused on:

1. Improving the capacity of Murara Health Center to provide high quality SRH services to adolescents.
2. Enhancing adolescent knowledge and positive attitudes towards ASRH issues and healthy SRH behaviors.

[14] Save the Children, *Rapid Needs Assessment of Adolescent Sexual and Reproductive Health in Goma, Democratic Republic of the Congo*, internal report (Goma. 2012).
[15] IAWG on RH in Crises, "Chapter 4: Adolescent Reproductive Health," *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (New York. 2010).

1. Improving the capacity of Murara Health Center

Training health providers on the *ASRH Toolkit*: The *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings* (*ASRH Toolkit*), was developed in 2009 by Save the Children and UNFPPA to guide health managers and providers to address barriers to ASRH service provision.[16] The toolkit complements the Inter-agency Working Group (IAWG) on Reproductive Health in Crises' *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (IAFM) adolescent RH chapter.[17] Facilitated by three Save the Children staff, a two-day training was held for seven health care providers (five female; two male) from Murara Health Center and two male teachers. Throughout the training, participants were encouraged to share their experiences and discuss how to create an adolescent-friendly environment. The training included multimedia presentations, group exercises, discussions and role plays, and was accomplished despite interruptions by cross-border insecurity. As part of follow-up support to trainees, participants were provided with a personalized ASRH resource file that was updated through the course of the project and included:

- *My Changing Body: Fertility Awareness for Young People*,[18] FHI360
- *HIV Counseling and Testing for Youth: A Manual for Providers and a Manual for Trainers*,[19] FHI360
- *Cue Cards for Counseling Adolescents on Contraception*,[20] Pathfinder International
- *Adolescent Job Aid: A Handy Desk Reference Tool for Primary Level Health Workers,* [21] World Health Organization (WHO)
- *Counseling for Maternal and Newborn Health Care: A Handbook for Building Skills*,[22] WHO

Systematizing age-disaggregated data collection and recording of key ASRH indicators: Existing registers and data collection systems were reviewed and adapted to include key ASRH indicators. In order to avoid overburdening the health center with reporting requirements, pre-existing indicators were age-disaggregated. No major changes were made except in family planning services, where a new register was introduced to record client age. Providers were mentored in the correct use of registers and data collection during supportive supervision visits. Age-disaggregated data were systematically submitted in a monthly report through the Karisimbi Bureau Central du Zone (MoH) and entered into the project database for analysis. The analyzed data were routinely shared with the health center to discuss gaps and ways to make improvements.

Creating an adolescent-friendly health center: In order to create a welcoming and confidential space for adolescents, a counseling room was created through basic rehabilitation. This room is located adjacent to the youth center's game room. The room was furnished with basic supplies such as a desk, chairs and a cupboard for storing resources, including a family planning counseling kit, guidelines for providers and leaflets for clients. Colorful posters were hung on the walls to provide information and to create a warm,

[16] Save the Children and UNFPA, *Adolescent Sexual and Reproductive Health Toolkit in Humanitarian Settings* (New York. UNFPA, 2009). https://www.unfpa.org/public/global/publications/pid/4169.
[17] IAWG on RH in Crises, "Chapter 4: Adolescent Reproductive Health," *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (New York. 2010). http://www.iawg.net/resources/IAFM%202010/IAFM2010chapter4.pdf.
[18] http://www.fhi360.org/sites/default/files/media/documents/My%20Changing%20Body%20-%20Fertility%20Awareness%20for%20Young%20People.pdf.
[19] http://www.fhi360.org/resource/hiv-counseling-and-testing-youth-manual-providers-and-manual-trainers.
[20] http://www.pathfinder.org/publications-tools/cue-cards-for-counseling-adolescents-on-contraception.html.
[21] http://www.who.int/maternal_child_adolescent/documents/9789241599962/en/.
[22] http://www.who.int/maternal_child_adolescent/documents/9789241547628/en.

friendly environment. The waiting area was brightened with a skylight and posters, and a bench was added for clients to wait comfortably. Additional improvements that were made included:

- **Providing clear signage** indicating that Murara Health Center offered free adolescent-friendly SRH services. Available services and hours of operation were painted on the wall outside of the center.
- **Conducting additional minor rehabilitation** through repairing and improving the existing solar power system to ensure sufficient lighting was available in the general reception area and maternity wing of the health center 24 hours a day, seven days a week.
- **Removing user fees** for ASRH services and providing medicines where available, although delivery fees were only covered for pregnant adolescents participating in support groups. Adolescents within the community were informed of free services through signage at the health center, in-school peer educators and community health workers (CHWs).
- **Instituting joint supervision with the MoH** that comprised discussions with providers, reviewing documentation and observing the functioning of the health center. Recommendations were made to improve the triage system and use of registers.

Developing and disseminating adolescent-friendly information materials with adolescent participation: Resources from existing ASRH projects—including from development settings—were adapted, translated and shared with providers and/or teachers for feedback. They were then distributed at Murara Health Center and through participating schools. Examples of developed resources include:

- **A mural with SRH messaging** was painted by adolescents on the external wall of the youth center situated within the compound of Murara Health Center. In order to create interest in the project within the community and initiate discussions with adolescents on SRH, the project was launched with an art workshop. ASRH topics were covered by Save the Children staff, while creative topics were facilitated by AptART, and international NGO. As an output of this workshop, 19 adolescents (13 boys and 6 girls, aged 15-19 years) developed and painted a creative and informative mural, which contained their own SRH messages.
- **Brochures/leaflets** on STIs that describe possible symptoms, what to expect during a sexual health check, how to prevent infection, and when it is advisable to undergo STI and HIV tests.
- **Posters** of various ASRH topics with photographs and messages proposed by peer educators.
- **Menstrual hygiene booklet** that explains the menstrual cycle, what to expect during menstruation and how to manage menstrual hygiene and pain. A frequently asked questions section was also included.

2. Enhancing adolescent knowledge and positive attitudes

The project sought to target two groups of adolescents in particular to provide them with a package of interventions to monitor changes, primarily in select SRH knowledge, attitudes and intentions.

Target Adolescents 1: Pregnant adolescents and adolescent mothers

Pregnant adolescent girls and new mothers were found to be particularly vulnerable to SRH risks in Goma. As a result, these girls were selected to comprise one target in the form of support group sessions. In

consultation with Murara Health Center providers, participants were identified through community health workers (CHWs), health care providers and self-referral.

Over the course of one month, the girls attended four support group sessions, each lasting two to three hours. Each session was facilitated by a different health care provider who had been trained in the *ASRH Toolkit*. A Save the Children nurse supervisor was present at all sessions to provide support and continuity between sessions. The following topics were covered in Swahili, using Save the Children's internal resources:

- Week 1: What to expect during pregnancy, the importance of antenatal care (ANC), danger signs in pregnancy and delivery plans
- Week 2: Nutrition and breastfeeding
- Week 3: Newborn care and postnatal care (PNC)
- Week 4: Birth spacing and contraception

The curriculum was adapted based on the needs of the participants and lessons learned from previous sessions. In addition to encouraging ANC, facility-based delivery and PNC, the project facilitated referrals and covered the delivery fees ($10 USD) for the participating girls. Participants who attended all four sessions received newborn kits that contained a delivery kit, hygiene and clothing materials for the baby and male and female condoms.

Target Adolescents 2: In-school adolescents aged 12-14 years

The second target group of adolescents was in-school adolescents aged 12-14 years from the first and second years of secondary school. This group was selected based on their readiness to receive basic SRH information through trained peer educators from their respective schools. Many activities were carried out within the schools to create a facilitative environment to discuss SRH issues:

Involving teachers to champion ASRH: Teachers from two secondary schools, Lycée Kimbilio and Institut Maendaleo, were invited to participate in the two-day *ASRH Toolkit* training. The trained teachers acted as focal points for the peer educators and were present during all in-school activities. They further participated in evaluating some of the activities by carrying out several interviews with students and peer educators.

Training and engaging peer educators: The main vehicle for information dissemination was adolescents themselves. Twelve peer educators from the first and second grades of Lycée Kimbilio and Institut Maendaleo were elected by their classmates. Parental and student consent were obtained from the 12 elected girls and boys who were trained on various subjects introduced in FHI360's *My Changing Body: Fertility Awareness for Young People*[23] curriculum over the course of two training sessions in September and November. The first two-day training went over "My Body, My Self," while the second two-day training covered "Female and Male Fertility." A third training that spanned five days in October was dedicated to developing peer educator skills, including: completing logbooks, holding discussions, carrying out mass sensitization, and using role play as a fun and effective way of transmitting messages. Peer educators received continuous, informal and formal support from both project staff and trained teachers. As

[23] http://www.fhi360.org/resource/my-changing-body-fertility-awareness-young-people-pdf-english-french-spanish.

incentives, they received a kit containing a school bag, logbook and stationery, as well as a t-shirt and hat to be worn during activities.

The series of activities offered by peer educators to first and second year students over the course of one month was organized to have students:

- **Attend one basketball match** where peer educators conducted **mass sensitization**. Two inter-school basketball matches were organized and supported through the provision of basketballs and jerseys. During the break, peer educators conducted mass sensitization around STIs and distributed leaflets.
- **Attend discussion groups** where the peer education team held group discussions on puberty during break time with students.
- **Observe role plays** by peers during school hours to stimulate discussions on age of sexual debut, STIs and HIV. A theater and communications consultant worked with the peers to develop their confidence and help them establish strong story lines.
- **Attend sessions using ASRH-themed game cards** that were developed for peer educators to organize informal games and foster learning. The large, brightly colored cards covered 13 topics, including menstruation and modes of HIV transmission.
- **Watch one theater performance** that was prepared in collaboration with a local theater group. Six peer educators and other students developed a theater piece that told a cautionary tale about early and unprotected sex. Post-performance discussions included the distribution of leaflets and condoms.

Through the above activities, in-school adolescents were given the opportunity to learn about puberty, menstruation, gender norms, HIV and other STIs, healthy relationships and pregnancy prevention, following FHI360's *My Changing Body: Fertility Awareness for Young People* curriculum. In all activities, peer educators informed students about the availability of free and confidential services at Murara Health Center. Discrete condom distribution at the schools was made feasible following several requests by students and discussions with the schools' authorities. Murara Health Center provided the male and female condoms.

III. Assessing Outcomes

1. Improving the capacity of Murara Health Center and affiliated youth center

In addition to reviewing service statistics to assess improvements at Murara Health Center to provide ASRH services, the IAFM's checklist of adolescent-friendly services[24] was administered prior to project implementation and again in late November 2013. Furthermore, the following tools were applied for qualitative feedback from participants and providers. The tools were adapted from those applied to the case study programs identified in the *ASRH Report*:

- Key informant interviews among program and clinical staff to learn about iterative processes for program improvement to overcome challenges.
- Exit interviews with adolescents using ASRH services, particularly family planning services.
- Focus group discussions with participants to gain their perspectives.

[24] http://wrc.ms/X2XF3l.

2. Enhancing adolescent knowledge and positive attitudes

While numerous activities were implemented at the community and school levels, changes to select SRH knowledge, attitudes and intentions were measured only for the two target groups of adolescents receiving their package of activities. To determine some measure of consistency in outcomes, the packages were applied to two cohorts of adolescents within the two target groups.

Target Adolescents 1: Pregnant adolescents and adolescent mothers

As part of data collection efforts, all girls were asked to participate in an interview consisting of 26 and 28 questions before the first support group session (baseline), and after the last support group session (endline), respectively. The questions aimed to measure select knowledge, attitudes and intentions around birth spacing, danger signs during pregnancy and newborn care, and were adapted from existing, related tools.[25] The questions were asked verbally in Swahili by either Save the Children staff or trained providers from Murara Health Center who were involved in running the support groups. Given the short duration of the sessions, as well as the lack of time between the first and second groups, the questions were not administered among those that were not immediately participating in the activities (Group 2) or those that had previously participated in the activities (Group 1) during data collection efforts for the other group. Hence, no controls are available for this project. Informed consent was sought from all participants prior to data gathering, and no identifier information was collected. Data were coded and analyzed by WRC staff using SPSS statistical software.

Target Adolescents 2: In-school adolescents aged 12-14 years

To all students in the first and second years of secondary school at Lycée Kimbilio and Institut Maendaleo, a set of five questions was asked prior to the start of and following the last of the first and final activity, respectively. The questions focused on select attitudes:

1. I believe that I am responsible for my own health and well-being.
2. Both the girl and the boy are equally responsible to prevent unwanted pregnancy.
3. I can refuse sex with my boyfriend/girlfriend, even if s/he insists.
4. I can use a condom correctly.
5. I can seek sexual and reproductive health information and services if I need them.

Questions 1-2 were scaled questions seeking the student's degree of agreement or disagreement over the statement, while questions 3-5 were scaled questions regarding the student's level of confidence regarding the statement. The questions were administered in writing, in French.

In addition, the pilot followed roughly 40 randomly selected students from both schools more closely to be able to ask additional knowledge, attitude and intention questions. The baseline and endline questionnaire for the intensive group contained 14 and 16 questions, respectively, including the five questions asked to all

[25] Adapted from Susan Adamchak et al. "A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs." FOCUS on Young Adults. Tool Series 5, 200. http://gametlibrary.worldbank.org/FILES/89_M&E%20Guidelines%20for%20Reproductive%20Health%20Programs-%20FOCUS%20project.pdf and MEASURE Evaluation, "Adolescent and Youth Sexual and Reproductive Health Programs," Family Planning and Reproductive Health Indicators Database. http://www.cpc.unc.edu/measure/prh/rh_indicators/.

students. The questions addressed physical changes during puberty, HIV and other STIs, gender norms, healthy relationships and pregnancy prevention, and were adapted from existing questionnaires for younger adolescents.[26]

Informed consent was sought from all participants prior to data gathering, and no identifier information was collected. Responses to the five questions were coded by University of Michigan Survey Research Center (SRC) staff and those from the intensive groups by WRC staff. SRC analyzed the data using simple difference in means t-tests on STATA. SRC staff further conducted comparisons between the intensive groups and the rest of the student body.

IV. Findings

1. Improving the capacity of Murara Health Center and affiliated youth center

Adolescent-friendly SRH services

Per the IAFM's checklist, Table 1 maps adolescent-friendly characteristics at Murara Health Center in December 2012 and late November 2013. Training, rehabilitation and service improvements were made based on the identified gaps. Available services and detailed program components are mapped in Annex 1.

Table 1: Adolescent-Friendly Checklist

Murara Health Center	Baseline	Endline
Health Facility		
Convenient hours	x	x
Convenient location	x	x
Adequate space and sufficient privacy		x
Comfortable surroundings	x	x
Provider		
Respect for adolescents	x	x
Non-judgmental attitude	x	x
Privacy and confidentiality honored	x	x
Peer counseling available		
Same-sex providers when possible	x	x
Strict confidentiality maintained	x	x
Staff trained in youth-friendly health service characteristics		x
Administrative		
Adolescent involvement		x
Boys and young men welcome	x	x
Necessary referrals available	x	x
Affordable fees		x
Drop-in clients welcome	x	x
Publicity and recruitment that informs and reassures adolescents		x

[26] Adapted from Susan Adamchak et al. "A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs." FOCUS on Young Adults. Tool Series 5, 200. http://gametlibrary.worldbank.org/FILES/89_M&E%20Guidelines%20for%20Reproductive%20Health%20Programs-%20FOCUS%20project.pdf and MEASURE Evaluation, "Adolescent and Youth Sexual and Reproductive Health Programs," Family Planning and Reproductive Health Indicators Database. http://www.cpc.unc.edu/measure/prh/rh_indicators/.

Use of SRH services by adolescents

Table 2 summarizes overall service use according to adolescent age group.

Table 2: Number of adolescents accessing SRH services at Murara Health Center from Aug-Nov 2013

Type of Services	10-14 years				15-19 years			
	Aug	Sept	Oct	Nov	Aug	Sept	Oct	Nov
Counseling	0	1	4	3	14	31	56	22
Contraception	0	0	0	0	0	0	0	32
STI treatment	0	2	4	3	18	16	36	22
HIV testing	6	3	3	2	41	30	42	40
ANC (new visits)	0	0	0	0	15	21	24	18
Deliveries	-	-	-	-	1	2	1	3
Clinical GBV services	1	0	0	0	1	0	1	2

Following sensitization within the community by peer educators and CHWs on the availability of free, adolescent-friendly SRH services, a sharp rise was seen in the number of adolescents visiting Murara Health Center's adolescent counseling room. The reason for the drop in November is unknown, although health facility staff reported that adolescents were directly accessing the services they required as they felt comfortable doing so. Additionally, several participants from the adolescent mothers support group also reported having shared information on contraception with their peers, which increased uptake of family planning services.

2. Enhancing adolescent knowledge and positive attitudes

Target Adolescents 1: Pregnant adolescents and adolescent mothers

In total, 30 girls between 13 and 18 years participated in the pregnant adolescents/adolescent mother activities. Fourteen girls were in Group 1 and 16 girls were in Group 2 at baseline. Thirteen and 15 girls were in Groups 1 and 2 at endline, respectively. The mean age for both groups was 16.5 years. The three participants under 15 years took part in Group 2, most likely as a result of news of the support group spreading in the community and particularly vulnerable girls feeling comfortable to participate. The vast majority (25) were unmarried and living with a family member. Some of these girls reported living with a partner (5) or having a partner who either fled or was away fighting. Five adolescents—aged 14-17 years—were married. Only three of these girls reported living with their husbands; one was a 17-year-old mother in a sero-discordant couple. Three out of the 30 girls had given birth within six months of starting the support groups, and another three gave birth in the month of their participation. Table 3 shows activities offered to the groups.

Table 3: Adolescent mothers support groups conducted in October and November 2013

Sessions conducted and kits distributed	Group 1	Group 2	Total
Support group sessions offered at Murara Health Center	4	4	8
Newborn kits distributed	14	16	30
Adolescents who participated in at least one support group session	14	16	30
Adolescents who participated in all 4 support group sessions	14	16	30

In terms of knowledge, attitudes and intentions, while improvements were observable, none were significant. Often, this was as a result of already positive baseline levels or a small sample size. For example, when asked during which part of the monthly cycle a woman has the greatest chance of becoming pregnant, participants chose between the following options: "during menstruation," "in the middle of the cycle," "just after the end of the cycle" or "just before the period." Despite no significant changes, both groups showed improvement with more correct responses of "in the middle of the cycle" at endline.

When asked whether participants planned to use contraception in the next 12 months, nearly twice as many women responded to the question at endline than at baseline for Group 1. Group 2 recorded a slight average increase in intentions to use contraception ($p = .876$). While no significant change was found in both groups, the overall increase in responses in Group 1 possibly suggests a positive impact of attending the support group sessions for increasing awareness and confidence among pregnant adolescents and new mothers in deciding whether or not they would use a family planning method within the year.

This is a good project that helps us a lot with the information. We thank you very much.
(Support group participant)

When asked the correct amount of time newborns should exclusively breastfeed, responses varied at baseline for both Groups 1 and 2. All participants answered the question correctly at endline, noting "0-6 months." A more detailed presentation of the data is available from Annex 2 online.

Target Adolescents 2: In-school adolescents aged 12-14 years

Activities conducted among peer educators are listed in Table 4. The peers were responsible for sensitization during basketball matches, holding discussion groups, convening card games, distributing condoms and performing in theater. The basketball games and theater reached beyond the students of the two grades, and many students shared their intention to adhere to abstinence or use condoms. The two theater performances were attended by 821 first- and second-year students, as well as by 19 teachers. A third performance was held in the internally displaced person (IDP) Camp Mugunga 1, where mass sensitization was held.

Table 4: Peer educators	
Number of training sessions held for peer educators	4
Number of support sessions held for peer educators	5
Number of trained peer educators	12
Number of peer educators in Lycée Kimbilio	6 (3 boys, 3 girls)
Number of peer educators in Institut Maendaleo	6 (3 boys, 3 girls)
% percent of adolescents trained as peer educators who are active during pilot period	100%

At baseline, 695 students from the two schools participated in the five-question questionnaire administered to all students in the two participating grades. Among them, 445 were from Lycée Kimbilio, while 250 were from Institut Maendaleo. Across schools, 304 participants were boys (156 from Lycée Kimbilio and 148 from Institut Maendaleo) and 383 were girls (282 from Lycée Kimbilio and 101 from Institut Maendaleo).

At endline, 781 students from two schools answered the questionnaire, 394 from Lycée Kimbilio and 387 from Institut Maendaleo. Across schools, 375 students were boys (139 from Lycée Kimbilio and 236 from Institut Maendaleo) and 405 were girls (254 from Lycée Kimbilio and 151 from Institut Maendaleo). The larger number of students at endline is likely a result of absenteeism on the day the baseline questionnaire was administered. Some students at both baseline and endline were beyond 14 years of age due to conflict that disrupted their education. The results from the five questions are shown in Table 5.

Table 5: Changes in attitudes by sex

Statement	**Overall** (p<.05)	**Boys** (p<.05)	**Girls** (p<.05)	**Type of significant change**
1. I believe that I am responsible for my own health and well-being.	No	No	No	None
2. Both the girl and the boy are equally responsible to prevent unwanted pregnancy.	No*	**Yes**	No	Improvement for boys only
3. I can refuse sex with my boyfriend/girlfriend, even if s/he insists.	**Yes**	**Yes**	No	Improvement overall, primarily from boys
4. I can use a condom correctly.	**Yes**	**Yes**	**Yes**	Improvement
5. I can seek sexual and reproductive health information and services if I need them.	**Yes**	No	**Yes**	Improvement overall, primarily from girls

*The overall difference is statistically significant at the p<.10 level, but is the product of averaging a difference among males that is large and significant at the p<.05 level, with a difference among females that is small and not statistically significant.

In terms of the extent that adolescents believe they are "responsible for their own health and well-being" at baseline, both boys and girls primarily responded that they "agree." Both groups reported slight changes when surveyed a second time, though not significant.

When asked if "both the girl and boy are equally responsible to prevent unwanted pregnancy," both boys and girls agreed with the statement overall. There was some improvement between initial and final responses, although significant improvement (p<.05) was only seen among boys.

When asked about confidence to refuse sex, both boys and girls showed improvement between initial and final responses. The overall change was significant (p<.01), but as a result of improvement among boys (p<.01).

When asked how confident participants were in using a condom correctly, both boys and girls reported being "somewhat confident" when initially surveyed. At endline, both boys and girls reported significant improvements in their level of confidence (at p <.01 and p<.05, respectively). As a group, therefore, overall results improved significantly (p<.001).

The last question surveyed participants' confidence levels to seek SRH information and services. Girls recorded the most significant change towards higher confidence between baseline and endline (p<.001). Boys also showed improvement in confidence, though not significantly. A more detailed presentation of the data is available from Annex 2 online.

In terms of differences in school, while no significant difference between the two schools was found at baseline for statements 1 and 5, large, significant differences were found between the two schools in baseline scores for statements 2, 3 and 4. The reason for this is not known. The program further produced large, significant differences between the two time intervals for statements 2-5 at Institut Maendaleo, but no significant change of any kind at Lycée Kimbilio (see Table 6). However, no overall change at Lycée Kimbilio may imply some students changing a lot, or different rates of change in the students at the two schools.

Table 6: Changes in attitudes by school

Statement	Overall (p<.05)	Lycée Kimbilio (p<.05)	Institut Maendaleo (p<.05)	Type of significant change
1. I believe that I am responsible for my own health and well-being.	No	No	No	None
2. Both the girl and the boy are equally responsible to prevent unwanted pregnancy.	No	No	**Yes**	Only at Maendaleo, but not overall
3. I can refuse sex with my boyfriend/girlfriend, even if s/he insists.	**Yes**	No	**Yes**	Improvement overall, primarily from Maendaleo
4. I can use a condom correctly.	**Yes**	No	**Yes**	Improvement overall, primarily from Maendaleo
5. I can seek sexual and reproductive health information and services if I need them.	**Yes**	No	**Yes**	Improvement overall, primarily from Maendaleo

Based on self-reports at endline, among the 443 students who were referred by Save the Children or peer educators to relevant services, 212 completed the entire referral, while 160 completed the referral partially. Only 40 students reported that they did not follow up at all.

We want this project to continue and not just for the first two classes but for everyone.
(Intensive student group participant)

In terms of the intensive in-school adolescent groups, while 39 students took the baseline questionnaire, 33 remained to complete the endline. Among those who completed the baseline, 19 were from Lycée Kimbilio and 20 were from Institut Maendaleo. Seventeen were boys (6 from Lycée Kimbilio and 11 from Institut Maendaleo) and 22 were girls (13 from Lycée Kimbilio and 9 from Institut Maendaleo). Among the 33 endline participants, 17 were from Lycée Kimbilio and 16 were from Institut Maendaleo. Eighteen were boys (9 from Lycée Kimbilio and 9 from Institut Maendaleo) and 15 were girls (8 from Lycée Kimbilio and 7 from Institut Maendaleo). A comparison of the intensive group's performance against the rest of the two grades is displayed in Table 7.

Photo (right): A member of the Save the Children project team demonstrates to a peer educator how to correctly use a condom during a training session.

Photo (left): An adolescent busy at work.

Table 7: Changes in attitudes among intensively followed students as compared to all students			
Statement	**All students** (p<.05)	**Intensive group** (p<.05)	**Type of significant change in intensive group**
1. I believe that I am responsible for my own health and well-being.	No	No	None
2. Both the girl and the boy are equally responsible to prevent unwanted pregnancy.	No	No	None
3. I can refuse sex with my boyfriend/girlfriend, even if s/he insists.	**Yes**	No	None
4. I can use a condom correctly.	**Yes**	**Yes**	Improvement
5. I can seek sexual and reproductive health information and services if I need them.	**Yes**	No	None

Overall, significant improvement was seen for three of five attitudes (p<.05), while in the intensive group, students only showed significant improvement in confidence to the statement "I can use a condom correctly" (p<.05).

When further follow-up was conducted with students in the intensive group regarding their sexual behavior, of the two that reported they were sexually active at baseline, one was using withdrawal and the other was not using contraception. Among students who had had their sexual debut, five students were using some form of contraception, two were not using any and one was not sexually active at endline. Based on self-reports at endline, among the 12 students that were referred by Save the Children or peer educators to relevant services, eight completed the entire referral.

Despite limited, significant changes—as a result of various probable reasons, including a small intensive group sample—improvements were seen and qualitative feedback from participants expressed much appreciation and excitement for the opportunity to learn about their sexual health.

V. Overcoming Challenges

Insecurity: The security situation in Goma fluctuated in cycles of high alert to consistent levels of tension. The proximity of multiple armed actors affected programming priorities for Save the Children as a whole, as well as staff safety. The *ASRH Toolkit* training was interrupted for several days as the office closed following inter-state violence in August 2013. Significant damage to schools resulted in school start dates being pushed back, after which the schools required all teachers and students to work on their rehabilitation, leaving no time for other activities. Insecurity also increased initial spending for Save the Children, as the project was directly transporting the majority of participating adolescents to and from their homes.

- To still be able to compare groups of target adolescents, while the pregnant adolescent/new mothers support sessions could be staggered, activities for in-school adolescents were conducted concurrently. The activities were implemented in two schools for a cross-school comparison. Further, the activities were tailored to be a series of focused, intensive activities, to accommodate losses to time and participation as a result of delays in school opening and insecurity.

- As direct transportation or payment of transport fees to participants had financial and/or logistical implications when targeting large numbers of adolescents, Save the Children expanded outreach through peer educators—including into the IDP camp for theater activities—which reduced some of these access barriers.

Negative provider attitudes: Despite previous ASRH experience with a prior international NGO project, Murara Health Center staff showed common misconceptions around SRH topics, such as condom use promoting promiscuity.

- Health staff that participated in the *ASRH Toolkit* training were pre-selected to ensure that those that would routinely work with adolescents were well trained to provide adolescent-friendly counseling and services. Save the Children further provided supportive supervision and regular feedback to encourage healthy and facilitative attitudes towards ASRH.

Limited familiarity among project staff with participatory methods: Engaging and participatory methods of teaching are not the norm in Goma. While Save the Children national staff were open to these methods, they required support and guidance in delivering activities in an interactive manner.

- Save the Children used internal resources such as its new *Toolkit for Participation in Health*, and trained providers on participatory methods discussed in the *ASRH Toolkit*. The training evaluation showed that 90 percent of participants noted their appreciation for participatory methods of teaching; the average score of trainee pre-/post-tests increased from 65.2 percent to 75.3 percent.

Limited confidentiality in SRH services: The health center initially lacked a confidential space (partitions offering privacy or separate counseling rooms).

- In addition to provider training, the establishment of the counseling room adjacent to the youth center's game room within the health facility offered a private room.

Low female participation: There was a significant gender imbalance during initial activities, including the art and SRH workshop, which attracted more boys than girls.

- The project selected pregnant adolescents/new mothers, as well as both sexes of in-school adolescents as target groups, to ensure girls were actively reached. Achieving gender balance in peer educator recruitment, as well as activity participation was a high priority for the project.

High illiteracy among adolescents: Despite many participants having had exposure to schooling opportunities, approximately 30 percent of adolescents showed difficulties reading and writing during the initial art and SRH workshop.

- Drawing upon Save the Children's wealth of experience working with groups of children with low literacy levels, the team used creative methods including theater to reach all adolescents.
- The baseline and endline questionnaires for pregnant adolescents/new mothers, peer educators and in-school adolescents were converted from a written to verbal format.

Menstrual hygiene management and impact on girls' attendance: During the training, several peer educators revealed that a lack of access to sanitary materials left them with no choice but to go home if they

began menstruating at school. Further FGDs with teachers and female students revealed that menstruating girls experienced embarrassment and teasing by fellow students. Girls lacked access to pain medication and affordable sanitary materials. Teachers reported girls missing school and some sent girls home. Improper waste disposal led to blocked latrines, and neither school had emergency sanitary pads or education materials.

- Save the Children added in-school menstrual hygiene management to the information disseminated by peer educators. The project developed informational booklets; distributed sanitary and complementary materials (sanitary napkins, laundry detergent and underwear) to girls who unexpectedly began menstruating in school; distributed soap for hand washing, bins and gloves for waste management and a small mirror for checking clothing to the girls' toilets; and established a "menstrual hygiene committee" consisting of a female teacher and peer educators to provide information and manage distributions.

VI. Reflections and Lessons Learned

1. Organizations—humanitarian and development alike—must invest time and staff in the development of a conducive, adolescent-friendly environment

As found in the *ASRH Report*, considerable institutional investment in time and human resources is necessary to build the environment needed to promote ASRH. This investment enables programs to successfully accomplish essential actions to maximize program effectiveness. These actions include:

- community sensitization;
- negotiations with Ministry of Health officials, health center, schools and other critical stakeholders;
- prepared materials are contextualized and culturally appropriate;
- recruiting and capacity building of program staff;
- training of health workers on adolescent-friendly approaches, especially new techniques for adolescent engagement and skills-building, and making the facility adolescent friendly;
- adequate training of peer educators to confidently carry out activities independently; and
- establish referral procedures, particularly for complications and deliveries by caesarean section.

To prioritize ASRH, the introduction of a solid project management team in Goma accelerated implementation. While integrated programs that address adolescent health are desirable, this may be more feasible in protracted settings than in acute emergency settings. The project further showed that training in particular was required at two levels. This included internal training for project staff, as well as external training for service providers, teachers and peer educators.

2. ASRH programs in emergencies must target achievable outcomes within short timelines

A major challenge for the project was recurring insecurity and the many delays to implementation that ultimately resulted in much shorter, focused interventions for the target groups. While statistically significant results were observed for some attitudinal shifts among students, especially among male students, significant improvements were limited overall. Results attest that for short-term emergency programs, knowledge and attitudes are more feasibly influenced, while behavior change is more challenging to monitor prior to stability. Further, structural and systemic barriers, such as a family's inability to pay

school fees that impact participation, present challenges beyond the scope of a project; programs must tailor activities to extend reach and balance the achievement of short-term success and longer-term sustainable solutions for adolescents that will remain beyond time-bound programs. Ideally, ASRH interventions should be built into every SRH proposal, as funding and sustainability can only be ensured if ASRH is seen as an essential part of SRH programming.

3. New, vulnerable groups emerge during conflict

While pregnant adolescents/new mothers and in-school adolescents were selected as target groups, conflict has created additional vulnerable groups that may have limited access to programs and services. Poverty in Goma has driven young girls into prostitution, and out-of-school boys are one of the groups that frequently visit sex workers. This subsequently poses a threat to both adolescent boys and girls. Girls also experience high levels of GBV, and the project needed stronger programmatic interventions to address the non-physical consequences of this systemic violence. Such groups should be better targeted in humanitarian settings, and protection/GBV programs need to work very closely with health programs to provide holistic care for survivors that take into account their protection, psychosocial and health needs.

4. Creative strategies should be employed to reach adolescents

The mural that was created at Murara Health Center was found to be a creative and durable approach to effectively communicate health messages, as were theater groups. While the students and the community affirmed that the written IEC/BCC materials were well received, some of the materials were occasionally removed from the schools. Coupled with the time required to develop, translate, contextualize and print the resources, the mural proved a more efficient, effective and participatory way of providing long-lasting and adolescent-owned messaging. The theater groups were also relatively low cost and popular among the students; the formation of a long-term partnership between students and the local theatre group could enable peer educators to develop and produce their own theater pieces for SRH education, as well as to continue building their capacity and confidence as they transition into adulthood. The support groups were similarly popular in reaching pregnant adolescents/new mothers. The initial plan called for 45- to 60-minute sessions; however, these sessions ended up lasting up to three hours, followed by a shared meal. Young and soon-to-be adolescent mothers reported feeling well supported despite their difficult circumstances.

5. Peer education activities should be integrated into adolescent schedules, such as routine recess hours

The project conducted most peer education activities during after-school hours. However, as students are often required to return home immediately after school to complete chores and spend time with their families, after-school hours were not ideal. Based on this experience, peer education activities could be integrated into the school's recess hours or during sessions such as the "life education" classes. This is particularly feasible in the DRC where a "life education" curriculum already exists for secondary school students. The curriculum would benefit from an updated curriculum, attractive adolescent-friendly resources and more participatory methods of learning.

6. Community buy-in is essential for project sustainability

The importance of community buy-in cannot be overstated, as Murara Health Center staff and school teachers were committed to addressing ASRH and requested additional information and activities. Once

trained, they often spearheaded problem-solving amidst tight budgets with their resourcefulness and creativity. Such resourcefulness and commitment can extend beyond a project's duration for full integration of youth-friendly attitudes and approaches.

VII. Conclusion

This project operationalized good practice principles to generate demand for ASRH services; but, as a pilot, unfortunately ended at its peak. Interest for ASRH services has been generated; additional resources are required over the long term to sustain the project. Learning from the project has shown that targeting marginalized adolescents should ideally be part of a more comprehensive ASRH project, and community strategies should include dedicated resources for community mobilization, sensitization and outreach with smaller local organizations. While the project operationalized several principles of identified good practice, additional funding is necessary to build on the project and lessons learned and to continue to diversify ASRH interventions to meet the needs of the most vulnerable adolescents. Rigorous research is still necessary to learn how to effectively reach vulnerable sub-populations (very young adolescents and married adolescents, among others) and establish programming practices that pilot models from development settings.

VIII. Limitations

The project in Goma faced limitations. While initially, the project intended to operationalize additional elements of good practice documented in the *ASRH Report*, this was not entirely feasible, given budget and context-specific constraints. This was especially the case regarding the principle of program integration, where linkages between child protection, education, health and livelihoods programming—should they have all existed—would have provided a more holistic and comprehensive ASRH program package.

More time was additionally anticipated to both space the groups of target adolescents, as well as implement additional activities among each group over a longer period of time. This would have enabled a quasi-experimental, interrupted time series design. Insecurity, as well as limited staffing capacity, resulted in synchronized group activities for students and shorter activities for all groups. Despite this, two groups of pregnant adolescents/new mothers and in-school adolescents were targeted (although not as control groups), providing for some comparisons across groups for what became focused interventions.

Given literacy challenges among target adolescents and limited available staff, written questionnaires for baseline and endline interviews were converted into verbal questionnaires. The questions were administered to the target adolescents by Save the Children and Murara Health Center staff; as a result, social desirability bias may be present among responses. The five questions asked of all participating grades at Lycée Kimbilio and Institut Maendaleo were administered as written questionnaires, however.

While data pairing would have offered opportunities for further analysis between baseline and endline, this was not feasible. Nevertheless, valuable information could still be derived, including areas where significant changes were not achieved, which is important learning for program improvement.

Annexes

- Annex 1: Program mapping
- Annex 2: Detailed findings from target adolescent groups (online at http://womensrefugeecommission.org/resources/reproductive-health/1001-asrh-pilot-annex-final/file)

Annex 1: Program mapping

Murara Health Center		
	Baseline	Endline
Components of Program Development		
A needs assessment	*	x
Community involvement	*	x
Parent involvement		
Adolescent participation		x
Available tools or guidance materials		x
Training	*	x
Communication and Outreach		
Peer workers	*	x
Plays or theater		x
IEC/BCC		x
Radio programming		
Television programming		
Cell-phone texting		
Helpline		
Computer literacy		
Parent involvement		
Community leader/religious leader outreach	*	x
Awareness and other education		
General health	x	
HIV	x	x
Sexuality	x	x
Fertility		x
Gender norms		
Health provider training	x	x
Parent training		
General ASRH services		
School support		x
Life-skills training		x
Vocational training/livelihoods		
Youth empowerment		x
Young mothers' programs		x
Prevention of transactional sex		
Health service delivery	x	x
Data collection on service utilization	*	x

Youth centers		
Health service days/health fairs		x
Mobile outreach	*	x
General adolescent health services		
Adolescent-friendly clinics	*	x
Family planning/pregnancy prevention	**	x
STI care and treatment	**	x
Antenatal care	**	x
Delivery/post-natal care facilities	**	x
Mental health and counseling		
Adolescent SRH services		
Fistula treatment		
Post-abortion care		
Post-rape EC	*	x
Post-rape injury treatment	*	x
HIV care and treatment	*	x
Family Planning Services		
Family planning counseling	*	x
Male condoms	*	x
Female condoms	*	x
Pills	*	x
Emergency contraception	*	x
Injectables	*	x
Implant	*	x
IUD	*	x
LAM	*	x
Withdrawal		x
Cycle beads/calendar method	*	x
Post-abortion family planning		x
Referral Services		
Post-rape injury treatment	x	x
Family planning/pregnancy prevention	x	x
STI care and treatment	x	x
Antenatal care	x	x
Fistula treatment	x	x
Post-abortion care	x	x
HIV care and treatment	x	x
Delivery/post-natal care facilities	x	x
Mental health and counseling		
Post-rape EC	x	x
* Previously existed when the Murara Health Center was funded to carry out adolescent-specific activities.		
** These services were provided in a general sense but not targeted to adolescents. If adolescents seek these services they are not denied of services but providers said that adolescents have stopped coming to the facility due to the lack of confidential spaces for young people and the fee associated with FP services.		

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