



ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN REFUGEE SITUATIONS:

**A practical guide to launching
interventions in public health
programmes**

ACRONYMS

| | |
|--------------|--|
| AFHS | Adolescent Friendly Health Services |
| AIDS | Acquired Immuno-Deficiency Syndrome |
| ASRH | Adolescent Sexual and Reproductive Health |
| CBO | Community Based Organizations |
| DSW | German Foundation for World Population |
| FGM | Female Genital Mutilation |
| HIS | Health Information Systems |
| HIV | Human Immuno-deficiency Virus |
| IPPF | International Planned Parenthood Federation |
| KAP | Knowledge, Attitude and Practice |
| LGTBI | Lesbian, gay, bisexual, transgender and intersex |
| NGO | Non-governmental Organizations |
| SRH | Sexual and Reproductive Health |
| STI | Sexually Transmitted Infection |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| WHO | World Health Organization |



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GLOSSARY

Adolescent – person aged 10-19

Adolescent-Friendly Health Services (AFHS) – Health services in which adolescents: are respected, are sure that their confidentiality is protected and adolescents' needs are met.¹

Adolescent Sexual and Reproductive Health (ASRH) – is a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes specifically applied to adolescents.

ASRH Information – is information useful to adolescents to know about their changing bodies, reproduction, infections as a result of sexual relations and how to successfully use life skills as they continue to develop.

ASRH Peer educator – a person who is the same age or slightly older than adolescents participating in the ASRH programme, who shares ASRH information and refers his/her peers to adolescent-friendly health services²

Community ASRH promoter – a refugee in his/her community that advocates for the ASRH programme and advises adolescents on ASRH information

Health service provider – A person that provides health services, including clinical care and counselling.

Programme staff – For the sake of this guide, those who are primarily responsible from UNHCR and partners for clinical or nonclinical programming, administration, management, finance and monitoring and evaluation of the ASRH programme.

Sexuality – is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.³

Sexuality Education – is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information. It provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality.⁴

Youth – The UN, for statistical consistency across regions, defines 'youth' as those persons between the ages of 15-24 years of age, without prejudice to other definitions by member states.

¹ This definition is the condensed version of the WHO's definition of adolescent-friendly health services as outlined in [Making Health Services Adolescent Friendly & Adolescent Friendly Health Services](#).

² For the purposes of this guide, peer educator is defined by UNICEF's [definition](#) with the purpose of teaching and sharing health information, values and behaviours by members of similar age or status group.

³ <https://bit.ly/2nJmx7L>

⁴ <https://bit.ly/1fhlsuS>

INTRODUCTION

Adolescents have often been side-lined in public health programmes, with programme staff unaware of the specific needs and vulnerabilities of this group. This toolkit aims to provide staff with practical guidelines on how to ensure that adolescents are able to fully engage with services and realize their right to health.

Adolescents, particularly girls, are especially vulnerable to sexual violence, which further increases the risks of unintended pregnancy, unsafe abortions and STIs, including HIV. Adolescents face increased risks to their sexual and reproductive health and the provision of appropriate sexual and reproductive health information and services is essential. Adolescents in key populations may be affected by criminalization of same-sex relationships, exclusion from school, and stigma and discrimination.⁵

Emergency situations can exacerbate the issues already faced by adolescents. Adolescents, aged 10-19 years, often feel bored and are left idle due to a lack of activities and opportunities targeting their age group. In some cases they may be forced to work, take responsibility for their families, and take on adult responsibilities. They may have lost access to family, social supports, and health services as a result of displacement. Adolescents have the right to participate in matters that affect their lives and will be invaluable contributors to the design and implementation of ASRH programmes.

The key to designing effective ASRH programmes is to incorporate adolescents' talents, capacities, and potential, in order to share sexual and reproductive health information and implement adolescent-friendly sexual and reproductive health services.

GOAL

The goal of this document⁶ is to guide UNHCR and partner staff to develop programmes ensuring adolescents' rights to access sexual and reproductive health (SRH) information and services.⁷

This practical guide provides information and guidance in the form of Ten Steps on how to effectively launch adolescent sexual and reproductive health (ASRH) interventions in refugee situations. It outlines what steps UNHCR and partner staff, in cooperation with refugee communities and adolescents, can follow to ensure a successful ASRH programme.

This guide also presents specific strategies and tools that UNHCR and partners can use to disseminate accurate sexual and reproductive health information to adolescents and improve, provide, as well as track adolescent-friendly health services (AFHS) at service delivery points. Every refugee situation and its population are unique, and it is expected that the strategies within are general enough for adaptation to suit context-specific needs.

Ensuring adolescents' rights to access SRH information and services can be achieved through an ASRH program that focuses on three primary strategies as outlined in this guide:

- Providing adolescent sexual and reproductive health information
- Improving access to reproductive health services for adolescents
- Increasing adolescents' leadership, engagement, and advocacy for their sexual and reproductive health

The overall goals of an effective ASRH programme are:

- Increased knowledge, attitudes and practices of adolescents concerning ASRH
- Reduction in early and unintended pregnancy
- Decreasing STI transmission
- Decreasing HIV transmission
- Empower adolescents to exercise their human rights to access information and care regarding their sexuality, sexual reproductive health, and emotional well-being
Encourage adolescents to make informed decisions and give informed consent regarding sex and sexual health.

This toolkit follows ten steps to design and implement effective ASRH programmes. The steps do not need to be done in perfectly sequential order, but rather as a continuous and sustained effort to implement an ASRH intervention. This means, for example, that initial discussions in Step One should not cease after Steps Two and Three begin. Refresher trainings, advocacy campaigns and assessments of adolescent and community engagement and support should continue throughout the programme's implementation.

⁵ <https://uni.cf/2IUaRgs>

⁶ This guide is for those who have already made commitment to ASRH and who understand its importance. This guide assumes that this importance is well understood by operations. For further information on the importance of ASRH please consult the ASRH [toolkit](#) designed by the UNFPA.

⁷ Adolescents are defined by the WHO as those between the ages of 10-19. <https://bit.ly/1gRxy8r>

STEP 1

BUILDING COMMUNITY PARTNERSHIPS

OBJECTIVES:

- ✓ Engage with community leaders and adolescents
- ✓ Understand community's perspective(s) on adolescents, their sexuality and their reproductive health needs
- ✓ Outline actions to address ASRH within the community
- ✓ Establish buy-in for proposed ASRH programme outline

To be truly community-based, programmes must involve the community at every stage: in assessment, analysis, prioritization, design, implementation, and monitoring and evaluation. The **primary aim of Step One** is to form effective partnerships with the refugee community to better understand existing knowledge, beliefs, attitudes and practices around ASRH and to determine potential barriers against acceptance of providing SRH information and services to adolescents. Additionally, this first step should be an opportunity to sensitize the community and start gaining their understanding and support on an ASRH programme. Partnerships are built through discussion on the topic of ASRH and information provided during these discussions will shape future steps in this practical guide.⁸

⁸ Discussions in Step One are very similar to the "Community Conversations" used in response to HIV. Programme staffs should have had similar training on these types of conversations. However, if they have not, advise them to become trained at their earliest convenience.



It is possible, in some communities, that discussing sexual and reproductive health for adolescents will be a taboo subject that community members will be reluctant or not open to discussing. This is *not* an excuse to give up at the start. Having preliminary discussions with community leaders and parents about the problems facing adolescents within their communities – with special emphasis on obstacles they face concerning their health – over longer periods of time, may make them more amenable to discussing the topic. It is important to emphasize that the program doesn't seek to educate adolescents *how* to have sex, but rather about how their bodies are changing and specific strategies to avoid the problems that community members have identified.

It may be helpful to do pre-meeting fact finding about the different types of challenges faced by adolescents in that particular community, including numbers of pregnancies in girls under-18 years, sexually transmitted infection (STI) rates in under 18's, etc. This information should, of course, not include any personally identifiable medical information, names or specific locations. It should only be used as a guide for the conversations with the community.

WHO TO PARTNER WITH⁹

- 1 Adolescents (both boys and girls, married and unmarried, those who are disabled and/or at-risk, 10-14 and 15-19 years of age, those both in and out of school)
- 2 Community Leaders
- 3 Parents
- 4 Teachers and School Development Committees/Parent-Teacher Associations
- 5 Religious Leaders
- 6 Associations of people living with HIV
- 7 Women's Groups
- 8 Older youth peer support networks
- 9 Refugee Service Providers
- 10 Other relevant community groups

Discussions for each these groups will be held separately from one another. Adolescents may need to be separated into different discussion groups by age and gender, when culturally appropriate, in order for them to speak freely.

⁹ Identify communities within communities to avoid exclusion of different ethnic or tribal groups within different sections of the refugee community.

WHAT TO DISCUSS

- 1 Concerns about adolescents' health, values and expectations
- 2 In the wider context, what ASRH is and why it is important for young people to understand
- 3 What are the benefits for adolescents and the community
- 4 Keys Issues
 - Early and Unintended Pregnancy
 - HIV and STIs
 - Information about the development of the reproductive health systems of girls and boys
 - Sex, sexuality and relationships
 - Decision-making and communication skills Sexual and Gender-Based Violence, Early Marriage, FGM, etc.

For more information on how to organize focus groups discussions with adolescents and community members, see Annex 1 Step 1: How to prepare for adolescent and community discussions

EXPECTED RESULTS FROM STEP 1

- ☑ Increased discussion by both adolescents and community members on ASRH's importance in the community and to provide further insight into the apprehensions/fears, beliefs and opinions about giving ASRH information and services to their communities' adolescents
 - Open discussion on ASRH may take time. Building trust and developing rapport, in most cases, does not happen after a single meeting, but after a series of meetings and discussions. This process may take weeks or months to develop and must not be forced
 - Adolescent discussions will also highlight adolescents' gaps in ASRH knowledge and misconceptions

- ☑ Increased understanding by UNHCR and partner staff of refugee communities' perspectives and desire to change ASRH outcomes
- ☑ Communities brainstorm and discuss actions to increase awareness and acceptance surrounding ASRH. Information gathered at this time will be used in Step Two to design the ASRH programme
- ☑ Both community members and adolescents have a better understanding of the trajectory and purpose of the ASRH programme in their communities

STEP 2

DESIGNING THE ASRH PROGRAMME

OBJECTIVES:

- ☑ Recognize that the ASRH programme is to provide SRH information and AFHS to all adolescents in refugee communities
- ☑ Identify Priority Groups
 - Analyze community perspective and demographics to assess which adolescent groups need additional focus in the ASRH programme
 - Review secondary baseline information to assess which adolescent groups need additional focus in the ASRH programme
 - Keep in mind groups that may be 'hidden' due to cultural or religious beliefs (disabled/differently-abled, LGBTI, survivors of sexual violence, etc.)
- ☑ Create a task force to develop an effective ASRH programme based on community feedback and analysis of secondary sources of information

Adolescents are not a homogenous group. Ultimately, the goal of any ASRH programme will be to deliver sexual and reproductive health information and services to all adolescents, but at the outset of the programme, there will be groups that are more vulnerable than others. Providing an effective ASRH programme will require a targeted approach for different priority adolescent sub-groups through community feedback and analysis of secondary sources of information. Adolescents will not be reached through only one approach; therefore a task force of UNHCR and partner staff and refugees must tailor a unique programme model to reach adolescents appropriate to their setting.

IDENTIFYING PRIORITY GROUPS

While analyzing information provided from initial community discussions in Step One, programme staff should start to gather, analyze and synthesize secondary information to assess which adolescent groups to prioritize in the ASRH programme.

SECONDARY INFORMATION TO REVIEW

- 1 Data from relevant surveys
- 2 Health Information Systems (HIS) data
- 3 KAP surveys
- 4 Focus Group discussion summaries
- 5 Previous qualitative assessments
- 6 School enrolment data and out-of-school assessment data

From analysis of secondary information and community discussion, priority issues may be identified among groups in following five categories. Effective ASRH programmes will endeavor to incorporate adolescents who represent all five categorical groups at its outset.

SPECIFIC INFORMATION TARGETED TO SPECIFIC GROUPS

While the ASRH programme will provide a basic level of information and services to all adolescents, targeted information and services will be given to specific groups that could be classified under the following five categories: Gender, Age, Disability, At Risk and School-status. Care should be taken not to stigmatize groups by openly targeting them.

1 GENDER

- a) Girls Only
 - i) Married, Not Pregnant
 - ii) Pregnant, Married or Unmarried
 - iii) Single – No children and Unmarried
 - iv) Mix of two or three of the above categories
- b) Boys Only
- c) Mixture of both a) and b)

2 AGE

- a) 10-14 years old
- b) 15-19 years old
- c) Mixture of both a) and b)

3 Disability

- a) Physical disability
- b) Learning disability
- c) Severe mental disorder¹⁰

4 AT RISK

- a) Unaccompanied/separated from family
- b) Primary laborer in family
- c) Head of Household
- d) Sexually exploited and abused child
- e) Mix of two or three of the above categories

5 SCHOOL-STATUS

- a) Enrolled in school
- b) Not enrolled in school
- c) Mixture of both a) and b)

A wide range of stakeholders should be consulted to successfully address the needs of adolescents across all categories. Programme staff will establish a temporary task force that will help design the ASRH programme.

¹⁰ Either diagnosed by a psychiatric nurse or doctor, or through UNHCR/WHO's Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for humanitarian [settings](#) (2012)



CREATING A TASK FORCE

Approximately 15-20 people, including adolescents and community members, will convene in a task force to design an effective ASRH programme.

TASK FORCE MEMBERS

The task force structure will consist of:

- Adolescent refugees
- Health Partner staff (secretariat)
- UNHCR staff (Health, Community-based Protection, Education, Child Protection)

- Partner staff from other sectors (Education, Protection, Health)
- Community-based organizations (CBOs)
- Teachers and other relevant community members

UNHCR and principal partners (including 6-8 adolescent refugee representatives) will develop the ASRH programme together. Adolescent refugee representatives will consist of disabled and at-risk adolescents, genders, different age groups and those who are and not enrolled in school. Provision will need to be made for language and literacy barriers. **The task force is a temporary institution and will dissolve after UNHCR, partner staff and refugees agree on and adopt their respective programme responsibilities.**



DESIGNING AN AGENDA FOR A TASK FORCE MEETING

The task force meeting should, ideally, take 1-2 days. An example agenda can be found in Annex 2.

Further guidance on creating an ASRH programme work plan can be found in the Annex to Step Two.

EXPECTED RESULTS FROM STEP 2

- Adolescent priority groups are identified and plans are in place to incorporate all 5 categories of adolescents into the ASRH programme
- A task force was convened to design an effective ASRH programme
- Relevant stakeholders on the task force are clear on their proposed inputs and how these might fit into an ASRH programme work plan.

STEP 3

TRAINING COMMUNITY PROMOTERS TO FACILITATE ASRH PROGRAMME IMPLEMENTATION

OBJECTIVES:

- ✓ Determine which community members will be responsible for promoting the ASRH programme
- ✓ Develop key tasks for proposed ASRH programme promoters
- ✓ Identify competent and knowledgeable trainers and training methodology for curriculum and programme implementation
- ✓ Train promoters on accurate SRH information
- ✓ Discuss how attitudes and beliefs of health care providers and promoters on adolescent sex and sexuality may hinder programme goals

Step Three assists with selecting those who will provide ASRH information within refugee communities. The promoters will help adolescents understand their sexuality and how to access AFHS as well as continue to build support for ASRH education. Promoters will need to understand and believe in the importance of ASRH as they will build rapport with adolescent participants and discuss sensitive subjects.

POSSIBLE PROMOTERS

COMMUNITY-BASED ADVOCATES are best for general community outreach because they already live amongst their communities and are aware of cultural and social practices that may better facilitate discussing ASRH topics.

- Recruited individuals may need to equally consist of those between 20-29 and those older than 30 due to their relative abilities to connect with adolescents and engage with the wider, older community
- They will also, ideally, have some school experience in order to read curriculum materials and/or effectively learn the material during training.
- Teachers may be best for school outreach because they are already familiar with the students they teach and may be more inclined to support them.

TEACHERS are not homogenous and there are those who will be more sympathetic and comfortable promoting ASRH than others. It is important for programme staff to identify and encourage such teachers to participate

- Refugee teachers themselves can sometimes be quite young, and may even be adolescents themselves – and therefore need ASRH information/support for themselves as well as their students
- If teachers aren't comfortable promoting ASRH, they can still make space in classrooms/school schedules for Community Advocates to run sessions
- Female teachers, where available, should be especially targeted to promote ASRH information with female students
- Students may also be more inclined to trust teachers of the same gender with sensitive information because of the amount of time they spend at school with the teacher
- In some situations, there is high teacher turnover and ASRH training will have to be repeated on a frequent basis.

Experience shows that **PEER EDUCATORS** can have important positive impact on increased sexual and reproductive health knowledge and increased contraceptive use, including condoms.¹¹ Peer educators may be the most effective at discussing RH issues with their fellows, in lieu of parents or other individuals, whether their peers are in or out of school.

¹¹ [Youth Peer Education in Reproductive Health and HIV/AIDS: Progress, Process, and Programming for the Future](#). Youthnet 2006.

NUMBERS AND DIVERSITY OF COMMUNITY PROMOTERS

There should be two community promoters (one female and one male when possible) per 100 adolescents.

- Promoters should be evenly distributed (as much as possible) throughout the refugee community by block and zone and according to differing cultures, ethnicities, etc.

TRAINING OF PROMOTERS

A challenge with sharing information on SRH is the high likelihood of community promoters reinforcing misconceptions they learned through tradition, popular opinion and their own biases about SRH. Community promoters need to undergo training on ASRH information before advising adolescents and supporting the ASRH programme in their communities.

UNHCR recommends the following training manual for training community promoters: DSW's [Youth to Youth SRH Facilitators' Training Manual](#). This SRH Training Manual is designed to empower young people with the knowledge and skills needed to make informed decisions on their sexual and reproductive health (SRH) and to become confident agents for change in their local communities. It can be used in the context of trainings for trainers, peer educators or peer learning group facilitators' respectively..

Additional information and suggestions on ASRH Facilitator position and training and in best practices for training new promoters can be found in Annex 3

Partners may create trainings as outlined in the ASRH programme work plan. Their designated trainer will have the skills and credentials to provide reproductive health, SGBV and life skills training and expertise; otherwise, multiple trainers may need to facilitate the training, in their respective disciplines. Partner staff may also be responsible for monitoring and evaluating the training's effectiveness and areas of needed improvement.



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EXPECTED RESULTS FROM STEP 3

- Community promoters were identified and chosen for training
- Competent and knowledgeable trainers and training methodology for ASRH information was chosen and implemented by partner staff
- Community promoters were trained on accurate ASRH information

A possible schedule for training promoters can be found in Annex 3.

Depending on the intended audience, more or less time should be spent on certain subject matters. Training should be adjusted for promoting ASRH information and services for adolescents 10-14 years of age, including information about the female and male reproductive systems. A useful manual by DSW [How to Reach Young Adolescents: A toolkit for educating 10-14 year olds on sexual and reproductive health](#) may help tailor the information provided. The [It's All One](#) and [Tuko Pamoja](#) curriculums also have activities specifically for young adolescents. These can be found in the Annex to Step Three.



STEP 4

INTRODUCING PEER EDUCATION

Peer education is defined as a system of delivering knowledge that improves social learning and provides psychosocial support. A peer is a person whose has equal standing with another in age, background, social status, and interests. Peers play a critical role in the psychosocial development of most adolescents. They, in fact, provide opportunities for personal relationships, social behaviors, and a sense of belonging. Therefore, peer education is considered as an effective health promotion strategy in adolescents.

OBJECTIVES:

- ✓ Identify peer educators to relay ASRH information and services
- ✓ Train and conduct refresher trainings for peer educators
- ✓ Equip peer educators with skills for advocacy within communities
- ✓ Facilitate peer educator service referral
- ✓ Motivate and retain peer educators

Many successful ASRH programs use peer education¹² to disseminate information about sexual reproductive health and services because adolescents naturally discuss these topics more easily with friends and peers than they do with an older adult or relative. Peer educators are also used to ensure AFHS referral within their adolescent networks and communities.

¹² Peer education is a process whereby motivated and well-trained young people participate in organized educational activities with people close to them in age, background or interests (peers) over a period of time. Peer education aims to develop peers' knowledge, attitudes and skills, enabling them to be responsible for and protect their own health.

Adolescents who serve as peer educators develop leadership skills, gain the respect of their peers, and improve their own knowledge base. They are also shown to positively change their own behavior after becoming a peer educator.

Peer educators facilitate formal and informal ASRH information sessions and refer their peers to AFHS at local health clinics¹³.

TYPES OF PEER EDUCATORS:

- 1 VOLUNTEER** – These peer educators do not receive any monetary compensation. They may be harder to retain without material incentives; however, positive feedback and recognition given by programme staff to show appreciation for their efforts is an effective retention aid.
- 2 IN SCHOOL** – These peer educators will be responsible for sharing ASRH information and providing service referral at schools. They should be enrolled students and should not receive any monetary compensation. Their role should be made known to relevant school administrators and teachers. They may also be harder to retain without material incentives, so should be given positive feedback for their efforts from both school and programme staff. After-school clubs is one way to organize and support peer educators, with the support of two teachers (male/female).
- 3 PAID** – These peer educators *do* receive monetary compensation for their work, and are usually equal to community health workers. They may be past peer educators who have aged-out of the programme, but still provide a valuable service as peer educator supervisors. Providing monetary compensation may be more effective in retaining and motivating peer educators in the long run, when feasible.

Programme staff may choose to use a combination of two or three types of peer educators based on the ASRH programme's needs. Ways to keep peer educators motivated should be identified by programme staff.

Further information on peer educators' selection, training guidelines, supervision, please read Annex 4

¹³ They are not necessarily better in transmitting factual health information. Peer educators and adult-led education can thus complement each other.



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EXPECTED RESULTS FROM STEP 4

- Peer educators were identified and trained to communicate ASRH information and provide AFHS referral to adolescents in their communities
- Training also provided peer educators with opportunities to develop leadership and advocacy skills
- Peer educators identified discussed obstacles to, and proposed strategies for, providing effective AFHS referral
- Programme staff understand and use strategies that motivate and retain peer educators
- Peer educators are supervised and supported

STOP EARLY MARRIAGE



Joojiya guurka
qasabka ah iyo kan degdega ah.

STEP 5 BUILDING CAPACITY TO CREATE ADOLESCENT- FRIENDLY HEALTH FACILITIES

OBJECTIVES:

- ✓ Conduct an initial or refresher training for health facility workers on the importance of providing SRH services to adolescents
- ✓ Assess how possible increased demand will affect current staff obligations and supply of service goods

The gold standard for adolescent-friendly SRH services is that they are “safe, effective and affordable; they meet the individual needs of young people [adolescent females and males] who return when they need to and recommend these services to friends.”¹⁴

¹⁴ *Adolescent Friendly Health Services: an Agenda for Change*. WHO, 2002. <http://bit.ly/2OHRVm4>

Step Five seeks, in part, to prepare and train health facility workers on the importance of providing SRH-friendly services to adolescents. If adolescents visit a local clinic and feel that they are being judged, discriminated against etc., they will likely not return.

WHO SHOULD BE TRAINED?

It is important to remember that health service providers are not the only people that supervise and/or work in a health clinic. Adolescents can face discrimination and stigma from not only nurses and doctors, but from other staff present on the clinic’s grounds.

Training should be provided for:

- Doctors
- Nurses
- Pharmacists/Dispensers
- Receptionists
- Gate Keepers
- Clinic cooks
- Clinic caretakers and drivers (if applicable)
- Any other employee present at the clinic on a regular basis

TRAINING FOR HEALTH FACILITY WORKERS AND SUPPORT STAFF

TRAINING SHOULD COVER:

- Information and services adolescents need to grow and develop in good health
- The role of health service provision in contributing to the health and development of adolescents
- Primary health problems adolescents face
- Who adolescents typically turn to when they face health problems and why
- Factors that make it difficult for adolescents to obtain health services they need
- What adolescents perceive as 'friendly' health services
- WHO recommendations for reaching adolescents with essential health services¹⁵

UNHCR recommends using [Reproductive Health Services for Adolescents Training Guide](#) by Pathfinder International. Other AFHS training manuals for and documents that may be useful for health service providers to use during their work with adolescents can be found in the Annex.

The WHO has also published a manual, [Making health services adolescent friendly – developing national quality standards for adolescent friendly health services](#), which could be useful in supplementing trainings. The manual's first chapter outlines the theoretical basis for actions to improve the quality of health service provision for adolescents.

REFRESHER TRAININGS

Health service providers and clinic staff should undergo refresher training at least every six months. These refresher trainings will last a day or two and provide opportunities for health service providers from all refugee community clinics to communicate any concerns or feedback they have regarding AFHS at their respective clinics, as well as share tips and best practices amongst their peers.

¹⁵ *Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services.* WHO, 2012.

PLANNING FOR INCREASED DEMAND

Before more demand for AFHS/ASRH is generated as a result of a successful ASRH programme, it is essential for the UNHCR public health officer(s) to ensure that adequate supplies are in place.

It is possible that increased demand will place a burden on current staffing obligations and contraceptive supplies. Clinic coordinators should analyze whether staffs' schedules adequately fall within AFHS appropriate hours and whether there are enough staff to meet both the new adolescent clients and those who normally come to the clinic for care.

It is important to remember that even if increased demand cannot be adequately accommodated at the outset of the programme, health clinics must document how many clients under the age of 18 requested ASRH services for future advocacy efforts and to fulfill high quality monitoring and evaluation standards.

EXPECTED RESULTS FROM STEP 5

- ☑ Trainings were held for health service providers and clinic staff on the importance of providing sexual reproductive health services to adolescents
- ☑ Plans are made for refresher trainings and health service providers shared feedback and tips with both programme staff and their fellow health service providers
- ☑ Public health officer(s) assessed how increased demand would affect current health service provider obligations and supply of service goods

STEP 6

IMPROVING ACCESS TO AFHS/ASRH IN HEALTH FACILITIES

OBJECTIVES:

- ✓ Assess health facilities' readiness to AFHS standards
- ✓ Task force partners establish which SRH services should be provided to adolescents
- ✓ Identify service gaps

An effective ASRH programme will not only provide accurate ASRH information but also ensure adolescents can access services and SRH counselling in either youth centres or health clinics, in a confidential and non-discriminatory atmosphere. Health facilities that fulfil the WHO's AFHS standards help ensure adolescents can access life-saving ASRH services.

Further information on AFHS tools for health service providers and identifying service gaps can be found in Annex 6

AFHS STANDARDS

To be considered adolescent friendly, health services should be¹⁶:

- **ACCESSIBLE:** Adolescents *are able* to obtain the health services that are available
- **ACCEPTABLE:** Adolescents *are willing* to obtain the health services that are available
- **EQUITABLE:** *All adolescents, not just some groups of adolescents, are able* to obtain the health services that are available
- **APPROPRIATE:** The *right health services (i.e. the ones they need)* are provided to them
- **EFFECTIVE:** The *right health services are provided in the right way*, and make a positive contribution to their health.

MONITORING WHETHER HEALTH FACILITIES MEET AFHS STANDARDS

[The Inter-agency Field Manual on Reproductive Health](#) proposes a list of "Adolescent-responsive health service characteristics", which make the service more responsive to the particular SRH needs of adolescents.¹⁷

¹⁶ *ibid*, reference footnote 1. Annex 1.

¹⁷ *Interagency Field Manual for Reproductive health in Humanitarian settings*, IAWG 2018, p. 117.

EXPECTED RESULTS FROM STEP 6

- ✓ Health service providers are willing to provide friendly services to adolescents
- ✓ Health providers have participated in identifying service gaps through focus group discussions and the Balanced Scorecard.
- ✓ Health facilities in the refugee community are regularly evaluated as to whether they've successfully fulfilled the AFHS standards.





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STEP 7

ENSURING REFERRAL LINKAGES BETWEEN COMMUNITY & HEALTH FACILITIES

OBJECTIVES:

- ✓ Strategize with community promoters/peer educators and clinic staff to deliver AFHS services to adolescents
- ✓ Define standard operating procedures for referral
- ✓ Outline effective presentations by health professionals to demonstrate proper use and information on services offered, taking into consideration the different types of learning styles of adolescents

After individual group trainings, community promoters, peer educators and health service providers (including clinic staff), will gather together and discuss how to provide SRH services to adolescents in an effective manner. Peer educators will serve as the voice of adolescents¹⁸ and the three groups will discuss what referral methods will be best for adolescents within their communities.

¹⁸ Provided peer educators are around the same age as the adolescent participants

STARTING A DISCUSSION ON REFERRAL STRATEGIES

Ensuring access to AFHS will require addressing concerns related to identifying barriers, including distance/location and anonymity/confidentiality. It will also require some thought as to how referral will be made. Some examples include: referral cards, written and oral referrals and health vouchers.

THERE ARE SOME BARRIERS TO REFERRAL THAT SHOULD BE CONSIDERED:

- Adolescents' homes and schools are too far from the nearest clinic
- Peer educators are too distant and not always available to advise adolescents
- Adolescents' schedules and familial obligations prevent them from accessing services
- Fear that peer educators will breach their confidentiality regarding service referral
- Fear that health service providers won't respect their desire to access services

DEFINING STANDARD OPERATING PROCEDURES FOR REFERRAL

These are some suggested conditions provided to community promoters and peer educators regarding AFHS referral:

- Consider and follow the advice given from community discussions on referrals
- Prioritize adolescents' views surrounding referrals
 - If the programme doesn't remove the barriers to accessing AFHS that adolescents identified, however real or imagined, then the programme will ultimately fail
- Peer educators cannot discriminate and decline or deny AFHS referral or ASRH information from adolescents.
- ASRH programme staff should inform adolescents that they have the *right* to access AFHS wherever and whenever it is available.
- Community promoters will be responsible for ensuring referral of adolescents to AFHS without discrimination or breaching confidentiality
- Peer educators and community promoters will make additional efforts to provide referrals in times and locations convenient for adolescents

AFHS/ASRH HEALTH PROVIDER VISITS

Community promoters and peer educators are encouraged to accompany small groups of adolescents to health clinics where health providers can introduce learning themes about AFHS.

Health professionals should prepare a tour of the facilities (where to go, reiteration of clinic hours, referral protocol/who's the best health provider to see, etc.), and the types of services offered.

While adolescents will receive information on different types of services from sessions with peer educators, it is predicted that health providers may give more credibility to explanations about these services.

Steps (tips) for an AFHS health provider visit in Annex 7

COLLABORATION BETWEEN PEER EDUCATORS AND HEALTH SERVICE PROVIDERS

After an adolescent visits the clinic, the health service provider may recommend that the individual return to the clinic for follow-up care. There should be a system created between peer educators and health service providers to communicating the need for the adolescent patient return for follow-up visits and how peer educators can support the adolescent to attend subsequent visits.

Peer educators and health service providers can confidentially share information about adolescents who need follow-up services at their regular feedback meetings. It is instrumental to explain to health service providers, peer educators and adolescent patients, that no one's confidentiality will be breached. Health service providers will simply tell the peer educators that they asked the adolescent patient to return to the clinic for a follow-up visit, not revealing the reason why, and to ask the peer educator to remind that individual.

Health service providers and adolescent patients will convey with peer educator supervisors and programme staff whether this is an effective method of ensuring confidential and smooth AFHS peer referral. Adolescent patients, as well as peer educators, will reveal whether they trust this additional referral method. If not, programme staff, community promoter supervisors, peer educators and adolescents will re-strategize the AFHS referral process.

EXPECTED RESULTS FROM STEP 7

- ✔ Peer educators and health service providers will have collaborated and created strategies to deliver ASRH to adolescents
- ✔ Peer educators, health service providers, and health facility staff will understand the standard operating procedures for referral
- ✔ Health service providers and peer educators will know how to introduce ASRH in a safe and comprehensive manner to adolescents
- ✔ Peer educators and health service providers have established a referral system for follow-up visits and continuous services.



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STEP 8

INTEGRATING ASRH INFORMATION & SERVICE PROVISION IN EXISTING ADOLESCENT-FRIENDLY INFRASTRUCTURES

OBJECTIVES:

- ✓ Assess youth centres' and schools' (etc.) abilities to integrate provision of AFHS/ASRH services
- ✓ Ensure coordination to facilitate successful and confidential AFHS/ASRH service integration

Existing youth infrastructures should be identified and evaluated as to their relative ability to integrate provision of AFHS/ASRH. If relevant programme staff and task force partners feel that existing youth-friendly infrastructures can support AFHS/ASRH, then they should collaborate to deliver successful and confidential integration. AFHS/ASRH in these environments can be distributed through peer educator referral; formal information sessions from health service providers, peer educators and community promoters; and informal discussions with teachers, and peer educators.

POTENTIAL PLATFORMS FOR ASRH ACTIVITIES

- Youth centres/Clubs
- Girls groups
- Women/girl-friendly spaces
- Livelihood development centers
- Schools
- Sporting Venues
- Churches, Mosques & Community Meetings Halls
- Radio programmes

Tips for how to plan integration of AFHS and ASRH information at youth centres and schools in Annex 8

EXPECTED RESULTS FROM STEP 8

- 📌 Programme staff have identified possible youth-friendly infrastructures in the adolescents' community
- 📌 Programme staff assessed whether youth-friendly infrastructures could integrate AFHS and/or ASRH information with partners
- 📌 Programme staff met and collaborated with relevant refugee actors at youth-friendly infrastructures to deliver AFHS provision and ASRH information
- 📌 Strategies are created and responsibilities are assigned to partner staff at youth-friendly infrastructures deemed appropriate for ASRH integration

STEP 9

PERFORMING EFFECTIVE MONITORING & EVALUATION

OBJECTIVES:

- ✓ Identify and define indicators to be measured
- ✓ Create a plan to measure adolescents' understanding of ASRH information
- ✓ Decide on tools and methods to gather the information to be measured
- ✓ Create a plan to measure how service access and provision improved by using HIS
- ✓ Evaluate how the programme met goals, identify gaps and strategize about how to bridge them in the future

One of the keys to creating a sustainable ASRH programme is to monitor and evaluate the progress of adolescents' information understanding and use of AFHS. Step Nine lays out a plan to examine and assess whether the ASRH programme in the refugee community is effectively progressing towards the ASRH programmes' primary goals:

IDENTIFYING AND DEFINING INDICATORS IN HIS¹⁹

The ASRH programme seeks to inform adolescents about ASRH information and provide AFHS with the ultimate goal of a reduction in teenage pregnancy and prevention of STI and HIV transmission. While the checklist from Step Seven assesses whether a clinic is adolescent-friendly, programme staff should emphasize to service providers that HIS has the following quantitative indicators that look at reproductive health for adolescents²⁰:

OBJECTIVE: REDUCE EARLY AND UNINTENDED PREGNANCIES

→ HIS Indicator: Delivery Care²¹

- Proportion of births to women under 18 years
- Proportion of births to women under 18 at home, without skilled birth attendant
- Proportion of births to women under 18 at health centers
- Rate of obstetric complications among under 18s in proportion to the number of births
- Proportion of live births to under 18 mothers that were delivered via caesarean section
- Number of antenatal visits:
 - First antenatal visit < 1st trimester under 18
 - First antenatal visit > 1st trimester under 18

→ HIS Indicator: Family Planning

- Proportion of total contraceptive users who are under 18 (male, female, and total- all methods)
- Proportion of total condom users who are under 18
- Proportion of total drop outs from family planning who are under 18
- Number of births to girls aged 15-19 years during a time period (years)

¹⁹ UNHCR, "Public Health List of Indicators" internal document in development. Accessed via epidemiology department, Nairobi/Geneva

²⁰ This refers to patients under and above the age of 18. Under HIS, it will be difficult to tell how many adolescents age 18 and 19 used AFHS and in what forms

²¹ While adolescents fall between the ages of 10-19 years old, for monitoring and evaluation purposes UNHCR will use HIS' current categories of above and under 18 years old to designate whether a patient is an adolescent or not.



OBJECTIVE: PREVENT STI TRANSMISSION

→ HIS Indicator: Syndromic Diagnosis

- Proportion of syndromic STIs diagnosed among under 18s (male, female, total)
- Number of male urethral discharge among male under 18 population
- Number of genital ulcer disease among under 18 population
- Ratio of contacts of suspected STI cases treated in under 18s to total number of suspected STI cases

OBJECTIVE: PREVENT HIV TRANSMISSION

→ HIS Indicator: Voluntary Counseling and Testing (VCT)

- Proportion of VCT clients under 18 years who were pre-test counseled, who accepted an HIV test
- Proportion of VCT clients under 18 years who were tested for HIV and who were HIV positive
- Proportion of VCT clients under 18 who were pre-test, counseled and tested for HIV, who received post-test result and counseling

→ HIS Indicator: PMTCT (Antenatal)

- Proportion of 1st time ANC visits by under 18s who were pre-test counseled, HIV tested and who received post-test results and counseling
- Proportion of ANC visits for under 18s who were tested for HIV and tested positive for HIV
- Proportion of ANC visits for under 18s who were pre-test counseled, and tested for HIV and who received post-test results and counseling
- Proportion of ANC partners who were pre-test counseled, who were tested for HIV, and who were HIV positive

→ HIS Indicator: PMTCT (Labour and Delivery)

- Proportion of under 18 mothers who swallowed Nevirapine during labor/delivery
- Proportion of HIV positive infants born to under 18s who swallowed Nevirapine within 72 hours of delivery
- Ratio of under 18 mother/infant pairs that swallowed Nevirapine on time to the number of HIV positive deliveries
- Proportion of HIV positive deliveries to women under 18 years
- All HIV positive delivery indicators: Under 18 at Home, Under 18 at Health Facility

OBJECTIVE: INCREASED USE OF AFHS/ASRH

→ HIS Indicator: Sexual and Gender-based Violence (SGBV)²²

- Rate at which rapes occur in the under 18 population
- Proportion of under 18 rape survivors who receive PEP within 72 hours and EC within 120 hours of an incident occurring
- All indicators: Males under 18, Females under 18, Total under 18

Programme staff should examine changes to these indicators from the beginning of the program, with an initial review of secondary baseline information and then on a yearly basis. Qualitative indicators will be used to assess how well adolescents understood and retained ASRH information.

MEASURING ADOLESCENTS' UNDERSTANDING OF ASRH INFORMATION

In addition to the quantitative indicators above, programme staffs from the task force are recommended to qualitatively evaluate how well adolescents have understood the information provided by peer educators and community promoters.

To create a plan to measure their understanding, programme staff familiar with the chosen curriculum or information given to adolescents should review both the chosen curriculum and recommended ASRH information given to adolescents from Step Three. From there, programme staff can decide which information is best to test or discuss in focus-group discussions to assess whether adolescents have understood and retained the information provided.

Tools and methods to measure adolescents' knowledge about ASRH information and services are provided in Annex 9.

²² Increases in other indicators also represent an increased use of AFHS. Sexual and Gender-based Violence is under this category because it doesn't fit well under the other objectives but is still a quantitative indicator.

EVALUATING WHETHER THE PROGRAMME MET GOALS

At the outset of the programme, task force partners will decide upon specific sub-goals for the ASRH programme, in coordination with the primary goals of any ASRH programme. Setting clear objectives for each sub-goal (i.e.: a specific percentage increase in referrals or attendance at adolescent-friendly health clinics), and analyzing whether their indicators have changed, shows whether the ASRH programme met the programme's goals.

Fixing those gaps, with feedback from adolescent participants, peer educators and community promoters can ensure a more successful ASRH programme. The feedback and discussions with adolescents, peer educators and the community should be similar to the strategies outlined by the community and task force in Steps One and Two.

ADDITIONAL MATERIALS:

Please consult the Annex to Step Nine for an in-depth comprehensive baseline survey for adolescents from UNFPA's *ASRH Toolkit for Humanitarian Settings*. This survey contains questions specific to circumstances and scenarios that adolescents experience as they seek AFHS/ASRH in their communities.

EXPECTED RESULTS FROM STEP 9

- ✔ Programme staff have defined which specific ASRH indicators they want to measure
- ✔ Questions were created that assess whether adolescents have retained the ASRH information given to them by peer educators and health service providers
- ✔ Surveys, purposive/snowball sampling and or focus-group discussions were used to understand adolescents' attitudes about improved AFHS and knowledge about ASRH information
- ✔ Using the HIS indicators relevant to ASRH, programme staff and health service providers recommitted to measuring how service access and provision improved
- ✔ The ASRH programme was evaluated as to how it met its goals; service and information gaps were identified with the help of adolescents, peer educators, and community; and plans were made to make the ASRH programme more successful

STEP 10

SUSTAINING INTEREST IN ASRH PROGRAMME THROUGH STRATEGIC ADVOCACY

OBJECTIVES:

- ☑ With adolescents, peer educators, and other community promoters, brainstorm advocacy events that build further community support for the ASRH programme
- ☑ Generate additional senior-management level support and advocacy for the ASRH programme

An essential element of reinforcing the importance of ASRH information and sustainable AFHS provision is to continue promoting the importance of ASRH, to both the refugee and host communities and senior-management staff at UNHCR and partner organizations. Step Ten outlines some possible strategies to engage adolescents and community members in leading these advocacy efforts and seeks to further build community and administrative support for the ASRH programme.

CREATING NEW STRATEGIES WITH THE COMMUNITY FOR FURTHER BUY-IN

Creating awareness about the benefits generated by the ASRH programme can be done through various formats including:

- Community events,
- Information campaigns, and
- Local celebrations and holidays, etc.

In collaboration with the community, especially adolescents, programme staff can generate more interest in the ASRH programme by bringing the programme's successes to the community's attention and emphasizing its positive benefits for the community.

SUSTAINING SENIOR-MANAGEMENT INTEREST AND SUPPORT

While programme staff, adolescents, and community members organize and campaign for increased and sustained support for the ASRH programme at the community level, UNHCR and partner staff will also need to prepare their own advocacy efforts to spread a positive message about ASRH programmes at the senior-management level.

EXPECTED RESULTS FROM STEP 10

- ☑ Programme staff collaborated with adolescents and community members to develop and execute advocacy events that build sustained local interest and support for the ASRH programme
- ☑ ASRH Programme staff, created publicity, awareness and support at the senior-management level for the ASRH programme

ANNEX OR “HOW-TO” GUIDE FOR ASRH

ANNEX 1: BUILDING COMMUNITY PARTNERSHIPS

Building School Partnerships

Many adolescents in refugee camps are eager to enroll or are actively enrolled in school. Adolescents can make learning and obtaining an education more difficult because they do not know how to avoid contracting STIs/HIV or how to prevent unintended pregnancy. Teachers working with adolescents on a daily basis may have a unique insight to the dynamics of adolescent sexual and reproductive health behaviors and knowledge within their classrooms. Therefore, it is instrumental for any ASRH intervention to incorporate the input and perspective of teachers, school directors, and the students themselves in the ASRH project’s initial community discussions.

Meetings with teachers and principals should be separate from discussions with students. Director and teacher discussions should follow the suggested questions from community discussions but should focus specifically on school intervention and outreach. As school directors and teachers spend almost as much time with adolescents as parents, it may be appropriate to spend more time allaying misconceptions about adults’ perspectives on ASRH.

Teachers, perhaps more so than prospective community-based facilitators, may feel ill prepared to provide information on ASRH to students because of their already “expert” status on their respective school subjects. Therefore, they might not want to diminish their authority in the classroom by revealing that they may have less than expert knowledge on sexual and reproductive health information. If they are selected as facilitators, it is instrumental to emphasize to teachers that they will be fully informed and trained on all relevant information related to sexuality education prior to teaching young people. In their initial training it also important to highlight that teaching this material should not be taught in the same manner as other subjects in the school’s curriculum due to the sensitivity of the subject (More information in Step 4).

Finally, you need to decide the best strategies for distributing ASRH information to adolescents enrolled in school. Decisions on how to start will be influenced by the educational policies of the Ministry of Education or other bodies, the availability of resources (including the availability of supportive school administration, trained teachers and materials), competing priorities in the school curriculum, the needs of learners; community support for sexuality education programs and timetabling issues. A pragmatic response might acknowledge that, while it would be ideal to introduce sexuality education as a separate subject, it may be more practical to build upon and improve what teachers are already teaching, and look to integrate

it within existing subjects such as social science, biology or guidance and counseling.²³

This choice would be in the event that the community feels it best to address only the school-enrolled adolescent population. Otherwise, it may be preferable to conduct the ASRH project outside of school with both adolescents who are and are not enrolled in school.

Suggested questions in school discussions:

- **Does the school have a policy framework in place concerning sexual and reproductive health information? Characteristics include:**
 - Provides an institutional basis for the implementation of sexuality education programmes;
 - Anticipates and addresses sensitivities concerning the implementation of sexuality education programmes
 - Sets standards on confidentiality;
 - Sets standards of appropriate behaviour; and
 - Protects and supports teachers responsible for delivery of sexuality education and, if appropriate, protects or increases their status within the school.²⁴
- **A policy on sexuality education will clarify and strengthen schools' commitments to:**
 - Curriculum delivery by trained teachers
 - Parental involvement
 - Procedures for responding to parental concerns
 - Supporting pregnant learners to continue with their education
 - Making the school a health-promoting environment (through the provision of clean, private, separate toilets for girls and boys, and other measures)
 - Action in the case of infringement of policy, for example, in the case of breach of confidentiality, stigma and discrimination, sexual harassment or bullying; and
 - Promoting access and links to local sexual and reproductive health and other services in accordance with national laws²⁵
- **Discuss how ASRH information can be integrated into the school curriculum**

- **Can the school provide adequate time (either during or after school) and space to a community ASRH intervention? If so, in what ways?**
- **Is there support amongst teachers to participate in providing ASRH information?**
- **Should teachers providing ASRH information be chosen by aptitude, school subject taught or by personal preference to participate in the project?**
- **How can teachers or peer educators effectively provide referrals and SRH services?**
 - Brainstorm specific strategies

ANNEX 2: DESIGNING THE ASRH PROGRAMME

How to run a community mapping discussion

- 1 **Begin by explaining that the boys and girls, separately, will be drawing a map of their community to identify where adolescents gather (by gender)**
- 2 **Identify a reference point, like a road or river, to give them a starting point**
- 3 **Have them locate some or all of their houses, if appropriate**
- 4 **Ask them to add other places or objects such as residence areas, fields, schools, churches, food distribution centres, reception, and institutions like markets, health centres, sports fields, police stations, and UNCHR and other partners' offices**
- 5 **Once their drawing is done, ask them to do two or three of the following:**
 - a) Identify where they spend most of their time
 - b) Identify places they like to be or feel comfortable and those they don't
 - c) Draw or write things they need or want in their community related to ASRH

²³ UNESCO. International Technical Guidance: An Evidence-Informed Approach For Schools, Teachers and Health Educators. Two vols. Paris: United Nations Economic, Social and Cultural Organization; 2009, <https://unesdoc.unesco.org/ark:/48223/pf0000183281>

²⁴ *ibid*, reference 23, page 11.

²⁵ *ibid*, reference 23, page 11.

These five steps serve as a springboard for peer educators and adolescent participants to share where they might find AFHS referral most convenient.

Other information you will need, which you can find out through focus group discussions or key informant interviews, is:

- Estimate the number of boys and girls per neighborhood within selected target age
- Locate schools/community centers/youth facilities- coordinate with other agencies
- From each targeted “community” identified, select 2 facilitators per 50 households:
 - Recommended: 1 male and 1 female to perform specific gender roles
- Establish adolescents’ timetable, daily activities and places where boys and girls go
 - Are there differences between communities?
 - When do adolescents have free time, if any?
- Brainstorm within each identified “community” how information on ASRH will be disseminated, where, how often and where adolescents can access SRH services.
- Identify platforms wherein the project could conduct ASRH activities

Example Agenda for Task Force Meeting

09:00 – 09:30

Introduction & Expectations

09:30 – 10:30:

Current situation

Present information gathered so far, based on community discussions and secondary analysis

Task force members present current adolescent programmes and information gained through their activities and prior analysis, sharing successes and challenges in each settings

10:30-11:00

Coffee/Tea Break

11:00 – 12:00:

Priority Issues

Small group discussions on major health issues affecting adolescents

- Focus on SRH
- Consider possible gender-based violence (GBV) / safety issues
- Reach consensus on which priority issues to focus on

12:00 – 13:00

Lunch

13:00 – 14:30

Planning

Plan strategies to address different topics and agree on consultation methods

- Agree which stakeholders will address which topic
- Agree to timeline
- Agree to locations
- Map available resources
- Discuss additional resource mobilisation, if needed

14:30 – 16:00

Plenary Session

Present strategies and receive feedback

Gathering Adolescent Baseline Information (if not previously done)

- A good place to begin to acquire quantitative and qualitative data from refugee adolescents is the *Comprehensive Sexual and Reproductive Health Survey for Adolescents in Emergency Situations* section in UNFPA's *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*.
- These survey questions should be paired with the CDC's *Reproductive Health Assessment Toolkit for Conflict-Affected Women*.

ANNEX 3: TRAINING COMMUNITY PROMOTERS TO FACILITATE ASRH PROGRAMME IMPLEMENTATION

Suggested Strategies to Advertise for ASRH Facilitator Positions & Training

- Consult with the adolescents involved in discussions in Step 1 for suggestions
- Ask adolescents from initial discussions if they have interest in the positions or specific names of friends or colleagues that they think would be interested
- If there have been previous initiatives related to adolescent empowerment and/or sexual and reproductive health, reach out to previous facilitators of these projects
- Reach out to those completing their studies from secondary school

- Do not create incentives such that boys or girls leave school to participate in the program; collaborate with schools to ensure that this doesn't occur
- Possible strategies could include supporting prioritization for employment with other camp NGOs after a set period of time or scholarships for future tertiary education
- Use current NGO refugee staff to recruit from their respective neighborhoods
- In community discussions in Step 1, ask community members if any of them (both males and females) are interested in learning more information about SRH and promoting ASRH within their communities.
 - Do they know anyone that would like to partner with the coordinating NGO to distribute information and ensure access to services?

Brainstorm on effective transport methods for facilitators in relation to their proposed stipend or incentives to participate in the program.

Best practices for training new promoters

- Ideally, training should take 3-4 full days.²⁶
- Select more trainees than needed volunteers so that there will be trained alternatives in case needed
- Choose a training location that is private and conducive to discussing sensitive health topics such as sexual reproductive health in a confidential space
- Outline promoters' responsibilities in participating in the training and expectations for implementing the programme
- At the training, community promoters should be provided with all relevant training and curriculum materials from the beginning of the training
 - ASRH materials should be theirs to keep upon successful completion of the training to better facilitate learning among adolescents and community
- Training should allow time to discuss any possible misconceptions promoters have about sexual and reproductive health information
 - Example: While some may feel that teaching adolescents about reproductive health is equivalent encouraging promiscuity, it is up to the trainer to explore beliefs and correct misconceptions on these and other SRH matters
- Training on ASRH could be integrated into on-going in-service teacher training activities

What to include during the training

- Values and Discussion about ASRH in participants' communities
- Puberty and Reproductive Systems
- Menstruation & Pregnancy
- Methods of Contraception & Negotiating Use
- Sexual Decision Making
- HIV & STIs
 - Stigma & Discrimination
- Sexual Exploitation, Rape & Gender-Based Violence
- Emotional Well-being & Life Skills
 - Life Goal Setting
 - Self-esteem
 - Peer Pressure
 - Conflict/Anger Management & Stress
 - Romantic Relationships; Love vs. Infatuation

This information will be delivered to community promoter trainees over the course of the training, possibly in the following schedule.

Expectations of community promoters at the end of training

Community promoters will:

- Have a thorough understanding of relevant ASRH information
- Discuss ASRH information with other community members, allay misconceptions surrounding ASRH and emphasize ASRH's importance in adolescents' lives
- Advise adolescents in their communities about their SRH

²⁶ Where and when there is funding and time, follow-up training(s) to reinforce core ideas is ideal.

EXAMPLE ASRH COMMUNITY PROMOTER AGENDA

| Time | Day 1 | Day 2 | Day 3 |
|---------------|--|--------------------------------------|--|
| 09:00 – 10:00 | Introduction & Expectations | Review of Day 1 | Review of Day 2 |
| 10:00 – 11:00 | Getting comfortable with Discussing Reproductive Health Game | Fertility, Reproduction & Pregnancy | Advocacy and Facilitation Methods & Planning |
| | Discussion about the importance of ASRH | | |
| 11:00-11:30 | Coffee/Tea Break | | |
| 11:30 – 12:30 | Puberty & Adolescents' Changing Bodies | Contraceptives & Partner Negotiation | Brainstorm Community Specific Advocacy Initiatives |
| 12:30 – 13:30 | Male & Female Reproductive Systems | HIV & STI transmission | Feedback |
| 13:30 – 14:30 | Lunch | | |
| 14:30 – 16:00 | Puberty & Adolescents' Changing Bodies | Developing good Life Skills | Monitoring and Evaluation |
| | | | Logistic Information & Next Steps |

ANNEX 4: INTRODUCING PEER EDUCATION

How to choose effective peer educators

Characteristics of effective peer educators are very similar to those mentioned in Step Three. Peer educators may be:

- Participants in community discussions from Step One
- Passionate about adolescent rights and health
- Group leaders in other community and school groups
- Well-known and respected by their peers
- Those who are at-risk, disabled or not-enrolled in school (as outlined in Step Two)
- Those recommended by teachers who they believe have potential

Adolescent participants from previous sessions lead by community promoters may also nominate their peers for training.

Training peer educators

There are many guidelines on training peer educators, detailed here.

Potential curricula to use as a guide

- 1 [It's All One Curriculum](#) (Global), IPPF
 - a) Additional resources (program examples, curricula and activities, promoter training and development, program implementation tools, training and technical assistance, international and regional advocacy organizations, as well as advocacy and policy documents) can be found at the end of their Activities manual.
- 2 [Tuko Pamoja](#) (Kenya), PATH & USAID
- 3 [Health & Life Skills Curriculum](#) (Zambia), Population Council & DFID
- 4 [Sexual, Reproductive Health and Life Skills for Youth Peer Education](#) (South Africa), IFRC
- 5 [GREAT Scalable Toolkit](#) (Uganda), IRH/ Pathfinder International/Save the Children
- 6 [GOAL Curriculum](#) (Girl's Football/Soccer), WomenWin
- 7 [My Changing Body: Fertility Awareness for Young People](#) (10-14 years old), FHI 360
- 8 Empowering Young Women to Lead Change, UNFPA

- 9 It's More than Just Sex: Curricula and Educational Materials to Help Young People Achieve Better Sexual and Reproductive Health (Various Curricula for Adult and Youth-led interventions), USAID & FHI 360

For more information, there are several curriculums focused primarily on peer-led or youth-led education. Here are a few examples:

- 1 Sexual and Reproductive Health Manual for Young People, DSW
- 2 Training Guide for Peer Health Education Programs in Africa; Guidance, Counseling and Youth Development Centre for Africa
- 3 *Youth-Friendly Services: A Manual for Service Providers*, Engenderhealth.²⁷

Other documents that may be useful for health service providers to use during their work with adolescents include:

- 1 *HIV Counseling and Testing for Youth: A Manual for Providers and a Manual for Trainers*, FHI 360²⁸
- 2 *Cue Cards for Counseling Adolescents on Contraception*, Pathfinder International²⁹
- 3 *Adolescent Job Aid: A Handy Desk Reference Tool for Primary Level Health Workers*, WHO³⁰

Tips for Facilitators Working with Adolescents and In the Community:

- Tips for handling sensitive topics
 - Clarify your own values
 - Be prepared and plan ahead – if you feel uncomfortable, perhaps you can ask a guest speaker more technically qualified than you to facilitate on a particular topic
 - Check with project implementers for approval
 - You don't need to know everything; get advice and help if you need it. It is ok to say, "I don't know the answer to that question, but I can find out!"
 - Do not dismiss or look down on what learners know, do not know or those who have differing opinions

→ Set limits – do not tolerate lewd or disrespectful behaviour. Agree on appropriate behaviors at the beginning of each training

- A one-way conversation, where health providers share their own moral guidelines or assume the role of a parent, will prevent:
 - Open communication
 - Cause the adolescent to disengage from care and
 - May compromise decisions made by the adolescent concerning his or her sex life
- Tips for Working with Parents:
 - Keep them informed
 - Talk with parents about concerns and fears
 - Know your community
 - Involve parents – encourage adolescents to share a fact they learned today with a respected elder or relative and ask how they feel about it
- Characteristics of a Good Facilitator:
 - Leans towards participants
 - Has an awareness of the discussion topics and participants' level of engagement and understanding
 - Is prepared
 - Uses good eye contact
 - Is aware of voice- volume, pronunciation, and diction
 - Is flexible

Training peer educators will be slightly different than training older community-based advocates or teachers. Initial training will help them understand ASRH information, how to refer their peers to AFHS and identify their early goals for the ASRH programme. Subsequent refresher trainings can help them assess their continued progress, challenges in information dissemination, and service provision; and provide opportunities for collaborating on strategies to overcome these obstacles.

As peer educators are the primary providers of ASRH information to refugee adolescents, they will need to be very familiar and comfortable discussing ASRH information. Peer educators will also be referring their fellow adolescents to AFHS. This requires a good understanding of the need for confidentiality and respect for their peers lives and decisions. Trainings will emphasize the importance of relationships between adolescents.

²⁷ <http://www.engenderhealth.org/files/pubs/gender/yfs/yfs.pdf>

²⁸ <http://www.fhi360.org/reseource/hiv-counseling-and-testing-youth-manual-providers-and-manual-trainers>

²⁹ <http://www.pathfinder.org/publications-tools/cue-cards-for-counseling-adolescents-on-contraception.html>

³⁰ http://www.who.int/maternal_child_adolescent/documents/9789241599962/en/

Therefore, peer education training and any subsequent refresher trainings must incorporate special emphasis on essential leadership and advocacy skills for adolescents. These topics prepare peer educators to build avenues for greater adolescent empowerment and successfully integrate them as equal participants in the ASRH programme. Documents on building leadership skills for adolescents in low and middle-income settings can also be found in the Annex.

UNCHR recommends UNFPA's [Youth Peer Education Toolkit](#). It offers guidance on standards for peer education, monitoring and evaluation tools, and some fun theatrical-based teaching techniques with manual.

Supervision of peer educators

There are five community promoter groups that can directly supervise peer educators, in order of preference.

- 4 **Peer educator supervisors** – These are former peer educators who have matured out of the programme and have the capacity to supervise their former peers. They collaborate with health service providers and are treated and compensated as if they are community health workers.
- 5 **Peer educator leaders** – These are current peer educators that have been nominated by their peers as those who are respected and recognized as those who will monitor how effectively their peers are performing their roles as peer educators. They also communicate with health service providers but are not monetarily compensated. These are more appropriate at the outset of the programme.
- 6 **Exceptional community-based advocates** – These are community-based advocates that adolescents recognize as trustworthy and respected who are willing to take on the additional responsibility of supervising ASRH peer educators. They will collaborate with health service providers but are not monetarily compensated. They may be chosen after a period of observation at the start of the programme.
- 7 **Community health workers** – These are already employed community health workers. The responsibility of supervising ASRH peer educators will be in addition to their other community health duties. They will also collaborate with health service providers and may receive monetary compensation for their tasks.
- 8 **Teachers** – The responsibility of supervising ASRH peer educators will be in addition to teachers' regular teaching duties. Teachers would be acceptable supervisors for ASRH groups based

at schools. They will also collaborate with health service providers, and school administrators.

Programme staff and peer educator supervisors or leaders will supervise peer educators' activities in the refugee community. They will supervise peer educators as mentors and their work in informal and formal settings. Programme staff and peer educator supervisors/leaders will also monitor peer educators' activities and provide individual and group feedback. Peer educator supervisors/leaders will need additional training in monitoring and evaluation for peer education, and contribute equally, with new peer educators, on effective strategies for supervision.

Peer educators refer to AFHS services

In addition to providing ASRH information to adolescents within their communities, peer educators are also responsible for referring their peers to AFHS. Effective peer educator service referral will primarily rely on:

- 1 Adolescents' locations and availability, as well as
- 2 Adolescents' trust in peer educators to provide confidential AFHS referral.

It may be beneficial for peer educators to answer the following questions:

- Where do adolescents congregate in their community?
 - Do girls and boys gather in the same or different places?
- How do their daily responsibilities, routines and time commitments relate to clinic hours and peer educators' availability?
- How often do peer educators have or plan to have information sessions with adolescents where they can most readily access referral?

An effective activity for reaching a consensus on where adolescents congregate, in relation to the rest of the community and in relation to clinics, is community mapping.

Managing and motivating peer educators

At the end of the training for peer educators, participants will appreciate receiving a certificate for their achievements, as tangible evidence of their participation and successful completion of the training. The certificate also serves as an empowerment mechanism. Certificates may also be awarded to participants who've completed an ASRH curriculum and tested satisfactorily on post-tests.

Most importantly, the ASRH programme should make peer educators feel important through recognizing and

praising their efforts in public. Previous initiatives have encountered problems with retention because trainings were too long, programmes had unreasonable targets and peer educators were not sufficiently supported in the field.

At least once a month, peer educators and (a) peer education supervisor(s) or programme facilitator, acting in a supervisory capacity, should meet to:

- Report back, discuss and receive emotional and practical support related to challenges with peer education activities
- Share new information and developments within communities that may affect the intervention
- Plan activities that include community advocacy, mobilization and group peer education
- Submit monitoring and report forms and deal with any problems with their supervisor
- Receive feedback on observation of peer educator activities
- Create and review work plans³¹

Refresher trainings should take place at least every six months. The trainings should be a day long and include new ideas for engaging youth, including new songs, games and activities that inspire adolescents to continue attending formal and informal ASRH sessions.

Two Options for Peer Educator Training

- 1 Partner Staff Peer Educator Training (Most Preferred)**
 - Like community promoters, professionals chosen by partner staff will train peer educators. This is the most effective training modality if programme staff wants to begin peer education concurrently with other community promoters' activities.
- 2 Training Community-Based Peer Educator Trainers**
 - In some instances, programme staff may feel it's wise to train previous community-based advocates, teachers or initial peer educators on how to conduct their own trainings of peer educators. This type of training can occur after the ASRH programme has had some success in the community. For more information on how to lead such an endeavor, please look at FHI 360's publication [Training of Trainers Manual: Youth Peer Education Toolkit](#).

Peer Educators Tips:

- Other initiatives in the camp that utilized peer educators will determine whether peer educators should be offered compensation or incentives.
 - If peer educators perceive there is a norm for receiving a t-shirt or beverages when participating in certain projects, they may lose any previous motivation they would have had to participate, without it.
 - It is recommended to start without any or just some small compensation (a bag or t-shirt that sets them apart as special) rather than a lot of goods, refreshment and/or monetary compensation.
- A stipend for peer educators, however, shows that they are making a valuable contribution to their peers and their communities

Additional Tips for Peer Educator Training

- Be flexible when scheduling training to maximize qualified peer educators
- Involve adolescents in developing and pre-testing the ASRH information materials and curricula, if applicable.
 - These serve as valuable opportunities for adolescents to practice facilitation skills and to gain ASRH knowledge
 - This also ensures an accurate reflection of the audience's cultural background and educational level
- Encourage peer educators to keep a journal of referrals made while maintaining confidentiality (i.e. tallies or a calendar with number of peers referred each day, without using names or other personally identifiable information)
- Prepare the peer educators for community resistance and public criticism to the ASRH programme and activities, and strategize how to handle it, should it arise.

Discussing confidentiality with peer educators

Peer educators will also need to discuss the importance of anonymity and confidentiality to effectively refer adolescents to AFHS. Trainers should consider posing the following questions:

- Who in the community can see adolescents coming to the clinic?
- Does the community (do community members) know why adolescents are going to the clinic? Do they suspect it's for ASRH and not other illnesses?
- What do you (as peer educators) believe are the best strategies to discreetly refer adolescents to ASRH services and health clinics?

³¹ United Nations Population Fund and Youth Peer Education Network (Y-PEER). 2005. *Youth Peer Education Guide for Trainers* pg. 24/25

- How do adolescents believe anonymity and peer educator confidentiality can be achieved?
 - Ask them to outline strategies they can all implement as peer educators

From the community mapping activity, and the discussion questions on confidentiality, peer educators will be able to more effectively choose the proper referral method to use in the field. It will be up to programme coordinators, with the support of adolescents, community members, and health providers, to determine which referral methods are the best for both monitoring and evaluation objectives and the most successful provision of AFHS. More information on successful referral can be found in Step Seven.

Expectations of Facilitators for Project Implementation & Completion

Training facilitators on accurate ASRH information and emphasizing their role in building referral systems for adolescent reproductive health services is important. It is equally important to ensure that there are established terms of reference and agreed upon expectations with facilitators.

Facilitators, trainers, and project staff should consider and agree upon the number of sessions or duties that facilitators will perform each week and how they will be compensated for their efforts. The discussions should conclude with agreed upon standards and goals for monitoring and evaluation of the project under the responsibility of the facilitator(s); this will be discussed further in Step 9.

Sample TOR from SAVIC's ASRH project from Kakuma:

Main Duty: The ASRH Coordinator will be in charge of coordinating, implementing and evaluating the SAVIC Adolescent Sexual Reproductive Health, a project that will use peer-to-peer education to reduce the rate of unintended pregnancies and increase access to adequate FP services for adolescents in Kakuma refugee camp.

Tasks:

- To report to work from Monday to Friday between the time of 9:00 am to 5:00 pm, with two hours of break, and on Saturday between 9:00 am to 12:30 pm
- To coordinate the recruitment or establishment of six (6) schoolgirls' clubs, six (6) community girls' sports clubs and three (3) girls discussion groups, which form an audience for weekly lessons on sexual reproductive health and life skills
- Making schedules/timesheets for workshops, talk sessions, and other project activities and submitting

the schedules to the Chairperson at the end of every month

- Liaise with SAVIC and the IRC MARPS clinic and the NCCC
- Coordinate ASRH project meetings and events in conjunction with the chairperson and other staff
- Help the Lead Peer Educator prepare weekly training sessions with different ASRH clubs and groups.
- Coordinate, with the support of the Lead Peer Educator and other SAVIC staff, the Voice of the Young People campaign to be held three times during the year
- Coordinate, together with other SAVIC staff, 3 girls' sport competitions to promote girls' participation in their sport clubs
- Evaluate and identify areas of improvement for the ASRH project
- Oversee proper budget spending and equipment usage, and work with the Finance Director to prepare activity budgets
- Document each project activity and prepare monthly progress reports; contribute to quarterly and annual project reports
- Prepare pay lists for ASRH staff and volunteers, where applicable; purchase requisitions and item requests, and submission of requests to the finance committee for payment of wages/incentive or procurement of supplies/services

I agree to take my duties as stated above.

Sign: Date:

SAVIC Chairperson: Date:

SAVIC TERMS AND CONDITIONS 2013 – ASRH COORDINATOR

- You are expected to fulfill the duties and responsibilities given herein in the time planned. Failure to attend more than 3 activities, events, or meetings will result in cut of pay or termination. The Management will give two written warnings before any termination.
- You are expected to understand and respect SAVIC mission and values, Rules and Regulations, and the Code of Conduct.

- 3 You will be subject to annual performance evaluation by the Management Committee of SAVIC.
- 4 Leaves are granted in the following ways: 24 days annual leave, 7 days paternity leave, 3 days mourning leave, and unpaid leave.
- 5 You should work exclusively for SAVIC during your current engagement. The opposite will result in termination.
- 6 Failure to submit work reports for periods of more than 2 months may result in warning or termination.
- 7 Any serious, inappropriate behavior in meetings, in front of SAVIC beneficiaries or members (insults, sexual violence, public drunkenness, or repeated discriminatory arguments) is subject to disciplinary action, which may include termination.
- 8 Disclosure of confidential information or other sensitive information concerning SAVIC beneficiaries, members or activities is subject to disciplinary action.
- 9 Your monthly incentive pay will be Kshs 5,500 (Kshs 5,000 paid through NCCK, and Kshs 500 paid from SAVIC local funds).

I agree to carry out my activities as stated above. I will also abided to the following rules set under SAVIC Rules and Regulations:

Staff Name: Sign:
Date:

Chairperson: Sign:
Date:

All prospective facilitators should read the first draft of expectations and TOR during the training and discuss possible changes and addendums with project staff. There should be ample time for discussion in order to avoid misunderstandings after the launch of the project.

- Have prior experience working with youth or a strong desire to assist young people in their communities, especially adolescent girls
- Speak confidently and comfortably when discussing ASRH topics and encourage peers to communicate openly about the subject
- Express their positive beliefs of providing ASRH information and services to adolescents
- Distribute condoms (male and female) and refer adolescents to local youth centers and health clinics as needed for other forms of contraception
- Contribute ideas to improve community acceptance of ASRH initiatives
- Lead theater/drama, radio, text message or billboard campaigns on ASRH information
- Are in their 20s or late teens. **
- Create appropriate rapport with participants, acting as both as an authority figure and as a friend and mentor
- Have an engaging attitude, a spirit of fun and willingness “to let loose” with their peers
- Are willing to assist future peer educators in the sustainability of the project
- Are NOT employed with other camp organizations whose schedule(s) conflicts with facilitator duties (information sessions, referrals to clinics etc.) and mandatory trainings
- Are literate and have good working knowledge of English or other primary language of host country (French, Swahili, Spanish, and Arabic etc.)
- Are, preferably, secondary school graduates or have completed enough education to make them appropriate role models and to able to understand training and ASRH materials.
- This is highly recommended, but there are many outstanding candidates that may not fulfill these entire criterion – be open!!

Have pilot project participants volunteer or nominate their peers for future peer educators and discuss their expectations for future peer educators.

Qualities of Successful Peer Educators

Peer educators...

- Are committed to the idea and importance of informing adolescents about their sexual and reproductive health, including access to contraceptives for both girls and boys
- Show a willingness to learn more about their own sexual and reproductive health and be open-minded about possible misconceptions

ANNEX 6: WHICH SERVICES TO PROVIDE TO ADOLESCENTS IN HEALTH FACILITIES?

Each host country has laws governing which sexual reproductive health services, including contraceptives, are available to adolescents. In addition, there are specific guidelines on how to provide SGBV counselling and HIV testing in refugee settings for adolescents. According to these stipulations, ASRH programme staff should make every effort to improve procedures and service delivery.

AFHS tools for health service providers

Pathfinder International has a set of cue cards for service providers for counselling adolescents on different methods of contraception. This job aid is designed to help a range of community and facility-based providers counsel adolescents and young people on their contraceptive options. The cards can be found [here](#).

Identifying service gaps

In conducting AFHS, there may be adolescents who are not adequately satisfied with the quality of available services; therefore, it is recommended to give adolescents opportunities to share their opinions, which will help to improve services. This feedback also serves to identify service gaps. Service gaps can be identified through:

- 1 Focus Group Discussions
- 2 Using Balanced Scorecard to Monitor Facility Capacity for Service Provision

The Balanced Scorecard is a UNHCR quality of care assessment tool to provide a multi-faceted measure of quality of care and identify areas for improvement. It looks at health facilities, supplies, service provision and uses client interview methodology to assess the perception of quality of service provision at the end of a health visit from randomly selected individuals. There is a Reproductive Health Scorecard covering multiple SRH service areas.

Programme staff and health service providers must include adolescents in the groups surveyed using this methodology at health clinics. This assessment should be done in a confidential setting and done as soon as possible after adolescents leave the clinic or health facility. Once health service providers and programme staff have identified service gaps, they will need to create new strategies to minimize them, preferably with peer educators. More information is provided in the Step Seven.

EXAMPLE PARTIALLY-FILLED ADOLESCENT-FRIENDLY HEALTH FACILITY CHECKLIST

| Name of Health Facility | Baseline situation | Goal |
|---|--|---|
| HEALTH FACILITY | | |
| Convenient Hours | Only open during school hours and not on Sundays | Expand opening hours to 2 additional hours in the evening and Sunday afternoons |
| Adequate space and sufficient privacy | Walls are very thin so confidentiality is compromised | Reinforce walls |
| Comfortable surroundings | Not enough chairs for people waiting. STI/HIV prevention materials all aimed at married couples. | Procure 50 more chairs. Develop additional materials to target adolescents. |
| PROVIDER | | |
| Respect for adolescents | | |
| Non-judgmental attitude | | |
| Privacy and confidentiality respected | | |
| Peer counselling available | HIV counselling is undertaken by people living with HIV | Train adolescents living with HIV as additional counsellors |
| Same-sex providers when possible | Staff ratio 8 men to 3 women | Ensure 3 women maintained; consider gender balance in future recruitment |
| Strict confidentiality maintained | Records always locked in cupboard. Staff well aware of confidentiality and respect it. | Maintain situation |
| Staff trained in youth-friendly health service characteristics | Staff trained 18 months ago | Organise refresher training |
| ADMINISTRATIVE | | |
| Adolescent Involvement | Adolescents not involved in planning services | |
| Boys and young men welcome | Services very focussed towards women and girls | |
| Necessary referrals available | | |
| Drop-in clients welcome | | |
| Publicity and recruitment that informs and reassures adolescents* | | |

Also refer to the Focus Group Discussion Guide in the Annex.

ANNEX 7: STEPS FOR AN AFHS HEALTH PROVIDER VISIT:

- 1 Tour of facilities
- 2 How to make an appointment
- 3 How to see an adolescent-friendly health provider during drop-in hours (when applicable)
- 4 Introduction of consultation room
- 5 Explanation of AFHS and SRH services provided at the clinic
 - a) Injectables
 - b) Implants
 - c) IUDs
 - d) Condoms
 - i) Male (Demonstration)
 - ii) Female (Demonstration)
 - e) HIV Testing
 - f) SGBV Counselling & Legal Service Referral
- 6 Sexual and Reproductive Health Questions & Answers
 - a) Use TARSC Auntie Stella letters³²

The session should last, at most, two hours to allow the health provider to still maintain their normal work schedule. Health providers should make the sessions as informational and interactive as possible.

ANNEX 8: HOW TO PLAN INTEGRATION OF AFHS AND ASRH INFORMATION AT YOUTH CENTRES & SCHOOLS:

- 1 **Discuss with administration and staff to gauge their interest in and the feasibility of offering AFHS**
 - Determine the scope of services to be delivered on premises
 - Find out whether staff are already trained on ASRH training or whether they need to be trained
- 2 **Find out current provision of any ASRH information or services**
 - (Schools): Determine whether there is a national sexuality education component in the schools' curriculum and how feasible it would be to provide information and services in this context
 - Seek out national teaching institutions that could offer training on effective facilitation and life skills etc., if applicable
 - Consult UNESCO's [International Technical Guidance on Sexuality Education: Volume 1 – The rationale for Sexuality Education and Volume 2 – Topics and Learning Objectives](#) to support schools' and teachers' efforts to provide ASRH information in school
 - Find out the ratio of male to female teachers per school. Female teachers are critical for sharing ASRH information with adolescents, particularly for girls
 - (Centres & Schools): Ask if they've tried these initiatives before – what were their successes and obstacles in AFHS provision?
 - Provide support to teachers and centre workers who might not be comfortable teaching ASRH – link them with community advocates or health providers who might be able to provide information in classrooms/schools
 - Determine with centre or school staff whether AFHS at either the centre or school could reach all adolescents
 - Consider who might be excluded at this facility (i.e. adolescents not-enrolled in school, adolescents with disabilities etc.)
 - Develop strategies to maintain respect, non-judgmental attitudes and confidentiality for AFHS and ASRH-information seeking students with both participating and non-participating students and teachers

³² This is a series of fictional letters to "Auntie Stella" that touch on common personal, emotional, and social issues that affect young women and men's lives, sexual health and their relationships with partners, family, peers and society. They were developed by the Training and Research Support Centre (Zimbabwe).

- Collaboration and discussion with parents about the importance and acceptance of AFHS provision and ASRH information sessions
- Consult with a parent group like the School Development Committee (SDC) or Parent Teachers Association (PTA)

3 Consider the location & building

- Designate space(s) for AFHS and ASRH information
 - Consultation Room
 - Information Session Room
- Choose convenient hours for AFHS provision and ASRH information dissemination according to: **school's schedule and adolescents' preferences**
- Determine whether consultation room and information session room are:
 - (Consultation Room especially) Non-threatening or associated with authority (i.e. the director's office may not be ideal)
 - Confidential & Private
 - Windows don't allow other students to see in – if not, who can supervise this problem?
 - Have doors
 - Far enough away from other students' activities and classrooms (can be time specific)

4 Consult with health service providers

- Examine whether health service providers' clinic work schedules allow them to provide AFHS at the centre or school's chosen convenient hours
- Ask them what materials they need at the centre or school and how they will bring additional materials from the health clinic
- Ascertain whether same-sex service provider(s) can be provided
- Discuss their acceptance of peer educators' ability to understand and teach ASRH information, and their role in peer counseling in AFHS.

5 Consult with adolescents (community adolescents or students)

- Ask whether they consider it comfortable and acceptable to obtain AFHS at the school or centre; Explain how service provision will be done
- Ask different genders, age groups, etc. what hours are convenient
- Discuss strategies to publicize AFHS provision and ASRH information sessions to their peers and other adolescents

- Discuss concerns surrounding mixed and same-sex information sessions
- Discuss with peer educators whether they believe AFHS referral can be made in a confidential and appropriate manner at the school or centre
- Identify (class) representatives that can express adolescents' remaining concerns regarding AFHS provision and ASRH information sessions

How to facilitate ASRH information sessions at sporting venues:

- Identify times when adolescents are present at matches or practice
- Identify age and gender of teams playing at different times throughout the week and speak with their coaches or captains
- Collaborate with adolescent/ adult coaches or captains on the acceptability of a ASRH presentation or information session during half-time or after the match
 - Ask if they've participated in ASRH training or are interested in doing so
- Peer educators in conjunction with coaches/ captains will decide the best time to present ASRH information and the topic to be discussed
- Determine whether football pitches could serve as meeting places prior to attending health provider presentations at adolescent-friendly clinics

How to facilitate ASRH information at churches, mosques and community meeting halls:

- Identify religious and community leaders who are more accepting of the ASRH programme (possibly those invited to participate in activities from Steps One and Two)
- Propose the idea of providing ASRH information at their respective buildings apart from normal activities
 - Ask if they've participated in ASRH training or are interested in doing so
 - Ask them to reach out to parents and other religious members to explain the importance of ASRH and to clarify the information being taught
 - Propose having information sessions provided exclusively for adults taught by community promoters
- Peer educators and their community-based advocates and supervisors must inform religious leaders on proposed topic before each session
- Determine whether religious buildings could serve as a gathering point to attend health provider presentations at adolescent-friendly clinics

Coordination with partners who supervise youth-friendly infrastructures

Successful integration can be achieved by programme staff collaborating with partners and other UNHCR staff, such as child protection and education officers, who are in charge of youth-friendly infrastructures like youth centres and schools. Their discussion could follow this general format:

- Programme staff will begin by:
 - Giving a brief explanation of the ASRH programme's objectives and goals
 - Explaining their proposal for AFHS integration at the centre(s) or school(s) and outlining why AFHS is important at this location
- Allow partner staff to ask questions and express concerns in conjunction with their current projects at the centre or school
- Programme staff and partner staff will adapt programme staff's initial proposal to better integrate AFHS with advice of partner staff
- Vote as to whether the facility can deliver AFHS
- Strategize with partner staff regarding their willingness and ability to contribute their resources to facilitating AFHS at the youth-friendly structure
- Decide which, if any, partner staff will take over new responsibilities related to AFHS integration
- Evaluate successful integration at 3 month intervals with partner staff and address all parties concerns about AFHS provision

ANNEX 9: METHODS TO MEASURE ADOLESCENTS' KNOWLEDGE ABOUT ASRH INFORMATION AND SERVICES

Please consult **UNFPA's ASRH Toolkit for Humanitarian Settings** for in-depth comprehensive baseline surveys for adolescents.

10 questions that programme staff can use to assess adolescents' improved understanding of ASRH include:

- 1 When during the menstrual cycle are you most fertile/likely to become pregnant?
- 2 Can you become pregnant the first time you have sexual relations? (Yes or No)
- 3 Name three methods of contraception/Family Planning
- 4 Name 3 ways that HIV is transmitted and 3 ways it's not
- 5 What form of contraception prevents pregnancy, STIs and HIV (besides abstinence)?
- 6 Name 2 symptoms of STIs and when a person with those symptoms should visit a health service provider
- 7 What are the forms of sexual and gender-based violence?
- 8 What can adolescents do to prevent SGBV?
- 9 Where can adolescents receive reproductive health services and at what times?
- 10 What kinds of services can adolescents receive from health service providers?

Tools and methods used to gather the information to be measured

These non-experimental designs are recommended to measure impact due to the comprehensive nature of the ASRH programme.³³

Ideally, before adolescents begin meeting with peer educators and community promoters, members of the task force will have been designated to carry out a baseline survey or focus group discussions to understand adolescents' knowledge about ASRH information and AFHS available.

³³ In the future, with more financial support and feasibility, it will be advantageous to move towards to randomized control trials and quasi-experimental studies.

If not, surveys are still important because they measure the amount of information that is known about the improved AFHS and ASRH information given to adolescents in conjunction with the ASRH programme.

Surveys:

Surveys can be given to known adolescent participants in the programme or to randomly assigned adolescents in the community.³⁴ The first group of participants will give a more accurate assessment of whether information has been retained if they were also given a baseline survey before the outset of the programme.

If a baseline survey was not possible, then it is recommended that task force partners in coordination with community promoters and peer educators distribute the survey to randomly assigned adolescents in the community.

After adolescent participants have received ASRH information and used AFHS for six months, then repeated surveys can be introduced. These repeated surveys should be performed every year.

Purposive and Snowball sampling:

These two methods use sampling based on certain criteria describing a target population. Programme staff contact adolescents who have participated in the ASRH programme, perform a short survey on their understanding of the ASRH information learned and ask them for friends who have also participated or whom they've spoken to about the programme. In this way, the sampling could interview those who have participated and those who have learned about ASRH information and AFHS through word of mouth from friends.

Focus-Group Discussions:

This method will help UNHCR staff understand the perception of users on the quality of services provided (how comfortable adolescents feel with improved AFHS etc.) and how frequently they practice safer sexual behaviors. Surveys can also acquire this information but focus-group discussions are less time-consuming and cost-prohibitive.

Use the Balanced Scorecard to assess the Quality of AFHS

To examine the quality of AFHS, in conjunction with the checklist from Step Seven, health service providers should pay special attention to the Balanced Scorecard. This evaluation tool is designed to assess the overall quality of care provided in primary healthcare facilities, and it also has a Reproductive Health Scorecard, measuring SRH service capacity, SRH service provision, SRH client satisfaction and SRH staff satisfaction. It also contains a number of indicators specifically related to sexual reproductive health.

Balanced Scorecard indicators directly related to ASRH and AFHS include:

→ Health Facility Observation Questionnaire

- Disease management protocols/wall charts
 - 7.5: Voluntary Counseling and Testing (VCT)
 - 7.6: Prevention of Mother-to-Child Transmission (PMTCT)
- HIV medicines/supplies
 - 9.1: Condoms
 - 9.2: HIV test kits
 - 9.3: Anti-retroviral (ART) for PMTCT according to national guidelines
 - 9.4: Post-exposure prophylaxis (PEP)

→ Reproductive health questionnaire

- Maternal nutrition
- Reproductive health medicines, including FP commodities
- RH equipment
- RH HIS
- RH Protocols

Adolescents should be included when conducting interviews or conducting the BSC.

³⁴ Mobile phone surveys are appropriate depending on the context and budget.

STEP 10: TO CREATE ADVOCACY EVENTS IN THE COMMUNITY:

- Identify successes of the programme and emphasize that these should continue
 - Also pinpoint gaps in community support for the programme; eliminating these gaps increases the chance of the programme's continued success
- Design messages and campaigns that appeal to community members, including adolescents, who have not endorsed the ASRH programme
- Determine appropriate opportunities to sustain and build support for the ASRH programme; examples include:
 - Presentations at youth group and/or community member meetings
 - Speeches at meetings with parents, schools administrators, women's groups and religious leaders
 - Theatre performances at community and school events, including sporting events and holidays
 - Programmes that use sports to teach adolescents about ASRH and life skills (ex: [Kicking AIDS Out](#))
 - Decide which day to hold the event – international awareness days are recommended but not necessary; examples include World Refugee Day, World AIDS Day, 16 Days of Activism against Sexual and Gender-Based Violence
- Outline a plan to effectively deliver the presentation, speech, performance, etc.
 - Define strategies
 - Identify partners, timeline and location
 - Assign responsibilities (Who will be responsible for which tasks?)
- Ensure continuous training/capacity building
 - activities should be reflected in annual plans with sufficient budget allocation

The end result of such advocacy events will be to help the intended audience understand that the ASRH programme has been successful in many ways, yet there is room for further improvement. The advocacy event is successful if it has created increased support and sustained interest for the ASRH programme.

To create advocacy efforts and initiatives towards senior-management:

- Identify programme successes from monitoring and evaluation activities in Step Nine
- Determine who at senior-management level would be most interested in the ASRH programme's successes
- Highlight the positive achievements the ASRH programme has made and brainstorm ways that the programme would benefit from additional support based on identified challenges.
- Determine appropriate opportunities to sustain and build support for the ASRH programme; examples include:
 - Presentations, speeches and performances on international awareness days
 - Programme reports
 - Fact Sheets
 - Press release
 - Representation at Regional Meetings and International Conferences
 - Invite senior-management to ASRH programme activities
- Outline a plan to effectively deliver the advocacy effort or initiative
 - Define strategies
 - Identify partners, timeline and location
 - Assign responsibilities
- Keep in mind possible obstacles and brainstorm ways to overcome them
 - Identify resources at one's disposal
 - Identify possible risks and how/if one can work around them

As a result of generating publicity at the local and senior-management level, ASRH programme staff in collaboration with relevant partners, can acquire additional interest, support and possibly funding for further ASRH programmes and initiatives for refugees.



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