

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH TOOLKIT FOR HUMANITARIAN SETTINGS

2020 EDITION

**A Companion to the
Inter-Agency Field
Manual on Reproductive
Health in Humanitarian
Settings**



**Inter-Agency Working Group on
Reproductive Health in Crises**



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Consultation & Review Process: The ASRH Toolkit for Humanitarian Settings—developed in 2009 and released in 2012—was updated in 2019/2020 in accordance with changes to the [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings](#) and [Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations](#). In late 2018/early 2019, the IAWG ASRH SWG conducted a desk review to collect information on new guidance, interventions, best practices, and developments in ASRH in emergencies since 2012. In addition to findings from the desk review, the SWG consulted with 15 IAWG agencies and one youth network in early 2019 to develop inputs for a consultation workshop. A small revision team comprised of IAWG ASRH SWG members discussed the gathered inputs and developed a work plan and structure for revising the Toolkit, which was later presented and approved by the larger SWG in April 2019. During 2019, the team revised and drafted new content according to the work plan and shared the revised version in January 2020 with IAWG networks and ASRH humanitarian and development stakeholders. The revision team incorporated two rounds of feedback from ASRH stakeholders at global, regional, and country levels. To ensure meaningful engagement from adolescents and youth, the SWG held four webinar series in Arabic, English, French, and Spanish, comprised of four sessions and covering the most salient youth topics of the Toolkit. The four webinars consulted with more than 90 young people, representing more than 30 organizations/networks across at least 17 countries, to gather and incorporate feedback, case studies, and tools into the revised Toolkit. The IAWG ASRH SWG presented the revised Toolkit and received endorsement from the IAWG Steering Committee in September 2020, prior to translation and dissemination.

In total, throughout the entire revision process, the IAWG ASRH SWG consulted and collected feedback from more than 130 people (approximately 68% young people; 12% field-based staff; 20% regionally-based staff) across 75 organizations and representing specialties in ASRH in humanitarian and development contexts, as well as the humanitarian sectors of child protection, education, food and livelihoods, gender-based violence, humanitarian operations and management, and mental health and psychosocial support.

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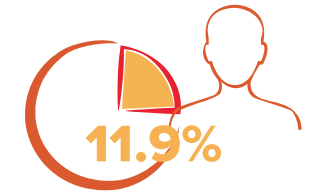
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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome	M&E	Monitoring & Evaluation
ART	Anti-Retroviral Therapy	MHM	Menstrual Hygiene Management
ARV	Anti-Retroviral	MHPSS	Mental Health and Psychosocial Support
ASRH	Adolescent Sexual and Reproductive Health	MICS	Multiple Indicator Cluster Surveys
BEmONC	Basic Emergency Obstetric and Newborn Care	MISP	Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations
BHM	Bureau of Humanitarian Affairs	MOH	Ministry of Health
BPRM	Bureau of Population, Refugees, and Migration	NFI	Non-Food Item
CDC	Centers for Disease Control and Prevention	NGO	Non-Governmental Organization
CEFM	Child, Early, and Forced Marriage	OCHA	United Nations Office for the Coordination of Humanitarian Affairs
CEmONC	Comprehensive Emergency Obstetric and Newborn Care	PAC	Post-Abortion Care
CERCA	Community-Embedded Reproductive Health Care for Adolescents	PEP	Post-Exposure Prophylaxis
CERF	Central Emergency Response Fund	PMTCT	Prevention of Mother-to-Child Transmission
CHW	Community Health Worker	PSEA	Prevention of Sexual Exploitation and Abuse
CMR	Clinical Management of Rape	RH	Reproductive Health
CSC	Community Score Card	RHRC	Reproductive Health Response in Conflict Consortium
CSE	Comprehensive Sexuality Education	SAC	Safe Abortion Care
EC	Emergency Contraception	SBC	Social and Behavioral Change
ECHO	European Commission of Humanitarian Aid	SOGIE	Sexual Orientation and Gender Identity and Expression
EmONC	Emergency Obstetric and Newborn Care	SR/MNCAH	Sexual and Reproductive Health and Maternal, Newborn, Child, and Adolescent Health
FCDO	Foreign, Commonwealth, and Development Office	SRH	Sexual and Reproductive Health
FDG	Focus Group Discussion	STI	Sexually-Transmitted Infection
GATHER	Greet, Ask, Tell, Help, Explain, Return	SWG	Sub-Working Group
GBV	Gender-Based Violence	TBA	Traditional Birth Attendant
GPS	Global Positioning System	TOR	Terms of Reference
HIV	Human Immunodeficiency Virus	TOT	Training of Trainers
IAFM	Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	TPI	Training Partnership Initiative
IASC	Inter-Agency Standing Committee	UN	United Nations
IAWG	Inter-Agency Working Group on Reproductive Health in Crises	UNAIDS	Joint UN Programme on HIV and AIDS
IDP	Internally Displaced Person	UNFPA	UN Population Fund
IEC	Information, Education, and Communication	UNHCR	UN High Commissioner for Refugees
IPPF	International Planned Parenthood Federation	UNICEF	UN Children's Fund
IPPA	Indonesia Planned Parenthood Association	UNISDR	UN Office for Disaster Risk Reduction
IRA	Initial Rapid Assessment	USAID	United States Agency for International Development
IRC	International Rescue Committee	VCAT	Values Clarification and Attitude Transformation
KAP	Knowledge, Attitudes, and Practices	VSS	Virtual Safe Space
LARC	Long-Acting and Reversible Contraception	VYA	Very Young Adolescents
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual +	WASH	Water, Sanitation, and Hygiene
		WHO	World Health Organization
		WRC	Women's Refugee Commission



Humanitarian crises around the world are growing in magnitude, frequency, and duration, as is the need for assistance—including in meeting the sexual and reproductive health (SRH) needs of adolescent boys and girls.



Of the nearly **168 million** people in need of humanitarian assistance globally, approximately **20 million** are adolescents and young people.

Natural disasters, human-made emergencies, public health emergencies, and protracted conflicts disrupt the support systems that many adolescents rely on, such as family, social, and economic structures. In these settings, education, social support, and health systems are suspended or unavailable, leaving many adolescents without access to SRH information and services when they need them most.

The global community recognizes the unique vulnerabilities and SRH rights of adolescents and has developed guidelines to address their needs; however, the SRH needs of adolescents continue to go unmet during emergencies. The barriers to meeting the SRH needs of adolescents vary across contexts, but the global community is in agreement that more must be done because these barriers are creating obstacles for adolescents to achieve their dreams.

A toolkit for adolescent SRH (ASRH) in humanitarian settings: helping humanitarian organizations prioritize and implement effective programs to address and fulfill adolescents' SRH and rights.

The Toolkit's vision is for all adolescents to exercise making informed and autonomous decisions about their SRH, have their SRH rights guaranteed, and be able to reach their full potential—no matter what circumstances they are living in. This Toolkit provides strategies and tools to help close the SRH service provision gap for adolescents by building upon the advocacy endeavors and lessons learned from the past decade to advance SRH prioritization for adolescents in humanitarian contexts. The Toolkit does not promote a one-size-fits-all approach; instead, it calls on humanitarians to prioritize life-saving SRH services throughout the entire program cycle and humanitarian continuum—not only during the crisis phase, but also before its onset, during the recovery, and beyond, toward long-term development.

Ready to dive into the Toolkit now?

Let's get started! [Chapter 1: Introduction](#) provides the foundation for the Toolkit, explaining what adolescence is, the unique needs, barriers, and capacities of adolescents, and why we should prioritize ASRH activities during humanitarian crises. [Chapter 2: Roadmap for Using the ASRH Toolkit](#) illustrates how the rest of the Toolkit is organized and provides information on how to navigate and use the Toolkit.

CHAPTER 1: INTRODUCTION

In this chapter, humanitarian responders will learn about adolescence, the unique needs, capacities, and sexual and reproductive health (SRH) barriers facing different groups of adolescents, and how those factors are different in emergency settings. The chapter comprises two sections, divided up by the following questions: **what is adolescent sexual and reproductive health (ASRH)** and **why should we prioritize ASRH during emergencies?**

Chapter 1: Learning Objectives

After reading this chapter, readers should be able to:

- Understand what adolescence is and define the SRH rights of adolescents
- Describe the capacities of adolescents to shape their own health outcomes
- Distinguish the unique risk factors and SRH needs of different groups of adolescents
- Explain the unique SRH needs and barriers adolescents face during humanitarian emergencies
- Describe why humanitarians should prioritize ASRH activities from the onset of an emergency

What is ASRH?

What is adolescence and who exactly are adolescents?

Adolescence is the period between childhood and adulthood—beginning with puberty and transitioning from dependence on caregivers to self-sufficient adult members of society. During this period of life, adolescents develop knowledge and skills, begin to understand how to manage emotions and relationships, and develop traits and capabilities to enjoy their adolescent years and transition to assuming adult responsibilities. While the official age bracket of adolescence varies across countries, the United Nations (UN) defines this period as between 10 and 19 years of age. It is important to note that the age when puberty begins varies greatly among individuals and may begin earlier; it usually occurs during early adolescence, while the transition to adulthood is taking longer due to a number of factors. This **transitional** period between childhood and adulthood is marked by changes to adolescents' physical, cognitive, behavioral, and psychosocial characteristics. During this time, adolescents experience increasing levels of individual autonomy, a growing sense of identity and self-esteem, and greater independence from adults. Adolescence is a critical time for shaping behavior and norms, including prevention of health problems and strengthening future resiliency of the next generation.

Age is not the only way to define adolescence—sex and gender are also important variables for adolescent development. Adolescent girls typically develop faster (up to two years ahead of adolescent boys), with gender norms varying significantly between adolescent boys and girls across the world. Age is just one way of specifying adolescence and is typically used to define and compare biological changes adolescents are experiencing, not the social transitions, which can differ based on the social and cultural norms and values of their environment. The biological changes for adolescents do not start at 10 years or end at 20 years. There are changes, such as producing hormones, that begin earlier than 10 years and other changes that extend into a person's early twenties, which is why recent work has expanded the definition and timeframe of adolescence to include young adulthood—often up to 24 years old. However, this Toolkit focuses on individuals from 10 to 19 years of age. To help compare these changes, practitioners have broadly categorized adolescents into two groups—very young adolescents (VYAs) (10–14 years old) and older adolescents (15–19 years old); however, several changes are happening throughout adolescence and do not always occur at the same time for every adolescent.

Overlapping Definitions

There are several terms that overlap with “adolescence”, including “children”, “youth”, and “young people”. While these terms are explicit, they are understood and applied in many different ways, depending on countries, cultures, and groups.

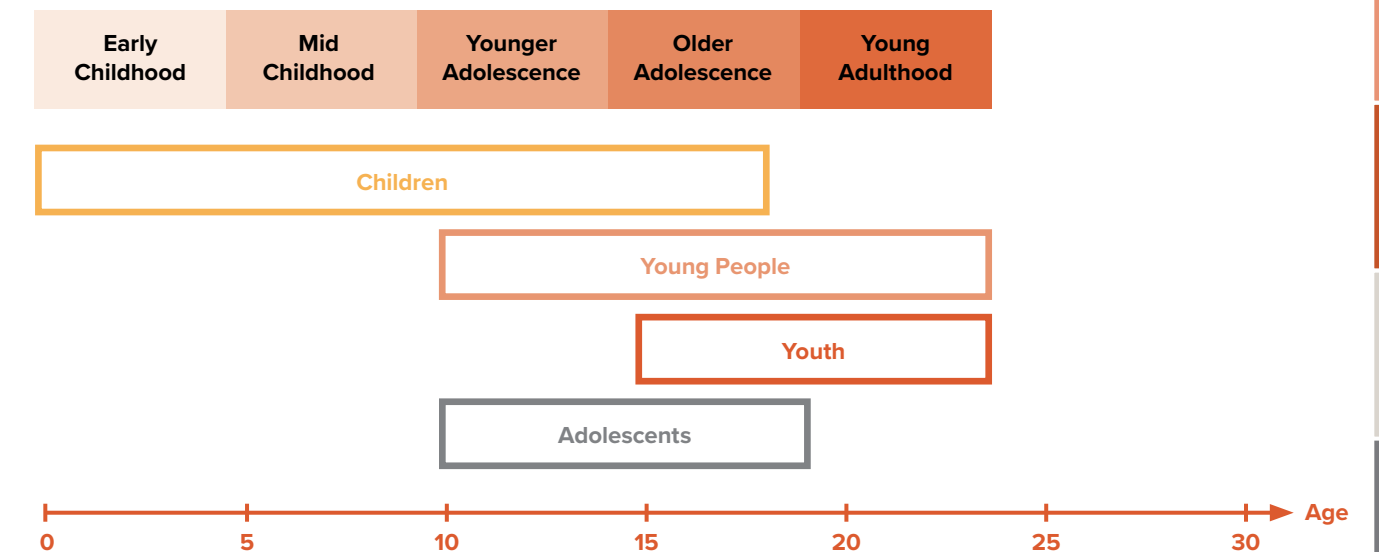
Children: The UN [Convention on the Rights of the Child](#) categorizes all individuals from birth to 18 years as “children”. Therefore, adolescents are covered under its protection until they reach 18.

Youth: The category of “youth” includes individuals aged 15 to 24 years old.

Young people: “Young people” comprise individuals between 10 and 24 years of age.

Understanding the definition of adolescence is important. The very few SRH programs in humanitarian settings that have addressed adolescent health needs have predominantly targeted older youth and rarely designed activities appropriate for younger populations.

Figure A: Adolescent or Young People?



At the onset of puberty, we start to see physical changes begin, such as growth spurts, sex organ development, and sexual characteristics. These changes may cause anxiety or be a source of excitement and pride for the adolescent. Less obvious are the adolescent's internal changes. The adolescent's brain is undergoing significant changes: the number of brain cells can nearly double in just a year, while their brain's connections are undergoing swift reorganization. For more on adolescent brain development, see "The Science Behind Investing in Adolescents". VYA girls and boys are becoming more aware of their gender and may begin changing their behavior or appearance to fit in with perceived gender norms. They may participate in or become a victim of bullying, as well as feel confused about their identity and their roles and rights according to shifting societal pressures. A global adolescent study on VYAs reveals common themes about gender roles as children enter adolescence: girls are viewed as vulnerable, weak, and requiring protection from boys, whereas boys are seen as powerful and projecting strength, which can sometimes be seen as threatening. Girls are expected to stay at home and complete the duties of marriage and motherhood, while boys experience a new level of independence and freedom of mobility. Boys also experience increased expectations to provide financially for their families. This evidence shows us that early adolescence provides a critical opportunity for reaching adolescents with preventative programming to improve their gender and health outcomes. Intervening early with VYAs helps adolescents and young people understand the benefits of proactively seeking services and avoiding engaging in risky health behaviors.

VYAs should be provided a safe atmosphere—surrounded by nurturing adults at home and in the community—to understand, accept, and ask questions regarding the cognitive, emotional, sexual, and psychological changes occurring at this time. With pervasive social taboos and norms regarding puberty, it is important that VYAs receive all the information and access to services they need related to their SRH (what is puberty and menstruation, how to protect against sexually transmitted infections [STIs], prevent early pregnancy, etc). For too many adolescents, this critical information is given too late, or not at all, when their lives have already been impacted and their development and welfare have been comprised.

As adolescents mature, they begin setting long-term goals, questioning experiences, and developing moral reasoning. They also experience several social and emotional changes, such as higher self-involvement and increased desire for independence, and begin exploring their sexual identity, which, without support from peers, family, or community, can be stressful. Sexual orientation develops progressively and non-heterosexual individuals may begin to experience internal conflict, particularly during this stage, due to potentially heteronormative and oppressive environments where divergent sexual orientations, gender identities, and expressions are seen as negative. During adolescence, individuals are moving from self-exploration of their sexuality to forming stable relationships, with mutual and balanced sexual relations (when surrounded by a supportive environment).

Research has shown that risk-taking behaviors—often a defining characteristic of adolescents—can be a way in which adolescents bolster their social reputation by showing how courageous they are to others; however, if positive opportunities for demonstrating courage are available (such as through sports, drama, civic engagement, and activism), adolescents are likely to use these activities to elevate their social reputation. Such activities can have positive effects on the adolescents' health and identity development, as well as prevent antisocial behaviors and self-injury. The influence of peers begins to diminish as the adolescent gets older and gains more understanding of and confidence in their identity and opinions; their tendency to engage in risk-taking behaviors decreases as their ability to assess risk, delay gratification, plan for the future, and make conscious decisions progresses. In many contexts, older adolescent girls are at higher risk of negative health outcomes compared to adolescent boys, and these risks are intensified by gender-based discrimination and abuse. Turning to positive aspects, adolescence is also marked by opportunity, idealism, and promise. Adolescents are beginning to move away from child-parent/guardian relationships to more equal adult-adult

relationships. Older adolescents may enter the workforce, further their education, gain a firm sense of their own identity and perspective of the world, as well as begin influencing the world around them.

Scientific evidence of adolescent brain development provides a compelling case for investing in adolescence to improve health, education, and social and economic outcomes (see The Science Behind Investing in Adolescents breakout box for more information). Conversely, the consequences of not addressing SRH needs and health conditions of adolescents can affect both their physical and mental health into adulthood and compromise their ability to lead fulfilling adult lives.

The Science Behind Investing in Adolescents



Numerous changes and learning experiences occur during the transition from childhood to adulthood. The transition begins with puberty (from age 10 for girls and 12 for boys) and creates a window of opportunity where life trajectories can be shifted based on negative or positive experiences. The pubertal transition begins a significant reorganization of neural circuitry, impacting neural circuits involved in processing emotions, risks, rewards, and social relationships. These neural developmental changes

do not occur in a vacuum—that is, biological changes do not determine behavior. Rather the biological changes lead to increased tendencies to behave in particular ways, and the actual behavioral patterns that emerge depend to a large extent upon the particular social context. Moreover, it is the emergence of these patterns of behavior, beginning during the developmental window of puberty, that can lead to cascading impact and the alteration of longer-term health trajectories. Understanding the interactions between social, emotional, and learning processes in adolescent interventions points to insights into both diminishing vulnerabilities for difficult-to-change negative spirals and enhancing opportunities to establish positive spirals.

The onset of puberty initiates a period of social, emotional, physical, and cognitive development associated with important changes in learning. Insights have emerged from the study of the biological, cognitive, and behavioral changes that occur during adolescence. These changes provide adolescents with the knowledge, skills, and capacity to successfully transition into self-sufficient adults; this in turn enables adolescents to adapt to emerging aspects of their identity, to learn how to relate to themselves and others, to navigate complex social relationships, and to process abstract concepts and future consequences. Thus, adolescence is a critical time for learning and growth, characterized by a sensitivity to the feelings of belonging and being valued and linked to their greater search for finding meaning and purpose.

This learning can shape the adolescent's goals and priorities, such as their inspiration, creativity, and innovation and when exposed to a positive learning environment may also promote healthy trajectories and identity development. Recent progress in science provides unique insights suggesting that the onset of puberty may sensitize the brain to learning more through discovery than traditional instruction, tapping adolescents' burgeoning tendencies toward exploration—particularly in the realm of social and emotionally-arousing contexts. A crucial element is moving away from didactic education about health (ie "telling" adolescents how to change their behaviors) to a discovery-learning model (ie helping to scaffold positive learning experiences whereby adolescents explore and discover new levels of understanding for themselves).

Why should we worry about adolescent health? Isn't this the healthiest time of life?

Because investing in their health is both the right thing to do and the smart thing to do.

- ▶ **The right thing to do:** ASRH is embedded in basic human rights, which must be respected, protected, and fulfilled.
- ▶ **The smart thing to do:** Promotion of ASRH could avert deaths from preventable causes, could improve health outcomes, and add to broader development goals and early recovery, including socio-economic benefits.

Over the next several sections, the Toolkit will explain adolescents' right to SRH, as well as the beneficial health and societal outcomes for making SRH easily available and accessible to adolescents in emergency settings. Additionally, the Toolkit provides information on what happens if we continue to deprioritize ASRH in emergency settings.

Currently, there are more than 1.2 billion adolescents in the world. That number is expected to increase through 2050, especially in low- and middle-income countries where nearly 90% of adolescents live and where the majority of humanitarian emergencies occur. As discussed previously, adolescence represents a critical window of opportunity for societies to invest in and provide opportunities for adolescents to develop the knowledge, skills, social and economic assets, and resilience required to lead healthy, productive, and fulfilling lives.

During adolescence, communities can instill preventative strategies to enable adolescents to survive, thrive, and transform their communities. Promotion of healthy behaviors could avert the deaths of an estimated 1.4 million adolescents that die from preventable causes, primarily from road traffic accidents, violence, suicide, Human Immunodeficiency Virus (HIV), and pregnancy-related complications. Prioritizing ASRH can delay the first pregnancy, reduce maternal morbidities and mortalities, improve health outcomes, decrease poverty, and add to broader early recovery and development goals. Additionally, prioritizing adolescent health is essential for reducing negative health outcomes for the next generation, including prematurity and low birth weight among infants born to adolescent mothers.

Adolescence also presents a strategic time to empower adolescents. Adolescents are **creative, passionate, resilient, and capable** of exploring creative solutions in difficult situations; they have tremendous capacities that, when utilized appropriately and effectively, can play an instrumental role in their health outcomes. Several organizations have identified assets, as well as specific intervention components, to develop and reinforce adolescent empowerment programs and activities. These assets—or protective factors—include human and social assets (communication skills, literacy, self-esteem, peer networks, relationships) and financial and physical assets—resources that help create security and develop income generation opportunities (savings, access to loans, identity cards, land ownership rights). Results from the Population Council's development project in Ethiopia, which targeted out-of-school adolescent girls to receive literacy and life-skills training in safe spaces, found an increase in literacy scores and health service uptake after just six months of program implementation. These results highlight the potential for integrating SRH activities with life skills and empowerment programming for adolescents in humanitarian settings.

Looking beyond health arguments, there is strong evidence of the socio-economic benefits of investing in adolescents. Healthy young people entering the workforce with the right knowledge and skills can help stimulate the economy. Economists emphasize that focused investments, particularly in the health and education of girls that allow them to delay marriage and childbearing, could significantly impact economic development of the countries in which they live—through increased productive capacity, increased birth spacing between generations, and redistribution of the dependency burden. However, the opposite is also true: not investing in adolescent health and development can feed a vicious cycle of poor health and poverty.

The below statistics provide a snapshot of adolescents' health needs across the globe.



The leading cause of death for adolescent girls aged 15–19 years across the world is complications from pregnancy and childbirth. Approximately 11% of all births globally are to adolescent girls between 15 and 19 years old. These pregnancies put adolescent girls at greater risk of maternal mortality from intrapartum-related risks for term pregnancies and from complications related to unsafe abortions. Each year, an estimated 3.9 million adolescent girls aged 15–19 years undergo unsafe abortions. Adolescents are more likely to die from unsafe abortions than older women and bear the brunt of the negative repercussions of unsafe abortions—making up 70% of all hospitalizations from unsafe abortion complications.



Globally, interpersonal violence, or violence between individuals, was the third leading cause of mortality among adolescents as of 2018—responsible for one-third of all adolescent male deaths in low- and middle-income countries. Approximately 84 million adolescent girls 15–19 years old, or one in every three girls, suffered from one form of physical, sexual, or emotional abuse and controlling behaviors by an intimate partner in 2018.



The Joint UN Programme on HIV and Acquired Immunodeficiency Syndrome (UNAIDS) estimates that approximately 1.6 million adolescents were living with HIV as of 2019, with an estimated 190,000 newly infected cases and 33,000 AIDS-related deaths among adolescents. Despite an overall reduction of 35% in the number of AIDS-related deaths from 2005–2013, AIDS-related deaths among adolescents have tripled from 2000–2015, with AIDS representing the second highest cause of death globally and the first cause of death in Africa.



Mental health disorders disproportionately affect adolescents. Half of all mental health conditions begin by age 14, but the majority of cases go undetected and untreated. Depression is one of the leading causes of morbidity among adolescents, with suicide reported as the second leading cause of death for adolescents.

Why should we address the sexual and reproductive health of adolescents? Aren't they too young to have sex?

This is a common social taboo in many contexts—that adolescents should not be having sex. Regardless of one's personal beliefs or attitudes toward the appropriate age of sexual debut, adolescents have a right to SRH information and services that are equitable, accessible, acceptable, appropriate, and effective. The 2018 Guttmacher-Lancet Commission developed a comprehensive definition of the right to SRH. The definition states that:

KEY MESSAGE

Most people initiate sexual activity during adolescence, and adolescents must be prepared and supported to ensure good SRH choices, decisions, and outcomes.

SRH is a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right.

“All individuals” includes adolescents. As such, ASRH includes sexuality and reproductive health processes, functions, and systems of adolescents, their right to make decisions about their body, and to access services that support that right. Thus, provision of ASRH information and services is **rights-based**, as well as **lifesaving**. Promotion of ASRH includes:

- healthy and positive sexuality;
- maternal and newborn health;
- positive puberty, menstrual health, and hygiene;
- prevention and response to HIV, AIDS, and other STIs;
- prevention and response to unintended and unwanted pregnancy;
- prevention and response to gender-based violence (GBV);
- prevention and management of reproductive cancers;
- prevention and treatment of complications of unsafe abortion;
- and safe abortion care services.

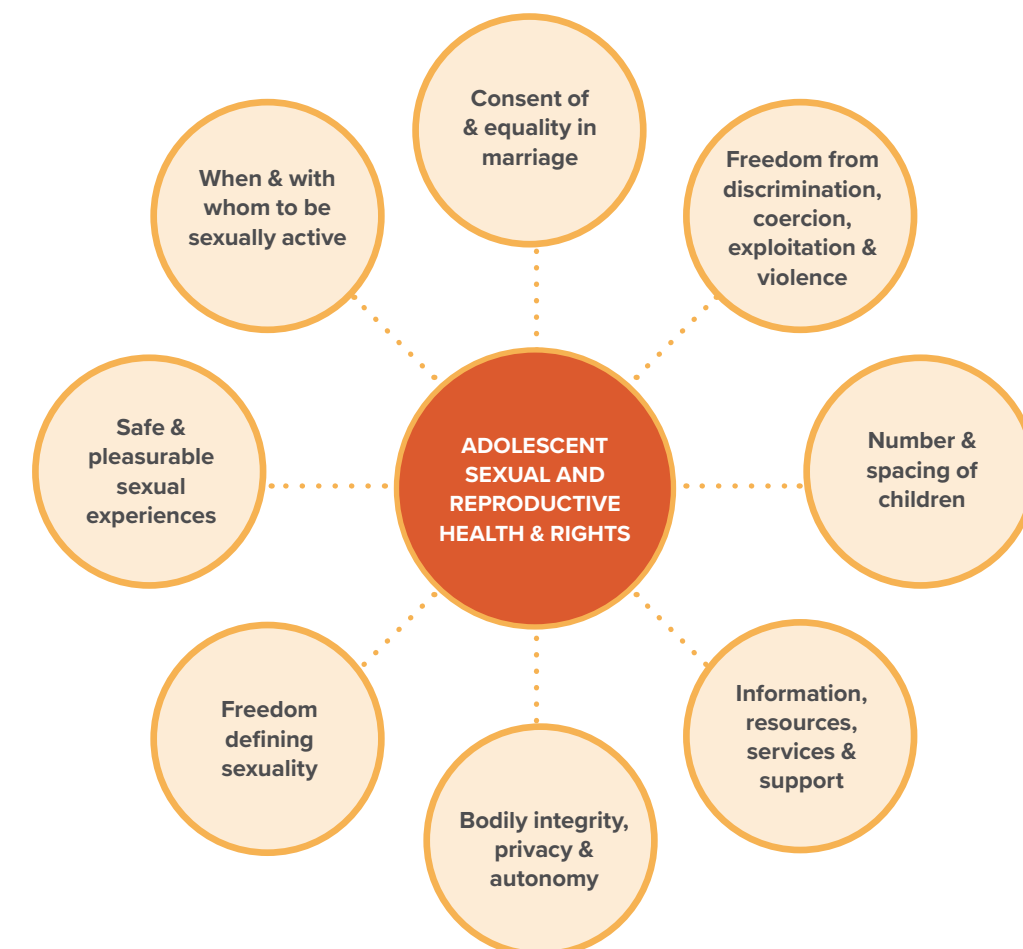
What is the role of humanitarian actors in advocating for ASRH?

Advocating for ASRH is not a unique, standalone issue: it is embedded in basic human rights, which must be protected for all persons during humanitarian crises. These human rights include the right to:

- have their bodily integrity, privacy, and personal autonomy respected
- freely define their own sexuality, including sexual orientation and gender identity and expression*
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- decide whether, when, and whom to marry
- decide whether, when, and by what means to have a child or children, and how many children to have
- have access over their lifetime to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence**

*For more information on understanding the different components of sexual and gender identity, sexual orientation, and gender expression, please see [Killermann's Genderbread Person](#)—a teaching tool for breaking down gender.

**This includes the right not to be forced to marry early.



In addition to providing SRH information and services to adolescents, humanitarians should be collaborating and coordinating with other sectors and with ongoing efforts that interact with adolescents to address the multifaceted factors that contribute to both positive and negative SRH outcomes, such as:

- child, early, and forced marriage
- gender, education, and income inequality
- harmful traditional practices
- intimate partner and non-partner violence
- mental health
- nutrition
- substance abuse

Are we there yet with ASRH?

Not quite. SRH advocates and stakeholders have made significant strides in the past few decades to prioritize SRH and rights at the global, regional, and national levels; however, progress for adolescents is still lagging behind. The below areas of concern highlight some of the remaining gaps in achieving SRH and rights for all.



Unmet Need for Contraception

Globally, much of adolescents' SRH needs are unmet. Unmet need for contraception among adolescents is the proportion of adolescents who want to stop or delay childbearing but are not using any method of contraception. This indicator allows practitioners to assess the success of their reproductive health programming in meeting adolescents' demand for services.

As of 2019, an estimated 32 million adolescent girls aged 15–19 years old wanted to avoid pregnancy. However, nearly half of them—approximately 14 million girls—were not using a modern contraceptive method but were in need of one. Adolescents regularly face barriers to accessing contraception (including provider bias and limited range of accepted methods), leading to increased rates of pregnancy during adolescence and higher risk of dangerous complications during childbirth. If agencies were able to address the unmet need for modern contraception of adolescents aged 15–19 years old, the Guttmacher Institute estimates that the number of unintended pregnancies would decrease by 6.2 million annually—averting 2.1 million unplanned births, 3.3 million abortions, and 17,000 maternal deaths.



Lack of SRH Information

Despite evidence that increased access to SRH information and comprehensive sexuality education has a positive effect on SRH, adolescents and young people continue to face barriers in receiving the information they need. They frequently experience difficulties accessing SRH information and comprehensive sexuality education, which includes age-appropriate and scientifically accurate information about sexuality and reproduction, as well as information related to adolescents' gender and rights.

Myths and misinformation about SRH and sexuality information leading to increased sexual activity or encouraging sexual activity have limited adolescents' and young people's access to SRH messaging. Taboos, discomfort, and fear deter parents and other trusted adults—including teachers and educators—from educating adolescents about the changes their bodies are experiencing or where to access additional information. Furthermore, in some countries, the policies and/or perceptions of the policies restrict how teachers provide sexuality education to adolescents and young people. Even in countries where comprehensive sexuality education is mandated, there are gaps in how the policies are implemented on the ground.



Unwanted Pregnancy and Forced Marriage

Millions of adolescent girls are pressured to marry or have unwanted sex—increasing their risk of unintended pregnancies, unsafe abortions, STIs, and dangerous childbirth. Approximately 27% of women in the least developed countries gave birth before age 18, representing an estimated 12 million girls that delivered children during their adolescent years.

Child marriage and early childbearing are violations of human rights and have negative socio-economic effects by disrupting girls' education and reducing future economic opportunities during girlhood, adolescence, and into womanhood, in addition to the increased likelihood of abuse for vulnerable child brides. Adolescent pregnancy and childbirth are linked to adverse pregnancy outcomes, as well as reduced education opportunities for girls, higher health costs, and increased likelihood of lifelong female poverty. Immature development of reproductive and muscular systems of pregnant adolescent girls increases their risks of obstetric complications. For example, a life-threatening obstetric emergency can develop for adolescent girls under 16 years old when the immature pelvis is too small to allow a fully matured fetus to safely pass through the birth canal. Failure to promptly treat this condition can lead to obstetric fistula or uterine rupture, hemorrhage, and death of the mother and fetus. Adolescent mothers face higher risks of eclampsia, puerperal endometritis, and systemic infections, compared to women aged 20–24 years. Newborns to mothers under 20 years of age also face higher risks of low birth weight, preterm delivery, and severe neonatal conditions.

Not all adolescents are the same, right?

No. Adolescents are a diverse group of individuals. Their SRH needs and risk factors differ based on age, sex, gender identity, sexual orientation, health status, developmental stage, marital status, socio-economic conditions, and contextual and environmental factors. Some adolescents can be more vulnerable to health and social problems compared to other groups based on these varying conditions and/or needs.

For example, a 12-year old adolescent girl living in Canada has different health needs compared to a 19-year old adolescent boy who survived a typhoon in the Philippines. Even within the same country, adolescents



Image from "Adolescent Sexual and Reproductive Health in Emergency Settings" video

face different conditions, such as an adolescent in school versus out of school or an adolescent living in a rural part of the country compared to an urban area. Additionally, adolescents may have overlapping vulnerabilities that increase their risk of poor health outcomes; for instance, being a 15-year-old pregnant adolescent girl in a forced marriage/union.

Implementation of programs and services must be tailored to take into consideration the different characteristics and corresponding needs of adolescents. The Toolkit explains how SRH needs and risk factors differ between adolescent girls and boys, and also includes descriptions of particularly at-risk adolescent subgroups below. Throughout the Toolkit, there are breakout boxes on different considerations humanitarian actors should remember when working alongside adolescent populations.

Adolescent Girls:

Much of the physical, emotional, and social consequences vulnerable girls experience through adolescence are rooted in gender inequality and poverty. Globally, adolescent girls from poor households experience a higher proportion of the health burden compared to adolescent boys due to social vulnerabilities associated with gender inequality, discrimination, and poverty—with girls' disadvantaged social position at the heart of most of these vulnerabilities. There are health risks that exclusively and/or predominantly affect adolescent girls, including menstruation; child, early, and forced marriage (CEFM); unwanted and early pregnancy; disproportionate share of care and household work; harmful traditional practices (eg female genital mutilation or cutting); migration for work; school safety and drop out; and STIs. In sub-Saharan Africa, where HIV infection rates are the highest in the world, adolescent girls reported infection rates nearly twice as high compared to adolescent boys of the same age. Adolescent girls are disproportionately exposed to GBV (see [breakout box](#) for more information) and more likely to experience sexual harassment and abuse compared to adolescent boys; however, under-reporting is a critical issue across both sexes. These health risks for adolescent girls also correspond to social risks that impact their SRH outcomes. For example, economic difficulties can lead to increased exploitation, such as trafficking, including for sexual exploitation, and transactional sex—elevating SRH risks (STIs, unintended pregnancies, and unsafe abortions).

Vulnerabilities to GBV for Boys & Girls

Power and gender imbalances between men and women in society perpetuate inequalities and violence against women and girls, primarily by men and boys, but also between men and boys. Evidence shows that men who experience violence as children and/or who witness violence against their mothers are more likely to have negative attitudes toward gender equality and to use violence against others as adults. These power dynamics, gender norms, and other societal factors are the underlying factors that place adolescent girls at higher risk of sexual violence compared to boys. It is estimated that between 12–25% of girls experience sexual violence and 8–10% of adolescent boys experience sexual violence. For many adolescent girls, their first sexual activity is associated with coercion and/or violence, which can result in unwanted pregnancies and lead to unsafe abortions, in addition to the long-term mental and physical health consequences. Reports show that the majority of sexual violence cases among adolescent boys and girls are perpetrated by a relative or someone they know (friend, neighbor, teacher, etc). Intersecting vulnerabilities also heighten risks of GBV for girls and boys. For example, girls with disabilities are ten times more likely to experience GBV than those without disabilities; as well, girls with mental impairments are particularly vulnerable to sexual violence.

Regardless of the sexes of perpetrator and survivor, sexual violence is a form of gender-based violence, and though the majority of sexual violence incidents are experienced by women and girls, boys also experience sexual violence in gender-differentiated ways. Adolescent boys are less likely to share their experience of sexual violence with others compared to adolescent girls. In some cases, adolescent boys are less likely to report and/or seek services. Gender norms that associate feminine values with weakness, inferiority, and victimization create an extra barrier for boys who have experienced sexual violence. They may be punished for pushing against traditional notions of binary gender expression or presentation, or not behaving like “real” men/not adopting the social expectations of masculinity. Both examples highlight the need to examine gender norms in GBV programming. Furthermore, amongst adolescent boys there are overlapping vulnerabilities, such as street boys being at higher risk for sexual violence compared to other groups of boys.

Adolescent Boys:

Interpersonal violence is the cause of death for one out of every three boys aged 15–19 years old. Across the world, men and boys are at higher risk of experiencing violence during adolescence and early adulthood than during any other time in their lives, which impacts young men's attitudes, perceptions, and normalization of violence. Adolescent boys aged 13–15 years old reported higher involvement in physical fights compared to adolescent girls 13–15 years old across several geographic regions. Looking at SRH risk factors, studies examining attitudes about gender and masculinity among adolescent boys and young men found that these beliefs significantly affected their sexual behaviors and decision to seek health services. Taboos surrounding health-seeking behavior related to dominant views toward masculinity negatively affect adolescent boys' and young men's decision to seek health services; however, reports of young and adult men with higher education and more equitable gender norms found a higher likelihood to seek STI testing—emphasizing how gender norms can positively shape SRH behaviors for boys and young men. Sexual exploitation, often under-reported across both sexes, is a critical issue for adolescent boys, with some countries reporting rates equal to or higher for boys compared to girls. A study in South Asia found that adolescent boys in South Asia had less legal protection (from abuse and exploitation, as well as legal recognition of rape, sexual harassment, and sexual exploitation) compared to girls of the same age, resulting in restricted access to services for boy survivors. In addition, stereotyped views of masculinity coupled with ingrained homophobia make it difficult for boys in some contexts to report sexual exploitation and abuse.



Figure B: Vulnerable Subgroups of Adolescents



VERY YOUNG ADOLESCENTS

Many VYAs do not have the knowledge and skills required to deal with the changes happening in their bodies and are discouraged from seeking information on puberty, sexuality, and other related topics due to social norms. Social taboos isolate VYAs from understanding their bodies, fertility, and barriers and benefits of using protective behaviors. VYAs are one of the groups at the highest risk of violence, while also typically receiving a minimal share of youth-serving resources and programs. VYAs also face increased vulnerability to sexual violence and coercion because of their limited life experience, which may result in not recognizing the sexual nature of abuse or exploitative actions in unknown settings.



ORPHANED ADOLESCENTS, UNACCOMPANIED MINORS, AND ADOLESCENT HEADS OF HOUSEHOLDS

Orphaned adolescents, unaccompanied minors, and adolescent heads of households report feelings of isolation, marginalization, trauma, and grief as a result of caring for themselves and/or their families on their own. These adolescents lack the livelihoods, security, and protection given to them from their family structure, putting them at greater risk from poverty and sexual exploitation and abuse. Orphan adolescents face economic stagnation as they seek work without adequate skills training; morbidity and malnutrition due to inability to meet basic needs; higher rates of HIV/AIDS; and increased risk of exploitation and abuse without adult protection. Adolescent heads of households and adolescents separated from families are ill-prepared to take care of family members, with adolescent girl heads of households at higher risk for exploitation and abuse. Adolescent boys and young men who are unaccompanied or separated from their families may face housing difficulties as a result of cultural limitations on having unrelated males in a household with females. Overall, adolescents separated from their families or adolescent heads of households may resort to marrying or selling sex to meet their needs for food, shelter, or protection.



ADOLESCENTS AT RISK OF SEXUAL EXPLOITATION THROUGH TRANSACTIONAL SEX

Children who are sexually exploited and young adults who engage in transactional sex are reported problems for both adolescent girls and boys in emergency contexts. Humanitarian crises can force households into poverty due to disrupted or destroyed livelihoods and leading to loss of property and decreased economic opportunities. Some families or adolescent heads of households may resort to transactional sex, or “survival sex”, as a coping strategy during these circumstances. Transactional sex puts adolescents at higher risk of health, physical, and emotional harm, including unsafe sex practices, early sexual debut, multiple concurrent sexual partnerships, sexual exploitation and abuse, and inconsistent condom use. Transactional sex is associated with poor SRH outcomes, such as STIs, unintended pregnancies, and unsafe abortions.



MARRIED ADOLESCENTS

Beyond reducing future opportunities, married adolescents also experience social isolation, face higher risks of intimate-partner violence, forced sexual intercourse, and early pregnancy, and are less likely to receive medical care while pregnant compared to older married women.



PREGNANT ADOLESCENTS AND ADOLESCENT MOTHERS

As discussed previously, adolescent girls', especially VYA girls', lack of biological maturity puts them at greater risk for complications during pregnancy and childbirth. The risk of pregnancy-related mortality is twice as high for girls aged 15–19 years old and five times higher for girls aged 10–14 years old compared to women in their twenties. As well, pregnant adolescents are more likely to pursue unsafe abortions. In Africa, adolescents make up 25% of all unsafe abortions.



ADOLESCENTS WITH DISABILITIES

Adolescents with disabilities, as well as adolescents who have caregivers that have disabilities, are often hidden within communities and may face isolation. Security and physical barriers (damaged roads, lack of handicap-accessible structures), in addition to social and environmental hindrances (negative attitudes toward people with disabilities, lack of trained personnel) can limit their mobility and access to services. Some adolescents with disabilities may be less able to evacuate. Estimates show that for every child killed in conflict, three others are injured or permanently disabled, underscoring the long-term effects of conflict on children. Adolescents with cognitive delays or intellectual disabilities, acquired through injury, illness, or congenital conditions, appear to be at higher risk compared to those with other impairments. Adolescents with intellectual impairments are more likely to be excluded from services and support, and their parents' lack of disability information is often central to their poor access to care.



ADOLESCENTS WITH DIVERSE SEXUAL ORIENTATIONS AND GENDER IDENTITIES

Adolescents with diverse sexual orientations and gender identities, such as adolescents who identify as lesbian, gay, bisexual, transgender, intersex, and queer+ (LGBTQIA+), are often targeted for sexual violence crimes by multiple perpetrators (landlords, drivers, neighbors, authority figures) due to their limited legal protections and double stigma as refugees/displaced persons and having a non-conforming sexual orientation/gender identity. These adolescents may be forced to live in poor quality, insecure housing and face threats of extortion and/or sexual exploitation. Refugee and migrant adolescent boys who identify as LGBTQIA+ reported sexual exploitation and abuse in Italy and/or in the journey to Italy.



ADOLESCENTS WITH DIVERSE SRH NEEDS

These adolescents include but are not restricted to former child soldiers; adolescent survivors of GBV; adolescents living with HIV/AIDS; adolescents belonging to indigenous or migrant groups; and widowed adolescents. Adolescents in these categories may face additional stigma, discrimination, and abuse, exploitation, and violence, in addition to having specific health needs, such as an adolescent living with HIV requiring antiretroviral medication. These adolescents often experience more difficulties accessing care due to cultural or social norms.

- Migrant and indigenous adolescents face additional risks and barriers in their travels, as well as difficulties accessing SRH services and information. Migrant adolescents can experience stigmatization, harassment, and violence depending on attitudes and beliefs in the host country toward their home country and/or their views toward the indigenous population. Migrant adolescents also face difficulties accessing services due to lack of registration and/or health insurance policies. Migrant adolescent boys and young men have experienced kidnapping, imprisonment, and violence, including sexual violence, en route to Italy from countries across Africa and the Middle East. Migrant adolescent girls are less likely to be informed about SRH compared to non-migrant adolescent girls. A study in Kenya also found that adolescent girls' migrant status and poor family support increased the likelihood of dropping out of school and getting married, which could then lead to early sexual initiation. Indigenous adolescents face the challenges of land dispossession, issues of birth registration, limited access to culturally appropriate SRH information, lack of access to judicial and other essential services, among others. Indigenous girls face elevated risk of violence, particularly in areas of intra- and inter-communal conflict and in communities that have deeply rooted patriarchal practices.
- Adolescents formerly associated with fighting forces may require additional mental health and psychosocial support (MHPSS) services and assistance in reintegrating into the community, along with other adolescents who may be shunned or ignored by community members—such as adolescents from indigenous or migrant groups, LGBTQIA+ adolescents, or widowed adolescents. Child soldiers are also at higher risk for STIs, particularly HIV, and risk-taking behavior, such as drug and alcohol use. Female child soldiers may also face health issues caused by violent sexual assault, including traumatic fistula, as well as unwanted pregnancy and unsafe abortion.
- Survivors of GBV face increased risk of unwanted pregnancy, unsafe abortion, STIs, including HIV, and social stigmatization. Survivors of GBV may also require additional MHPSS services.

What kinds of barriers need to be addressed to ensure adolescents are able to obtain the information and services they need?

Adolescents face many barriers to quality SRH, which are discussed below in the context of the Social-Ecological Model (Figure C). The social-ecological model illustrates the various types of influences adolescents face in obtaining SRH information and services. The model recognizes the need to address health at multiple levels and through a social empowerment lens. There are four levels to the model: individual, interpersonal, community, and structural, and there are different factors at each level that prevent or support adolescents in obtaining SRH information and services.

Social-Ecological Model

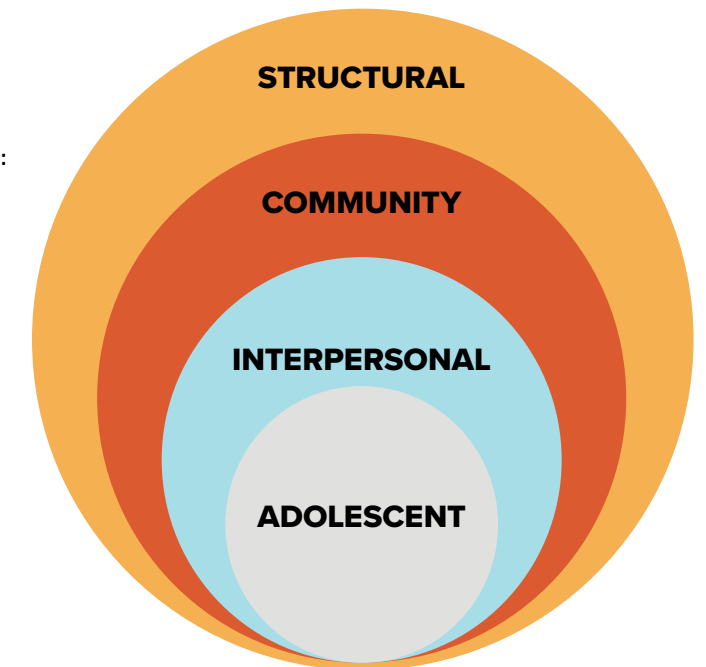
Adolescent (individual level): At the center of this model are adolescents. Their biological and personal attributes, attitudes, beliefs, and experiences with obtaining SRH information and services within their families, communities, and the health system affect their ability to seek quality information and services. These include factors such as age, personality, sex, mental health, agency, and awareness, among others.

Interpersonal level (relationships): The relationships adolescents have with family members, partners, peers, community members, and other social networks play a role in adolescents' ability to seek SRH information and services. Their attitudes, beliefs, behaviors, knowledge, norms, and values influence how adolescents seek information and services. Other family-level factors include household income/wealth status.

Community level: Adolescents live and socialize in communities that are made up of schools, workplaces, and neighborhoods. At the community level, there are social and cultural norms that restrict or support access to SRH services, such as if it is taboo to discuss sex or cultural norms surrounding abstinence.

Structural level: This level refers to the infrastructure and systems surrounding adolescents. Their ability to obtain information and services is influenced by the availability of health facilities, the safety of their communities, as well as by policies and laws that restrict or support access to SRH services. In a humanitarian setting, however, the infrastructure and/or systems may be disrupted, partially functional, or non-existent.

Figure C: Social-Ecological Model



Why Should We Prioritize ASRH During Emergencies?

With so much need and limited financial resources for the increasing number of humanitarian emergencies in the world, some may ask why ASRH should be prioritized when there are so many people in need of assistance. The answer is quite simple: we have a humanitarian mandate to save lives, and providing ASRH information and services—in coordination with adolescents themselves—is life-saving and has a compounding, positive impact on communities. The ASRH global community affirmed this charge in 2016. During the World Humanitarian Summit in 2016, humanitarian actors launched the [Compact for Young People in Humanitarian Action](#), showing an unprecedented and collective commitment of over 50 humanitarian agencies to ensure that the priorities of young people are addressed and that they are informed, consulted, and meaningfully engaged throughout all stages of humanitarian action.

ASRH is a huge issue in humanitarian crises, but is often neglected or overlooked

Half of the 1.4 billion people living in countries affected by crises and fragile conditions are below 20 years of age. Today, with many of the current protracted crises lasting several years, adolescents can remain displaced or in need of humanitarian assistance for up to 20 years, extending well into adulthood and affecting their educational, economic, and health outcomes. Adolescents (and children who age into adolescence during a crisis) are tremendously impacted by humanitarian emergencies and require critical SRH services to prevent unwanted pregnancies and unsafe abortions; sexual violence and physical abuse, exploitation, and violence; mental health issues and disorders; STIs; and overall morbidities and mortalities.

In fact, ASRH needs and risks intensify in times of crises. For example, during the COVID-19 pandemic, lockdown measures disrupted supply chains for contraceptives and restricted travel to health facilities, while economic declines related to the pandemic increased GBV, CEFM, and other rights violations—all further exacerbating SRH needs for adolescents.

Adolescents are exposed to a range of risks and hazards with which they are ill-prepared to cope. This includes violence, sexual violence, abuse, and exploitation; separation from families; gaps in accessible and affordable services; delays or disruptions in school attendance; a sudden loss of resources and the protection of family/social supports; and the breakdown of law and order. Their new environment can be full of new dangers, stressors, and unfamiliar conditions, including changes to marital norms and arranged marriages. These disruptions significantly affect adolescents' ability to protect themselves and engage in safe and healthy practices, including SRH behaviors. These challenges are discussed below within the structural level of the social-ecological framework.

Adolescent level (individual): Adolescents are often forced to assume adult responsibilities—such as taking care of their family members or seeking employment for which they may be unqualified or that pose dangers. They may be coerced or forced into marriage or transactional sexual relationships to generate resources that meet their basic survival needs and those of their families.

Interpersonal level (relationships): Families may see child marriage as a way to cope with economic hardship and to protect girls from violence. Nearly all ten countries where child marriage rates are highest are also considered either fragile or extremely fragile states.

Community level: Cultural or social norms can become more emphasized or even shift during humanitarian emergencies, which can have harmful effects upon adolescents' health. In Myanmar's ethnic conflict-affected communities, military and community leaders have discouraged young people from using contraception, restricted SRH education in schools and community institutions, and promoted childbirth and increasing the population to encourage ethnic culture and autonomy, as well as future military recruitment.

Structural level: Adolescents are often displaced from their homes and/or countries and have to confront issues related to legal status, as well as differing laws, religions, or cultural values that can affect their overall wellbeing. As well, adolescents will likely experience less secure physical environments, which increases their risk of physical harm. Health and other basic need services may be unavailable or difficult to access. Specialized services, such as obstetric care, are often harder to obtain or completely unavailable, which is a particular concern for adolescent girls who are at higher risk of pregnancy complications.

What do adolescents say?

Consultations held with refugee adolescents and youth in 22 countries found that many young people report poor access to adolescent-friendly and responsive healthcare, including psychosocial support. Refugee adolescents also cite few opportunities for their participation and/or involvement in responding to crises; no access or ability to engage with decision makers; high rates of gender inequality, exploitation, and violence; limited employment and livelihood opportunities; restricted freedom of movement; and discrimination, racism, and xenophobia—including for LGBTQIA+ adolescents—and an inability to acquire legal recognition and documentation of their status.



Photo : Instituto Guttmacher

Certain adolescents face higher risks during emergencies

As described earlier, adolescents can have overlapping vulnerabilities, risks, and barriers based on a number of factors, including their living conditions. Humanitarian crises represent an additional layer of vulnerability for adolescents, who may already face risks or barriers due to their age, sex, gender identity, sexual orientation, health status, developmental stage, marital status, socio-economic conditions, and contextual and environmental factors.

Adolescent Girls in Humanitarian Settings are extremely vulnerable to GBV, female genital mutilation or cutting, CEFM, unwanted pregnancy, unsafe abortion, STIs (including HIV), and death. Sexual violence is a common tactic of war, which has a profoundly negative effect on adolescent girls' physical health (pregnancy, unsafe abortion, etc), emotional and mental health (depression, substance abuse), and social health (discrimination, exclusion, disrupted social networks). As many as one in five forcibly displaced women and girls will experience sexual violence, rape, or abuse. Adolescent girls are also at increased risk of human trafficking, forced prostitution, and sexual exploitation and abuse. They may also be more likely to engage in high-risk behaviors compared to adolescent girls in more stable settings.



61% of the women and adolescent girls who die every day from causes related to pregnancy and childbirth were from countries considered fragile because of conflict or disaster—representing **3/5** of all maternal deaths globally.



Adolescent Boys in Humanitarian Settings experience high rates of physical and sexual exploitation and violence, as well as harassment and potential detention and/or arrest by police or security forces, particularly if they cannot produce proper identification. Adolescent boys are also trafficked for child labor and as child soldiers and/or drug smugglers.

1/3 of the **89** Rohingya men and adolescent boys consulted in Cox's Bazar, Bangladesh knew a man or boy with direct experience of conflict-related sexual violence.



Adolescent boys and young men in Myanmar reported being forced to witness sexual violence against female family- and community-members, which resulted in severe mental trauma and fractured family relationships. Men and boys reported physical injuries and sexual violence, as well as feelings and thoughts of shame, powerlessness, and suicide while fleeing from Syria to Turkey.

Adolescents at Increased Risk During Emergencies

Certain subgroups of adolescents face increased risks and vulnerabilities compared to other adolescents (recall [Figure B](#) in the earlier section). The needs, risks, and barriers of these subgroups of adolescents are exacerbated during emergencies. This list is not exhaustive but shows the diversity of at-risk adolescents during humanitarian emergencies.

- Adolescents associated with fighting forces
- Adolescents born of rape in conflict
- Adolescents caring for persons with disabilities
- Adolescents experiencing homelessness or in temporary housing
- Adolescents engaged in (the worst forms of) child labor or forced labor
- Adolescents from minority linguistic, religious, and ethnic groups, including indigenous young people
- Adolescent heads of households
- Adolescents impacted by gang violence
- Adolescents in contact with the law, including those in detention
- Adolescents who are exploited in transactional sexual relationships
- Adolescents living with HIV and other chronic illnesses
- Adolescent mothers
- Adolescent survivors of GBV, including sexual violence, trafficking, and other forms
- Adolescents who bear children of rape in conflict
- Adolescents with disabilities
- Child brides
- Married adolescents
- LGBTQIA+ adolescents
- Orphaned adolescents
- Refugee and internally displaced adolescents
- Returnee adolescents
- Stateless adolescents
- Unaccompanied and separated adolescents
- Undocumented adolescents
- VYAs
- Widowed adolescents

Regardless of the source of their vulnerabilities, all at-risk subgroups of adolescents require particular attention and targeted interventions to ensure that their SRH needs are met during times of crises. Table 1 provides examples of the barriers, increased responsibilities, risks, and assets and capacities of a few at-risk subgroups of adolescents in humanitarian settings and compares these risks to an adolescent in a non-crisis setting. It is important to always remember and utilize the opportunities of adolescents' capacities and the assets of the community, even in a crisis.

Table 1: Risks and Opportunities Facing Adolescents in Emergencies

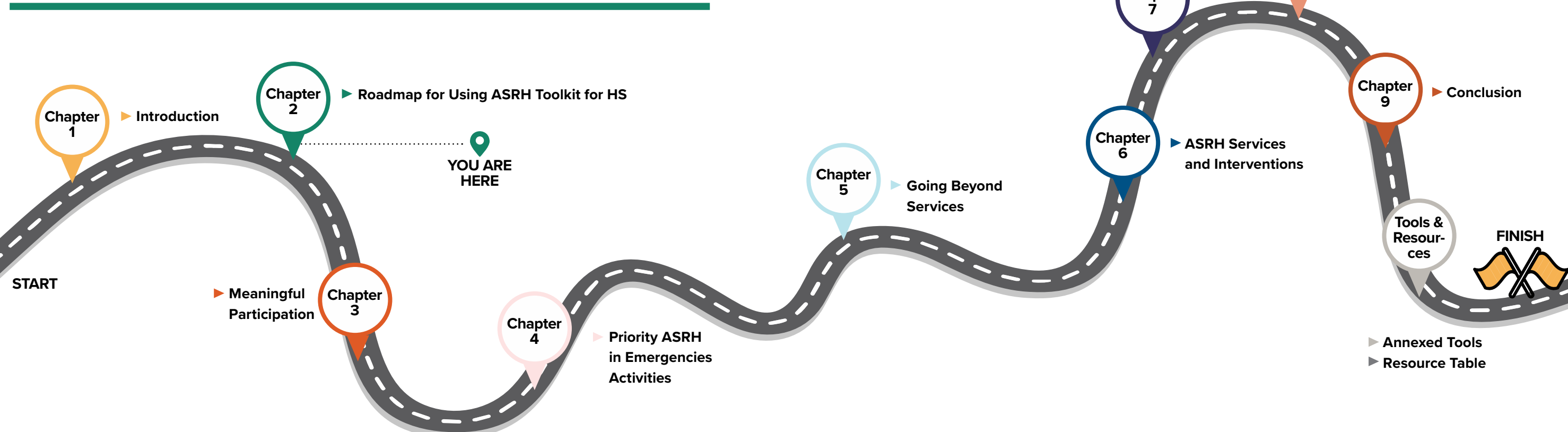
Population	Barriers	Increased Responsibilities	Risks	Assets & Capacities
Adolescent in non-crisis settings	Specific to SRH, sensitivities discussing SRH needs and stigma from community	<ul style="list-style-type: none"> Going to school Helping family, such as looking after siblings 	<ul style="list-style-type: none"> Road accidents Risky behaviors (drugs, alcohol, unsafe sex) 	<ul style="list-style-type: none"> Adolescent (and youth) networks Family support Coping skills and positive identity
Pregnant adolescent in crises	Finding SRH services when normal facility operations have been disrupted	<ul style="list-style-type: none"> Taking care of self and baby 	<ul style="list-style-type: none"> Birth complications for mother and baby 	<ul style="list-style-type: none"> Adolescent mothers club Commitment to learning
Orphaned adolescent in crises	Receiving assistance /services without head of family or caregiver	<ul style="list-style-type: none"> Finding food, shelters, health, and other services on your own 	<ul style="list-style-type: none"> Forced labor, human trafficking, including trafficking into armed group 	<ul style="list-style-type: none"> Adolescent programs Girl-friendly center Positive peer models
Adolescent with a physical disability in crises	Restricted mobility finding services from damaged roads and/ or insecurity	<ul style="list-style-type: none"> Finding services and items needed in new setting 	<ul style="list-style-type: none"> Injury Malnutrition Isolation 	<ul style="list-style-type: none"> Caring community Resistance skills



Photo : UNFPA



CHAPTER 2: ROADMAP FOR USING ASRH TOOLKIT FOR HS



ASRH Toolkit for Humanitarian Settings

What (the Toolkit is): The Toolkit provides practical guidance to assist sexual and reproductive health (SRH) humanitarian staff and organizations in designing, implementing, monitoring, and evaluating adolescent sexual and reproductive health (ASRH) activities, with the ultimate goal of increasing access to and delivery of SRH services for adolescents in emergency contexts. The Toolkit will also assist organizations and their staff, in collaboration with national implementing partners (government offices, community-based organizations, local non-governmental organizations [NGOs], etc), to invest in local capacity, as well as health system strengthening. The Toolkit is a complementary resource to the [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings \(IAFM\)](#) and the [Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations \(MISP\)](#). The first iteration of the Toolkit was in 2012; the main updates to the 2020 Toolkit version include:

1. increased emphasis on meaningful participation of adolescents and community members throughout the program cycle and across the emergency-to-development continuum;
2. added prioritization of integrating ASRH activities across all humanitarian sectors;
3. and a shift from stand-alone ASRH projects to more holistic programming.

All of the updates to the Toolkit align with the changes made to the IAFM in 2018. In accordance with [IAFM's Chapter 6 on ASRH](#), the programming modalities, intervention activities, and project guidance discussed in this Toolkit are based on the current evidence base and emerging best practices for initiating and scaling up ASRH programs—using a human-centered approach. The revised Toolkit also adds guidance on data for action and management tools for program and field managers to utilize when implementing ASRH activities.

- CHAPTER 1
- CHAPTER 2
- CHAPTER 3
- CHAPTER 4
- CHAPTER 5
- CHAPTER 6
- CHAPTER 7
- CHAPTER 8
- CHAPTER 9
- ANNEXED TOOLS
- RESOURCE TABLE

What the toolkit is not: A depository of all ASRH activities, interventions, and programs from across the world. However, the Toolkit does provide guidance on the necessary components to include in ASRH activities and programs, as well as tools and links to several ASRH intervention resources and tips.

Why (we are updating it now): The [ASRH Toolkit](#) was originally developed in 2009 by Save the Children and the United Nations Population Fund (UNFPA) as a companion to the IAFM. Since 2009, there has been an increase in evidence and knowledge acquired from the field. Thus, in 2019, the IAWG ASRH Sub-Working Group began revising the original ASRH Toolkit for Humanitarian Settings in accordance with changes to the IAFM (2018) and MISP (2019) and release of [Compact for Young People in Humanitarian Action's Guidelines on Working with and for Young People in Humanitarian and Protracted Crises](#) (2020).

Who (the Toolkit is for): SRH coordinators and managers in humanitarian settings are the primary audience for the 2020 ASRH Toolkit for Humanitarian Settings. These include, but are not limited to, individuals from youth organizations and networks, local and international NGOs, government entities, UN agencies, and private institutions. However, other health professionals, such as service providers (doctors, nurses, midwives) and non-health humanitarian staff, such as case management coordinators, will also find useful information about a range of SRH issues affecting adolescents in emergency settings.

How (to use the Toolkit): The Toolkit includes nine chapters, as well as annexed tools, a resource table, and alphabetized lists of all sources cited throughout the Toolkit ([available online](#)), which are organized by chapter.* As the above roadmap shows, the chapters are color-coded and chapter links are provided at the start of each chapter for quick navigation. The Toolkit also includes several breakout boxes to draw readers' attention to important messages, considerations, and case studies. For key messages and implementation considerations, readers will find these in this [color box](#). For case studies, readers will find these in this [color box](#). For links to additional guidance or resources, readers will be taken to the resource table, where a short description, citation, and link to the resource is included.

**Note: For more information on sources for specific sentences or paragraphs, please contact info.iawg@wrcommission.org.*

What should humanitarian responders do to better identify and respond to adolescents in humanitarian crises?

The level of effort to address the SRH and rights of adolescents in emergency settings has simply not corresponded to the level of need, and, over time, ASRH programming in humanitarian settings has been deprioritized and underfunded. The results from an IAWG mapping exercise showed that ASRH proposals made up only 3.5% of all health proposals from 2009–2012, and even at that extremely low level, few efforts were funded. More recently, ASRH has emerged as a priority area for the global humanitarian agenda, which has helped generate more resources and mechanisms of support for ASRH programming.

There are a few specific actions that can be taken at the onset of a humanitarian response that will ensure ASRH is acknowledged and addressed. These three key actions are emphasized throughout the Toolkit chapters and align with IAFM standards and World Health Organization (WHO) global guidance. WHO has also developed a set of global standards for providing quality health care services for adolescents, in line with their adolescent-responsive framework. For more information on the global standards, see [Annex A: WHO's Global Standards for Quality Health-Care Services for Adolescents](#). Both the IAFM and WHO's sets of standards push for humanitarian health staff to implement an appropriate package of ASRH services at well-provisioned and welcoming facilities and other entry points with competent staff and in collaboration with community stakeholders and adolescents themselves.

1. Include and Involve Adolescents

Humanitarian responders must understand the diversity of adolescents and develop tailored and inclusive ASRH programming that targets specific vulnerable groups. Programs should aim to address the full range of adolescents' SRH needs, risks, and preferences, and consider the numerous challenges and barriers they face. A one-size-fits-all approach is not effective and fails to reach the most vulnerable adolescents.

Humanitarian responders must create opportunities for young people to be engaged in the design, implementation, and evaluation of ASRH programs. Evidence shows that meaningfully engaging adolescents is essential for accurately identifying needs, appropriately addressing barriers, and providing tailored and relevant services for adolescents. In addition, effective ASRH programming utilizes the capacities of adolescents to lead their own empowerment. A humanitarian crisis presents adolescents with an opportunity to demonstrate their capacity to assume new responsibilities and leadership roles, as well as their adaptability to rapidly changing environments. Humanitarian responders can ensure adolescents' voices are involved in program design, implementation, and monitoring of a project, but it does not stop there. They can further engage adolescents as:

- active team members
- first responders
- powerful spokespersons

More on this approach is outlined in [Chapter 3: Meaningful Participation](#), as well as how to work with community members to successfully fulfill ASRH programming.



Photo : Joshua Roberts

2. Implement Adolescent-Inclusive MISP

The MISP—a chapter within the IAFM—provides guidance for reproductive health provision during different phases of a humanitarian crisis, and, when implemented from the onset of a crisis, saves lives and prevents illness, especially among women and girls. It is a coordinated set of priority activities aimed at preventing and responding to sexual violence, reducing Human Immunodeficiency Virus (HIV) transmission, preventing unintended pregnancy, and transitioning to more comprehensive SRH services, as the situation permits.

KEY MESSAGE

Ensuring adolescents' access to quality contraception—as well as safe abortion care—to the full extent of the law is aligned with the MISP's goal to reduce maternal mortality and ensure the rights of adolescents are upheld.

The MISP is implemented as part of the humanitarian program cycle, which is a coordinated series of actions undertaken to prepare for, plan, manage, deliver, and monitor collective humanitarian responses. Throughout the Toolkit, guidance will refer to the humanitarian program cycle to illustrate how specific considerations, approaches, and tools should be used during every part of this cycle—from preparedness efforts through implementation and during early recovery and development strategies. [Figure D](#)—taken from the IAFM—provides an illustration of how the MISP should be implemented during a humanitarian crisis, as well as how to prepare for a crisis and/or transition toward comprehensive SRH care during a humanitarian emergency.

The IAFM's MISP chapter is not tailored specifically to adolescents. This is why the ASRH Toolkit for Humanitarian Settings exists—to provide additional guidance on the provision of MISP services that meet the unique needs of adolescents in emergency contexts, including subgroups of adolescents at increased risk, and to provide other resources and tools needed to fully address the SRH and rights of adolescents. The Adolescent-Inclusive MISP provides information not only on how to tailor MISP activities for adolescents but also on how to involve adolescents in preparedness efforts, implementation of the SRH activities during a crisis, and moving toward comprehensive SRH care during protracted crises and/or early recovery phases. These strategies for engaging adolescents before, during, and after a crisis are also integrated throughout all chapters of the Toolkit.

Further guidance on how the MISP can be inclusive of adolescents' needs is provided in [Chapter 4: Priority ASRH in Emergencies Activities](#).

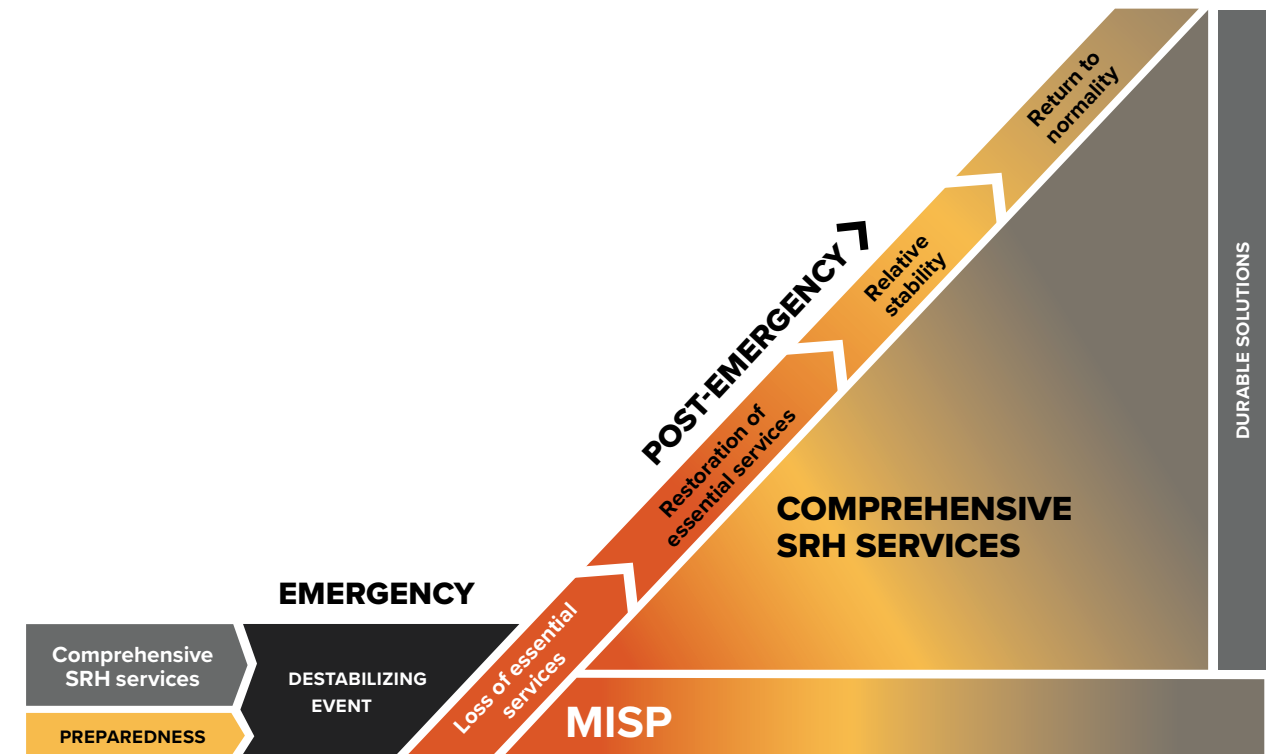
3. Ensure Holistic ASRH Programming

Humanitarian responders must approach ASRH activities, programming, and projects with a holistic lens. A holistic approach looks at the needs of the “whole” person, not just providing clinical SRH services. To provide holistic programming, responders must examine the multiple levels of influence that impact adolescents' access to and use of SRH services, using the social-ecological model. In addressing these multiple levels of influence, responders must engage several stakeholders (family, community, health partners, non-health colleagues, gatekeepers, decision-makers, etc) in activities for adolescents—beginning early in adolescence to provide age- and developmentally appropriate SRH information and services that address the multiple barriers facing adolescents. Responders must also strengthen program linkages, referral pathways, and coordination mechanisms between health and related sectors to deliver multi-sectoral responses, which is particularly critical in humanitarian settings. While engaging ASRH stakeholders and bolstering multi-sectoral linkages, responders should utilize best practices, employ flexibility, and be creative to overcome challenges in addressing the unique needs of this population.

More information on this approach, how it applies to adolescents in emergency contexts, and what steps humanitarian responders can take in achieving ASRH holistic programming is included in [Chapter 5: Going Beyond Health Services](#).

In the following chapters, the Toolkit will address how to capitalize on the momentum and energy from the global community in regards to adolescents' SRH and rights through case studies, evidence-based interventions, and global guidance and materials from the humanitarian field—with the ultimate goal of saving more lives.

Figure D: The Continuum of an Emergency



Note: Crises seldom take a linear, clear-cut path from emergency, stability, recovery to development. Often, they are complex, with settings experiencing varying degrees of improvement or deterioration that can last decades. The provision of RH services must therefore take into account the non-linear trajectory of a crisis, and the gaps in services due to insecurity, competing priorities or swindling funds in protracted settings. The IAFM is applicable for all settings, wherever an agency finds itself on the emergency continuum.

In the following chapters, the Toolkit will address how to capitalize on the building momentum and energy from the global community to address the SRH and rights needs of adolescents, and ultimately, save lives, by providing case studies, evidence-based interventions, and global guidance and materials from the humanitarian field.



CHAPTER 3: MEANINGFUL PARTICIPATION

The initial and essential stop in the Adolescent Sexual and Reproductive Health (ASRH) Toolkit roadmap is the Meaningful Participation chapter. This chapter includes guidance on how to meaningfully engage adolescents and their communities in the design, implementation, and evaluation of ASRH programming in humanitarian settings. As identified in the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM), creating an enabling environment for youth leadership and meaningful participation of adolescents is a rights-based approach and provides avenues for meaningful and inclusive representation among diverse groups of adolescents in humanitarian settings. It is also important to recognize that adolescents are influenced by individuals, adults, their community, and societal factors; thus, ensuring participation of adults and the broader community is important in creating an enabling environment for adolescents, garnering wide support and commitment from adults for ASRH programs, and easing some of the barriers to accessing services.

Chapter 3 Learning Objectives

After reading this chapter, readers should be able to:

- Describe what “meaningful participation” of adolescents is and the different levels of adolescent engagement
- Explain why involvement of community members in humanitarian programming is necessary
- Recognize adolescents’ capacities and identify opportunities and approaches to meaningfully engage adolescents throughout the humanitarian program cycle
- Describe how to involve adolescents in ASRH humanitarian programming

What you will find in this chapter:

- An overview of continuums for meaningful adolescent and community participation
- Guidance on how to integrate meaningful participation strategies for ASRH programming across the preparedness, response, and recovery stages of an emergency
- Practical tools and considerations for the implementation of meaningful participation strategies

So what is meaningful participation?

Meaningful participation requires that people are able to participate in the decisions that directly affect them, including in the design, implementation, and monitoring of health interventions.

Meaningful participation is essential to the success and eventual longevity of knowledge, skills, behavioral change, and commitment to ASRH programming in humanitarian settings. Working with adolescents and building respectful partnerships with communities are fundamental principles of sexual and reproductive (SRH) programming in humanitarian settings, as outlined in the [IAFM](#).

KEY MESSAGE

Remember, adolescents are not a homogeneous group and have diverse needs. As mentioned in [Chapter 1: Introduction](#), their needs are based on intersecting identities and socio-economic factors, such as gender, sexual orientation, race, ethnicity, religion, social class, disability, and much more. It is important to actively seek out guidance and meaningfully engage under-represented vulnerable populations of adolescents on a continuous basis throughout the humanitarian cycle.

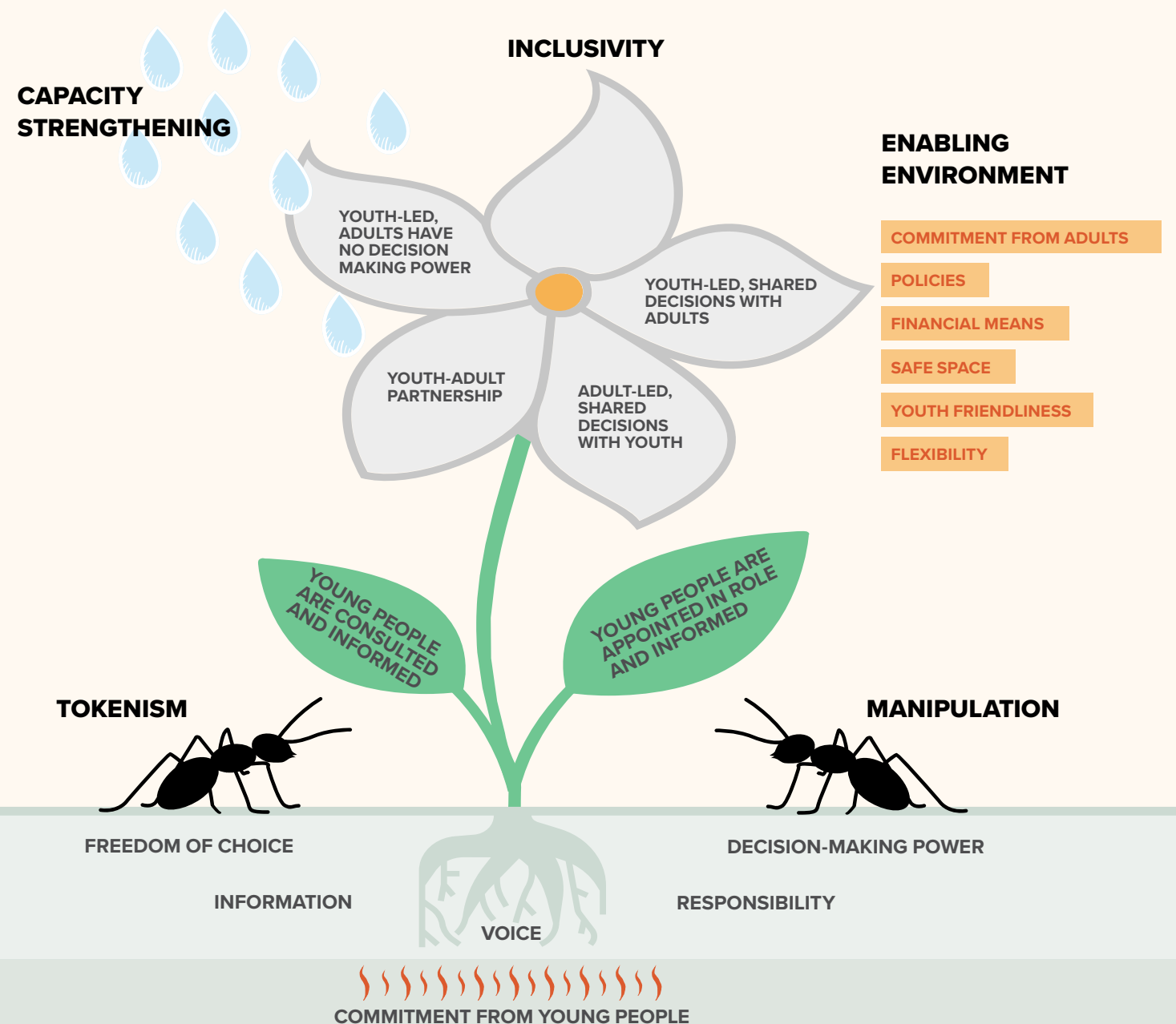
Adolescent Participation

Adolescent participation at all stages of the program cycle can:

- lead to more relevant programming,
- strengthen program outcomes, and
- contribute to meaningful partnerships between adolescents and adults in humanitarian settings.

Meaningful adolescent participation has varying degrees of non-participation and participation—as illustrated in the flower below. [The Flower of Participation](#) is a resource developed by CHOICE for Youth and Sexuality and YouAct that utilizes a blooming flower as a metaphor to describe the various forms of meaningful participation with adolescents and youth, and the environment required to enable meaningful participation to thrive and flourish.

Figure E: The Flower of Participation



The resource can be used to distinguish between different forms of participation and to explore whether they are meaningful or not using the roots of the flower to represent the core elements of meaningful participation; the leaves and petals to convey the different forms of meaningful participation; the insects to symbolize the non-meaningful forms of participation; and the sun and water to illustrate the preconditions for meaningful participation.

It is important to note that increasing adolescent participation is a **dynamic process** in complex humanitarian settings. Programs should evaluate what forms of meaningful youth participation they are starting off with and set appropriate targets that strive to nourish all forms of participation. Each participation stage should depend on the proposed project and wishes of the adolescents involved.

Different contexts naturally require different levels of participation; however, through the fostering of an inclusive environment, humanitarian responders can afford adolescents and adults opportunities for capacity strengthening and working towards higher levels of participation. Similarly, it is important to note that the benefits of participation are neither automatic nor guaranteed. Participation should not be a one-off event (tokenism); instead, it must be thought of **as an ongoing process**. Participatory approaches must also involve a capacity-building component in order for adolescents to develop their skills while also feeling empowered to contribute to programming in a significant way. Different program components can also operate at different stages of adolescent participation, and programs can combine them depending on the type of decision.

What adolescents are saying: “Engage us in humanitarian programming”

A recent mapping of adolescent and youth participation in humanitarian programs (Humanitarian Response Plans and Regional Refugee and Resilience Plans) highlighted that only 14% of partners support systematic participation in all components of adolescent and youth programming, including assessment, design, implementation, and monitoring of their interventions. Too often, adolescent and youth engagement is reduced to training or consultation. Very seldom does training or consultation translate into action based on young peoples’ inputs; if it does, the outcome of their participation is often not documented or measured. There is an urgent need to move away from approaches that merely consult young people as beneficiaries and towards engagement approaches that recognize young people as actors with their own agency and a right to engage in decision-making.

A growing number of humanitarian actors are beginning to recognize and prioritize this need. The Compact for Young People in Humanitarian Action, for example, is an unprecedented and collective commitment of key actors to ensure that the priorities, needs, and rights of young people affected by disaster, conflict, forced displacement, and other humanitarian crises are addressed and that they are informed, consulted, and meaningfully engaged throughout all stages of humanitarian action.

Opportunities to engage adolescents in humanitarian settings

As highlighted in the [IAFM](#), adolescents must be engaged:

- along the program cycle—from assessment to design, implementation, and through to monitoring and evaluation;
- and throughout the emergency-to-development continuum (preparedness, response, and recovery)—not solely during the acute phase of an emergency.

The following matrix provides some examples of ways that program implementers can support adolescents to participate in ASRH program implementation in humanitarian settings.

Table 2: Participation Guidance on ASRH in Humanitarian Settings

<p>Who to engage</p>	<ul style="list-style-type: none"> • Adolescent leaders <ul style="list-style-type: none"> • Who are adolescent leaders? Individuals that demonstrate a focused energy in an activity or a cause they care deeply about and have the knowledge and confidence in their ability to take action. • Existing adolescent groups and networks <ul style="list-style-type: none"> • What are peer adolescent groups and networks? They are social mechanisms that adolescents of diverse identities and interests are actively engaged in and that support their well-being and provide avenues by which to advance adolescent social and rights-based causes. • Humanitarian institutions, such as the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) ASRH Sub-Working Group (SWG), actively reach out and partner with adolescent networks to ensure they have a seat at the decision-making table and lead initiatives. • Adolescents at increased risk (sub-groups with diverse SRH needs, ideally intersectional considerations). See Chapter 1: Introduction for more information on sub-groups of adolescents at increased risk. <hr/> <p>KEY MESSAGE: Female adolescents should have equal access to and participate equally in all activities. Why? In many cultures, uneven division of household labor starts early; outreach and engagement activities may need to be adapted to a schedule that encourages girls' participation. For example, girls may be caretaking for family members after school; or girls may not be in school due to menstruation or pregnancy. Leadership roles can be rotated to ensure more girls have opportunities to become leaders.</p>
<p>Ways to improve adolescent participation during needs identification & program design</p> <p>[See Chapter 6: ASRH Services & Interventions for guidance on engaging adolescents and youth as first responders.</p>	<ul style="list-style-type: none"> • Support their participation in humanitarian coordination mechanisms, including SRH SWG, Gender-Based Violence (GBV) Sub-Cluster and Child Protection Sub-Cluster, as well as in other decision-making bodies (such as camp committees). <ul style="list-style-type: none"> • Adolescents are identified or nominated to attend cluster and working group meetings and specifically encouraged to share first-hand information on the ASRH status, needs, and risks among the affected group and how best to reach them. • Provide logistical support to ensure active and sustained engagement. • Work directly with adolescents to support ASRH advocacy campaigns and key messages for different humanitarian stakeholder groups. • Work directly with adolescents to develop humanitarian response plans and design ASRH strategies.

<p>See Chapter 7: Data for Action for guidance on engaging adolescents in response planning, mapping, and assessment exercises, as well as for examples of FGD guides and resources.]</p>	<ul style="list-style-type: none"> • Conduct focus group discussions (FGDs) with adolescents (including sub-groups at increased risk) to collect feedback on their needs and solicit assistance in identifying their peers who are most at risk. • Work with adolescents to undertake thorough mapping of adolescent-oriented, gender-sensitive services in support of adolescent-responsive programming.
<p>Ways to improve adolescent participation during program implementation</p> <p>[See Chapter 6: ASRH Services & Interventions for more information on tools and guidance for engaging adolescents in implementation]</p>	<ul style="list-style-type: none"> • Encourage adolescents to share information: <ul style="list-style-type: none"> • with other adolescents about the importance of seeking medical care for survivors of sexual violence and where that care is available; • with pregnant adolescents about where to seek skilled delivery care when they go into labor; • with peers about where to access adolescent-friendly, gender-sensitive and confidential SRH services, including contraceptive methods (eg emergency contraception), treatment for sexually transmitted infections (STIs), and safe abortion care. • Integrate adolescents into response efforts through distribution of SRH supplies (clean delivery kits to pregnant adolescents, menstrual hygiene management supplies, condoms, etc). • Encourage adolescents to support other adolescents to access SRH services through accompaniment to the health facility and/or accessing the referral system. • As the situation stabilizes/in protracted settings, train youth volunteers to support awareness-raising, community-based distributions (where appropriate and feasible), and referrals to SRH and other relevant humanitarian programming. • As the situation stabilizes/in protracted settings, set up clubs that strengthen youth networks to support awareness-raising and social behavior change activities for adolescents at increased risk. • Engage with, build capacity of, and include existing youth networks and social media platforms on SRH preparedness efforts to empower them to play a meaningful role in future emergency responses.
<p>Ways to improve adolescent participation in program monitoring, evaluation, and accountability</p> <p>[See Chapter 7: Data for Action for more tools and guidance on engaging adolescents in monitoring, evaluation, and accountability].</p>	<ul style="list-style-type: none"> • Build adolescent capacity and enable them to provide routine feedback on program implementation through participation in SRH coordination, GBV Prevention Taskforce, child protection coordination groups, camp committees, health committees, and other similar forums. • Capacitate and involve adolescents in monitoring data for decision-making and accountability approaches for SRH programs. • Ensure adolescents participate in the evaluation of ASRH programs by contributing to the elaboration of the methodology, the analysis, and the actual data collection process. • Build leadership skills of adolescents and youth and provide mentorship to support their meaningful participation. • Develop capability statements outlining activities and outcomes of meaningfully engaging adolescents in ASRH humanitarian preparedness and response programming.

Source: Updated from [ASRH Toolkit for Humanitarian Settings](#) (IAWG, 2012).

How to identify and engage hard-to-reach adolescents

Identifying adolescents in humanitarian settings can be challenging—particularly if their mobility is restricted, they live in a remote place, and/or possess multiple vulnerabilities. There are a number of steps that can be taken to systematically identify diverse groups of adolescents, their locations, and their unique capacities and needs:

1. Conduct a [social mapping](#) exercise to identify different groups of vulnerable adolescents in the emergency-affected community, including those in hard-to-reach locations;
2. Conduct a [community mapping](#) exercise to identify all the different places in the community adolescents are concentrated, including key ASRH service delivery points;
3. Identify the unique ASRH needs and capacities of different adolescent groups using assessment and/or mapping results, create plans to address them, and develop approaches to meaningfully engage adolescents in programming.

The Women's Refugee Commission has developed the [I'm Here Approach](#), a complementary set of steps and smartphone-based tools—including global positioning system (GPS) service area resource scans, real-time monitoring tools, and an analytics dashboard. This approach rapidly enables humanitarians to reach the most vulnerable adolescent girls, ensuring their safety, health, and well-being from the start of the response to a crisis.

Engaging adolescents in coordination meetings

Adolescents should be identified or nominated to attend cluster and working group meetings—specifically the Reproductive Health (RH) Working Group/SRH Working Group and the Child Protection Sub-Cluster—to share firsthand information on the ASRH status, needs, and risks among the affected group and how best to reach them. Their representation in these forums ensures that interventions are designed by and accountable to adolescents themselves. It is important to ensure that a mechanism is in place to support these adolescents in developing their confidence, skills, knowledge, and critical reflection, and to have opportunities to exercise agency and contribute to decision-making.

Adolescents who are easily identifiable, such as college students, youth leaders, and peer educators, may not be representative of the majority of affected youth. At the beginning of a crisis, it may be challenging to identify the most representative adolescents, including those from sub-groups at increased risks. However, every effort should be made to set out the criteria for identifying and nominating affected and high-risk adolescents to represent their peers in RH Working Group meetings and in other forums. Remember, adolescent girls and vulnerable adolescent groups should have equal access to and participate equally in all activities!

CASE STUDY

Youth Participation in Indonesia

After the 2018 earthquake in Lombok, Indonesia, the International Planned Parenthood Federation (IPPF), Indonesia Planned Parenthood Association (IPPA), and United Nations Population Fund (UNFPA) Indonesia collaborated to establish an interesting model to allow for youth participation and accountability. It was originally difficult to ensure that various youth voices were included in the coordination mechanisms, and it came to light that youth did not always feel comfortable sharing their experiences within coordination due to stigma and lack of acceptance in some cases. Subsequently, IPPA youth volunteers formed a youth forum—managed and led by youth themselves—that enabled the group to come together and identify specific needs, barriers, and strategies for meeting their SRH needs during the response. The youth forum discussed specific action items, strategies, and recommendations to raise at SRH Cluster meetings via IPPA staff. While it is no doubt important to include youth in coordination mechanisms, IPPA found it was best to establish forums where youth felt comfortable and had a platform to share their opinions free from stigma. It is important these forums are led and managed by youth themselves as a key driver of success.

Adolescent participation remains essential in crisis settings, even though the favorable conditions that encourage adolescents' participation—including time, funding, and commitment—might be limited by emergency circumstances. However, there are unique opportunities in emergencies to engage adolescents right from the onset of the emergency. Adolescents have demonstrated during emergencies how they can serve as active first responders, willing to be quickly trained and mobilized to distribute kits, be involved in data collection for rapid assessments, assist in camp registration and food distribution, disseminate camp announcements and health messages, and serve as volunteers in health and education centers and in child-friendly spaces. Two different organizations have documented how to meaningfully engage adolescent participation in disaster preparedness and contingency planning: Restless Development and ActionAID developed a program guide, [Shifting Power to Young People—How Young People Can Lead and Drive Solutions in Humanitarian Action](#), and UNICEF created [Practical Tips on Engaging Adolescents and Youth in the COVID-19 Response](#). More information on how to involve adolescents as first responders and in data for action activities is included in [Chapter 6: ASRH Services & Interventions](#) and [Chapter 7: Data for Action](#).

In addition to adolescent participation in the acute response and protracted situations/recovery phases, it is equally important to ensure their participation in the preparedness phase. This can be facilitated through mapping of youth networks; capacity building in technical SRH areas, as well as in leadership skills; and working to shift gender and power norms to make space for young people's voices in decision-making bodies and accountability structures at the national, provincial, and local/community levels, including technical working groups, camp committees, and health development committees. More information on mapping youth networks is provided in [Chapter 7: Data for Action](#), and information on increasing leadership skills and other assets of adolescents and youth leaders is included in [Chapter 6: ASRH Services & Interventions](#).

CASE STUDY

Youth involvement in Bangladesh Preparedness Activities

As part of preparedness efforts in coastal areas of Bangladesh, affected by cyclical flooding, Plan International Bangladesh developed youth groups and supported building their capacity to mobilize their communities when the government raised weather warning signals. This enabled young people to serve as first responders by supporting their communities in coordination efforts and sharing information on availability of nearby shelters and where to receive immediate assistance.

How can SRH managers create an enabling environment for meaningful adolescent participation?

- **Attaining commitment from adults and stakeholders** with decision-making power and influence is important to ensure policies, programs, and resources are available to nurture an adolescent-friendly, inclusive, flexible, and equitable environment.
- **Intentionally recruiting** across the diverse cross-section of adolescents creates paid opportunities for young people to participate in programming.
- **Budgeting for adolescent participation** in SRH program plans and activities ensures adequate resources and prioritization of their participation. For example, SRH managers can provide funds to cover travel arrangements and materials for adolescents/youth, as they often have limited capacity to pay for costs associated with travel and participation.
- **Providing ongoing capacity building and mentorship** for adolescents on ASRH, values clarification, representation and advocacy, program implementation, and research into your program plan ensures sustainability and continuous support for adolescents.
- **Building the capabilities and assets** of existing youth movements, youth organizations, and community-based organizations allows these networks and organizations to more fully engage in the response.
- **Training program staff** to adopt adolescent-friendly and non-discriminatory attitudes ensures adolescents are treated respectfully and receive the quality SRH services they need.
- **Adopting a “do no harm” approach** for all interactions with adolescents is necessary to avoid sexual exploitation and abuse, exacerbating disparities, discrimination, conflict, insecurity, and environmental degradation for adolescents in humanitarian settings.

[See [Community-Based Services & Outreach Platforms](#) under Chapter 6: ASRH Services & Interventions for more information and tools on these activities, as well as guidance for supervising adolescents/youth as first responders. See also [Chapter 8: Manager Guidance Notes & Tools](#) for additional guidance on supervision of staff, including adolescents/youth.]

KEY MESSAGE

Common challenges among field practitioners include sustaining adolescent participation throughout the program cycle and reaching adolescents beyond those targeted by the program—such as adolescents with disabilities and pregnant adolescents, or adolescents recruited as leaders, such as peer educators. There is a continued need for intergenerational engagement that involves investing in activities that continue to build adolescent capacity, including ongoing supervision and supporting their ability to serve as mentors to other/younger adolescents.



Community Participation

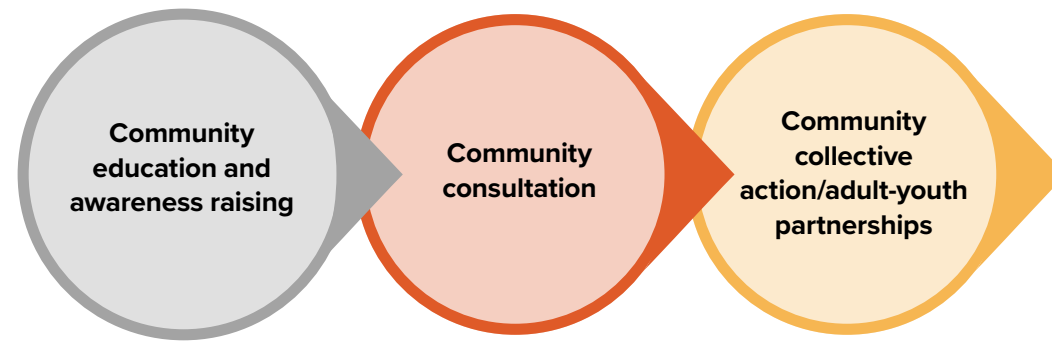
Implementing agencies, health staff, and adolescents may embrace ASRH programs and youth leaders, but these programs are unlikely to be sustainable if they do not have the support and commitment of the local community, including parents and other adult gatekeepers. Communities and gatekeepers play an important role in reducing stigma with ASRH programming and in supporting vulnerable adolescents and families. In order to have lasting effects, a program should lead not only to changes in the knowledge, skills, and behaviors of individuals (in this case, adolescents), but also to social and structural changes. Even in emergency settings, parents and community members should be involved in and consulted from the design phase of ASRH programming.

Community participation encompasses a continuum of approaches, as outlined below. Similar to adolescent participation, there are varying degrees of adult participation, with some more meaningful than others.

KEY MESSAGE

Remember that engaging with decision-makers and stakeholders in the community is important to ensure they are open to the idea of ASRH programming. In addition to intergenerational dialogue, gender-sensitive approaches should be addressed throughout the community participation continuum. Please refer to Chapter 6: ASRH Services & Intervention's [breakout box](#) on adopting a gender-integration lens for ASRH programming for additional information.

Figure F: Community Participation Continuum



Community education & awareness raising

On one end of the continuum, adults and the wider community are simply exposed to ASRH awareness-raising activities, using a variety of information, education, and communication (IEC) techniques. While sustaining interest and attendance can be challenging for any type of community outreach work, these types of ASRH awareness-raising activities can help to encourage intergenerational dialogue, wider discussion on taboo subjects, and help to break down stigma and discriminatory attitudes. Oftentimes, activities such as these are essential in making ASRH interventions possible and for generating a climate wherein they can be introduced. Integrating these IEC activities into community events, such as festivals and sports events, and into multiple social media platforms can be helpful in reaching large numbers of people. However, in order for them to have lasting impact, these activities should be part of a longer, sustained approach, rather than one-off meetings.

CASE STUDY

Building Support for ASRH among Crisis-affected Communities in South Sudan and Nigeria

As part of an ASRH operational research study conducted in Nigeria and South Sudan, the International Rescue Committee (IRC) facilitated meetings with community leaders and parents of adolescents—aimed at improving their knowledge of ASRH and discussing ways they can better support ASRH in their communities. During these meetings, IRC used participatory activities to discuss puberty, common myths and misconceptions around ASRH, and reflect on ways to improve community support for ASRH. The Toolkit has provided IRC's example [session plans](#) for conducting meeting with parents and community members.

But what if community gatekeepers don't want to talk about adolescents having sex?

In order for community awareness-raising activities to be most effective, they should involve tackling the stigma and discrimination surrounding adolescent sexual activity, opening up discussion on SRH, and challenging gender norms. Evidence shows that programs that intentionally address gender norms and power imbalances, involve community members and multiple stakeholders, and foster critical awareness and participation among affected community members can significantly improve both health and gender outcomes for adolescents.

Community consultation

The next stage of the continuum is community consultation—where humanitarian program implementers consult or engage with community members to achieve a concrete goal. For example, community-based organizations, support groups, and both adult and adolescent networks can provide support in identifying at-risk adolescents, making referrals to services, or providing direct support to at-risk adolescents. Consulting with local power-holders, such as traditional and religious leaders, is critical in building a supportive environment for ASRH and raising awareness about the specific risks faced by adolescents.

Community collective action

On the other end of the continuum, there is community collective action, where the community is involved in the design, implementation, and evaluation of ASRH programming to help ensure the needs of the population are met and are sustainable in the long term.

CASE STUDY

CARE's Vijana Juu Project

One key element of CARE's Vijana Juu project in North Kivu, Democratic Republic of the Congo (DRC), was the use of the Community Score Card—a citizen-driven accountability approach for the assessment, planning, monitoring, and evaluation of service delivery. Through Vijana Juu, CARE invited adolescents to contribute their thoughts on how local clinics could better serve their SRH needs and then invited health providers and community members to consider the identified challenges in delivering SRH services to young people. Representatives from these groups then came together to develop a shared strategy for improvement and indicators—aligned with what youth-responsive services meant to them—that would be tracked to measure progress toward their goals. Adolescents were periodically engaged to monitor youth-friendliness of health service delivery and to collaborate with health providers and leaders to strengthen program quality.

Remember: it's a continuum of inclusive participation and engagement

As outlined in the [Minimal Initial Service Package for Sexual and Reproductive Health in Crisis Situations \(MISP\)](#) and [IAFM](#), in the early stages of an emergency it is often challenging to implement community participation approaches beyond "community education and awareness raising", particularly in contexts where limited development programming or preparedness activities have been undertaken prior to the emergency. However, emergency response efforts can build upon community awareness-raising activities and strive towards implementing approaches that contribute to community collective action, even during emergencies.

Several models initially developed for development contexts and then adapted to fragile contexts for adolescent participation emphasize community collective action and adolescent-adult partnerships. These models are key to bringing together adolescents, parents, health providers, and community members in identifying adolescents' SRH needs and developing and implementing programs to address those needs, all the while ensuring adolescent participation across the program cycle.

IMPLEMENTATION CONSIDERATION

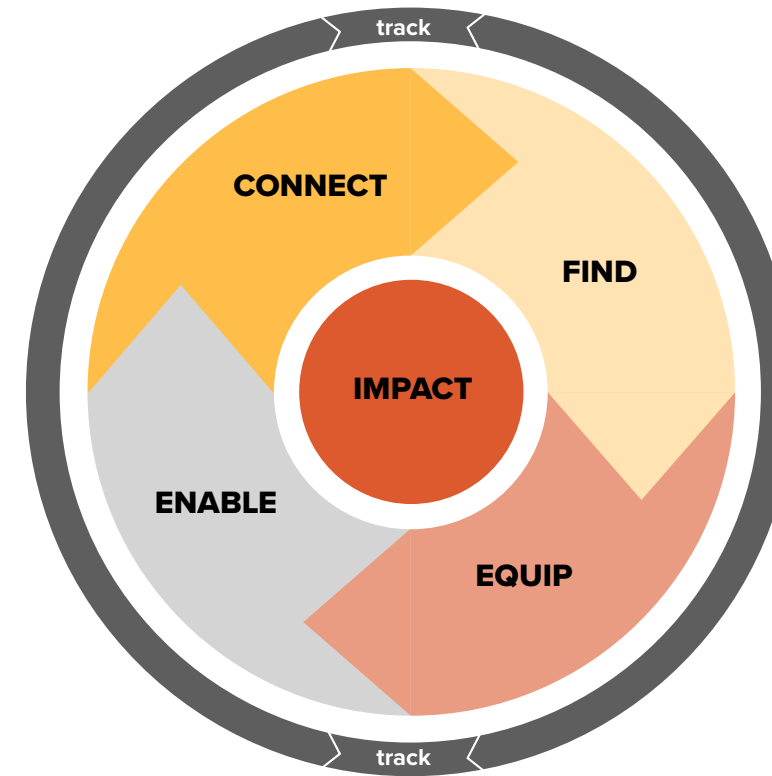
Adult-Youth Relationships Provide Protective Factor

While a primary focus of ASRH programming is to provide tailored support to meet adolescents' distinctive needs by placing them at the center, safe and supportive environments are a key protective factor for healthy development and well-being of adolescents. As outlined in [Figure C: Social-Ecological Model](#), adults play an important role in this regard and can help adolescents weigh the consequences of their behaviors (particularly risky behaviors) and identify options. The intergenerational influence of at least one positive adult and a nurturing family are protective factors during this period of development and can help adolescents cope with stress and develop resilience.

Programs can work with parents, who are caregivers of adolescents, to enhance their parenting skills and self-care, strengthen adolescent-caregiver relationships, link families to multi-sectoral services, and raise awareness on ASRH. A few examples of curricula and guidance include the [Girl Shine Caregiver Curriculum](#) and [Families Make the Difference](#).

This chapter provided guidance on the importance of identifying, enabling, equipping, and connecting adolescents and community stakeholders to ensure meaningful and impactful adolescent participation in the humanitarian program cycle. [Figure G](#) summarizes each step of meaningful adolescent participation into a process map, which has been adapted from the [YIELD Project](#).

Figure G: Meaningful Adolescent Participation Process Map



FIND: Identify and engage adolescents, in all their diversity, as participants in ASRH efforts across the ecosystem;

EQUIP: Provide training and continuous support to build adolescent knowledge, skills, and capabilities;

ENABLE: Cultivate supportive environments with decision-makers and gatekeepers in the community that reduce stigma and allow adolescents to exercise their autonomy and become leaders and active contributors to ASRH efforts;

CONNECT: Create pathways for adolescent participants to engage with adults in humanitarian crises; and

TRACK: Develop and implement monitoring and evaluation systems that document the results of adolescent participation at different levels of the meaningful adolescent participation process map.

As we make our way through the toolkit roadmap, meaningful participation of adolescents and community members will be emphasized throughout all phases of the humanitarian continuum and all parts of the program cycle. The next chapter—[Priority ASRH Activities in Emergencies](#)—describes the importance of implementing activities and priorities of the MISP that are inclusive of adolescents' needs, barriers, and capacities.



Photo : Daphnee Cook

Participation Tools

Included below are some participation tools and resources for program managers as they begin working with adolescents and young people. As with other guidance documents, these materials should be adapted to each response and setting as appropriate. In Chapters 6, 7, and 8, the Toolkit provides additional guidance, tools, and resources for engaging adolescents in each phase of the program cycle (design, implementation, and monitoring and evaluation) and the humanitarian cycle (preparedness, response, and recovery).

The [Adolescent and Youth Engagement Toolkit](#) has a number of practical resources aimed at supporting humanitarian implementers in planning for adolescent participation, including:

- *Principles of Young People's Participation:*
Outlines key principles to guide adolescent engagement ([Annex B](#))
- *Basic Requirements for Planning Young People's Participation and Engagement:*
This checklist helps implementers plan for adolescent engagement and can be created by adapting or using the table's requirements ([Annex C](#))
- *Key Actions to Increase Young People's Engagement in Programming:*
This resource outlines the steps needed to increase youth engagement in the programming cycle as well as in the interagency humanitarian programming process ([Annex D](#))

There are several models for meaningful adolescent and community participation that could be adapted for use in humanitarian settings, as described earlier in CARE's Vijana Juu project. Many of these program models help guide groups of adolescents, community members, and health providers through an iterative process aimed at identifying barriers and enablers to ASRH in their communities; developing and implementing actions to address them; and creating adult-youth partnerships to advance ASRH goals. Each of these tools include an overview of the program framework, as well as a facilitator guide with instructions for different program activities. Program managers should ensure adequate resources, time, and appropriate staffing are available to effectively implement all program activities.

Some examples of meaningful participation models include:

- [Partnership Defined Quality for Youth](#)
- [The Community Score Card](#)
- [Participatory Action Research for ASRH](#)
- [Youth Participation Guide: Assessment, Planning and Implementation](#)



Photo : Souvid Datta



CHAPTER 4: PRIORITY ASRH IN EMERGENCIES ACTIVITIES

The next step on the Toolkit roadmap is Priority Adolescent Sexual and Reproductive Health (ASRH) in Emergencies Activities, which provides guidance on how to implement the [Adolescent-Inclusive Minimal Initial Service Package for Sexual and Reproductive Health in Crisis Situations](#) (MISP). The Adolescent-Inclusive MISP outlines the critical sexual and reproductive health (SRH) activities that humanitarians should prioritize in emergency settings to address adolescents' unique needs. These activities should be implemented from the onset of an emergency through to the recovery phase.

Chapter 4: Learning Objectives

After reading this chapter, readers should be able to:

- Provide examples of adolescent-inclusive SRH activities from each of the six MISP objectives
- Describe the key priority action of the MISP—the provision of safe abortion care for adolescents

Let's talk about the MISP

The MISP is a coordinated set of priority life-saving activities that aim to prevent mortality, morbidity, and disability in crisis-affected populations by preventing and responding to sexual violence, reducing Human Immunodeficiency Virus (HIV) transmission, preventing unintended pregnancies, and transitioning to more comprehensive SRH services for the recovery phase or during chronic or protracted crisis situations. The MISP is the international standard of care that outlines the humanitarian response to the SRH needs of populations, including adolescents, at the onset of an emergency (within 48 hours, wherever possible). All MISP activities must be implemented simultaneously through coordinated actions with all relevant partners.

The MISP is a part of the [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings](#) (IAFM)—the authoritative source that provides guidance on SRH service provision during different phases of a humanitarian disaster. The IAFM was last updated in 2018, along with the MISP—[Chapter 3 of the IAFM](#)—in 2019. The MISP is also a health standard within the 2018 [Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response](#). When implemented from the onset of a crisis, **the MISP saves lives and prevents illness, especially among women and girls.**

The six objectives of the MISP are:

1. Ensure the health sector/cluster identifies an organization to lead implementation of the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce the morbidity and mortality due to HIV and other sexually transmitted infections (STIs).
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the health sectors/cluster partners to address the six health system building blocks.

Other priority activity: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

ANOTHER MISP PRIORITY ACTION: Safe Abortion Care

Making safe abortion care available is critical to saving the lives of women and adolescent girls in fragile settings. In humanitarian crises, adolescent girls experience significant burdens, barriers, and restrictions to accessing safe abortion care. In turn, this creates a perfect storm for adolescent girls to resort to unsafe abortion, delay seeking help for abortion-related complications, and delay accessing services later in pregnancy. As mentioned in [Chapter 1: Introduction](#), the high number of adolescent girls who continue to resort to unsafe abortions makes it critical to ensure that they, regardless of marital status, have access to safe abortion care.

The MISP includes safe abortion care as another priority activity and recommends safe abortion care to the full extent of the law. Post-abortion care remains a signal function of emergency obstetric and newborn care (EmONC), which requires the timely and appropriate management of unsafe and spontaneous abortion (post-abortion care) for all women and girls.



As outlined in [Objective 4 of the MISP](#), the 2018 IAFM explicitly references safe abortion care and provides updated guidance on the provision of safe abortion care at the onset of a crisis, which include:



To respond to the needs of sexual assault survivors.

- Survivors are entitled to: pregnancy testing, pregnancy-options counseling, and safe abortion care to the full extent of the law



To the full extent of the law as another “SRH Priority”:

- When capacity exists, access to safe abortion care should be facilitated *from the onset of an emergency*
- When capacity does not exist, safe abortion care should be made available when MISP priority activities are underway

For detailed technical and clinical guidance on providing safe abortion care, refer to the MISP and IAFM manual.



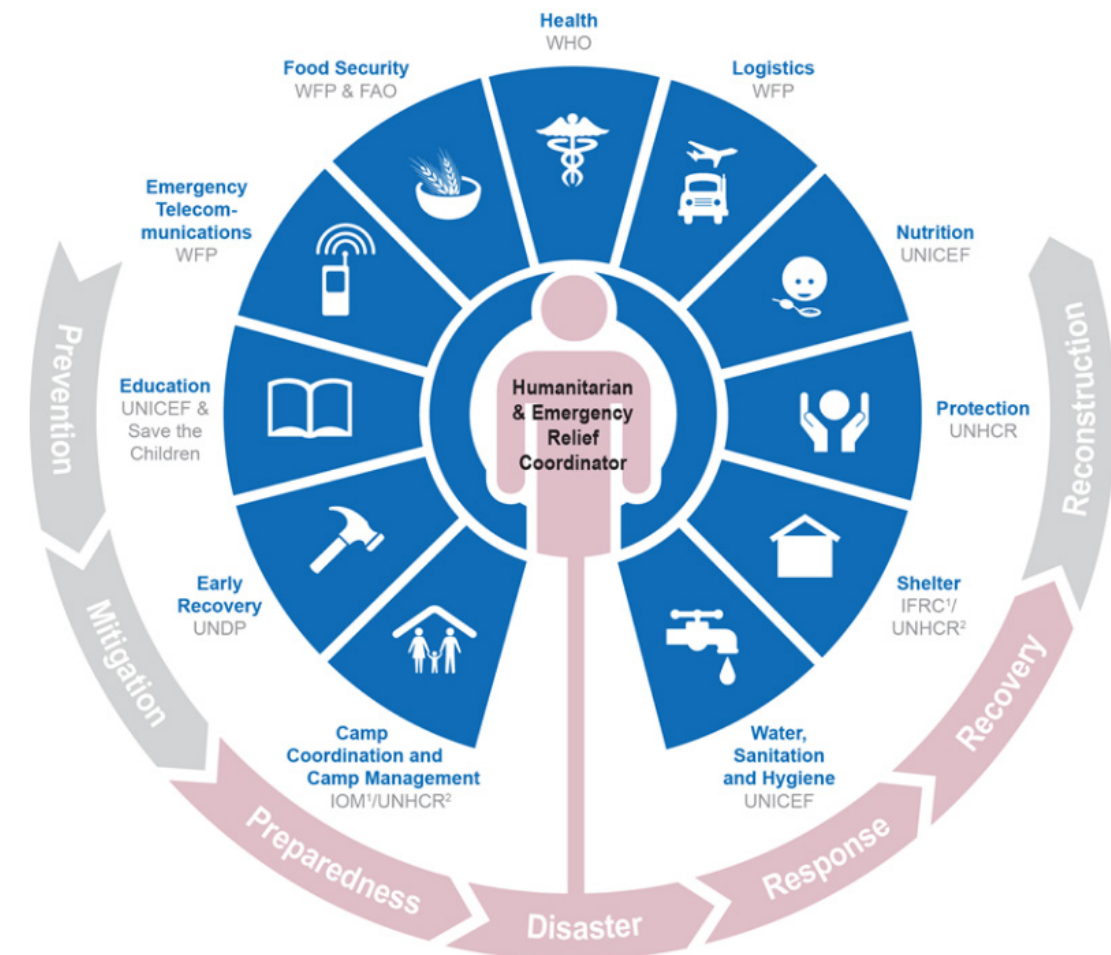
How does the MISP work with the overall health response?

Delivering comprehensive SRH services to a crisis-affected population is the health sector's overarching goal and aim of the SRH response during an emergency. However, the nature of emergencies makes this challenging. In many humanitarian contexts, the population's access to many, if not all, of their basic survival needs—food, sanitation, security, shelter, and water—for their health and well-being are disrupted. Limited resources also further compound the situation for the crisis-affected population. This means that some activities must be prioritized sooner than others to prevent morbidity and mortality. The MISP is a vital resource for humanitarian responders in that it defines which SRH services are most crucial to saving lives as soon as a disaster strikes; it also includes recommendations on how to transition from the MISP to comprehensive SRH services for the recovery phase or during chronic or protracted crisis situations.

CLUSTER APPROACH

The health sector must work with other sectors to ensure crisis-affected populations receive the SRH information and services they need (discussed further in [Table 3](#) under MISP Objective 1). To better understand how the sectors function together, please see [Figure H: Cluster Approach](#). In 2005, the Humanitarian Reform Agenda was established and introduced a number of new elements to improve predictability, accountability, and partnership. The Cluster Approach was one of these new elements. Clusters are groups of humanitarian organizations, both UN and non-UN, in each of the main sectors of humanitarian action (eg education and health). They are designated by the Inter-Agency Standing Committee (IASC) and have clear responsibilities for coordination. The aim of the Cluster Approach is to strengthen system-wide preparedness and technical capacity to respond to humanitarian emergencies and provide clear leadership and accountability in the main areas of humanitarian response. At country level, it aims to strengthen partnerships and the predictability and accountability of international humanitarian action by improving prioritization and clearly defining the roles and responsibilities of humanitarian organizations with the host country. Please see the figure below for a visual representation of all of the sectors and how they work under the Humanitarian and Emergency Relief Coordinator throughout all phases of the emergency. For more information on each of the sectors, visit the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) website [here](#).

Figure H: Cluster Approach



While not all actors of the humanitarian system are included in this figure (eg government, line agencies within the UN, civil society actors, non-governmental organizations), these entities are considered essential partners for ensuring robust system-wide preparedness and that response interventions are implemented at the onset of a crisis.

Why do we need an adolescent-inclusive MISP?

While the MISP chapter of the IAFM recognizes the importance of adolescent-inclusive approaches for implementing the MISP, it does not address all the needs of adolescents, nor does it provide guidance on how to do so—enter the ASRH Toolkit for Humanitarian Settings. The ASRH Toolkit for Humanitarian Settings: 2020 Edition is a companion to the revised IAFM and MISP, providing practical tools and resources on implementation of the MISP. The Adolescent-Inclusive MISP ensures that even during emergencies we provide adolescent-friendly services. The Adolescent-Inclusive MISP has tailored activities, specific to the SRH needs of adolescents, beginning in this chapter and extending through the rest of the Toolkit.

The below table provides the key SRH activities, organized by the six objectives of the MISP, as well as implementation considerations for providing adolescent-inclusive SRH programming (**bolded**) based on guidance from the [2012 ASRH Toolkit for Humanitarian Settings](#), the [2018 IAFM](#), and humanitarian organization experience.

Table 3: Adolescent-Inclusive SRH Activities: During the MISP

MISP Activities & ASRH Implementation Considerations
<p>Objective 1: Ensure the health sector/cluster identifies an organization to lead implementation of the MISP</p> <p>The lead SRH organization:</p> <ul style="list-style-type: none"> Nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services <ul style="list-style-type: none"> Orient SRH Coordinator to ASRH needs and services Hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP <ul style="list-style-type: none"> Ensure adolescents and/or youth are included in coordination meetings and decision-making Leverage existing adolescent and youth networks to engage adolescents and youth, as well as local organizations, in stakeholder meetings Reports back to the Health Cluster, Gender-Based Violence (GBV) Sub-Cluster, and/or HIV national coordination meetings on any issues related to MISP implementation <ul style="list-style-type: none"> Advocate with Health Cluster to ensure ASRH services and information are accessible to adolescents during MISP implementation In tandem with health/GBV/HIV coordination mechanisms, ensures mapping and analysis of existing SRH services <ul style="list-style-type: none"> Advocate with Health Cluster to ensure adolescents' SRH needs are included in rapid needs assessments (See Initial Rapid Assessment [IRA] under <i>Chapter 7: Data for Action for more guidance and a link to the annexed IRA tool</i>) Shares information about the availability of SRH services, information, and commodities <ul style="list-style-type: none"> Coordinate with other organizations to identify adolescents at increased risk and ensure that they have access to reproductive health services <ul style="list-style-type: none"> For example, coordinate with the Health Cluster and other sectors to identify pregnant adolescents in the community and link them to health services Map ASRH stakeholders and services and share information among SRH partners to avoid duplication of services and ensure SRH coverage for all adolescent populations (See Risk and Resource Mapping under <i>Chapter 7: Data for Action for more guidance and tools</i>) Ensures the community is aware of the availability and location of reproductive health services <ul style="list-style-type: none"> Strategize with community members and/or adolescents and youth organizations and networks on communication channels to reach adolescents at onset of emergencies (See Community-Based Services & Outreach Platforms under <i>Chapter 6: ASRH Services & Interventions for more guidance and tools</i>)

Objective 2: Prevent sexual violence and respond to the needs of survivors

- Work with other clusters, especially the Child Protection or GBV Sub-Cluster, to put in place preventative measures at community, local, and district levels—including at health facilities—to protect affected populations, particularly women and girls, from sexual violence
 - Develop close coordination with child protection to ensure needs of sexual violence survivors, including adolescent boy survivors, are recognized and adequately responded to**
- Make clinical care and referral to other supportive services available for survivors of sexual violence (eg child protection, GBV, safe abortion care services, etc)
 - Provide adolescents with information about what SRH services are available and where they can be accessed**
 - Engage community health workers (CHWs) to link adolescent survivors of sexual violence to SRH and health services**
- Put in place confidential and safe spaces within the health facilities to receive survivors of sexual violence and provide them with appropriate clinical care and referral
 - Provide adolescent-friendly care and safe abortion services if desired for adolescent survivors of sexual violence at health facilities**

So, what is GBV?

Definition of GBV

The IASC defines gender-based violence, or GBV, as:

An umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed differences between males and females.

There are also different forms of violence: (1) sexual; (2) physical; (3) harmful traditional practices; (4) socio-economic; and (5) emotional and psychological. A root cause of GBV includes unequal power between the genders, where violence and oppression is used against someone because of prescribed roles and perceptions applied to that gender. As discussed, women and girls are most at risk of experiencing GBV in every context due to their perceived inferior status in the gender hierarchy, resulting in systemic gender inequality and the power and advantages experienced by men and boys globally. While GBV affects men, women, girls, and boys, the majority of abuses are carried out against women and girls, and the perpetrators against women, girls, men, and boys are disproportionately men.

It is important to remember that survivors of sexual violence can be of any sex, gender, or age, including women; men; adolescents; people with disabilities; young children; lesbian, gay, bisexual, transgender, queer, intersex, asexual+ (LGBTQIA+) people; ethnic and religious minorities; and people who are sexually exploited and/or who sell or exchange sex, among others. However, as emphasized above, women and children are most affected. Sexual violence perpetrators are often male intimate partners or others known to survivors (family, friends, or community members) or might be individuals in uniform, such as security or peacekeeping forces and combatants.

Select forms of sexual violence:

Rape	Sexual slavery and/or trafficking	Sexual harassment, indecent assault	Female genital mutilation or cutting	Child, early, and forced marriage, as well as levirate marriage
Sexual exploitation and/or abuse	Forced pregnancy, forced abortion, sterilization	Strip searches	Incest	

Objective 3: Prevent the transmission of and reduce the morbidity and mortality due to HIV and other STIs

- Establish safe and rational use of blood transfusions
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms and, where applicable (eg already used by the population), ensure provision of female condoms
 - **Provide adolescents with information about what STI services are available and where they can be accessed**
 - **Promote the use of dual protection methods (prevention of pregnancy and prevention of STIs, including HIV) for adolescents**
- Support the continued provision and adherence of antiretroviral (ARV) treatment for people who were enrolled in an antiretroviral therapy (ART) program prior to the emergency, including women and girls who were enrolled in Prevention of Mother-to-Child Transmission (PMTCT) programs
 - **Ensure adolescents have continued access to ART and provide post-exposure prophylaxis (PEP) to adolescent survivors of sexual violence as appropriate and for occupational exposure**
 - **Ensure ART adherence support activities are available for adolescents**
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs
 - **Ensure that adolescent-friendly health services are available for adolescents presenting to facilities with symptoms of STI**

(See [Counseling Tools & Resources](#) under Chapter 6: ASRH Services & Interventions more guidance and tools)

Objective 4: Prevent excess maternal and newborn morbidity and mortality

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and life-saving EmONC services, including:
 - At referral-hospital level: Ensure availability of skilled medical staff and supplies for provision of comprehensive EmONC (CEmONC) to manage complications
 - **Encourage facility-based delivery for all pregnant adolescents and provide them with information about what SRH services are available and when and where they can be accessed**
 - At health-facility level: Ensure availability of skilled birth attendants and supplies for uncomplicated vaginal births and provision of basic EmONC
 - At community level: Provision of information to the community regarding the availability of safe delivery and EmONC services and the importance of seeking care from health facilities
 - **Clean delivery kits should be provided to visibly pregnant adolescents, as well as to birth attendants to promote clean home deliveries when access to a health facility is not possible**
 - **Raise community awareness about the risks of adolescent pregnancy, danger signs in pregnancy, and the importance of skilled birth attendants and facility-based delivery for adolescent mothers**
 - **Engage trained birth attendants (TBAs) and CHWs to link pregnant adolescents and mothers to health services**

- Establish a 24-hour, 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital
 - **Engage TBAs and CHWs to link pregnant adolescents to health services**
 - **Provide pregnant adolescents with information about what SRH services are available and when and where they can be accessed**
- Ensure the availability of life-saving post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable

Objective 5: Prevent unintended pregnancies

- Ensure availability of a range of contraceptive methods (including long-acting reversible contraceptives [LARCs], male and female condoms, and emergency contraceptives) at primary health care facilities to meet demand
 - **Emphasize that all contraceptive methods, including LARC methods, are safe and effective for adolescents**
 - **Ensure service providers are fully aware of local policies to offer adolescents a full range of contraceptive methods to the full extent of the law**
- Provide adolescents with information, including existing information, education, and communication (IEC) materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, patient privacy and confidentiality, equity, and non-discrimination
 - **Health staff should be aware that adolescents requesting contraceptives have a right to receive these services, regardless of age or marital status, in accordance with local laws and policies** (See [Counseling Tools & Resources](#) and [Facility-Based Services](#) under Chapter 6: ASRH Services & Interventions for more guidance and tools regarding privacy, confidentiality, equity, non-discrimination, and the [Principle of Capability](#))
- Ensure the community is aware of the availability of contraceptives for women, adolescents, and men
 - **Promote the use of dual protection methods (prevention of pregnancy and prevention of STIs, including HIV) for adolescents**

Other Priority Activities: Safe abortion care

- Ensure availability of at least one World Health Organization (WHO)-recommended safe abortion method (surgical or medical management), specifically manual vacuum aspiration, or mifepristone and misoprostol, or misoprostol only, at all facilities
 - **Ensure at least one trained provider is available to provide adolescents with counseling and safe abortion care services with at least one WHO-recommended method and post-abortion contraceptive services**
 - **Safe abortion care should be provided to adolescents in accordance with local laws and providers should not impose additional barriers for adolescents to access safe abortion care**
- Establish a referral system for abortion cases to facilitate transport and communication from the community to the health center and hospital
 - **Engage TBAs, CHWs, and adolescent champions to link adolescents seeking abortion services to the health facility**
- **Inform community leaders and adolescents regarding the availability of safe abortion services for women and adolescent girls**
- **Conduct outreach activities and distribute IEC materials that outline the national laws and policies related to safe abortion care and consent for adolescents**

Objective 6: Plan for comprehensive SRH services, integrated into primary health care as soon as possible.

Work with the health sector/cluster partners to address the six-health system building blocks.

When planning for comprehensive SRH services, collaborate with all stakeholders to carry out the below activities. This list provides examples of what should be assessed and planned for in each of WHO's six health system building blocks; it is not an exhaustive list. To begin working with health sector/cluster partners in addressing the six health system building blocks, please refer to the section below on how to transition to comprehensive SRH care.

Service Delivery

- Identify SRH needs in the community
 - **Including the needs of adolescents and youth, particularly those from sub-groups that are at increased risk and with unique SRH needs (such as indigenous populations, adolescents living with HIV/AIDS, etc)**
- Identify suitable sites for SRH service delivery
 - **Recognize the importance of privacy and confidentiality for adolescents when identifying sites**

Health Workforce

- Assess staff capacity to deliver SRH services
 - **Including staff capacities to counsel and provide SRH services and information to adolescents and youth (eg family planning, safe abortion care, and clinical management of rape)**
- Identify staffing needs and levels
 - **Including observing staff attitudes and biases toward providing SRH services and information to adolescents**
- Identify and hire local staff from members of the host community, as well as from the affected community who have skills and experience to provide quality contraceptive services
 - **If possible/feasible, hire male and female staff with appropriate skills and experience to allow patients to choose their preferred provider**

(See [Counseling Tools & Resources](#) under *Chapter 6: ASRH Services & Interventions* more guidance and tools)

Health Information System

- Include SRH information in the health information system
 - **Advocate for and identify approaches to integrate age- and gender-disaggregation of data**

Medical Commodities

- Identify SRH commodity needs
 - **Examine SRH commodity needs of adolescents to better anticipate stock shortages and ensure availability of commodities for crisis-affected adolescents (eg ARV medications, clean delivery kits, and abortion commodities)**

Financing

- Review SRH-related laws, policies, and protocols
 - **Begin discussions with adolescent/youth organizations to understand financial barriers and opportunities**

Governance and Leadership

- Review SRH-related laws, policies, and protocols
 - **Examine how perceptions of SRH services for adolescents affect providers' ability/delivery of SRH services for adolescents**
- Coordinate with the respective Ministry of Health (MOH)
 - **Begin discussion with MOH on adolescent strategies**

- Engage communities in accountability
 - **Discuss opportunities to bring adolescents/youth and community members together to talk about SRH needs, barriers, and opportunities for adolescents to receive the services they need**

How do we transition to comprehensive SRH services?

The MISP not only includes ways to implement life-saving services, it also outlines how to address comprehensive SRH as soon as possible. As displayed in [Objective 6](#), humanitarian responders should begin implementing activities to prepare for comprehensive SRH care during the initial emergency phase. The MISP recommends that as soon as possible (ideally within three to six months, but it could be within weeks), national and international organizations and stakeholders should work toward providing comprehensive SRH services. The intent of transitioning to comprehensive SRH is to “build back better” by working with local actors to reinforce resiliency at all levels of the [Social-Ecological Model](#) for ASRH programming; for example, SRH managers can invest in adolescents' capacity to implement SRH/MISP activities and serve as first responders in new emergencies as part of protracted crises responses, recovery and reconstruction strategies, and preparedness efforts. For more information on “building back better”, please see the [Ready to Save Lives: SRH Care in Emergencies](#) preparedness toolkit. Humanitarian responders should maintain and strive to improve the quality of MISP clinical services established during the initial emergency response, in addition to enhancing those services with other comprehensive SRH services and programming provided throughout protracted crises, recovery, and reconstruction.

As the situation stabilizes, the MISP calls for humanitarian actors to work with community members to fully address the six [WHO Health System Building Blocks](#). Humanitarian actors may have the resources to begin implementing some of the comprehensive ASRH activities earlier than others and/or at the same time as they are implementing priority MISP activities included in [Table 3](#). The ability to plan and begin implementation of comprehensive ASRH activities depends on the context, capacity, and resources of the government and local partners, and prior preparedness efforts and experience with humanitarian emergencies.

IMPLEMENTATION CONSIDERATION**Emergencies in Countries with Established Health Systems**

The IAFM calls for humanitarian responders to work within the local, host community, and national health system. If the context has pre-existing mechanisms and functional health operations, utilize them. Do not reinvent the systems or processes. Whenever possible, use existing resources and strengths of the country's health system. For example, during the refugee response effort in Greece, humanitarian responders utilized hospitals and specialists to deliver services to populations affected by the humanitarian crisis. It was not necessary to train staff on how to provide these services, as the health workforce capacity was already present. Similarly, as part of the Venezuelan response in Colombia, social workers have been a part of the humanitarian response—allowing humanitarian responders to use their technical expertise to deliver mental health assistance to affected populations, among other services.

The Adolescent-Inclusive MISP is a minimum and essential set of life-saving interventions for humanitarian practitioners to implement from the onset of an emergency and along the entire humanitarian continuum. The next chapter of the roadmap, [Chapter 5: Going Beyond Health Services](#), provides guidance on how SRH managers can deliver holistic ASRH programming for adolescents in humanitarian contexts.



CHAPTER 5: GOING BEYOND HEALTH SERVICES

This chapter describes how to provide adolescent sexual reproductive health (ASRH) programming that looks at all levels of the Social-Ecological Model and integrates sexual and reproductive health (SRH) activities and information across multiple humanitarian sectors.

Chapter 5: Learning Objectives:

After reading this chapter, readers should be able to:

- Provide examples of activities that address the individual, interpersonal, community, and structural influences affecting adolescents' ability and decision to seek and use SRH services in emergency settings

In addition to meaningfully engaging adolescents and community members in implementing the Adolescent-Inclusive Minimum Initial Service for SRH in Crisis Situations (MISP), which focuses largely on provision of services, SRH managers should be thinking about how the multiple levels of the Social-Ecological Model affect adolescents' access to and use of SRH services and information. This also requires SRH managers to think beyond health services—or sector-specific programming—and adopt a holistic lens to address the unique needs of the adolescent. Multi-sectoral guidance and activities are discussed further in Chapter 6: ASRH Services & Interventions in the [Building Multi-Sectoral Linkages](#) section.

What is a holistic lens?

A holistic lens seeks to address the needs of the "whole" person, not just those identified by health staff themselves. It means humanitarian practitioners are also taking notice of other factors that impact adolescents' ability to get the services and information they need, not just at the health facility but in their environment. To understand what these factors are, SRH managers need to talk to adolescents themselves, as well as family and community members, service providers and community health workers, other health partners, and humanitarian responders working in other sectors. These conversations will reveal obstacles that health and SRH managers can overcome with SRH programming and those that require multi-sectoral engagement. By strengthening program linkages, referral pathways, and coordination mechanisms, SRH and health managers can address the full range of barriers affecting SRH information and service provision for adolescents. This multi-sectoral approach helps avoid duplication of efforts, prevent gaps in ASRH service delivery, and opens up opportunities for identifying and providing SRH information and services to hard-to-reach adolescents.

Recalling the [Social-Ecological Model](#) from Chapter 1: Introduction, adolescents in humanitarian settings experience setbacks and opportunities at the individual level, among their relationships, within their communities, and in the structural environment (laws, policies, systems) that surrounds them. Adopting a holistic lens allows humanitarians to see a more complete picture of adolescents' barriers, needs, and capacities. They can use this holistic lens when discussing the design, implementation, and monitoring and evaluation of ASRH activities and programming with adolescents, health providers, community members, other humanitarian staff, development staff, civil society members, and government agencies. This ensures all people involved in ASRH activities are working together toward a common goal of providing holistic ASRH programming.

Descriptions of the influences and barriers at each social-ecological level, as well as the Toolkit's recommended response to those factors, are outlined in Figure I and Table 4. [Figure I](#) provides a visual of how all of the social-ecological levels—individual/adolescent, interpersonal, community, and structural—fit together and impact access and use of SRH services and information by adolescents, who are at the center of the figure.

[Table 4](#) provides more details on each of these levels and helps explain how SRH managers can work with other ASRH stakeholders—including other humanitarian sectors—to overcome the barriers, anticipate needs, deliver services, and ultimately improve SRH outcomes for adolescents in humanitarian settings.

Just as humanitarians should be planning to transition to comprehensive SRH services from the start of an emergency, they should also be thinking about how to respond to adolescents' SRH needs beyond the health facility early in the response. In the following chapters ([Chapter 6: ASRH Services & Interventions](#), [Chapter 7: Data for Action](#), and [Chapter 8: Manager Guidance Notes & Tools](#)), the Toolkit provides further guidance on how to operationalize the concept of holistic programming. Plan International also recently released the [Adolescent Programming Toolkit](#)—a toolkit, based on past experiences and research and consultations with adolescents, that sets out strategies to address the needs, risks, and barriers of adolescents along the Social-Ecological Model, with particular attention to girls and at-risk adolescents. Plan's toolkit also identifies the results necessary for adolescents, families, communities, and society to achieve our desired impact: a world in which adolescents learn, lead, decide, and thrive—before, during, and after emergencies and protracted crises.



Figure I: Holistic ASRH Programming Along the Social-Ecological Model

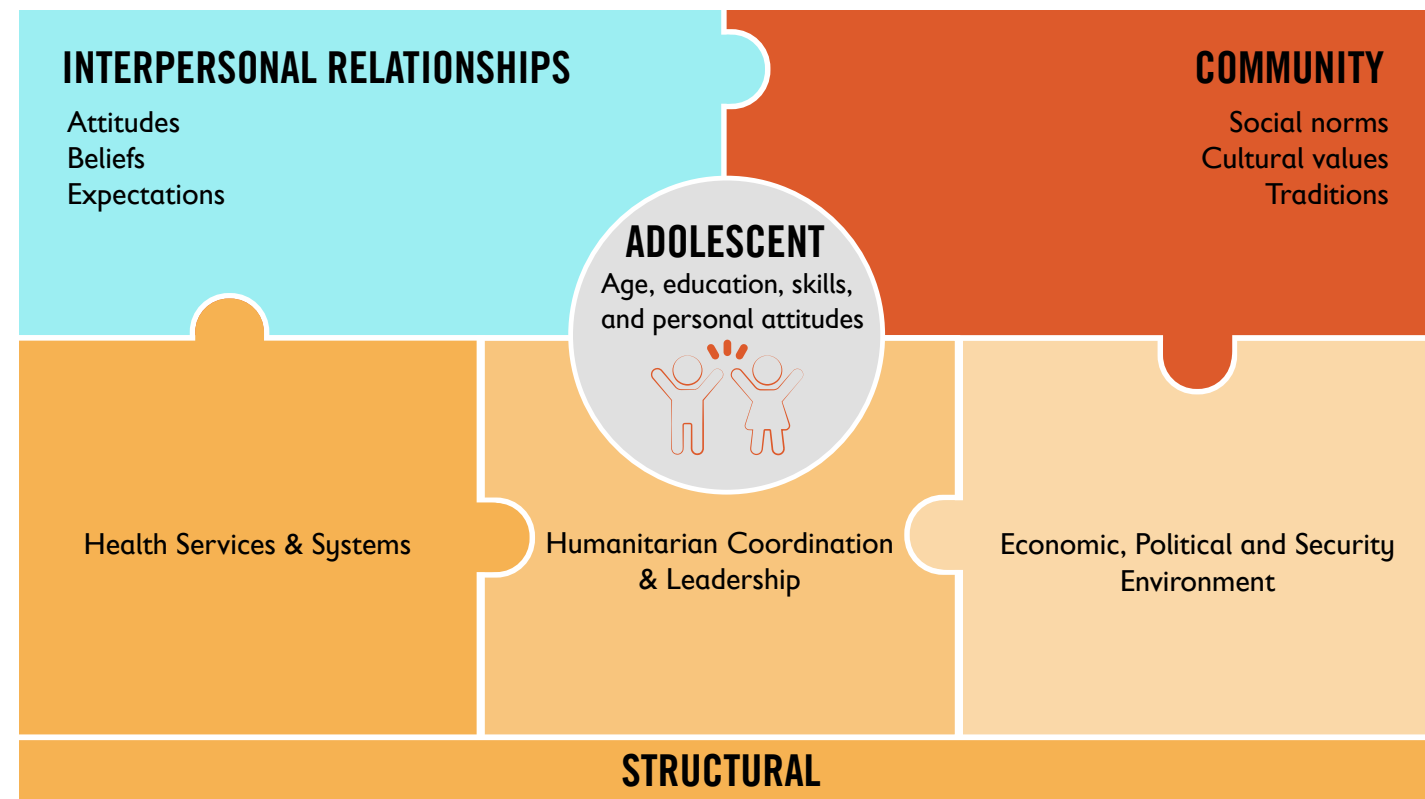


Table 4 provides more details on each of these levels and helps explain how health managers can work with other ASRH stakeholders to overcome the barriers, anticipate needs, deliver services, and ultimately, improve SRH outcomes for adolescents in humanitarian settings.

Table 4: Holistic ASRH Programming Along the Social-Ecological Model

SOCIAL-ECOLOGICAL SPHERE	
DESCRIPTION	RESPONSE
Factors at all levels of the Social-Ecological Model that may enable or restrict their access to SRH information and services.	Sample activities, beyond providing health services, to mitigate risks, overcome barriers, and improve access to SRH information and services for adolescents.
ADOLESCENTS	
DESCRIPTION	RESPONSE
At the individual level, biological and personal attributes of adolescents affect their ability and decision to seek and use SRH services and information. This includes their age, education or knowledge, skills, income, past experiences (and/or trauma), attitudes, beliefs, behaviors, and motivations (goals, ambitions).	<ul style="list-style-type: none"> Conduct needs assessments and/or focus group discussions with adolescents from subgroups at increased risk (such as very young adolescents [VYAs], adolescents with disabilities, etc) to understand their unique needs and barriers. See Chapter 1: Introduction for more information on adolescents from subgroups at increased risk. Work with adolescents to develop age-appropriate and adolescent-friendly information, education, and communication (IEC) materials that provide information on questions they are posing or knowledge they are seeking. Provide adolescents with sexuality education and dialogue opportunities, such as during puberty initiation rites, to gain knowledge, explore values, and build skills concerning their SRH and rights, including understanding how and when to seek SRH services.

SOCIO-ECOLOGICAL SPHERE

INTERPERSONAL RELATIONSHIPS

DESCRIPTION

The relationships adolescents have with others affect their ability, motivation, and decision to seek and/or receive SRH services. This includes the opinions, expectations, attitudes, and beliefs of the adolescent's family members/guardians, his or her peers, and in some cases his or her spouse.

For example, if other peers have had a negative experience with a humanitarian organization, it may dissuade the adolescent from seeking any SRH services at that organization's program sites.

RESPONSE

- Assist with forming peer groups to have adolescents support each other and identify needs/barriers to SRH service provision (these could focus on certain subgroups, such as VYAs or adolescent mothers).
- Develop interventions to bolster adult-adolescent relationships, including adolescent-parent communication, and provide education on SRH in a safe environment for the adolescent (such as at an education center, other program site, or community member's home). See [Chapter 3: Meaningful Participation](#) for more guidance and tools on conducting meetings with parents.
- Include opportunities to discuss topics concerning relationships, including sexual relationships and sexual consent, in sexuality education initiatives and life-skills trainings.

SOCIO-ECOLOGICAL SPHERE

COMMUNITY

DESCRIPTION

The community and social environment (including social norms, cultural values, and traditions) surrounding adolescents affect their ability and decision to seek or receive SRH services. This includes the opinions, expectations, attitudes, and beliefs of informal and formal community leaders, religious leaders, and informal and formal youth leaders.

For example, if the religious leader is opposed to discussing contraception in their community, this impedes adolescents from accessing SRH information and may hinder them from seeking services.

RESPONSE

- Utilize alternate points of entry ([Community-Based Services & Outreach Platforms](#) and [Building Multi-Sectoral Linkages](#)) to conduct community interventions.
- For example, implement participatory reflection and dialogue processes that use drama, games, and videos to advance changes in attitudes and norms.
- Facilitate community dialogues led by trained facilitators. See [Chapter 3: Meaningful Participation](#) for more guidance and tools on conducting meetings with community members.
- Identify, support, and promote ASRH champions in the community (such as religious leaders).

SOCIO-ECOLOGICAL SPHERE

STRUCTURAL: Health Services & Systems

DESCRIPTION

This level includes factors that affect the adolescent's experience at the health facility or clinic, such as the cost of services. Adolescents in humanitarian settings are likely to have limited financial means to take care of themselves and/or are required to take on the responsibility of also taking care of their family. Cost should not be a barrier for them to access services.

Other questions that might be asked at this level include: Was the facility welcoming? How did the provider treat the adolescent? Does the facility have the services/commodities they need?

RESPONSE

- Provide cash and voucher assistance for adolescents and/or link them with income-generating activities.
- Engage with the health sector to improve quality of service provision. See [Chapter 6: ASRH Services & Interventions](#) for more examples of how to overcome barriers at this level.

STRUCTURAL: Humanitarian Coordination & Leadership

DESCRIPTION

The capacities of government agencies, local partners, and humanitarian actors to coordinate effectively at national and subnational levels and to respond to the emergency also affects adolescents' ability and decision to seek care and make free and informed choices about their SRH and rights. This includes any preparedness efforts they have completed prior to the onset of the emergency and/or the strengthening of the country's health system to deliver SRH services. This level also looks at how well health services are integrated within the response (with other sectors), as well as how well the humanitarian health organizations coordinate with one another to refer services.

For example, are health staff working with non-health staff to provide other entry points for adolescents to access SRH information and services?

RESPONSE

- Include and empower adolescents, including integrating adolescent and youth networks and organizations, in government leadership bodies, coordination mechanisms, and humanitarian decision-making, such as meetings/inputs for the Humanitarian Needs Overview and Humanitarian Response Plans.
- Strengthen linkages between sectors, including prioritizing referrals and integration with education, mental health and psychosocial support (MHPSS), and child protection sectors. As well, highlight the particular needs of adolescents across the humanitarian response during coordination meetings.
 - For example, provide sexuality education, including about menstrual health, puberty, and Human Immunodeficiency Virus (HIV) and post-exposure prophylaxis to adolescents through education centers, child protection safe spaces, and other supported sites. See the [Menstrual Hygiene Management \(MHM\) in Emergencies Toolkit](#) from the International Rescue Committee for additional guidance on implementing MHM in humanitarian contexts.
 - With the Child Protection Cluster and Gender-Based Violence (GBV) Sub-Cluster, identify and/or establish referral and complaint mechanisms, such as a multi-sectoral referral network for young survivors of GBV and adolescent-friendly complaint mechanisms for sexual exploitation and abuse.
 - Work with national authorities, affected community, and (where appropriate) camp management experts to identify possible new sites to deliver comprehensive SRH services (eg sexually transmitted infection [STI] outpatient rooms).

See other examples provided in [Building Multi-Sectoral Linkages](#).

STRUCTURAL: Economic, Political & Security Environment

DESCRIPTION

Finally, laws, policies, and mandates affect ASRH information and service provision in the country, including economic conditions (eg if the government can afford to make SRH services free for adolescents or not) and security conditions (how safe are the roads and paths for adolescents to travel to facilities and/or humanitarian program sites).

This level also looks at how development and humanitarian actors work together in planning for comprehensive SRH services, as well as early recovery, resiliency, and stabilization efforts.

RESPONSE

- Work with national leadership to identify where existing policies, guidelines, and protocols do not support SRH and rights or meet international standards and work to address them.
 - Train national trainers on ASRH.
 - Advocate to liberalize policies for adolescents to access SRH services. For example, expand policy waivers for refugee adolescents to have access to contraception with or without their parent's/guardian's consent.
- Continue engaging government entities on ASRH to ensure national leadership, ownership, and accountability.
 - Work with local partners and government agencies to facilitate citizen monitoring of subnational budgets to ensure sufficient resources are dedicated to ASRH services.
 - Advocate with leadership of uniformed services (police, military) for establishment and enforcement of zero-tolerance policies for GBV.
 - Train law enforcement personnel and uniformed persons on protection of adolescents in emergencies.
- Strengthen regional platforms that link to national and subnational representation of youth.
 - For example, the [Ouagadougou Partnership](#) (initiative that brings together nine governments of West Africa to accelerate progress in using family-planning services) has youth ambassadors as part of its coalition who work with community leaders, religious leaders, and government officials in building stronger communities and reducing the number of pregnancy-related deaths among youth.



CHAPTER 6: ASRH SERVICES & INTERVENTIONS

The next step in the Toolkit's roadmap discusses adolescent sexual and reproductive health (ASRH) services and interventions. This chapter provides guidance on how to implement the priority ASRH activities outlined in [Chapter 4](#)—as well as additional ASRH services and interventions—with a holistic lens that addresses different levels of influence along the [Social-Ecological Model](#). This chapter aligns with the [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings](#) (IAFM), guiding sexual and reproductive health (SRH) managers and humanitarian practitioners on how to train and build the capacity of staff, deliver facility-based services, foster community-based services, utilize outreach platforms, and ensure multi-sectoral linkages and referral pathways.

Chapter 6: Learning Objectives

After reading this chapter, readers should be able to:

- Explain how a health facility's characteristics impact adolescents' decision to seek and receive SRH services
- Highlight the importance of training health and non-health staff on ASRH services and how to work with adolescents
- Identify proven approaches, tools, and platforms for service providers, community health workers (CHWs), and other staff to provide SRH services to adolescents at the health facility and within the community
- Provide examples of how to integrate SRH services for adolescents into other clusters/sectors (outside of the health sector)
- Describe how to make referrals across humanitarian sectors for adolescent clients

[Chapter 4: Priority ASRH in Emergencies Activities](#) includes an overview of the necessary activities humanitarian responders should provide from the onset of an emergency. Chapter 6 demonstrates how to put those activities into practice by showing responders how to train staff on ASRH service and program delivery, implement those activities at the facility and community levels, and work with other sectors to address the full range of SRH needs of adolescents. As discussed in previous chapters, SRH preparedness is an important foundation in the humanitarian continuum. The [Ready to Save Lives: SRH Care in Emergencies](#) preparedness toolkit guides humanitarian responders on actions to undertake that, at a minimum, will ensure timely and quality provision of essential SRH services from the onset of an emergency.

What makes a successful ASRH intervention?

In line with IAFM standards and the [Global Standards for Quality Health-Care Services for Adolescents \(Annex A\)](#) from the World Health Organization (WHO), humanitarian health staff should be implementing an appropriate package of ASRH services at well-stocked and welcoming facilities and other entry points with competent staff and in collaboration with community stakeholders and adolescents themselves. These characteristics follow current evidence that indicates successful ASRH programs are those that focus on and/or utilize the following elements:

1. [Adolescent-Friendly Services](#)
2. [Training & Capacity Building of Staff](#)
3. [Facility-Based Services](#)
4. [Community-Based Services & Outreach Platforms](#)
5. [Multi-Sectoral Linkages & Referral Pathways](#)

This chapter is organized by these five WHO and IAFM elements of successful ASRH programming.

Where's the evidence?

An evidence review in 2015 showed an increase in ASRH service use by implementing three complementary approaches:

- Training health staff to provide non-judgmental and responsive services to adolescents
- Providing consistent communication and outreach activities to adolescents to raise awareness about SRH services and encouraging health facilities to be more adolescent-friendly
- Engaging with community members to help them understand the importance of providing health services to adolescents

Additionally, a United Nations Population Fund (UNFPA) evaluation of support to adolescents and youth from 2008–2015 found that ASRH programs that were integrated, multi-sectoral, and that actively engaged communities were more successful in increasing access to and making services comprehensive for young people.

Let's first discuss adolescent-friendly health services

For a health facility to provide SRH services that are adolescent-friendly, the services must adhere to five principles—as shown in Figure J. In this figure, you will see the adolescent patient at the center of the adolescent-friendly services. All of the characteristics of the facility, competencies of the staff, and quality of the services delivered impact the adolescent's decision to seek and/or return back for SRH information and services. The five adolescent-friendly principles are described more fully in Table 5, along with how to apply these principles toward providing SRH services for adolescents in humanitarian settings.

Figure J: Principles of Adolescent-Friendly Services

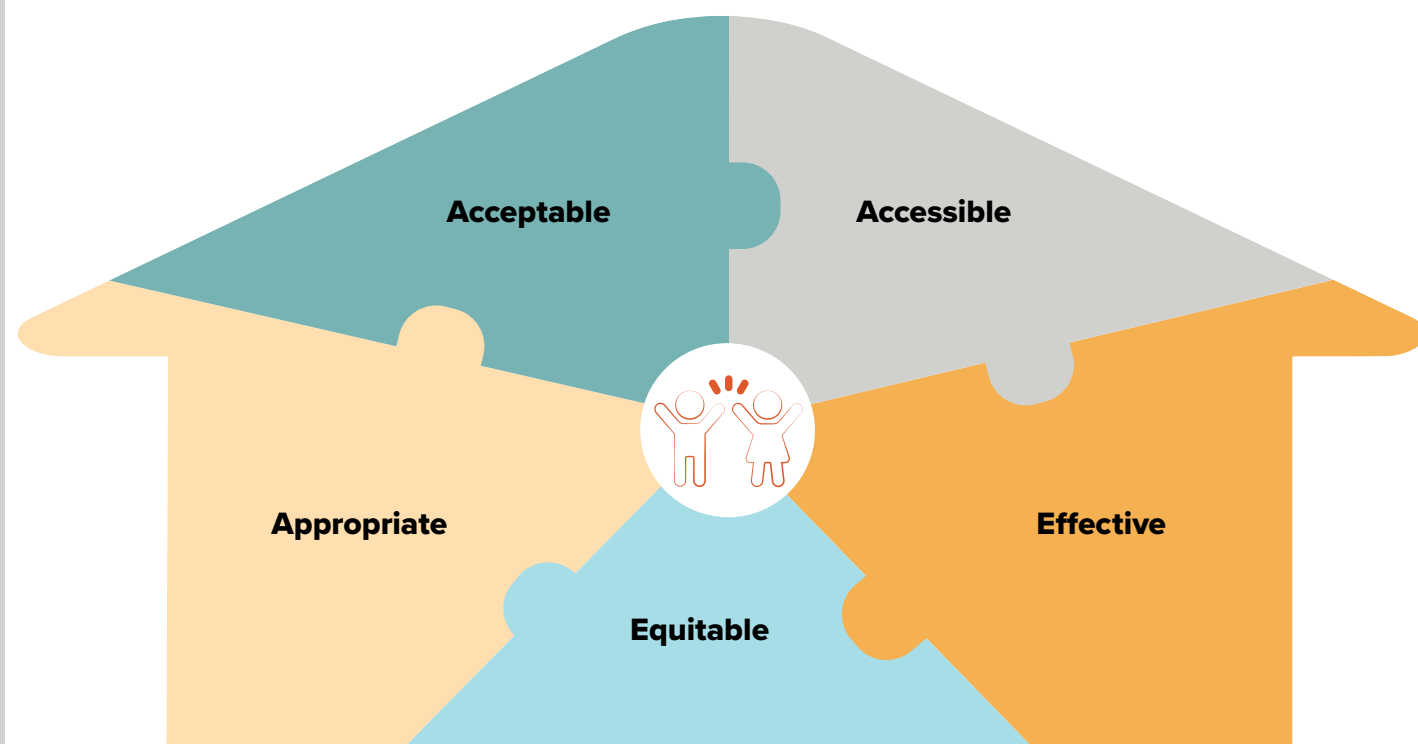


Table 5: Adolescent-Friendly Principles

PRINCIPLE	
ACCESSIBLE	
DESCRIPTION	APPLICATION
There are policies & procedures in place that ensure health services are free or affordable for adolescents.	Adolescents in humanitarian settings are likely to have limited financial means to take care of themselves and/or are required to take on the responsibility of also taking care of their family. Cost should not be a barrier for them to access services.
The facility has convenient working hours.	The facility should be open in the early morning or in the late evenings—ideally 24 hours where possible—to accommodate adolescents who may need to take on additional responsibilities (childcare, jobs to provide for family, attending education or vocational classes, etc).
Adolescents are well informed about the range of SRH services available and how to obtain them.	Understanding what services are available can encourage adolescents to use those services. CHWs, community mobilizers, or other means of connecting health services to the community should be utilized for raising awareness about the types of services adolescents can receive. CHWs and other staff should be educated on what services adolescents can receive at the facility and be able to dispel any myths about SRH services for adolescents.
Community members understand the benefits that adolescents will gain by obtaining the health services they need and support their provision.	Community members can be gatekeepers for adolescents' access to SRH services. If community members do not understand or trust the services provided, they are likely to be a large impediment to adolescents seeking or receiving services. In some contexts, this may be the first time communities have been introduced to the idea of providing SRH services to adolescents. Engaging community members is important for establishing trust and creating understanding about the services provided. This is discussed fully in Chapter 3 under Community Participation .
Some health services and health-related commodities are provided to adolescents in the community by selected community members, outreach workers, and/or adolescents themselves.	Due to social or cultural norms, adolescents may be hesitant to visit a health facility to receive SRH services. Offering services and commodities, such as condoms and menstrual hygiene management (MHM) products, at other delivery points in the community and from people adolescents can relate to will increase potential SRH entry points and access to SRH services and information for adolescents. See the MHM in Emergencies Toolkit from the International Rescue Committee (IRC) for additional guidance on implementing MHM in humanitarian contexts.

PRINCIPLE

ACCEPTABLE

DESCRIPTION

APPLICATION

Policies & procedures are in place that guarantee patient confidentiality.

Confidentiality is defined by WHO as “the duty of those who receive private information not to disclose it without the patient’s consent.” This means that any information the adolescent shares with the service provider is not shared with anyone else and all collected information from the adolescent is kept in a safe and secure place. Providers will refrain from discussing what patients have shared, including what service(s) adolescent patients were seeking or if they received any services. In humanitarian settings, adolescents are often displaced from their homes and the provider may be the only person they trust to confide in, so it is paramount to foster and maintain that trust.

Point of service delivery ensures privacy.

WHO defines privacy as “the right and power to control the information (about oneself) that others possess.” This means that adolescents have a right to discuss information without fear of someone seeing them (physical privacy) or hearing them (auditory privacy). In a health facility, it is important to ensure that consultation rooms have sheets or barriers to separate patients and those in the waiting room, and prevent them from seeing each other. In addition, the facility should be organized so that people in the waiting room cannot hear what adolescent patients are saying during consultations.

Healthcare providers are non-judgmental, considerate, and easy to relate to.

As provider bias and attitudes can significantly affect adolescents’ decisions to seek or receive services, it is important to hire, train, mentor, and supervise staff that are welcoming, respectful, and non-judgmental toward adolescents. Providers should be trained on how to create a trustful atmosphere for adolescents seeking SRH services, which includes respecting their autonomy, maintaining confidentiality and privacy, as well as other competencies discussed in Chapter 6 under [Training and Capacity Building of Staff](#).

Point of service delivery ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral.

Adolescents have reported facing stigma in the waiting room as an impediment to seeking SRH services. In some emergencies, adolescents may have to travel longer distances and/or face additional security risks to obtain SRH services. They may have restricted freedom of movement to travel where they want to go. This is why it is important that once adolescents arrive for SRH information or services (despite barriers they may have faced to get there), humanitarians must ensure they receive prompt attention to encourage adolescents to seek these services without the deterrence of long waiting lines.

Point of service delivery has an appealing and clean environment.

Maintaining a clean and proper facility is important for all patients. For adolescents, health staff should think about ways to make the facility more welcoming and attractive. This includes ensuring all staff (including receptionist) understand where adolescents can seek services. The facility may have a discreet entrance for adolescents or a special card/bracelet for adolescents to show providers what services they are requesting to expedite seeing a provider and to avoid having to tell others why they are there.

Point of service delivery provides information and education through a variety of channels.

Adolescents have differing learning needs, with some who are not literate and others who process information better through pictures. Adolescents may be embarrassed to ask questions; providing SRH information through a variety of channels will allow them to obtain information on topics that their parents or community members may be unwilling to discuss.

Adolescents are actively involved in designing, assessing, and providing health services.

Involving adolescents in assessment activities and service provision ensures that programming is more sensitive and responsive to their needs. This topic is discussed more fully in Chapter 3 under [Adolescent Participation](#).

PRINCIPLE

APPROPRIATE

DESCRIPTION

The required package of healthcare is provided to fulfill the needs of all adolescents either at the point of service delivery or through referral linkages.

APPLICATION

All adolescents, regardless of their mental or physical capacities and heterogeneity status in the adolescent ecosystem—including unmarried girls, very young adolescents (VYAs), internally displaced persons (IDPs), adolescents with diverse sexual orientation and gender identity and expression (SOGIE), or other characteristics—should be able to receive health services that address their SRH needs from the health facility or from other points of delivery, such as a mobile health unit. Not every clinic or facility in a humanitarian context will be able to provide the full package of services from the beginning of the emergency, which is why a strong referral system is necessary to ensure adolescents receive the services they are seeking. This is discussed fully in Chapter 6 under [Tools for Establishing Referral Pathways](#).

PRINCIPLE

EQUITABLE

DESCRIPTION

Policies & procedures are in place that do not restrict the provision of health services.

APPLICATION

In accordance with humanitarian principles, organizations should establish procedures and written policies that ensure no factor (sex, age, social status, etc) hinders the provision of services to all or some groups of adolescents or hinders the ability of all or some adolescents to obtain those services. These policies should include adolescent considerations that specify the services adolescents are entitled to and how they should be treated within the facility.

Principle of Capability

Adolescents who request SRH services can be considered capable of receiving SRH counseling and services without parental oversight. When applied to SRH care for adolescents, the Principle of Capability means that a young adolescent—who identifies that they want SRH services and voluntarily requests SRH care, such as maternal care, contraception, Human Immunodeficiency Virus (HIV)/sexually-transmitted infection (STI) care, or to terminate a pregnancy—is capable of consenting to services. This principle removes the expectation or assumption that service providers should determine if adolescents can receive the services they are requesting and appropriately puts the decision-making power in the hands of the adolescent patients.

Healthcare providers and support staff treat all adolescents with equal care and respect, regardless of status (age, sex, marital or social status, cultural background, ethnic origin, disability, or any other reason).

Cultural or social norms may affect how providers or support staff interact with and/or deliver SRH services to adolescents. In a humanitarian setting, providers may be asked to deliver services to a population from another country, belief system, or culture from their own. It is important to assess the attitudes and beliefs of all staff that interact with adolescents and educate staff on the SRH rights of adolescents and their facility's policies in providing equitable care to all adolescents. This is discussed further in Chapter 6 under [Training and Capacity Building of Staff](#).

PRINCIPLE

EFFECTIVE

DESCRIPTION

Healthcare providers have the required competencies to work with adolescents and to provide them with the required health services.

APPLICATION

Adolescents are not a homogenous group. They have unique SRH needs, and providers should be trained on the clinical and counseling competencies, as well as the interpersonal skills required to deliver quality SRH services to adolescents. There are specific considerations providers will need training on, such as using more simple terminology and language with adolescents. This is discussed further in Chapter 6 under [Training and Capacity Building of Staff](#).

Healthcare providers use evidence-based protocols and guidance to provide health services.

Providers should be following quality standard protocols of the country they are in and the organization they belong to. In contexts where the standards of the country are not in alignment with global standards, humanitarians should work toward updating and improving those guidelines.

Healthcare providers are able to dedicate sufficient time to deal effectively with their adolescent patients.

Adolescent patients may be hesitant to discuss why they are at the facility or find it hard to describe what their SRH needs are. They may also be unaware of why, what, or how their bodies are changing. Perhaps their sexuality education was disrupted or they never received any education at all. The provider needs to build trust, make the adolescent feel comfortable, and answer their questions before providing any SRH services they request. All of these tasks require adequate time to effectively meet adolescents' needs.

The point of service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.

Without the needed materials and supplies, healthcare providers cannot deliver quality SRH services. Adolescents may be hesitant to visit the clinic, may have faced tremendous barriers in reaching the facility, or overcame stigma and discrimination to meet with a provider. Lack of supplies or materials should not be an impediment for adolescents to obtain the services they need.



Training and Capacity Building of Staff

Why is it important to train staff on ASRH?

Adolescents may feel hesitant to seek out SRH services due to the stigma or cultural factors surrounding SRH or from a lack of understanding or knowledge of their bodies or needs; these factors are more prevalent for adolescents in crisis settings, as many are displaced from their communities, norms, and practices. Thus, providers, CHWs, and project staff must work together to create a welcoming environment for adolescents to receive high quality, private, and confidential care.

IMPLEMENTATION CONSIDERATION

National Training Curricula

In certain countries, the Ministry of Health (MOH) may have their own ASRH training curriculum. Program managers can use the MOH curriculum, but should review the guidance and tools to ensure they are up to date and in line with international best practices—both technically and as it relates to inclusion, gender, and human rights approaches. If the country does not have specific guidance for ASRH or SRH more broadly, humanitarians should advocate for incorporating global standards, including WHO's [Global Standards for Quality Health-Care Services for Adolescents](#). The curriculum should also integrate participatory adult learning methods. In the listed training resources, there are several activities included to ensure trainers are utilizing a variety of competency-based adult-learning teaching methods to address the needs of all types of adult learners. Adult-learning teaching methods may include positive learning environment, coaching, modeling and practice on anatomical models (especially for clinical trainings), role-play, etc. Refer to Ipas's resource [Effective Training in Reproductive Health: Course Design and Delivery](#), specifically the Reference Manual and Trainer's Manual, for additional guidance.

Who should be trained?

At the core of ASRH service provision is the relationship between the adolescent patient and the staff who interact with them. Orienting all health staff—from the facility receptionist to the CHW to the doctors, nurses, and midwives—on how to greet, answer questions, and provide services to adolescents helps address key barriers to ASRH service uptake. All health providers and support staff in health facilities implementing the Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (MISP) must understand who adolescents are, including their unique needs, what services are available to adolescents, and how to receive and assist adolescents seeking SRH services.

Several studies and results from focus group discussions with adolescents and youth have shown that judgmental and unfriendly behavior of facility staff, such as the receptionist, dissuaded adolescents from even entering the health facility due to feelings of shame or fear. Thus, **it is critical to provide facility-level and community-level orientation workshops on ASRH and child safeguarding policies to all individuals that interact with adolescents and youth**, including services that may refer adolescents to the health facility, such as safe spaces.

How should humanitarians be trained?

Training on ASRH can be a separate, focused training tailored to the knowledge, experience, and capacity levels of the participants. However, components of ASRH training should also be incorporated into other

trainings for health staff, such as adding adolescent considerations when providing a clinical training. For example, when delivering a clinical training on contraception, a trainer could incorporate sessions on how to counsel an adolescent patient, contraceptive side-effects, mitigating taboos, etc (see [Counseling Tools & Resources](#) for more information). Whenever possible, trainers should utilize local experts from the context and/or build the capacity of local experts to ensure lasting and sustainable change. Regardless of the training format, trainers should ensure that continued mentorship, supportive supervision and refresher trainings, and provision of essential supplies and equipment are prioritized. Trainees must have the adequate resources, including human resource support and supplies, to use and apply the learning acquired from the trainings in their job duties. Interventions with insufficient or limited financial and human resources have been shown to be ineffective in providing SRH services to adolescents.

IMPLEMENTATION CONSIDERATION

When To Train

Training is a human rights approach and an important element in all phases of the humanitarian cycle. Providing training to staff ensures strategies are employed to increase adolescents' access to services that enhance their SRH. So, who trains staff and when? To create a sustainable ASRH ecosystem, SRH interventions need to deliver a training at the right time. **The fundamental challenge in humanitarian settings is delivering the right training at the right time.**

Preparedness Phase: *During the preparedness phase*, train staff via standard four- or five-day trainings and/or training of trainers (TOTs) to increase their capacity to cascade down ASRH trainings and provide ASRH programming and services.

Acute Response Phase: *During the onset of an emergency or amid an acute emergency*, it becomes challenging to deliver full-length trainings or TOT workshops. At minimum, organizations—in coordination with the cluster system—can deliver select priority life-saving SRH services, as outlined in the [MISP](#). The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) [Training Partnership Initiative](#) (TPI) provides refresher training packages that are consolidated and concise to meet the needs of providers and their time constraints. In addition to TPI trainings, humanitarian practitioners can provide clinical updates, orientations, or refresher workshops. These workshops are 1–2 days long and are aimed at increasing skills and knowledge on a particular subject (such as ASRH), but they do not prepare participants to put skills into practice during a clinical practicum. Another important training strategy is on-the-job training and coaching by skilled healthcare providers who are either located within a facility or are seconded to provide on-the-job training for a period of time to ensure the trainees have the confidence and competence to provide care.

Protracted Crisis and Comprehensive Phase: *During a protracted crisis and/or when planning for comprehensive SRH services*, organizations can consider delivering standard clinical trainings, TOTs, clinical updates, orientation workshops, on-the-job trainings, and refresher workshops to strengthen the health system as needed.

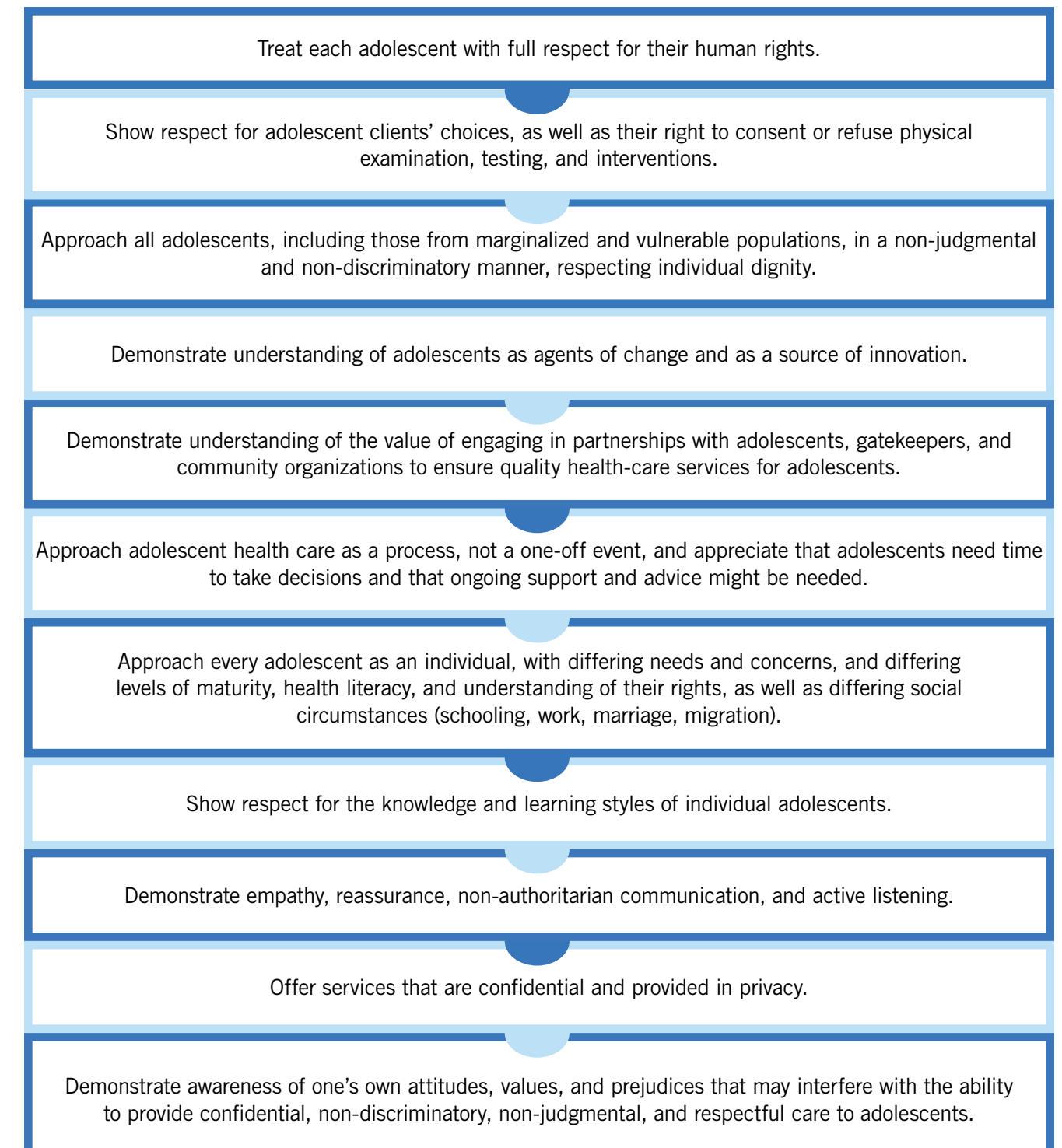
Tools for Clarifying Values

Why are values and attitudes toward SRH important for providing services to adolescents?

In many countries, a major barrier to adolescents seeking care is stigma and negative attitudes toward ASRH among clinicians, supporting staff, and community stakeholders. Values clarification and attitude transformation (VCAT) activities and workshops support participants to explore, question, clarify, and affirm their values and beliefs about adolescents and SRH issues. They are designed to challenge participants to reflect on their own attitudes and beliefs and the outside forces and experiences that have shaped them, while encouraging participants to question deeply held assumptions and myths. VCAT activities explore these issues to help move participants toward positive ASRH attitudes and close the service-delivery gap in clinical and community settings. WHO provides guidance on what positive attitudes providers (and other humanitarian responders serving young people) should have or work towards in their resource [Core Competencies in Adolescent Health and Development for Primary Care Providers](#). The Toolkit has adapted WHO's list of attitudes that are critical for delivering adolescent healthcare into [Figure K](#).



Figure K: Fundamental Attitudes for Delivering Adolescent Healthcare



KEY MESSAGE

Adolescents who are living with family members may not be able to independently access and obtain ASRH services. Service providers, CHWs, and humanitarian practitioners need to ensure they have the supporting tools to navigate family influence vis-a-vis confidentiality, consent, and assent, as well as the local legal context. Refer to the [Principle of Capability](#).

How do I integrate VCAT into my trainings?

VCAT workshops can be conducted with providers before a clinical training, integrated into the clinical training components, and into health site orientations with ancillary staff to support efforts in creating an enabling environment. VCAT workshops are commonly used to strengthen linkages across the continuum of care, such as in community outreach sessions by CHWs to destigmatize reproductive health issues, thereby aiming to reduce barriers to care. VCAT activities should be adapted for each humanitarian setting. Ipas has two separate VCAT toolkits: [Abortion Attitude Transformation: A Values Clarification Toolkit for Humanitarian Audiences](#) and [Abortion Attitude Transformation: Values Clarification Activities Adapted for Young Women](#).

GENDER CONSIDERATIONS FOR VCAT

Humanitarians must examine how gender dynamics impact men, women, boys, and girls' vulnerabilities, including gender-based violence (GBV) and the available care and support to all survivors; however, practitioners should pay special attention to females due to evidence of their increased risk, including GBV, documented discrimination, and restricted access to safe and equitable humanitarian assistance. Sexual violence, a type of GBV, is common in humanitarian contexts, occurs at every stage of a conflict, and may become more heightened following a natural disaster. The survivors are typically women and adolescents (whose vulnerability increases in the aftermath of a crisis), but men also experience sexual violence. Separation from family and support structures and/or taking on new responsibilities or roles, such as collecting firewood or searching for food, can increase women and adolescents' risk of exploitation and abuse.

The Toolkit includes a sample VCAT activity tool SRH managers can use with different audiences in [Annex E](#). This exercise was adapted from the Postabortion Care (PAC) Consortium's [Youth-Friendly Postabortion Care Supplemental Training Module Trainer's Manual](#), Ipas's [Abortion Attitude Transformation: A Values Clarification Toolkit for Humanitarian Audiences](#) toolkit, and Ipas's [Abortion Attitude Transformation: Values Clarification Activities Adapted for Young Women](#) toolkit.

ADOLESCENT ENGAGEMENT IS KEY!

Utilizing adolescents, as well as facilitators, in the training design process ensures active engagement and inclusivity. This, in turn, creates a positive environment of learning and quality ASRH service provision.

Training Tools

SRH Coordinators & Managers

The first objective of the [MISP](#) indicates that SRH coordinators and managers are largely responsible for coordinating and delivering clinical training, as well as providing training and orientation on SRH for other staff members and those outside of their organization. For each of these training modalities, SRH managers will need to adapt the language, phrasing, and content of their ASRH trainings to reflect the context and the needs of their audience. For example, during the COVID-19 pandemic, SRH organizations involved with the IAWG ASRH Sub-Working Group had to adapt their training strategies—adopting remote, virtual, and blended learning approaches while applying infection prevention and control measures—to prevent transmission of the virus and comply with appropriate risk mitigation measures.

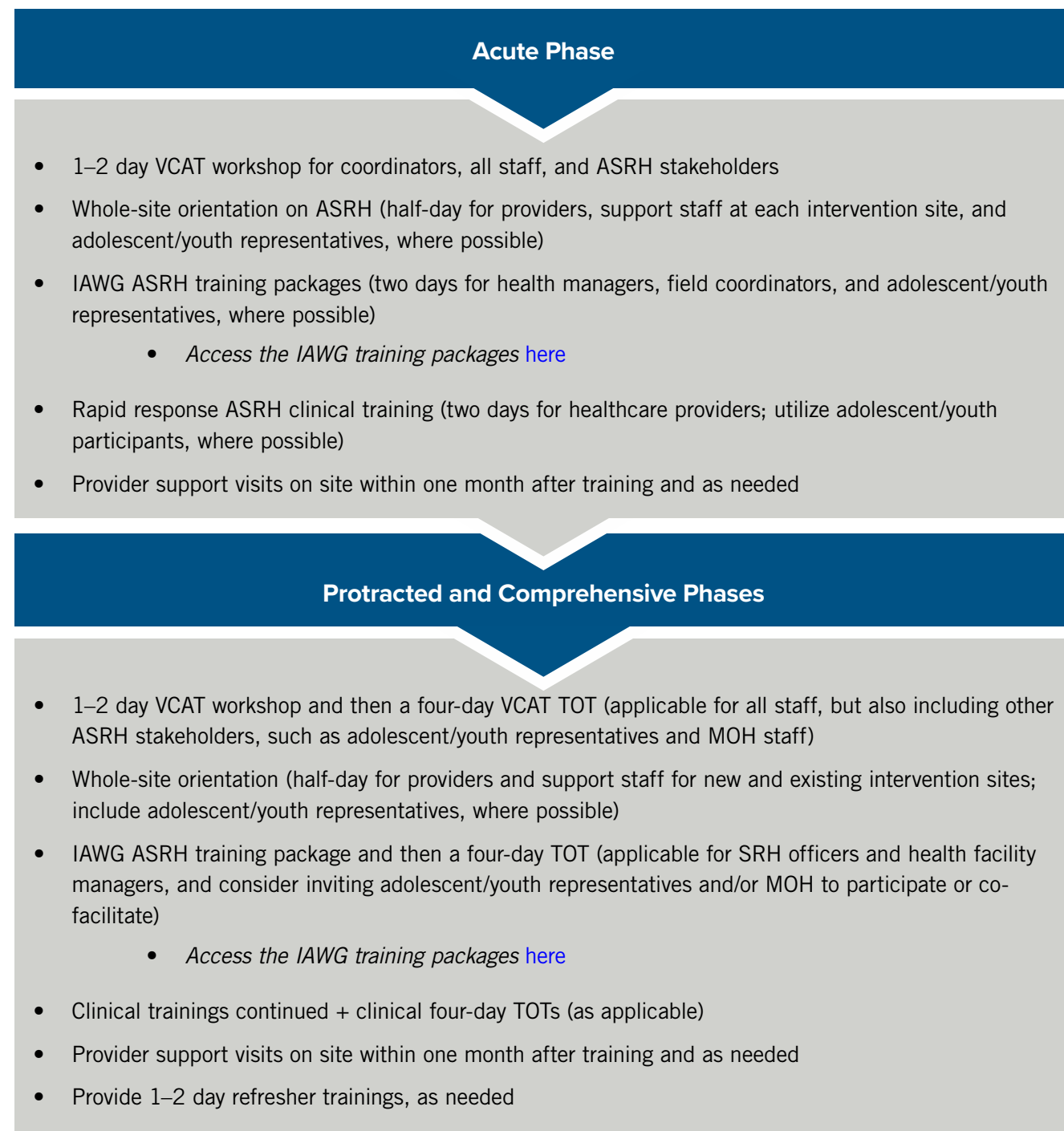
Given the wide range of staff and stakeholders that need training on ASRH, SRH managers must recognize the distinctive challenges and opportunities for training different audiences, particularly for sensitive topics like ASRH. IAWG has developed a training package for SRH managers (see below for links to training resources), which provides tips on how to train others and manage difficult questions or sensitive topics about ASRH. One of the recommendations in this package is to provide [VCAT](#) exercises prior to or at the beginning of an ASRH training to understand the audience's views toward ASRH. The package also shows SRH managers how to teach a range of learners, as participants learn in different ways and have different preferences on how they learn best.

[Figure L](#) provides an example of how SRH managers can organize training strategies during the acute and protracted/comprehensive phases of an emergency.



Photo : Médicos Sin Fronteras

Figure L: Training Strategies for Response Staff



We completed the training; now we are done, right?

No. Repetition. Repetition. Repetition. For training to be effective, like learning lessons in school, the messages must be repeated and the students must be supported. SRH managers are also responsible for ensuring mechanisms to support and monitor quality implementation of SRH activities are available after the trainings. One-time trainings are not effective in achieving the intended results for participants; participants must be supported following the training via refresher trainings, supervision, continuous coaching, and mentorship. Dosage matters. A review of ASRH interventions to decrease STI transmission and pregnancy among adolescents found that those programs that delivered trainings with greater dosage (or more consistently and/or for a longer duration) were more effective compared to shorter programs. See [Chapter 8: Manager Guidance Notes & Tools](#) for more information on supportive supervision resources and tools.

CASE STUDY

Pathfinder’s Mentorship Program In MZ & TZ

Pathfinder implemented an SRH program for youth in Mozambique and Tanzania that integrated youth-friendly SRH services within the public sector facilities and communities supported by the organization. While this project was implemented in a development setting, it provides evidence of the impact of a mentorship approach upon ASRH outcomes. A significant component of this program was their mentorship piece. To ensure providers, facility staff, and health facilities met quality standards, the project trained all providers and staff and implemented a mentorship program to support providers in delivering the full range of contraceptive methods, including long-acting reversible contraception (LARC). Pathfinder integrated quality standard components from each country’s MOH curriculum and the [WHO Medical Eligibility Criteria for Contraceptive Use](#) into trainings and its mentorship program. The mentorship program used mentorship teams—comprised of project staff and MOH staff—who visited each facility, monthly the first year and quarterly onward, and observed providers and staff using a tablet-based mentorship tool. The mentorship teams also offered on-the-job training, developed individual work plans for quality improvement, and monitored facility characteristics through the tablet tool.

For training general health staff (assistants, logisticians, receptionists, etc) and non-health staff (colleagues from child protection, education, etc), SRH managers should provide trainings and ongoing supportive supervision, mentoring, and coaching on the following topics:

- ASRH, with focus on the unique needs of adolescents
- What and where SRH services are provided to adolescents
- How to refer services (both health service referrals and referrals between sectors) for adolescents
- Social norms in the community, attitudes/biases of service providers, and the impact on utilization and uptake of ASRH services
- Legal and policy frameworks of the host country, as well as relevant human rights frameworks
- Advocacy, communication, and coordination strategies with stakeholders. Refer to Ipas’s [Providers as Advocates for Safe Abortion Care: A training manual](#) for advocacy training content and adaptation to host country context.
- Data collection, management, and documentation. See [Chapter 7: Data for Action](#) for additional information.

KEY MESSAGE

All trainings—regardless of the audience—should include an evaluation component that assesses not only ASRH knowledge but also attitudes and behaviors. This includes VCAT pre- and post-tests but also ASRH knowledge, attitude, and practice pre- and post-tests. Moreover, all trainings, regardless of whether they are for providers or program staff, should have a session and module on data collection, management, and documentation. Refer to [Chapter 7: Data for Action](#) for detailed guidance.

REMOTE TRAINING OPPORTUNITIES

In some situations, in-person trainings may not be feasible due to security constraints, access restrictions, or health policies, such as during Ebola virus disease outbreaks and the COVID-19 pandemic when countries prohibited and/or restricted gatherings of people to reduce transmission. Humanitarian responders, ever flexible, should adapt their training strategies to fit their operating context. Organizations can utilize online platforms (where internet/technology permits) to deliver distance learning courses and webinar sessions, as well as broadcasting live sessions, such as via [Facebook Live](#) or [YouTube Live](#). Practitioners should integrate interactive training methodologies and/or programs in their virtual trainings to increase participation from users, including breakout room functions ([Zoom](#)), short videos ([TikTok](#)), data visualization ([Tableau](#)), and online collaboration tools ([Mural](#)). If live sessions or webinars are not feasible due to internet speed or appropriate equipment, responders can record sessions in shorter sessions or provide safe, central locations (where internet and technology is available) for smaller groups to gather and watch/participate. IAWG has provided some online resources on [Adolescent Sexual and Reproductive Health in Humanitarian Settings eLearning Course](#) and a [compendium of resources for the COVID-19 response](#).

Note: Further research and evidence-gathering is required to study the effectiveness of these digital interventions, particularly during pandemic responses, upon ASRH outcomes.

Below are links to IAWG's ASRH in Emergencies training packages for SRH managers to use for training other SRH staff, frontline health workers (eg service providers and CHWs), and non-health staff.

- [TOT Package on ASRH in Emergencies for SRH Managers](#)
- [Training Package on ASRH in Emergencies for Frontline Health Workers](#)
- [Training Package on ASRH in Emergencies for Non-Health Staff](#)

Service Providers

SRH managers will likely be in charge of organizing trainings for service providers and may assist clinicians with facilitating their trainings. As mentioned earlier, SRH managers can incorporate ASRH components into clinical trainings and do not always have to hold a separate ASRH training to train service providers on how to deliver services to adolescent patients.

Service providers know how to deliver SRH services. Why do they need training for providing SRH services to adolescents?

One of the most commonly reported challenges by adolescents seeking SRH services was non-friendly attitudes and negative biases toward adolescents from service providers. Effective engagement with adolescents by health and community health workers may reduce the stigma and barriers adolescents encounter when trying to access quality healthcare. Opportunities to interact with adolescents at the facility in counseling sessions, clinical services, or health promotion activities in the community can assist providers to identify and respond to adolescents' emotional and physical health needs, as well as other concerns. Healthcare providers should recognize how adolescents differ in age, gender, developmental stage, educational and literacy levels, marital status, and living conditions during an emergency setting. This will ensure healthcare providers deliver quality, appropriate, and effective communication and counseling services that meet their unique needs.

What ASRH training components should be included for service providers?

Service providers should receive training to become competent in SRH technical and clinical components and provide follow-up and inter-sectoral coordination on how to safely refer adolescents to the services they need. Providers should also receive training on the importance of soft skills, including how they communicate with patients and how their attitudes toward the patient affect their service quality. WHO helps outline these different competency areas in their resource called [Core Competencies in Adolescent Health and Development for Primary Care Providers](#), which follows [IAFM](#) and [WHO global guidance](#). Trainers will need to consult the [IAFM](#) and other clinical resources (such as [WHO's Intrapartum Guide](#)) for guidelines and more thorough information on how to train service providers to deliver SRH services. These domains provide ideas for how to structure and incorporate ASRH components into a clinical training and/or conduct a stand-alone clinical training on ASRH. In the three domains, there are special considerations providers should understand about providing health services to adolescent patients.



Domain 1: Basic Concepts in Adolescent Health, Sexuality, and Development, and Effective Communication

In the first domain, providers of ASRH services must have specialized skills in consultation, interpersonal communication, and interdisciplinary care that are appropriate to the developmental phase and context of the adolescent. In recognizing adolescents' unique needs and traits, the healthcare provider ensures the counseling, consultation, and services are tailored to the specific and holistic needs of each adolescent to improve their overall health and safety. Child protection practitioners can also support providers with communication, referrals, and strengthening linkages with VYAs. These competencies are called Basic Concepts in Adolescent Health and Development, and Effective Communication. In addition, WHO developed the resource [Brief Sexuality-Related Communication: Recommendations for a Public Health Approach](#), which provides additional guidance for training service providers on brief sexuality-related communication.

At Risk Adolescents: VYAs



Looking at Domain 1, service providers should receive training on the unique characteristics and needs of adolescents, including what makes some adolescents more vulnerable. VYAs, for example, may not understand the changes occurring in their bodies due to lack of access to SRH information, disruption in school attendance, and/or inadequate or unavailable comprehensive sexuality education (CSE). Their lack of knowledge and/or skills can increase the risks associated with puberty, such as unplanned pregnancy and STIs. Service providers should be prepared to explain menstruation and puberty, as well as any other questions the VYA may have. As VYAs are undergoing intense physical, mental, and social changes and beginning to figure out their own attitudes, behaviors, and identity, they are seeking guidance from peers and adults, which can also put them at greater risk of coercion (in certain environments, such as a humanitarian setting). Thus, providers must make sure the VYA understands their right to privacy—meaning that if they want to be alone with a provider, they can request it.

Domain 2: Laws, Policies, and Quality Standards

In the second domain, providers must understand and apply clinical practice laws and policies that promote, protect, and fulfill adolescents' right to health, which are in line with professional and quality standards and consistent with human rights principles. These competencies are called Laws, Policies, and Quality Standards. Providers will refer to the host country's SRH laws, policies, and quality standards concerning adolescents that are represented in national guidelines and/or clinical protocols. Providers should apply these laws, policies, and standards during site setup and quality service provision through capacity assessments, which include both the strengths and improvement areas for clinical service delivery and around social adaptation. As well, providers should be apply these standards in their coordination efforts with stakeholders to ensure that the SRH needs of adolescents are met. If local laws and policies do not exist for ASRH quality service provision, utilize international protocols, such as [IAFM](#), [MISP](#), and the [Principle of Capability](#).

At-Risk Adolescents: GBV Survivors



A critical piece of responding to sexual violence is supporting justice for survivors. Providers should be educated on the medico-legal system and mandatory reporting and legal implications, including the laws and policies surrounding sexual violence. It is important to note that local laws and policies may not align with international human rights standards and may violate the right to privacy. In humanitarian settings, it is often not possible to collect forensic evidence; however, this must not be a barrier to service delivery. First and foremost, service providers must provide medical services to adolescent survivors (eg post-exposure prophylaxis [PEP], emergency contraception to prevent unintended pregnancies after sexual violence, and/or access to safe abortion services, including if the adolescent requests the services at a later time). If the survivor agrees to pursue an investigation, the provider should conduct the exam and collect forensic evidence at the same time (to minimize trauma to the survivor). Providers should only collect forensic evidence if that evidence can be tested, analyzed, and used, in addition to ensuring its safe storage. The survivor must receive a full explanation of each procedure and consent to all steps prior to collecting any evidence. Moreover, it is imperative for the provider to maintain the client's confidentiality at all times—even when coordinating with law enforcement and the broader legal system.

Domain 3: Clinical Care of Adolescents with Specific Considerations

The first and second domains are not limited to any particular clinical condition; thus, Domain 3 is related to caring for adolescents with specific conditions. This domain requires tailoring management approaches that are sensitive to adolescent development. These competencies are called Clinical Care of Adolescents with Specific Considerations.

In line with the [IAFM](#), humanitarian responders should adopt a rights-based approach to delivering ASRH services—respecting the rights and bodily autonomy of all adolescents, regardless of their age, ethnic background, residential status, sexual orientation, gender identity, and cognitive or physical capacities. At the foundation of all of these domains is the respect for the human rights principles of equity and meaningful participation and inclusion. These principles, along with other fundamental attitudes of adolescent health, are outlined in Figure M and are crucial to all of the competencies outlined within the three domains. Please see [Figure M](#) for further explanation of the competencies included within Domain 3.

Figure M: Clinical Care of Adolescents with Specific Considerations

3.1	Assess normal growth and pubertal development, and manage disorders of growth and puberty
3.2	Provide immunizations
3.3	Manage common health conditions during adolescence
3.4	Assess mental health and manage mental health problems
3.5	Provide sexual and reproductive health care
3.6	Provide HIV prevention, detection, management, and care services
3.7	Promote physical activity
3.8	Assess nutritional status and manage nutrition-related disorders
3.9	Manage chronic health conditions, including disability
3.10	Assess and manage substance use and substance use disorders
3.11	Detect violence and provide first-line support to the victim
3.12	Prevent and manage unintended injuries
3.13	Detect and manage endemic diseases

Source: [Core Competencies in Adolescent Health and Development for Primary Care Providers](#) (WHO, 2015)

In addition to the above IAWG training resources for service providers (in the [SRH Coordinators & Managers](#) section), Pathfinder has developed a training manual for service providers as part of their [Comprehensive Reproductive Health and Family Planning Training Curriculum](#). The purpose of the training manual is to prepare service providers (physicians, nurses, counselors, and midwives) for delivering quality RH services to adolescents. Parts of the manual can also be adapted for use with CHWs.

Community Health Workers

SRH coordinators and managers will likely assist health facility managers and/or service providers in organizing and/or helping co-facilitate trainings for CHWs, community mobilizers, and other modalities of community health.

Why do we need to train CHWs on ASRH?

CHWs play a key role in creating a safe and supportive environment for adolescents to access quality adolescent-friendly services and information. CHWs should be trained and have a mechanism to be kept up to date on relevant information and resources available for adolescents. Their specific job function is to increase access to SRH information and services and is discussed at length in [Community-Based Services and Outreach Platforms](#). This section focuses on the capacity-building tools that SRH managers can use with CHWs and/or that CHWs can utilize for their work streams. Similar to service providers, WHO has a helpful guide for training CHWs found under [Core Competencies to Support the Delivery of Sexual and Reproductive Health and Maternal, Newborn, Child, and Adolescent Health](#) (SR/MNCAH) Care by CHWs in their technical brief on strengthening CHW capacity. This guide outlines key competencies for CHWs to possess and/or work toward obtaining to deliver quality SRH services for adolescents. Trainers can use these domains when organizing their training workshops with CHWs to ensure these topics are covered.

Domain 1: Working with the Community on Health Promotion, Education, and Counseling

The first domain includes training CHWs on the day-to-day functions of their job. This includes how to identify, support, motivate, and mobilize community leaders, community members, populations at risk (eg adolescents), and social networks, such as young mothers' clubs and youth groups. CHWs should also understand how to recognize health concerns in the community and facilitate community dialogues to promote healthy behaviors, including preventative actions. CHWs should be trained in how to use a variety of techniques to engage with community members, including basic counseling methods and summarizing findings and reflections from the community. More guidance and tools on these topics are provided in [Community-Based Services and Outreach Platforms](#).

Domain 2: Attitudes for Promoting and Providing Quality SR/MNCAH Care

Domain 2 highlights personal and ethical standards that CHWs must comply with in accordance with [IAFM](#) and [WHO standards](#), as well as their organizations' policies. It is important for CHWs to develop and promote effective relationships with team members and colleagues from the start. This includes CHWs understanding their scope of practice, which is needed for effective referral and for seeking opportunities to foster continuous learning and professional growth. When initially engaging CHWs, SRH managers should organize [VCAT](#) workshops with providers and CHW participants to ensure appropriate linkages, as well as promote positive attitudes of CHWs toward adolescents.

Also included in Domain 2 is developing CHWs' communication skills. CHWs should treat adolescents in a non-judgmental, non-discriminatory, and gender-sensitive manner. They should ensure confidentiality of adolescents' rights, including subgroups of adolescents with diverse SRH needs. CHWs should demonstrate empathy, reassurance, non-authoritative communication, and active listening, in addition to respecting the knowledge and learning styles of individuals, families, and communities. CHWs should pay attention to ensuring confidentiality, privacy, and respecting individuals' choices, as well as their right to consent or refuse care.

Domain 3: Effective Management to Allow the Efficient Promotion and Provision of Quality SR/MNCAH care

Domain 3 covers the management aspects of CHWs. CHWs need to know how to plan community and household visits and foster coordination and continuity of care through appropriate and safe referrals and counter-referrals (see [Facility-Based Services](#) for more information on how to provide health service referrals). For example, it is essential that CHWs are involved with and incorporated in referral pathways for child and adolescent survivors of sexual violence—meaning they are actively coordinating and collaborating with case management services and are trained by child protection service providers and experts on guidelines/standards for safety when conducting home visits and communicating with families. CHWs should understand the importance of accurate and complete record-keeping and timely reporting, as well as using information to adjust programming and improve quality of services (see [Chapter 7: Data for Action](#) for more information on using data to adjust and improve program quality). Also included in this domain is training CHWs on how to effectively manage logistics of supplies and equipment. Lastly, CHWs should be able to demonstrate accountability and transparency in all actions—in line with [IAFM](#) and [WHO standards](#), as well the supporting organizations' company policies (such as child safeguarding and prevention of sexual exploitation and abuse [PSEA] policies).

The above competencies, as well as other resources for strengthening the capacity of CHWs to provide ASRH services, are included in a resource developed by H4+ called [Technical Brief on Strengthening the Capacity of Community Health Workers to Deliver Care for Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health](#). The technical brief includes health system and programmatic considerations, core competencies, and evidence-informed interventions for CHWs along the sexual and reproductive health and maternal, newborn, child, and adolescent health (SR/MNCAH) continuum of care. For guidance and supplementary trainings on ASRH for CHWs, see the [IRC's ASRH Operational Research Toolkit](#) and Pathfinder's [GREAT Scalable Toolkit](#).

Facility-Based Services

This section provides links to facility resources (found in the [IAFM](#)), but also provides guidance on: engaging adolescents in facility operations; adolescent considerations for setting up a facility; counseling and delivering clinical services to adolescents (including particularly at-risk subgroups of adolescents); and referring health services for adolescents. The section also includes ways to expand the reach of facility services through mobile health clinics and other modalities. The [Data for Action](#) chapter describes in detail the documentation approaches and example indicators for these services and activities.

Are adolescents capable of making decisions about their SRH?

Yes. Adolescents are capable of making decisions about their own body and have a right to make those decisions. Service providers should counsel and offer SRH services to adolescents in line with the [Principle of Capability](#) to the full extent of local laws. Service providers should understand and respect adolescents' capacity to receive SRH information, counseling, and services without parental oversight. In many countries, parental consent is not required in cases of medical emergency. When governing professional codes of conduct, clinical/national guidelines, or laws do not include guidance on managing ethical and legal conflicts, practitioners should act in the best interests of the child (adolescent), apply the Principle of Capability, and provide desired services. For more information on consent and assent, see [Chapter 7: Data for Action](#).

What makes a facility appealing to adolescents?

As we know, adolescent–staff communication at the facility and within the community sets the precedence for further engagement and whether they return for SRH information or services. To the extent possible, the facility should include a diverse range of providers and support staff, including a range of ages and genders. Adolescents may feel more comfortable speaking to a provider of the same gender.

Equally important as increasing the capacity of providers and staff to provide a hospitable environment for adolescents is the infrastructural and policy changes needed to make facilities more friendly and responsive to adolescents' needs. To meet [IAFM standards](#) and [WHO's Standard 5: Facility Characteristics](#), the health facility must have convenient operating hours, a welcoming and clean environment, sufficient equipment, medicines, supplies, and technology needed to provide the necessary package of services that respond to the health needs of all adolescents. These services are outlined in the MISP (see [Chapter 4: Priority ASRH in Emergencies Activities](#)) and summarized below. For complete guidance on MISP implementation, please refer to the [IAFM](#), [MISP Distance Learning Course](#), and [IAWG TPI website](#) to find opportunities to participate in in-person and virtual trainings.



IMPLEMENTATION CONSIDERATION

Dispelling Myths—Introducing Facility Changes Does Not Always Require Considerable Investment

A study in Kenya and Zimbabwe assessing adolescents' preferences for SRH services found that adolescents did not prioritize stand-alone youth services but valued service aspects that are also important to adult patients, such as confidentiality, short waiting time, low cost, and friendly staff. Improving these aspects of clinical service does not always require a considerable investment of external resources. Capacities readily available in the clinical setting or existing program can be harnessed to make facilities more attractive to young patients. For example, program managers can integrate adolescent-specific messaging and content into ongoing health provider trainings or regular supportive supervision. Construction of stand-alone youth consultation rooms may not always be feasible, so health teams may opt to repurpose unused consultation rooms or redesign clinic flow to make sure the facility is more responsive to adolescent needs.

What SRH services are offered at a health facility?

In [Chapter 4: Priority ASRH in Emergencies Activities](#), we discussed the life-saving services that should be provided from the onset of an emergency. The Toolkit outlines considerations that providers should understand when providing SRH information and services to adolescent patients. These considerations are mainly focused on counseling guidance, as clinical SRH procedures are no different for adolescent patients compared to adult patients (eg all contraceptive methods are safe and acceptable for adolescent patients). Clinical guidance on these services (outlined below) is included in the [IAFM](#).

The clinical services from the [Adolescent-Inclusive MISP](#) that must be made available at the facility level include but are not limited to:

- Clinical management of rape (CMR) for survivors of sexual violence, as per [WHO CMR Guidelines](#), and provision of other supportive services, including providing PEP
- Screen, diagnose, and treat STIs (including HIV): safely deliver blood transfusion; distribute condoms; and provide antiretroviral (ARV) drugs and antiretroviral therapy (ART)
- Provide clean and safe delivery, essential newborn care, and emergency obstetric and newborn care (EmONC) services. Remember, post-abortion care (PAC) is a signal function of EmONC!
- Provide safe and supported referrals for life-saving services, as well as other support services, such as mental health and psychosocial support (MHPSS) and case management services
- Provide safe abortion care services to the full extent of local laws
- Counsel and provide contraceptive methods, including short- and long-term methods and barrier methods
- Disseminate SRH information during counseling sessions, as well as via information, education, and communication (IEC) materials
- Link health facility services with community outreach efforts to ensure community members know where and what services are available

REFERRALS TO HEALTH SERVICES

What is a health service referral?

Referral of health services is when a health worker at one level of the health system requests assistance from a different level of the health system due to insufficient resources or skills. Thus, it is important to ensure referrals—both intra and inter referrals—at the primary and tertiary levels of the health system for SRH services are functional. Health facilities cannot provide all types of healthcare to all regions in a country in stable times, as some parts of the country will have more specialized care available compared to other regions. In humanitarian settings, this is especially true with the disruption of health systems and services and the introduction of several types of organizations working together to deliver health services to all crisis-affected populations. Thus, an effective referral system—one where all levels of the health system work together and in which the humanitarian cluster and coordination system is involved—is critical to ensure people receive the life-saving services they need. Due to the frequent changes in humanitarian conditions, as well as staff turnover, these referral pathways should be revisited throughout the humanitarian continuum to ensure viability.

[WHO](#), [United States Agency for International Development \(USAID\)](#), and other agencies have provided examples of referral forms and resources to assist organizations with setting up a referral system, training staff, and utilizing the system. The Toolkit has included WHO's referral templates in [Annex F](#).

What types of referrals may be required outside of the health system?

There are also referrals humanitarian responders can make that are not primarily within the formal health system. These include referrals between different sectors of the humanitarian coordination system (eg child protection case worker referring adolescents to health facility services; health worker referring adolescent girls to girl-friendly safe space services; or referring adolescents to MHPSS services), as well as referrals between humanitarian sectors and different departments of the government (eg referring a GBV case to legal assistance services). Guidance on how to conduct referrals between sectors—including linkages to the humanitarian coordination system—and general referral resources, such as steps to make a successful referral and examples of referral forms, are available in [Tools for Establishing Referral Pathways](#).

IMPLEMENTATION AND MONITORING OF ACCESSIBLE AND EQUITABLE SERVICES

Throughout each phase of an emergency response, all services must remain equitable and accessible for everyone, including adolescents with disabilities and lesbian, gay, bisexual, transgender, queer, intersex, and asexual+ (LGBTQIA+) adolescents. This means no adolescent is turned away and organizations are continually utilizing outreach efforts and coordination mechanisms with other humanitarian organizations to reach at-risk subgroups of adolescents. Responders should be referencing rapid needs and gender assessments and focus group discussions for information on the locations and needs of these subgroups (see [Chapter 7: Data for Action](#) for more information on conducting and using information from assessments).

How can we involve adolescents in facility operations?

As emphasized throughout the Toolkit, adolescent involvement is crucial in all aspects of the program cycle and throughout all phases of the emergency. Meaningful engagement of adolescents in facility operations (site set-up, day-to-day operations, and close-out) bears minimal to no additional cost for implementation but ensures that service provision meets IAFM and WHO standards of care and, thereby, meets the needs of adolescents.

Opportunities to involve a diverse group of adolescents in site set-up and service delivery include:

- Recruitment and training of health staff: Adolescents could help by informing health staff what characteristics, skills, or values are important to them and/or can assist with hiring and training staff, such as co-developing/reviewing job aids and supporting ASRH orientations and clinical training via role play or similar activities.
- Facility site set-up and design: Adolescents can provide input on where they want to access services and propose creative ideas for ensuring discreet and confidential mechanisms for adolescents to request information or services on sensitive topics, such as SRH.
- Creation, procurement, and dissemination of IEC: Involving adolescents in developing IEC materials ensures the messages are relevant to their issues, age appropriate, speak in terms they understand/that relate to them, and ultimately address their SRH information gaps and needs.
 - IEC materials can be used not only to educate adolescents on SRH, but also to create demand for services. Other demand creation activities and ideas are included in [Community-Based Services and Outreach Platforms](#).
- Assisting with facility operations: This includes empowering adolescents to help service providers and support staff with day-to-day activities, co-facilitating referrals, and supporting linkages between the facility, providers, and adolescents in the community. As mentioned earlier, evidence shows receiving information from peers or professionals closer to the adolescent's age can put the adolescent at ease and yield better results.
- Assessment and monitoring of facility: SRH managers can work with adolescents to capacitate them in assessing and monitoring health facility operations. The Toolkit provides tools for assessing and monitoring the facility in [Facility Quality Improvement Tools](#) and in [Chapter 7: Data for Action](#).

Note: Limited evidence exists on the impact of utilizing these approaches upon SRH service uptake among adolescents. However, in line with meaningful engagement approaches and limited evidence and experience from humanitarian organizations, the Toolkit advocates for organizations to explore, pilot, and document their effectiveness.



Photo : Kathleen Prior

CASE STUDY

Strengthening ASRH Coordination and Referral Systems with Young People

After completing the TOT workshop on ASRH in Emergencies held by IAWG, Save the Children's Colombia emergency team responding to the Venezuelan crisis trained all of their health team on ASRH in Emergencies using the IAWG training package for frontline workers. During this training, health staff developed several activities as part of their action plan for becoming more responsive to adolescents' SRH needs. One of the action plan steps was to orient case management, child protection, education, and MHPSS staff, as well as community mobilizers, on ASRH in emergencies. As a result, Save the Children held a 2.5-day workshop on how emergency situations affect the SRH needs of adolescents, as well as how to integrate MHPSS and SRH activities with child protection, case management, and education programming. The objectives of the orientation workshop were to have participants: increase knowledge and risks associated with MHPSS; describe the SRH needs of adolescents in emergency settings; understand what SRH services Save the Children provides to adolescents and how to refer cases; encourage positive attitudes toward ASRH; and discuss ways to ensure a professional standard of high quality SRH care that is responsive to adolescents' needs and preferences. On the second day, Save the Children invited adolescents and youth to brainstorm and provide recommendations on how to ensure their SRH and MHPSS programming was responsive to the needs of adolescents and youth. The participants were divided into four groups—each with representatives from case management, child protection, education, health, and MHPSS, as well as an adolescent/youth representative. From this workshop, Save the Children staff—together with adolescents and youth—developed a tentative work plan to integrate SRH and MHPSS topics into community mobilization activities and implement SRH activities that took into consideration the needs and barriers identified by adolescents and youth during the workshop.

What other health service delivery options are there?

- Mobile Health Clinics and Teams
- Telemedicine and Other Outreach Methods
- Self-Care Approaches

Mobile Health Clinics and Teams

During emergencies, access to health facilities becomes constrained due to insecurity, destroyed or damaged infrastructure, and many other factors. Another way to reach crisis-affected populations with SRH services is through mobile health clinics/units and mobile health teams, which can reach remote and hard-to-reach populations in locations unable to access facilities. These mobile teams are comprised of a small clinical team (typically a doctor, midwife/nurse, lab technician, and driver), life-saving medicines and supplies in line with the [MISP](#), laboratory supplies, and a vehicle. Some mobile health teams may establish services in tents, temporary structures, identified health facilities, or refurbished rooms to deliver SRH services to crisis-affected populations living in camps or outside of camps. Regardless of the location of mobile clinic operations, effective referral pathways must be established. Mobile health teams are not only utilized in situations where facilities are hard to access or overwhelmed (such during Ebola outbreaks and the COVID-19 pandemic), but can also be used in outreach efforts to meet the SRH needs of vulnerable populations, such as gathering information on needs, offering a first point of contact for adolescents and youth, disseminating ASRH information to the community, and providing MHPSS/psychological first aid (PFA)—in teams where staff are trained on how to provide these services.

While there are limitations to mobile health clinics—such as challenges with ensuring a safe environment for clinical services, privacy and confidentiality, consistent hours of operation, adequate supply levels, among others—mobile health teams can adjust programming and use these challenges as opportunities to conduct group health education sessions on SRH subject matters affecting adolescents. To note, mobile health clinics should be utilized as an extension of health facilities, not to serve as stand-alone programming that provides all health services to all beneficiaries. As aligned with [Objective 1 of the MISP](#), humanitarian responders should make sure that mobile health teams are well coordinated and integrated with other health programming, ensuring referral channels are used efficiently and appropriately. For more guidance on mobile health clinics/units, see the International Committee of the Red Cross' guidance: [Mobile Health Units: Methodological Approach](#).



AT-RISK ADOLESCENTS: ADOLESCENTS WITH DISABILITIES

Alternate ways of delivering facility services to adolescents (mobile health teams, telemedicine, etc) can provide avenues for reaching adolescents with mobility constraints, such as adolescents with disabilities. Humanitarian responders should look at adopting other outreach strategies, as well as consulting local organizations serving populations with mobility restrictions, to ensure they are reaching the most vulnerable adolescents.

Photo : Victoria Ziegler



Telemedicine and Other Outreach Methods

Telemedicine, or telehealth, allows patients to use digital technologies (mobile devices or computers) to access healthcare services remotely. Telemedicine helps health organizations overcome access barriers and improve access to health services, particularly for hard-to-reach communities, such as rural or humanitarian contexts. While utilizing technology may be promising with adolescents, humanitarian practitioners must remain diligent in continuing to implement multiple modalities of reaching adolescents who may not have the same level of access to technology and information. Médecins Sans Frontières (MSF) and other organizations have been employing telemedicine approaches to deliver health services to crisis-affected populations for several years. Below are some ways telemedicine can be utilized in humanitarian settings and the benefits of employing them:

Additional evidence needed

While some organizations have documented the effectiveness of using telemedicine in humanitarian settings, there are few studies that look at the direct effects of telemedicine on SRH outcomes and even fewer that look at SRH uptake among adolescents. It is important to look at evidence focusing on adolescents, as telehealth solutions that work for adults are not necessarily suitable for adolescents.

Self-Care Approaches

Due to stigma and socio-economic barriers to accessing care, adolescents may prefer approaches like self-care for privacy and avoiding negative attitudes and/or treatment by unsensitized health professionals. It is essential for SRH managers to recognize the importance and potential of self-care, especially when it intersects with fragile health systems with limited infrastructure and services, supplies, and minimal availability of health staff in humanitarian settings. In fact, self-care can play an essential role in improving ASRH outcomes. According to WHO, “Self-care is the ability of individuals, families, and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare provider.” The extent of self-care interventions is wide-ranging and it has the potential to increase choice—when it is accessible and equitable—and increase opportunities for adolescents to make informed decisions regarding their health and healthcare options. SRH managers may include a variety of self-care approaches throughout the humanitarian continuum, including health promotion and disease prevention activities; peer-to-peer outreach and support activities; and, most importantly, provide adolescents the agency to practice self-medication. For example, SRH managers can use digital health interventions to improve SRH knowledge, such as use of modern contraceptives to prevent unwanted pregnancy, and self-efficacy while supporting the self-management of abortion and self-administration of injectable contraceptives, such as [Sayana Press](#), after an abortion. In developing ASRH self-care approaches, SRH managers must equip adolescents with the necessary knowledge and materials to effectively use SRH products and involve adolescents in designing and disseminating these materials. Also, programs should ensure that adolescents have a source of accurate information and continuous access to a health provider whenever they need or want support. For more information, please refer to the [WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights](#) and Ipas’s [Abortion Self-Efficacy Scale](#).



Telemedicine can be deployed quickly (with adequate resources and capacity).

Example: During Typhoon Haiyan, humanitarian responders used telemedicine to provide onsite patient examinations while communicating live with doctors in the United States.



Telemedicine can provide a non-stigmatizing and confidential way for patients to receive SRH services, such as safe abortion care services.

Example: In Northern Thailand, community-based organizations provided abortion services through a telemedicine intervention that linked women who requested abortion services to a trained professional for guidance on self-administering quality-verified misoprostol.



Telehealth can also help bridge skills gaps among health staff.

Example: In Guatemala, community health nurses call into a weekly tele-education conference with experts at the Children’s Hospital at the University of Colorado Center for Global Health.



Organizations have combined telemedicine with other technologies and activities to best tackle access constraints.

Example: In Jordan, MSF combined 3D technology with telemedicine services to provide comprehensive rehabilitation services for patients with facial burns and upper limb differences.

In addition to telemedicine, there are m-health and other community health approaches to deliver SRH information and services to adolescents. See [Community-Based Services and Outreach Platforms](#) for more information.



Photo : Relief International

CASE STUDY

Increasing Access to Abortion Self-Care Through Social Media Platforms and Telehealth Approaches During the COVID-19 Pandemic

Since 1973, Bolivia has allowed abortion in cases of rape, incest, or to protect a woman's health. However, most abortions are still performed clandestinely, either by women themselves or with accompaniment. These abortion self-care (ASC) behaviors live in a gray zone of national law—not quite legal but also not criminalized—and can leave people uncertain about their options for safe abortion or even care for abortion complications.

The COVID-19 pandemic exacerbated confusion and further restricted access to facility-based abortion care in 2020, forcing human and material resources to deploy in new ways to meet healthcare demands of the pandemic. For women and girls attempting to access abortion services during the pandemic, social distancing and service delivery changes in the health system caused additional challenges and increased reluctance to visit a health facility. In response, Ipas Bolivia acted quickly to support an organically growing social media movement with the slogan “I decide”. Ipas-trained community health volunteers, particularly younger volunteers, began utilizing social media networks—Facebook and Whatsapp—as a more effective way to meet the increased abortion care needs brought on by COVID-19. Social media was especially effective for reaching young women—who were already less likely to visit a health facility and avid users of social media. Abortion information was provided to those with a code from allies in the network to protect the integrity of information and privacy of users. Users continued to increase as people in isolation and self-quarantine shared news of these efforts. A volunteer group of young people, university students, house wives, and others committed to abortion rights and access managed the network's referral mechanisms—providing life-saving information on ASC, closely monitoring and supporting women and girls during abortion or PAC until the services were completed, and preparing trained medical providers and lawyer allies to respond to any complaints from legal authorities or PAC complications from clients.

One story shared from Ipas volunteers was of a 17-year-old adolescent who contacted a volunteer using the “I decide” Facebook page requesting information on her options for abortion. The client was six-weeks pregnant and—due to social isolation during the pandemic—lacked a strong support network. The young community agent counselled the adolescent on her abortion and contraceptive options and provided information for her abortion needs. Since community agents in Bolivia were already working in a quasi-legal environment on a stigmatized topic, the protections necessary for giving information and delivering medication without a prescription were already in place. The adolescent used the medication at home, taking six hours to complete the process, and then visited a health post to choose a contraceptive method. This example, and others from humanitarian settings where healthcare access is limited, highlights how social media can be used as a vital resource for providing information to women and girls who need abortion care. Moreover, it emphasizes the opportunity to promote and/or continue self-care strategies in mobility-restricted environments—such as during disease outbreaks or in contexts where freedom of movement is limited—when the public health system is reluctant to prioritize SRH services and abortion, even when it is within the law.

Facility Quality Improvement Tools

Practitioners must understand what SRH services are offered to adolescents, where they are offered, and the quality of those services in order to deliver them and/or refer adolescents to other facilities to address their SRH needs. To assess the quality of SRH services offered to adolescents, humanitarians can refer to [Chapter 7: Data for Action](#) for additional monitoring and evaluation methods and annexes. For example, the service tool provided in [Annex G](#)—adapted from Women's Refugee Commission (WRC)—includes areas to document the service provider/facility, the services provided, who can access those services, identified barriers for adolescents accessing the SRH service, quality of services provided, and additional notes. The column for providing a short assessment of the services is where practitioners should examine the quality of the SRH services provided, using their own quality standard checklists and/or other organizations' checklists.

[Annex I](#) provides an ASRH Health Facility Checklist, which helps humanitarian staff assess the facility's characteristics, policies, and actions in regards to responding to adolescents' SRH needs. Included in this checklist are the clearly displayed obligation and responsibilities providers must adhere to when delivering SRH services to adolescents. If the health facility's policies and clinical protocols do not include adolescent-specific guidance and/or list adolescents as part of providers' obligations and responsibilities to provide quality SRH services—including respecting their SRH rights—then staff should amend the guidance to include these components and orient staff to the added provisions accordingly. For more information on how to use the checklist, please refer to [Annex H](#).

The ASRH Health Facility Checklist can serve as a proxy for assessing the quality of ASRH services provided in the facility; however, organizations should be using quality standard checklists on a regular basis as well. Here are some examples of quality standard checklists for assessing the quality of SRH service provision. Some are already adapted for adolescents, while others need to be adapted accordingly (like the WRC tool above).

- [WHO Standards for Improving Quality of Care for Children and Young Adolescents Aged 0–15 Years in Health Facilities](#)
- [WHO Quality of Care in Contraceptive Information and Services](#)
- [WHO Quality of Care for Maternal and Newborn Health: A Monitoring Framework for Network Countries](#)



Counseling Tools & Resources

This section provides clinical health workers and CHWs with several counseling tools and high-level guiding principles on how to provide integrated counseling on SRH services to adolescents. Additional resources for CHWs and other community health modalities can be found in [Community-Based Services and Outreach Platforms](#). The tools included or referenced below provide guidance on the core components of counseling adolescents with different methods and mechanisms (checklists, assessments, cue cards, etc).

How is counseling adolescents different from other patients?

As discussed earlier, adolescents listed negative experiences regarding the providers' attitudes, biases, or lack of skills or knowledge as major barriers to seeking or receiving SRH services. This demonstrates a clear need for providers to better understand how to talk to, counsel, and provide services to adolescents. The below guidance helps point out what some of these differences are and how practitioners can provide more tailored counseling that meets adolescents' needs. Since adolescents face immeasurable obstacles in accessing healthcare, providers should utilize the opportunity to provide holistic care or make referrals for specialized care, as referred to in [Chapter 5: Going Beyond Health Services](#). This means that if service providers see signs of depression, suicide, any form of GBV, and other risk factors, they should take the appropriate actions related to international and organizational principles of child safeguarding. It is also important to note that counseling adolescents on their SRH needs does not equate to therapy, and front-line providers should make the appropriate referrals to specialists.

Save the Children—in consultation with the IAWG ASRH Sub-Working Group—developed a list of five principles for staff to use to create a trustful atmosphere in counseling adolescents.

These principles align with other counseling guidance, but are not the only principles. As with other guidance and tools in the Toolkit, the counseling principles and related guidance must be contextualized—meaning staff providing counseling sessions should use language that is appropriate and relevant to the culture and community of the context. This list is merely a guide for helping health staff (eg service providers, CHWs, social workers) to create an environment that is more comfortable, inviting, and open for adolescents seeking SRH services. Save the Children's counseling resource has been piloted in Colombia, with plans to pilot in their other SRH emergency country programs. For more information on these principles and how to train others using these principles, Save the Children has developed a half-day [training package](#) for service providers on how to counsel adolescents on contraceptive methods.

Five Principles for Creating a Trustful Atmosphere for Adolescent Counseling

1. **Be respectful and non-judgmental with the adolescent patient**
2. **Listen actively and show interest in the adolescent**
3. **Ensure privacy and confidentiality of the adolescent patient**
4. **Use terms and counseling resources that are adolescent-friendly**
5. **Allocate more time for counseling adolescent patients**

1 Be respectful and non-judgmental with the adolescent patient

- a. Respectfully introducing yourself is vital, as this is the initial moment to provide a safe environment and terminate possible walls of shame and stigma. Use plain language and utilize accurate terminology. For example, say, "Hello, I am Shirin, and the last five years I have been providing a broad range of health services, such as pregnancy care, contraception, abortion, STI, and sexual violence services, and I have worked with lesbian, gay, bisexual, and transsexual young people, and children who have been sexually assaulted." Putting what is considered destigmatizing language on the table provides adolescents with reassurance, invites confidence in you as the provider, and assures them that they are in the right place to access SRH services.
- b. Providers should also use general questions to make the adolescent feel more comfortable. For example: "How are you? What do you do for fun?" instead of, "Why are you here?"
- c. Providers should respect adolescents' autonomy, including their choice of contraceptive method and/or their choice of provider, where possible. Providers should not make assumptions about their level of sexual activity (such as assuming adolescents with cognitive impairments or physical disabilities are not sexually active), nor about their sexuality preferences (see [Using Gender-Neutral and Non-Stigmatizing Language](#)).
- d. It is important to recognize and acknowledge biases and perceptions of staff before thinking about how to address those attitudes when counseling others. [VCAT](#) exercises provide an excellent resource for identifying staff's attitudes and biases.

Using Gender-Neutral and Non-Stigmatizing Language

Given the vulnerability of adolescents in humanitarian settings, it is important for providers to utilize inclusive language and refrain from other forms of discrimination and stigmatizing language and services. Below are some inclusive, gender-neutral, and non-stigmatizing language that providers can utilize when initiating services with adolescents:

DOs	DON'Ts
Say, "The patient is here in the waiting room," or use the term "they". For example, "They are here for the 3pm appointment."	Avoid using gender terms and pronouns when first addressing adolescents or when talking to other staff about a client. Avoid referring to a person as "it".
Ask: "How may I help you?" Ask: "I would like to be respectful. How do you wish to be addressed?" Use the terms that adolescents want to use to describe themselves.	Avoid assuming an adolescent's gender identity and avoid using gender terms and pronouns. Avoid using Mr/Mrs/Miss/Ms.
Ask: "Are you in a relationship?" Use the terms that adolescents use to describe their partner. For example, if an adolescent refers to their "girlfriend," then say, "your girlfriend" when referring to her.	Avoid using: "Do you have a boyfriend or husband?" Avoid saying "your friend".
Display positive and warm facial expressions and verbal and body language.	Avoid showing disapproval or disrespectful language, negative facial expressions, staring or expressing surprise at someone's appearance, or gossiping about an adolescent's appearance or behavior.
Reaffirm that the adolescent's gender status will remain confidential and only disclosed if necessary for adolescent's healthcare.	Avoid disclosing an adolescent's gender status unless it's necessary for the adolescent's healthcare.
Ask yourself: "Is my question necessary for the patient's care, or am I asking it for my own curiosity?" Ask yourself: "What do I know? What do I need to know?"	Avoid asking adolescent unnecessary questions for your own curiosity.
When sharing results of clinical labs, say "healthy" or use "HIV negative".	Avoid using stigmatizing language and services. Avoid using "normal" or "clean". Avoid disclosing an adolescent's test results.

For additional guidance for providers establishing gender-neutral and inclusive services, refer to National LGBT Health Education Center's [Providing Inclusive Services and Care for LGBT People](#), Essential Access Health's [Providing Inclusive Care for LGBTQ Patients](#) and IRC's [Inclusion of Diverse Women and Girls Guidance Note](#).

2 Listen actively and show interest in the adolescent

- a. Active listening includes:
 - i. **Silence** that allows one to hear the concerns and questions of the patient;
 - ii. **Paraphrasing** language to show attention and understanding and to encourage the patient to continue; and
 - iii. **Using Clarifying Questions** to better understand what the patient has said.
- b. Sit in a position so that the adolescent can choose to establish eye contact or not. As the provider, it is essential to maintain eye contact when you are speaking to the adolescent and when the adolescent is speaking to you. If the adolescent does not establish eye contact, do not be discouraged, as it could be cultural or due to feeling self-conscious.
- c. Adolescents are going through many changes that they may not understand. They may have questions about these changes but be too afraid to ask. Thus, it is very important that the adolescent feel like you are interested in their concerns, fears, and questions. Using the active listening technique and establishing eye contact throughout the counseling session are good ways to show your interest to the adolescent. By providing a calm, open, and welcoming atmosphere, the adolescent will be more willing to share.

3 Ensure privacy and confidentiality of the adolescent patient

- a. Privacy relates to the physical surroundings (both auditory and visual privacy) of the patient. We want to ensure that anything they share will not be heard by other people.
 - i. When counseling adolescent patients, providers should be talking to them in a setting where visual and auditory privacy can be ensured and where adolescents feel comfortable. With the exception of life-saving situations, humanitarians should take extra care to ensure confidentiality and privacy for GBV survivors, adolescents seeking abortion services, and SO-GIE populations.
 - ii. Per the [Principle of Capability](#), adults are not required to be in the room during a counseling session. Healthcare workers can confidently trust adolescents and follow the adolescents' lead in whether or not they prefer a parent or caregiver present at the time of counseling and service delivery. If the adolescent wants someone present, allow it, but use discretion and ensure there is no coercion.
 1. Healthcare workers can utilize other options to reassure the parent or caregiver. For example, without breaking confidentiality, the provider can reassure the parent/caregiver by providing a brief status update on the adolescent's condition—stating if they are safe and well.
- b. Confidentiality is related to privacy because we want to ensure that anything that is shared in these private settings is kept private—meaning that we will protect that information from being shared with anyone else. For confidentiality, all service providers must sign/agree to confidentiality policies. This means that they are not permitted to discuss any aspect of the appointment with anyone else. Should the provider need to consult another staff member for advice on how to provide services, the patient's identity must be protected.

- i. Equally important, providers must clearly communicate what confidentiality entails to ensure the adolescent understands the concept. Similarly, any information collected from the patient must be guarded and kept in a safe location at all times (under lock and key) and should be destroyed responsibly when the time comes for discarding patient information.
- ii. When discussing confidentiality with the adolescent it is also important for providers to be up-front regarding local medico-legal restrictions.

4 Use terms and counseling resources that are adolescent-friendly

- a. SRH terms can be confusing to explain to adults. Think about how these concepts might be difficult for adolescents to understand, particularly if they have never heard these words before your session.
 - i. For example, if you tell an adolescent that your conversation is confidential, they may not understand what that means. Instead, you should try to use terms they are familiar with. The provider could instead say, “Whatever you want to share with me during our discussion will stay between only you and me. This is a safe space.”
- b. Remember to adapt your words or phrasing depending on the needs and capacities of the adolescent patient.
 - i. The way you explain menstruation to a VYA should be different to the way you explain the term to an older adolescent. Be prepared to adjust your explanations to ensure comprehension.
 - ii. Adolescents might be hesitant to ask questions about their body or the services they are requesting. Some adolescents may have difficulty understanding verbal or written explanations due to cognitive impairments, language difficulties, or other factors. Using pictorial [job aids](#) and SRH-related commodities that are user friendly are ways of helping to overcome some of these challenges.

5 Allocate more time for counseling adolescent patients

- a. As demonstrated through the previous four principles, many of these considerations for adolescents require more time than other patients.
- b. Providers should allow additional time for adolescent appointments to ensure adequate time to greet them and make them feel comfortable, answer questions in terms they understand, and provide all the information and optics they need for them to make an informed choice.
- c. The principle of “do no harm” is extremely important when working with adolescents. Ensure that you follow through on your efforts. For example, if you have established trust and the adolescent begins to disclose information on difficult subject matters, ensure that you stay with the adolescent and finish the task of providing the necessary support and referrals they may need. As a provider, if you end the visit earlier than the adolescent needs, you can do a lot of harm by creating additional disappointment, confusion, and a deeper sense of loneliness and helplessness than was there previously.

- d. When ending the appointment, it can be useful to ask an open question regarding if the adolescent has any additional concerns or questions. For example, "Is there anything else you would like to talk about and/or do you have any additional questions?" Seeking counseling can be intimidating for adolescents, and asking them an open question at the end allows the adolescent to ask or disclose information that they perhaps were not comfortable doing at the beginning of the appointment, as well as providing an opportunity to refer them to additional services they may need or request.
 - i. Accept that not all adolescents may want to access additional services. For example, some survivors of sexual violence may not want MHPSS counseling.
 - ii. Lastly, when a follow-up session is scheduled, make sure that you look through your notes from the previous session before starting the follow-up session. It gives a sense of identity to the adolescent patient (as opposed to being a number or simply the next in line) and re-establishes the trustful atmosphere.

What are some other counseling resources we can use with adolescent patients?

The five principles outlined above broadly provide a glimpse into the complexities of counseling adolescents. Below are tools that provide healthcare workers with detailed guidance on providing quality and integrated counseling to adolescents and adolescent heterogenic groups.

GATHER Counseling Checklist

Given the increased risks faced by many adolescents during crises, it is crucial to take the time to carry out individual assessments to identify adolescents at increased risk and provide them with immediate counseling or link them to support systems as soon as the situation permits. The GATHER (Greet, Ask, Tell, Help, Explain, Return) checklist tool can be used in trainings and by health providers to facilitate counseling sessions with adolescents and informed decision-making on SRH and services. The questions and actions in the guide in [Annex J](#) have been adapted for use with adolescent patients and provide examples of how the GATHER assessment might look in an emergency context.

Skills Assessment Checklist for ASRH Counseling

A counseling checklist provides an opportunity for providers to practice their skills. A skills assessment checklist can be used in trainings, supportive supervision and coaching visits, and as a self-assessment guide for providers to refer to and improve their skill set. The [IAFM](#) and other resources (eg [WHO Family Planning Handbook](#)) include additional guidance on how to provide quality and clinically accurate information and counseling for SRH services aligned with the [MISP](#). Pathfinder International created a [counseling skills assessment checklist](#) that healthcare providers can use as a quick guide throughout all phases of a humanitarian emergency response.

SRH Counseling Cue Cards and Flip Charts

Pictorial counseling cue cards, brochures, and flip chart tools strengthen provider–adolescent communication by helping community- and facility-based providers to remember and reinforce key information and messages, while also supporting adolescents to conceptualize the information. The compilation of resources outlined below facilitate communication processes that are appropriate for adolescents by conveying core reproductive health concepts using images. All resources are evidence-based and can be adapted to any context.

- Population Council's [Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings](#) (Third Edition) includes counseling cards and method brochures to prompt discussions during a health facility visit.
- WHO's [Decision-Making Tool for Family Planning Patients and Providers](#), [Reproductive Choices and Family Planning for People Living with HIV Counseling Tool](#), and [A Guide to Family Planning for Community Health Workers and Their Patients](#) flip charts are tools that are readily available to use and adapt to your setting.
- Pathfinder's [Cue Cards for Counseling Adolescents on Contraception](#) are designed to help a range of community- and facility-based providers to counsel adolescents on their contraceptive options.
- USAID's [Adolescent Age and Life-Stage Assessment and Counseling Tool](#) includes a compilation of counseling cards for healthcare workers who treat and counsel adolescent patients. The purpose of these resources is to support healthcare providers in using the counseling session as an opportunity to holistically support the patient.

Counseling Considerations for Adolescent Survivors of Gender-Based Violence

The [Inter-Agency Standing Committee \(IASC\) Guidelines for Integrating GBV Interventions in Humanitarian Action](#) state that humanitarian practitioners must assume that GBV is occurring in any humanitarian emergency and take action to address it—with or without the presence of data about its scope and impact.

GBV is a principal concern for health and human rights, and is part of the integrated definition of SRH. Health services are often the first—and sometimes the only—point of contact for survivors seeking assistance for GBV. While the Protection Cluster is responsible for the coordination of the GBV response, mitigation and managing consequences of sexual violence are under the remit of the Health Cluster. Providing information to survivors in a safe, ethical, and confidential manner—including information about their rights and options to report, the associated risks with reporting, and how to access appropriate services—is an obligation of frontline providers and all humanitarian practitioners.

What are the best practices for counseling GBV survivors?

While the evidence for universal screening for gender-based violence in humanitarian contexts has become a subject of debate, the IASC Guidelines for Integrating GBV Interventions in Humanitarian Action recommends that all non-specialized GBV practitioners and service providers who interact with the affected population must be trained on the Key Elements of the Survivor-Centered Approach for Promoting Ethical and Safety Standards (see below breakout box). Otherwise, survivors may face increased risk of additional violence and stigma from peers, partners, family, and/or community members. A survivor-centered approach “aims to create a supportive environment in which a survivor’s rights are respected and in which the person is treated with dignity and respect. The approach helps to promote a survivor’s recovery and their ability to identify and express needs and wishes, as well as to reinforce their capacity to make decisions about possible interventions.” It is important to note that in humanitarian settings, adolescent perpetrators may have experienced sexual violence themselves. These adolescent perpetrators are also traumatized and need counseling and support services.

This means the application of this approach and the guiding GBV principles by all those who are engaged in SRH programming and service delivery must prioritize the rights, needs, and wishes of the survivor.

Key Elements of the Survivor-Centered Approach for Promoting Ethical and Safety Standards

The [IASC Guidelines for Integrating GBV Interventions in Humanitarian Action](#) outline key elements of a survivor-centered approach for GBV-related programming.

- **Safety:** The safety and security of the survivor and others, such as their children and people who have assisted them, must be the number one priority for all actors. Individuals who disclose an incident of GBV or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them.
- **Confidentiality:** Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust, and empowerment.
- **Respect:** The survivor is the primary actor, and the role of helpers is to facilitate recovery and provide resources for problem solving. All actions taken should be guided by respect for the choices, wishes, rights, and dignity of the survivor.
- **Non-discrimination:** Survivors of violence should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation, or any other characteristic.



Photo : Reginald Louissant Jr

During counseling sessions, WHO encourages healthcare providers to raise the topic of GBV with patients who have injuries, symptoms, or behaviors that they suspect may be related to violence. A provider's responsibility is to “do no harm”; they should encourage conversation if injuries or conditions are suspected to be related to violence and refer the patient to providers with CMR training and other GBV and protection services. IRC's [ASIST GBV screening tool](#) has proven valuable in several humanitarian contexts when implemented according to the established best practices; however, if the local context is not appropriate, this screening tool should not be utilized as it could do more harm. Many survivors will not disclose violence to a healthcare provider (or any other provider) due to fear of repercussions, social stigma and shame, rejection from partners/families, and other reasons. Survivors may be inadvertently discouraged from asking for help for GBV-related health problems for a number of reasons, including:

- if the survivor does not want to disclose their GBV trauma, respect their decision;
- if the provider does not ask the right questions;
- if communication materials in the facility do not make clear the types of services that are available and that they are available for all;
- if the provider makes remarks or in some other way implies that the disclosure of GBV will not be met with respect, sympathy, and confidentiality.

There is a fine line that providers need to balance along with providing care—not overburdening the client with questions and triggering re-traumatization is paramount. While WHO encourages raising the topic of GBV, it also advises to never raise the issue of violence unless the adolescent is alone—even if the client is with a friend or family member, as they could be the abuser. It is advised providers ask about violence in an empathic, non-judgmental manner and refer clients, if desired, to various protection, GBV, and MHPSS services. For example, adolescent survivors of sexual violence or adolescents who struggle with their sexual identity may need therapy and presenting this option of support is one of many actions a healthcare worker can provide. Moreover, similar to any counseling session, providers should use language that is appropriate and relevant to the culture and community they are working in. For example, some adolescents may not like the words “violence” and “abuse”. It is important to use the words that adolescents themselves use. Cultures and communities have ways of referring to the problem with other words, and organizations can consult community leaders and adolescents on the best terminology to use.

In summary, SRH managers should put in place the following minimum requirements for asking about GBV (such as intimate partner violence), specifically: develop/adhere to a protocol/standard operating procedure, provide training on how to ask adolescents questions about GBV trauma, ensure a private setting and confidentiality, and establish/guarantee systems for referral are in place. Healthcare workers may use [WHO's LIVES method](#) that guides providers to Listen, Inquire about needs, Validate, Enhance safety, and Support through coordinating confidential referral procedures between health, psychosocial, security, and protections services. Humanitarian practitioners and healthcare workers who actively engage with affected populations should have documentation with information about where to refer adolescent survivors. Remember, GBV survivors often require multi-sectoral referrals, and it is important to know where to connect adolescents (see [Multi-Sectoral Linkages and Referral Pathways](#) for tools and more information).

Additional GBV Resources

There are several key resources for healthcare workers and SRH managers that provide guidance for the minimal standards for GBV in humanitarian settings—including GBV screening guidance, PFA, MHPSS, as well as inclusion guidance for women, adolescent girls, persons with disabilities, and SOGIE populations. Due to the large number of guidance documents included, we have provided the GBV additional resources in [Annex K](#).

Community-Based Services and Outreach Platforms

This section builds upon the [Meaningful Participation](#) chapter. It provides tangible guidance on how humanitarian responders can engage with adolescents through community-based health services and social and behavior change (SBC) strategies that promote higher participation levels along the humanitarian continuum, thereby creating an enabling environment and improving demand for ASRH services. There are several community outreach platforms and SBC and communication strategies humanitarian responders can utilize to engage adolescents and their communities during emergencies. Research shows that evidence-based SBC programs can increase knowledge, shift attitudes, and produce a variety of different changes in behavior, including for ASRH. To help improve the design and implementation of SBC activities, including many of the community outreach platforms described in this chapter, the [Urban Adolescent SRH SBCC Implementation Toolkit](#) walks you through the process, as does the [SBCC for Emergency Preparedness Toolkit](#).

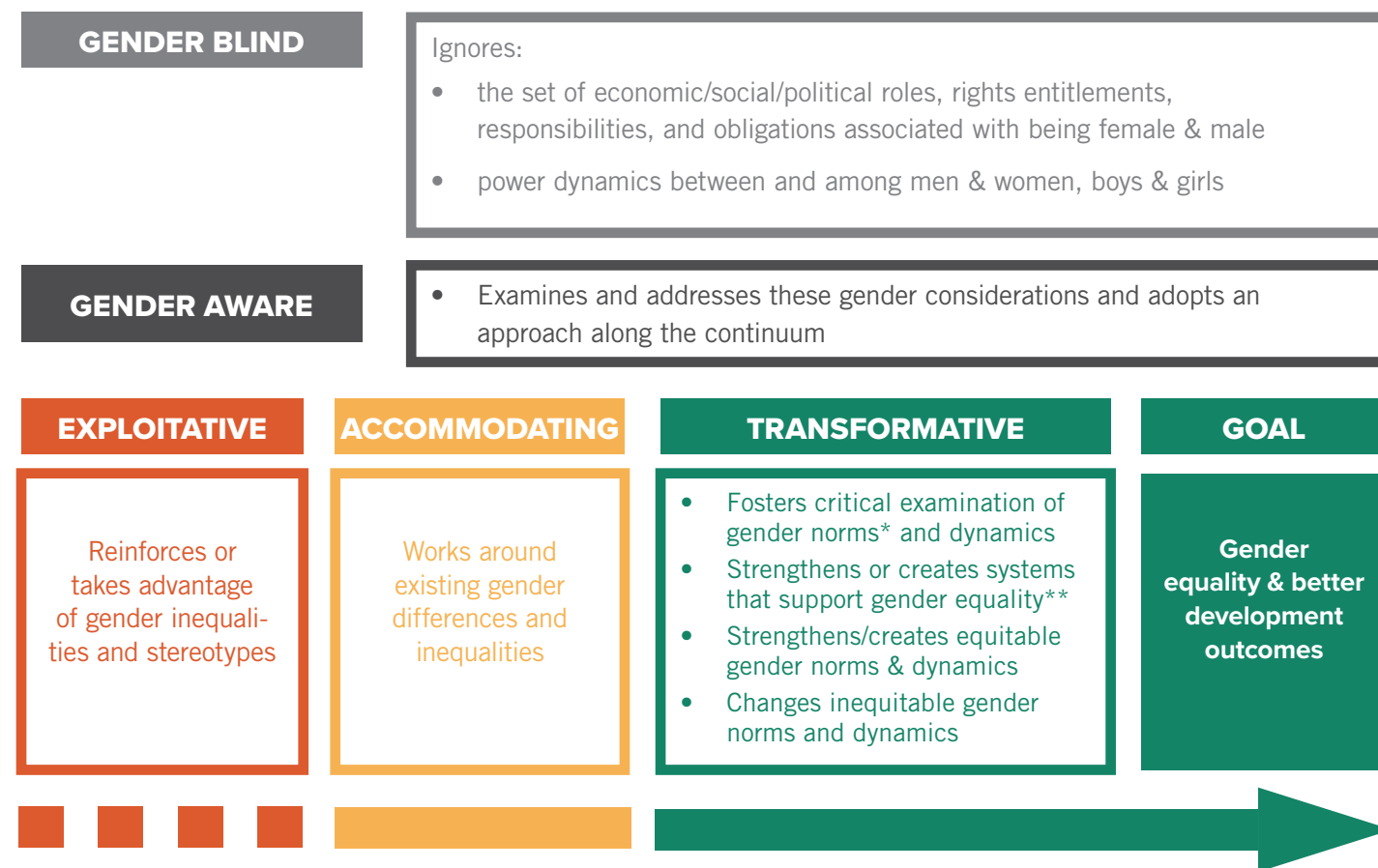
KEY MESSAGE

In addition to adopting SBC strategies, all SRH programming—including community-based activities—should include a gender-integration lens. Gender-aware programs and policies deliberately examine and address the anticipated gender-related outcomes during both design and implementation. An essential requirement for all gender-integrated activities is to be gender-aware. There is a growing recognition among practitioners that engaging men and boys alongside women and girls in SRH programming is fundamental to addressing gender inequality and realizing SRH and rights for all people. IRC provides a humanitarian example of equipping adolescents with life skills to positively influence gender attitudes from their [Girl Empower](#) project. However, much of the existing evidence in this area comes from more stable, low-income settings, including approaches from [Youth Power Community of Practice for Gender and Positive Youth Development](#) and the [Institute for Reproductive Health \(IRH\) website](#). The Population Reference Bureau for the Interagency Gender Working Group developed specific guidance for [how to engage men and boys in health promotion and gender equity programming](#).



The Interagency Gender Working Group developed a training module for program designers and implementers to use in planning how to integrate gender into their programs or policies. A part of this module is their [Gender Equality Continuum Tool](#), which shows how practitioners can go from gender-blind to gender-aware programming—with the aim of equality and better development outcomes (see Figure N below).





Figure N: Gender Equality Continuum Tool



* Norms encompass attitudes & practices

** A system consists of a set of interacting structures, practices & relations

This section focuses on different community-based activities and outreach strategies humanitarian responders can implement outside of the health facility:

-  1. Engaging adolescents/youth as first responders
-  2. Local organizations and youth-led organizations
-  3. Community health
-  4. Communications, media, and technology

In addition, there are long-term strategies to implement within the community—in coordination with other sectors—for comprehensive SRH programming. The Toolkit has included a few of these strategies in [Transitioning from Acute to Comprehensive](#).



1. Engaging Adolescents/Youth as First Responders

As indicated in the [IAFM](#) and in the [Chapter 3: Meaningful Participation](#), it is critical that humanitarian actors recognize not only the needs of adolescents in emergencies but also their ability to contribute at all levels of the humanitarian response framework and within their own communities.

One way of moving toward shared decisions between adolescents/youth and adults (Refer to the [Flower Participation Tool](#)) is by engaging adolescents and youth as first responders in a humanitarian emergency. The terminology used for this engagement varies across contexts and organizations. For example, many humanitarian organizations may use the term “youth volunteer” to refer to a youth who is providing condoms to their peers, whereas a development agency may use the term “peer leader” or “peer provider”. Several organizations have developed toolkits, guidance documents, and training resources for their respective youth or peer models. For detailed guidance on these approaches, refer to [Included Involved Inspired: A Framework for Youth Peer Education Programmes](#) from International Planned Parenthood Federation (IPPF), [Youth Peer Education Toolkit](#) from FHI 360, and Y-PEER’s [website](#) for additional resources and detailed guidance.

For the purposes of this Toolkit, we will be focusing on how humanitarian responders can work with youth should they choose to engage them in SRH and community outreach activities.

The More You Know: Youth/Peer Models

Working with peer leaders and youth volunteers is one element of an ASRH program and should be combined with other efforts to increase SRH knowledge and service uptake. Peer education has not been evaluated in emergency settings and may still be an effective model given limited access to services. While the Peer Educator Model contributes to important information-sharing among adolescents, evidence from development contexts indicates that it is not effective in improving behavior change on SRH, and often, it is peer educators who experience the benefits of the programming rather than intended beneficiaries. However, peer educator models may be more successful when complemented by other ASRH interventions and with adequate supervision and mentorship for peer leaders.



What do I need to know before engaging youth as first responders?

Engaging adolescents as first responders strengthens program response strategies and implementation. To effectively engage adolescents as members of the core response team of your organization, there are key best practices any organization should follow.

BEST PRACTICES FOR WHEN ENGAGING ADOLESCENTS

- Cross-check local human resource laws pertaining to adolescent engagement.
- Make sure your agency has a policy on engaging volunteers under the age of 18 years old. Issues such as how volunteers under the age of 18 years will be reimbursed through non-cash incentives, the maximum number of hours they are allowed to volunteer per day and per week, and minimum supervision requirements in order to engage young people should be addressed.
- Program managers should have clear selection criteria for adolescent and youth volunteers to ensure they are representative of the crisis-affected population and are able to reach those at increased risk (consider age, gender, in/out of school, marital status, cultural background, disability status, etc).
- Ensure that youth volunteers are not given tasks or duties that will risk their lives, safety, or lead them to become stigmatized by their community.
- Program managers should ensure young people are remunerated for their contributions to the envisioned ASRH program and terms of reference (TOR).
- The TOR for engaging young people should be communicated not just with the volunteers but also with program staff of other sectors so that they also understand the role. This is to both allow the opportunity to coordinate with other sectors and also to protect the volunteers from not being burdened by tasks from other sectors, as they can be seen as an easily available resource. Any work beyond the scope of the TOR should first be discussed and approved by the supervisor before engaging adolescents.
- Regardless of the stage of the emergency, all youth volunteers should be properly onboarded on the agency's ways of working, including undergoing orientation on child safeguarding, PSEA, and reporting incidents.
- Young volunteers should understand that they can stop volunteering at any time.
- Young volunteers must receive adequate supervision and mentorship along with continuous capacity-building support (**one-time trainings are not effective!**).

Note: This guidance is in line with evidence-based programs from development contexts. Additional evidence is needed for humanitarian contexts.

How do we ensure adolescents and youth have the right supervision?

As mentioned earlier, supervision and mentorship of adolescents/youth is critical. Young people need continuous training, mentorship, support, advice, and supplies. If supervision, mentorship, and programmatic resources cannot be guaranteed, it is advised organizations refrain from engaging adolescents/youth as first responders, but instead meaningfully engaging adolescents/youth in other components of the program cycle and throughout the humanitarian continuum.

Who are considered supervisors of young people?

Any SRH manager or field coordinator overseeing key adolescent programmatic components in the field. Ideally, all the engaged adolescents/youth are within the same location to allow easier access between supervisors and the adolescents/youth. Ensuring supervisors have the necessary skills to mentor is paramount. In [Annex L](#), IPPF outlines the essential characteristics of supervisors for mentoring youth. Equally important to recruiting the right supervisors is also making sure organizations are implementing appropriate child safeguarding policies (such as PSEA) and measures, as well as other provisions to guarantee the safety and protection of adolescents.

Supervisors should (in coordination with adolescents/youth/young people, where appropriate):

- Provide training: young people need continuous training on ASRH material to ensure they are providing accurate information, in addition to training on the importance of privacy and confidentiality.
- Mentor young people: young people may encounter difficult questions that they cannot answer and need guidance on how to respond in these situations.
- Supply needed materials: young people learn and communicate with one another using different learning methodologies. Based on specific activities, young people should be provided the appropriate supplies they need to meet the intended deliverables.
- Oversee a small group of young people: the smaller the group, the better the supervision.
- Hold group meetings: allows young people to share information and experiences.
- Have office hours: allows young people to seek in-person advice or consultation.

CASE STUDY

Y-PEER Nepal Emergency Response and Supervisory Support of Youth Networks at the Onset of 2015 Nepal Earthquake Response

In the wake of a series of earthquakes in Nepal in 2015, youth volunteers were able to mobilize and provide SRH services to their peers due to the coordination efforts of and strong networks established by Y-PEER. A group of Y-PEER Nepal youth members, as well as youth from a local club, gathered within three days after the first earthquake and began distributing menstrual materials to friends and community members sheltering in relief structures in Kathmandu, Nepal, and neighboring districts. In the following weeks, Y-PEER trainers from Nepal communicated with Y-PEER networks in the Philippines and Lebanon, who had more experience working in humanitarian settings, to deliver SRH services. Taking learnings from the Philippines and Lebanon, the Y-PEER Nepal trainers assembled more than 25 young people in Kathmandu to discuss a rapid needs assessment, which would include questions to measure the SRH needs of adolescents and youth, and began training the youth volunteers on how to conduct the needs assessment. Y-PEER Nepal was able to finance most of the cost for the needs assessment, but youth volunteers also worked with private organizations to provide menstrual materials and sanitation supplies. Youth volunteers used the survey results to plan SRH activities in coordination with the GBV and SRH Clusters. Y-PEER was able to receive funds from UNFPA for Youth LEADS in Emergency, a program involving more than 35 youth volunteers from Y-PEER and two other organizations. The program served adolescents and young people from 16 locations—including camps, schools, and temporary shelters—to provide SRH information and services, as well as peer-to-peer sessions and an IEC campaign to raise awareness about GBV and other SRH issues via radio broadcast. The program also produced contextualized tools that were developed and used by young people themselves.



2. Local organizations serving youth and youth-led organizations

Why do we need to invest in youth-led and local organizations?

Whether at international conferences or during consultations for programming and generation of toolkits and guidance documents, the message is the same: young people want more investment in their ideas and in the organizations they are leading or a part of.

Beyond young people asking for this type of investment, supporting local organizations—including youth-led organizations—helps humanitarian organizations better reach adolescents with SRH information and services. Local organizations serving youth and youth-led organizations are uniquely positioned to help design and implement effective ASRH community outreach strategies because they have the best understanding of the context adolescents are living in and what their needs are. Moreover, in humanitarian contexts, local organizations typically have better access to hard-to-reach populations, like adolescents, and can begin implementation quicker due to established trust and reputation within the community. Building that trust could take longer for international organizations, particularly those who have not worked in that area before—resulting in lost time in providing life-saving assistance to those in need.

Donors and implementers understand the need for and value of further investment in local organizations and have endorsed and supported localization efforts, particularly to support youth-led organizations. In 2011, the United Nations International Strategy for Disaster Reduction (UNISDR) declared children to be “the group most affected by disasters each year” and endorsed their active participation in disaster risk reduction (DRR) activities. Since then, UNISDR—in coordination with the UN Youth Strategy—has supported the DRR 2015–2030 ([Sendai Framework](#)), which advocates for young persons to be key stakeholders in reducing risk and building resilience.

In the [Grand Bargain](#) (a 2016 agreement between some of the largest humanitarian donors and agencies), signatories gathered with the goal of finding and increasing support for local and national responders. With this agreement, signatories committed to investing in local efforts—including working with local organizations—as much as possible and as necessary, while continuing to recognize the vital role of international actors, in particular in situations of armed conflict. What this agreement represented for humanitarian settings was that increasing localization efforts was not only a priority for organizations working in stable settings but also those working in emergency settings. In alignment with the Grand Bargain, IAWG and partners have also developed the [Ready to Save Lives: SRH Care in Emergencies](#) preparedness toolkit—intended for humanitarian agencies committed to localizing humanitarian action, involving affected communities, and coordinating work between humanitarian, development, and government actors.

How can we build the capacity of youth-led organizations?

To advance this commitment, humanitarian responders must identify and partner with youth-led organizations, youth advocates, and younger leaders working within and outside of the SRH field across the preparedness, response, and recovery phases. Partnership should include direct funding support, as well as efforts to build their organizational, management, leadership, and technical capacities over a sustained period of time. For example, capacity-building activities can include workshops on how to fulfill donor and reporting requirements, including financial accountability and organizational/legal registrations. While these domains are not in the purview of SRH program managers, humanitarian practitioners must work with their business development, finance and grants management teams, and monitoring, evaluation, accountability, and learning teams to strengthen the organizational capacity of these organizations. This in turn would support local youth-led organizations, groups, and networks to qualify for funding opportunities. Program experience shows that partnering with youth-led organizations and supporting collective action at key moments, such as during international days like World Youth Day, can also be helpful in improving ASRH awareness and demand.

CASE STUDY

Capacitating Youth-Led Organizations during COVID-19

The time to capacitate youth-led organizations is always. The IAWG ASRH Sub-Working Group and Save the Children—through funding from the Dutch Ministry of Foreign Affairs—released a call for proposals to youth-led organizations in Rwanda to implement activities to address the SRH needs of refugee adolescents and youth during COVID-19. In addition to providing US\$20,000 in funding for the ASRH programming, the grants also provided mentorship, coaching, and other capacity-building support to the youth-led organizations, including additional funds for one-time operational needs (eg laptops, Wi-Fi router, etc). Save the Children and IAWG ASRH Sub-Working Group members provided capacity-building technical assistance throughout the project to help grantees better manage funds, improve reporting, and adjust programming in response to new data on adolescents and youth.

Below are some additional resources for working with youth-led organizations, both to provide guidance materials to youth-led organizations and to help humanitarian organizations working with youth-led organizations:

- [Advocating for Change for Adolescents Toolkit](#): this toolkit—developed by and for young people—provides guidance to youth networks on the design, implementation, and monitoring of an effective national advocacy action roadmap on adolescent health and well-being.
- [Investing in Youth Impact: A Toolkit on Funding for Youth-Led Organizations](#) — this toolkit is for youth-led organizations learning how to fundraise, as well as for youth-serving organizations working with youth-led organizations to understand the issues faced by their partners/grantees.
- [Youth-Led Organizations and SRH and Rights: A Step-by-Step Guide to Creating Sustainable Youth-Led Organizations Working on Sexual and Reproductive Health and Rights](#) — this guide provides guidance on building a sustainable youth-led SRH organization, examining key lessons learned related to ensuring the sustainability of a youth-led SRH organization, and overcoming challenges faced by a youth-led organization.
- [Youth Compact Champions Programme](#): this initiative—a part the Compact for Young People in Humanitarian Action—is a new fund to support youth action around the world, where decisions on which projects are funded are made by young people themselves. The Youth Fund was launched in 2020.

Additional evidence needed

There is limited data on the effectiveness of larger organizations in capacitating youth-led and/or community-based organizations serving young people in humanitarian activities.



3. Community health

As previously described, adolescents—particularly those in humanitarian settings—face unique barriers to accessing SRH services or information. Recalling [Chapter 3: Meaningful Participation](#), humanitarian organizations must engage community members, particularly the gatekeepers, as part of their programming to create trust, encourage raising topics that might otherwise be taboo, and ultimately, be responsive to community needs. During the acute phases of emergencies, these gatekeepers are often seen as sources of support and should be utilized in response efforts.

To address these barriers, humanitarian responders must recognize CHWs as a key community outreach platform. CHWs or similar health outreach mechanisms often expand the reach of facility-based health services by improving the quality of adolescent services through increasing access to services and information for people living in settings where access and mobility is constrained. For example, in Myanmar, WRC and partners piloted community-based medical care for survivors of sexual assault in conflict-affected states and trained CHWs to provide post-rape care where facility-based services were not feasible.

What are some existing community health outreach roles?

Globally, there are various modes of community health outreach roles. There are community healthcare workers, community mobilizers, community and/or health volunteers, traditional birth attendants, community engagement facilitators, and many other types of community roles. The labels and associated roles differ based on the context. For example, only 14 of the 23 countries/regions within the WHO Eastern Mediterranean Region had some form of CHWs as part of their health system. Local non-governmental organizations (NGOs), civil society organizations, teachers, religious leaders, and community leaders are all important sources for community sensitization, community mobilization, and commodity distribution activities. These are important channels, especially in middle-income countries that do not necessarily have CHWs but do implement some community-level outreach services. For the purposes of this Toolkit, we will be using “CHWs” as the terminology to apply to all of these community outreach roles.

CASE STUDY

Social Accountability and Action in DRC and North East Nigeria

In the Democratic Republic of the Congo (DRC) and North East Nigeria, CARE provided training to gatekeepers, including community and religious leaders, on their approach, called [social analysis and action](#). This approach trained community leaders, or Community Engagement Facilitators, on how to conduct situation analyses with community members on specific topics, such as child marriage and adolescent pregnancy. The facilitators used information from these analyses to structure discussions and reflective sessions on community attitudes and norms regarding these topics. Social analysis and action allows for humanitarian responders to adapt their programming to the contextual factors, such as religious norms, urban, rural, and camp-based factors.

How do these community health roles improve ASRH access and outcomes?

CHW roles provide a critical link between communities affected by humanitarian emergencies and the healthcare system; task-shifting specific health roles to CHWs has garnered recognition in all parts of the world as an effective approach to strengthening a health system that is strained on multiple fronts, ultimately helping improve quality of care. CHWs can support demand generation, health promotion and preventative care, and also, increasingly, curative care—thanks to new rapid diagnostic tests, simplified treatment protocols, and mobile health technologies and support systems. Given the barriers communities face in accessing health services, CHWs play a crucial role in bridging this gap, particularly for rural communities, as CHWs are often well-regarded members of their communities. CHWs can broaden access and coverage of health services in remote areas and take actions that lead to improved health outcomes, including for adolescents.

Remember, in this Toolkit we are using “CHWs” as a term for all community mobilizers and volunteers, etc; thus, CHWs can also be used to reach adolescents, particularly in:

- Identifying hard-to-reach and vulnerable adolescents, as CHWs are well-regarded members of their local communities and can garner trust and link hard-to-reach adolescents and adolescents at increased risk to health facilities.
- Raising awareness and providing culturally appropriate health education information and services provided to the community (eg contraception, including emergency contraception, maternal health, HIV/STIs, abortion, and GBV), as well as advocating for the needs of adolescents.
 - ▶ CHWs should be creative in their approaches to reaching adolescents and youth. This can include using artwork (banners, murals, posters, billboards), community theater and role-playing, games, sports, and several others. CHWs can consult with education and child protection colleagues for other ideas to creatively reach adolescents and youth with SRH messages (see [Building Multi-Sectoral Linkages](#) section).
- Mobilizing community leaders and facilitating dialogues and discussions with community members, adolescents and youth, and adolescent/youth networks, clubs, and groups.
 - ▶ In the [Community Participation](#) section, IRC shared an example and resources on how to facilitate community dialogues from their program experiences.
- Providing community-based counseling and service delivery. CHWs can also serve as referral agents for health services for adolescents, especially assisting survivors of sexual violence and pregnant adolescents with a birthing plan and helping them to identify transport mechanisms to the health facility for their deliveries.
 - ▶ For more guidance on counseling techniques for CHWs, see [Counseling Tools & Resources](#).
 - ▶ For more guidance on referral of health services, see [Facility-Based Services](#).
- Distributing supplies, such as contraceptive commodities or menstrual hygiene products. In emergencies, CHWs are critical in the distribution of safe delivery kits and they can be trained to identify pregnant adolescents.
 - ▶ John Snow, Inc. provides a resource to help managers with engaging CHWs in community distribution activities called [Supply Chain Models and Considerations for Community-Based Distribution Programs: A Program Manager’s Guide](#).
 - ▶ The IRC developed the [MHM in Emergencies Toolkit](#) to provide guidance on implementing MHM in humanitarian contexts.

Adolescents Supporting Community GBV Initiatives

While little has been documented on community GBV initiatives, adolescents could potentially provide emergency contraception and other components of clinical care for survivors of sexual assault if they have better access to marginalized adolescents in their communities. Adolescents may be able to prevent and address different forms of GBV, including domestic violence, child, early, and forced marriage (CEFM), female genital mutilation or cutting, trafficking, and other forms by:

- Raising awareness about the problem of sexual violence, strategies for prevention, and care available for survivors through adolescent/youth volunteers in the community
- Involving adolescent leaders, parents, and community leaders in the development of strategies to prevent GBV in the community

For strategies on developing a community mobilization plan that meaningfully engages adolescents, youth, and community members, Advocates for Youth has created a list of best practices to adopt in their resource, [Strategies Guided by Best Practice for Community Mobilization](#). Once your organization has started any of these community health programs, it is always important to plan for the supervision component. Supportive supervision is important for any program, whether your organization is using service providers, community mobilizers, CHWs, or other health staff. WHO developed [Community Health Worker Assessment and Improvement Matrix \(CHW AIM\): A Toolkit for Improving CHW Programs and Services](#)—a resource to help ministries, donors, and NGOs assess and strengthen their CHW programs to improve their functionality.

Considerations for Mobility-Restricted Environments

When mobility becomes restricted due to security constraints or other conditions (eg disease outbreaks), engaging community health outreach approaches may not be feasible. In these circumstances, humanitarian organizations should utilize innovative solutions, such as communications, media, and technology activities (below) or [self-care approaches](#), to ensure access and pathways to critical SRH services are maintained. Refer to IRC's [risk mitigation resources](#) for adapting programming related to access restrictions.



4. Communications, Media, and Technology

Integrating communications, media, and technology into SRH programming offers humanitarian practitioners unique opportunities for strengthening outreach efforts and coordination actions among varying sectors. Young people represent the highest proportion of global consumers of mobile technology. Utilizing mobile phones to improve SRH behaviors and access to services is a promising practice. Privacy, convenience, and access make these technologies especially appealing to adolescents, particularly for those that face geographic and transportation barriers, fear, stigma, or negative attitudes of providers, as well as adolescents who receive misinformation about or have misconceptions on SRH topics, such as contraception and STIs (including HIV).

Interpersonal communication, mass media, and technology—including mobile health, social media, IEC materials, and video edutainment—can be used to provide and reinforce information on SRH and rights and also motivate and build skills for adolescents. Internet-based new media has significantly changed the ways of working and social interaction with those close and far from each other, making the world ever

more connected. These innovative approaches have changed access to information for personal and social development, particularly for young people. For example, telemedicine interventions have increased access for populations unable to access facilities (see [Facility-Based Services](#) for more information).

What factors lead to successful communications, media, and technology programming?

At the heart of all of the below elements to create successful communications, media, and technology programming is meaningful engagement with adolescents and youth—whether that is collecting information on SRH needs and preferences from adolescents and youth, involving them in the design of products, or recruiting adolescents/youth to deliver the messages or products.

1. Linking communications, media, and technology with other services, facilities, activities, and intervention strategies. Media and technology should not be used as a stand-alone activity.
2. Making communications, media, and technology interactive, including using games and stories or narratives to appeal to young people.
3. Ensuring communications, media, and technology are accessible to a wide range of adolescents, including adolescents with limited literacy, adolescents with disabilities, and adolescents who do not have access to a mobile device or have limited internet connectivity.
4. Refraining from communications, media, and technology activities that put adolescents at an increased risk of violence, including violence in the household or online/cyber violence.
 - Although mobile technology is a useful tool to reach adolescents, service providers and program managers also need to be aware of the risks associated with it and social media, including sexual harassment, especially affecting girls.
5. Promoting communications, media, and technology platforms that have informative content disseminated on a consistent basis to increase knowledge and change attitudes and behaviors.

What are some examples of using video edutainment for ASRH activities?

In general, video edutainment includes video games, television programs, or other material, intended to be both educational and enjoyable. Below are examples of using different edutainment technology in ASRH outreach and engagement activities in fragile settings.

- Resource Center for Gender Equality in Lebanon—in partnership with the United Nations Children's Fund (UNICEF)—developed an animated video, called “[Marriage is not a Game](#),” to educate adolescents, youth, parents, caregivers, providers, and other audiences on the risks associated with early marriage. The video combines key messages based on field testing and focus group discussions with the story of a young girl who faces the negative outcomes of an early marriage. The video was then paired with an informational brochure and screened by representatives of UN agencies, local and international NGOs, civil society activists, and the medical community.
- CARE recently developed a [series of videos](#) on ASRH messages for Syrian and Jordanian adolescents living in Jordan to show at community centers and initiate dialogues around adolescent pregnancy, child marriage, puberty, and fertility awareness. This video series is accompanied with a training guide by the [AMAL initiative: Adolescent Mothers Against All Odds—Unleashing the Power of Adolescents in Fragile Settings](#).

What are some examples of using mobile phones for ASRH activities?

- It is critical to support additional opportunities and resources for crisis-affected young people to innovate

using technology that improve access to SRH services. Reproductive health organizations, including UNFPA, have organized youth-centered Hackathons, bringing together adolescents to listen to their needs, perspectives, and experiences to design appropriate health solutions to the problems they are facing. For example, young people have developed mobile apps to monitor fetal distress, diagnose breast cancer, and disseminate information on HIV and Acquired Immunodeficiency Syndrome (AIDS). Two former students from Uganda's [Makerere University College of Computing and Information Technology](#) in Kampala developed [WinSenga](#), a mobile medical device linked to a mobile phone that can scan a pregnant woman's womb or detect fetal problems.

- In Bolivia, a Community-Embedded Reproductive Health Care for Adolescents (CERCA) project used adolescent-friendly text messages as a cost-effective and efficient way to communicate with adolescents about SRH issues. The messages connected the adolescents with pre-existing public health services and allowed them to receive advice and ask health questions. The CERCA project showed that directly connecting adolescents with health centers and health service professionals reduced the barriers for adolescents who would not normally have access to health centers due to stigma, taboo, costs, or long waiting times.

CASE STUDY

Using an Integrated Approach with Virtual Safe Spaces

As the best practice list stated above, communication, media, and technology approaches should be integrated with your organization's SRH programming. The below case study shows how organizations can combine different approaches with communications, media, and technology to increase access to and use of SRH information and services for adolescents and youth living in humanitarian contexts.

In 2019, WRC and UNICEF designed and piloted a Virtual Safe Space (VSS) platform for adolescent girls and mothers/female caregivers in Lebanon and Iraq, with the overall goal of expanding access to SRH and GBV information and services. The VSS platform was designed in response to identified information needs and priorities of adolescent girls, while taking into consideration concerns related to accessibility, privacy, and safety. The VSS platform allowed adolescent girls to access SRH and GBV information on a website, locate services, and ask questions to safe space staff. Overall, participants felt strongly that the information provided by the VSS platform was essential for adolescent girls in their communities and that the platform was especially valuable for girls unable to attend programming in physical safe spaces (eg girl-friendly centers). For more information on the key learnings and recommendations from this intervention, see [WRC's presentation](#).

Transitioning from Acute to Comprehensive

As mentioned in the MISP, transitioning from acute to comprehensive programming should be at the forefront of humanitarian staff when developing response plans during the acute phase. The MISP also highlights the need for approaches that both provide critical life-saving services and utilize community outreach interventions to increase demand of health services. Comprehensive strategies outlined in [Objective 6 of the MISP](#) expand healthcare access to women and adolescents from essential life-saving SRH care, described in Objectives 2–5, to holistic comprehensive SRH services. The crux of comprehensive SRH programming reinforces the concept of “building back better,” and while there are varying definitions, fundamentally, building back better “advocates for the restoration of communities and assets in a manner that makes them less vulnerable to disasters and strengthens their resilience.” For additional information and resources on

building back better, refer to [United Nations Office for Disaster Risk Reduction](#). For additional guidance on preparedness, refer to [Ready to Save Lives: SRH Care in Emergencies](#) preparedness toolkit.

As discussed earlier, it is critical to plan for comprehensive SRH and begin implementing comprehensive SRH care for adolescents as soon as the situation permits. Below are longer-term interventions to implement for increasing demand generation when transitioning from acute to comprehensive SRH activities during protracted crises or when moving toward early recovery efforts. Some of these activities require dedicated resources, staff, and longer implementation periods, and thus may be more relevant to program implementers supporting programs that are transitioning from the MISP to comprehensive SRH.

Comprehensive Sexuality Education

CSE has been shown to improve ASRH knowledge, attitudes, and behaviors when implemented well, and particularly when an empowerment approach emphasizing gender and rights is included. Widely implemented and tested CSE curricula for low-resource settings include Population Council's [It's All One Curriculum](#) and Rutgers's [Whole School Approach for Sexuality Education](#), as well as UNFPA East and Southern Africa Regional Office's [Regional Comprehensive Sexuality Education Resource Package for Out of School Young People](#). When integrating CSE into a humanitarian program and/or in conservative contexts, it is important to work with local stakeholders to design the curriculum with careful consideration to the context, institutionalize programs within school systems, showcase school programs to increase transparency, and engage the media to build positive perceptions. There are successful examples of this being done in fragile settings. For example, the Palestinian Family Planning and Protection Association, an IPPF member associate in Palestine, successfully developed a CSE manual in Arabic tailored to the local context and approved by the Ministry of Education for use in schools.



Life-Skills Curricula

Life-skills curricula can provide adolescents with holistic and integrated knowledge and information on SRH, GBV, mental health, livelihoods, and life-transitions. The IRC led a program, called Girl Empower, to support girls in emergency settings with the skills and experiences necessary to make healthy, strategic life choices and to stay safe from sexual exploitation and abuse. The IRC implemented the intervention in both Liberia and Ethiopia and conducted an impact evaluation in Liberia. In summary, this rigorous impact evaluation demonstrated that:

1. Adolescent girls in Nimba County, Liberia, are exposed to staggeringly high rates of sexual violence.
2. The Girl Empower program filled a need in the community. Attendance rates of girls and their parents, even outside of the group, that received the conditional cash transfer were high over a period of 32 weekly sessions.
3. The Girl Empower program reduced rates of child marriage, teen pregnancies, and risky sexual behaviors, all of which were sustained one year after the end of the program.
4. The Girl Empower program plus the cash incentive for participation (conditional cash transfer) reduced the likelihood of marriage and the number of sexual partners in the past 12 months and increased sexual abstinence and condom use in the past 12 months by more than 50% compared to Girl Empower alone.
5. The Girl Empower program equipped adolescent females with important life skills and positively influenced gender attitudes.

For details of the evaluation protocol and results refer to the IRC's [Impact Evaluation](#).



Multi-Sectoral Linkages and Referral Pathways

This section provides information on how to integrate SRH programming for adolescents into other sectors, utilizing all the entry points available in the humanitarian response to best meet adolescents' SRH needs. The section also includes guidance on establishing referral pathways between sectors, as well as general tools and resources for conducting referrals for adolescents.

Why is integration between sectors important?

Humanitarian interventions often fail to provide comprehensive support to address all of the barriers affecting adolescents' SRH access and fail to respond to their needs holistically, which can have devastating and long-term consequences upon adolescents' health outcomes and future opportunities. Providing multi-sectoral responses that incorporate ASRH training and relevant activities across sectors is required to address the “whole person” and should be considered a key strategy for protecting and responding to adolescents' SRH needs. As well, applying multi-sectoral approaches allows organizations to reach target groups, maximize resources, avoid duplication of efforts, address barriers to service access and utilization at different levels of the Social-Ecological Model, and, ultimately, reach adolescents with SRH services that are responsive to their needs.

Establishing referral mechanisms is only for referring adolescents to health services, right?

No! In an emergency setting, humanitarian responders should be working together to avoid duplication of services and gaps in all humanitarian programming. [Objective 1 of the MISP](#) discusses the importance of strengthening linkages and referrals for SRH services between primary health facilities. Thus far, we have discussed various strategies ranging from youth engagement, telemedicine, media to CHWs as mechanisms for strengthening linkages and referrals for SRH services to primary health clinics. As noted in [Facility-Based Services](#), referral of health services is different from referring adolescent cases between sectors—with health service referral related to referring cases between different levels of the health system and sectoral referrals related to referring cases between sectors (eg referring a child protection case to a social worker or MHPSS services). In addition to the coordination efforts outlined in Objective 1 of the MISP, humanitarian organizations should also be working together to proactively refer cases between agencies and sectors to ensure the needle moves towards holistic programming.



Ensuring Coordination for GBV Cases

One of the activities included under [Objective 2 of the MISP](#) is working with other clusters, especially the Protection Cluster or GBV Sub-Cluster, to put in place preventative measures at community, local, and district levels—including at health facilities to protect affected populations, particularly women and adolescents, from sexual violence. The Toolkit provides more information and examples of integrating ASRH with child protection and MHPSS services in [Tools for Building Multi-Sectoral Linkages](#). Additionally, the Toolkit provides a referral tool from [IASC Reference Group for MHPSS in Emergency Settings](#) that has been modified for use with adolescent clients (see [Tools for Establishing Referral Pathways](#) for more information).

Building Multi-Sectoral Linkages

What is multi-sectoral integrated programming for better health outcomes?

Integrated programming for better health outcomes refers to “a way of working whereby there is coordination and strategic collaboration across two or more clusters or sectors with the goal of achieving better health outcomes through collective action.” Furthermore, it is essential that this approach is applied and implemented within organizations and across their thematic programming. Integrating ASRH across sectors includes establishing links with other sectors that provide services for adolescents and youth, such as child protection and education, and establishing appropriate referral mechanisms to ensure adolescents receive the care they need. There is a broad range of entry points humanitarian staff can utilize to disseminate ASRH information and provide and/or refer adolescents to SRH services in a humanitarian crisis.

Multi-sectoral programming is attentive to the context in which young people live, in addition to complying with relevant international standards, including the [Sendai Framework for Disaster Risk Reduction 2015–2030](#) and the [UN Sustainable Development Goals](#). To guarantee that adolescents and youth thrive, organizations and sectors must work together—in collaboration with adolescents and youth—to identify and address obstacles impeding the progress of young people successfully transitioning into adulthood.

What multi-sectoral programming has been done with adolescents in humanitarian settings?

Plan International Research: Voices of Adolescent Girls in Crisis

Plan International's Adolescent Girls in Crisis is a research project informed by and centered upon the voices and experiences of girls in some of the most troubled and volatile locations in the world—the Lake Chad Basin, Rohingya refugee camps in Bangladesh, South Sudan, and among Syrian refugees in Lebanon. The research found that adolescent girls face a complexity of factors and barriers affecting their situation, including underlying gender discrimination and inequality that limits their opportunities wherever they are. These factors must be addressed holistically, rather than narrowly focusing on response activities that address a few more obvious needs. Plan International's recommendations (listed below) point to the need for multifaceted and integrated responses to successfully meet the SRH needs of adolescents. Plan recommends humanitarian responders:

- Increase participation of adolescent girls in decision-making.
- Ensure adolescent girls' education does not suffer.
- Prioritize provision of adolescent-girl-friendly health information and services, including mental health and SRH.
- Tackle GBV in all its forms to improve security for adolescent girls.

IRC: Highlighting the Advantages of Women-Led Community Centers as ASRH Delivery Points

ASRH and GBV services are not always accessible to adolescent girls in humanitarian settings. Humanitarian organizations are increasingly integrating SRH into community-based women and girl-only safe spaces; however, there is a lack of evidence on the benefits and risks related to integrating ASRH into women's centers versus traditional health facilities.

IRC's Comprehensive Women's Centers (CWCs)—being women-centered and community-based—have the advantage of offering services that are considered inappropriate and controversial in patriarchal and male-dominated cultures, and, therefore, often denied to adolescent girls and women by health providers and male family and community members. These CWCs serve as a social meeting point with skills acquisition activities, income-generating schemes, and social networking for adolescent girls and women only. As well, the CWCs offer GBV and ASRH services that are safe, confidential, and non-discriminatory by providers who have been specially trained in women-centered care. This allows for adolescent girls and women to move around freely, participate in activities, socialize, talk to health providers and case managers, and seek services in “unlabeled” consultation rooms.

The IRC currently operates CWCs in Bangladesh, Nigeria, Kenya, Yemen, and South Sudan. From internal evaluations and patient feedback, CWCs have proven to increase access, safety, and agency for women and adolescent girls—with a particularly positive impact on unmarried women, adolescent girls, and stigmatized minority populations during emergencies. Adolescent girls and women report that they feel respected and empowered to define for themselves what kind of services they need, which further leads to a sense of empowerment and agency. In terms of actual service delivery, the CWC approach has demonstrated increased uptake of SRH services for women and adolescent girls, including safe abortion care counseling, STI treatment, contraception, and comprehensive GBV care. Service providers from different sectors are working under the same roof, with joint objectives and a standard operating procedure, which facilitates referrals and follow-up across teams.

Tools for Building Multi-Sectoral Linkages

IAWG developed a multi-sectoral tool to assist SRH managers with identifying ways to integrate ASRH activities across all humanitarian sectors and identify strategies for reaching adolescents. The tool, included in [Annex M](#), begins with a matrix of examples of ASRH activities that SRH managers should advocate for implementing in all sectors, followed by specific guidance for integrating SRH activities within each sector, including integration within the health sector. The second table provides a template for SRH managers to use when discussing SRH opportunities with other sector staff, including questions to use at the top for guiding those conversations.

Additional evidence needed

There is limited guidance for integrating ASRH services across all humanitarian sectors, which is why the IAWG ASRH Sub-Working Group created [Annex M](#). This tool has not been tested or validated but is based on experiences and lessons learned from humanitarian organizations implementing SRH programming with adolescents. Further research and guidance is needed for providing multi-sectoral programming to improve SRH outcomes for adolescents in humanitarian settings.

Establishing Multi-Sectoral Referral Pathways

As discussed above, SRH and rights information and services can be integrated into a broad range of interventions. In addition to understanding how to provide health service referrals for different levels of the health system (see [Facility-Based Services](#)), it is critical that all sector staff understand what services are and are not provided by their organization. In line with [Objective 1 of the MISP](#), humanitarian staff should establish safe referral pathways across sectors for services provided by their organization and other organizations. These referral pathways will help ensure adolescents can access the relevant services within the cluster system and actively participate in mapping exercises and development of referral pathways. Humanitarian staff should review the resources provided in the Toolkit and adapt according to their context. Whether existing or newly established, referral systems should be systematically tracked to ensure they are working properly, which requires a functional data collection mechanism (see the next chapter on [Data for Action](#) for more information).

IMPLEMENTATION CONSIDERATION

Building on Existing Structures

Humanitarian responders should avoid use of parallel systems and build on existing structures. Whenever feasible, organizations should use and support existing national health systems. Depending on the health system capacity and context, referrals should be channeled through the national public health network and/or the private non-profit health service. In some settings, the target population could be included in national healthcare systems if the system has the capacity to deal with the additional caseload in an adequate manner. Humanitarian agencies should work with their partners to improve the existing system's capacity whenever possible (eg rehabilitate health structures and provide medications and trainings to clinics or hospitals in areas that are highly populated by the affected population), which will contribute to health system strengthening and early recovery efforts, as well as working toward the provision of comprehensive SRH care.



What is required to make a successful multi-sectoral referral?

Agencies should follow a standardized process and coordinate with organizations to ensure consistency across the referral pathways. The Toolkit highlights a resource from the IASC Reference Group for MHPSS in Emergency Settings, which includes several materials to assist providers and health staff with facilitating inter-agency referrals, referral pathways, training and workshops, as well as to use as a minimum standard for documenting referrals. The guidance note instructs practitioners on how to make a successful referral and how to coordinate with other agencies (outlined below). The Toolkit has made slight adaptations to the below guidance for adolescent considerations.

Steps to Make a Successful Referral

- 1** Identify the problem: What does the adolescent client need? Identify and/or assess the adolescent's problems, needs, and capacities with them (eg if the adolescent has cognitive impairments or physical disabilities that require additional assistance). Refer back to the [Five Principles for Creating a Trustful Atmosphere for Adolescent Counseling](#) and the [Principle of Capability](#).
- 2** Identify which organization or agency can meet the identified need. This information can be identified in the mapping and referral pathway tools developed in coordination within the cluster system and agencies. Identify and map other services that may be able to assist the adolescent with their needs. As mentioned earlier, information about other services in your geographical areas can be obtained from service guides, [3/4/5 Ws](#) (Who does What, Where, When, and for Whom) mapping reports, or coordination meetings. Check if the adolescent is already included within the child protection management system.
- 3** Contact organizations that can provide the requested service(s) in advance to find out more about their services and eligibility criteria, unless the specific type of referral is commonly done with a specific agency. Confirm eligibility with the agency who will provide the requested service. Requested information should include what their referral protocol entails and whether or not they will be able to assist the adolescent.
- 4** Explain referral to the adolescent. Provide information about available services and explain the referral to the adolescent. What services are provided and where? How can the adolescent get there and receive services? How can the adolescent get information on direct and indirect costs associated with referrals? Why do you recommend the referral? Keep in mind that the adolescent can choose not to be referred. In addition, if the adolescent is in need of life-saving interventions and is not conscious, move forward with the referral.
- 5** Document consent. If the adolescent agrees to the referral, obtain consent from them before the adolescent's information is shared with others. Also explain how information will be shared between referring and receiving agencies and obtain consent from the adolescent regarding which information can be shared. If the adolescent is not conscious and life-saving interventions are required, consent is not needed; however, this should be documented. Providers and referring agencies should document consent to the full extent of local laws. If no local policy exists regarding consent, international standards for documenting consent should be adhered to. Refer to the [Principle of Capability](#) about consent, and note that International Standards do not require consent from an adult to receive services. Refer to [Facility-Based Services](#) and [Data for Action](#) sections on consent and assent to find more detailed guidance.

6 Make the referral. Fill out the inter-agency referral form in triplicate (one copy with referring agency, one copy with adolescent client, and one copy with receiving agency). Provide the referral agency's contact information to the adolescent and accompany them to the referral agency if needed. Referrals can also be made over the phone (if in an emergency), via email, or through an app or a database. See annexed forms included in [Tools for Establishing Referral Pathways](#).

7 Follow up with the adolescent and the receiving agency to ensure the referral was successful and exchange information, where patient consent allows for this. Areas for follow-up include: Did the adolescent receive the planned services? What was the outcome? Was the adolescent satisfied with the referral process and the services received?

8 Storage of information and confidentiality. All referral forms and case files should be stored in secure (locked) cabinets to ensure the implementation of safe and ethical data collection, management, and storage of information.

Coordinating Referrals with Other Agencies

The successful implementation of an inter-agency referral system for SRH services requires that participating agencies within the cluster system:

1. endorse uniform referral documentation (eg a uniform referral form; see annexed forms included in [Tools for Establishing Referral Pathways](#));
2. agree on specific referral pathways, procedures, and standards for making referrals (eg which organization will be best suited to provide care);
3. train relevant staff on the use of ethical and safe documentation, standards (eg child safeguarding), and procedures (eg not disclosing the identity of adolescent survivors); and
4. participate in coordination activities, such as a [3/4/5 Ws](#) MHPSS service mapping, coordination meetings, and referral workshops (see [Tools for Establishing Referral Pathways](#) for [3/4/5 Ws](#) resources and other mapping tools).

Establishing Multi-Sectoral Referral Pathways as Part of the MISIP

In line with [Objective 1 of the MISIP](#), SRH organizations involved with response activities should immediately engage with the SRH Sub-Cluster to coordinate and map service delivery sites and establish referral pathways. Mapping of multi-sectoral services, as well as referral pathways, should be done in coordination meetings such as the Health Cluster, SRH Sub-Cluster, or through relevant clusters/working groups. SRH organizations, in coordination with other staff, should establish referral pathways through the humanitarian coordination mechanisms—utilizing the [3/4/5 Ws](#) and then expanding to more elaborate service mapping, service directories, and referral pathways. This multi-sectoral integration approach must include all the different humanitarian sectors, specifically camp coordination and management, education, food and livelihoods, MHPSS, protection, shelter, GBV, SRH, and WASH sectors of the humanitarian coordination system. Communicating the referral pathways should be coordinated with service providers and communities, including adolescents. These coordination activities enable all humanitarian partners to establish cross-sectoral linkages across the humanitarian cluster system.

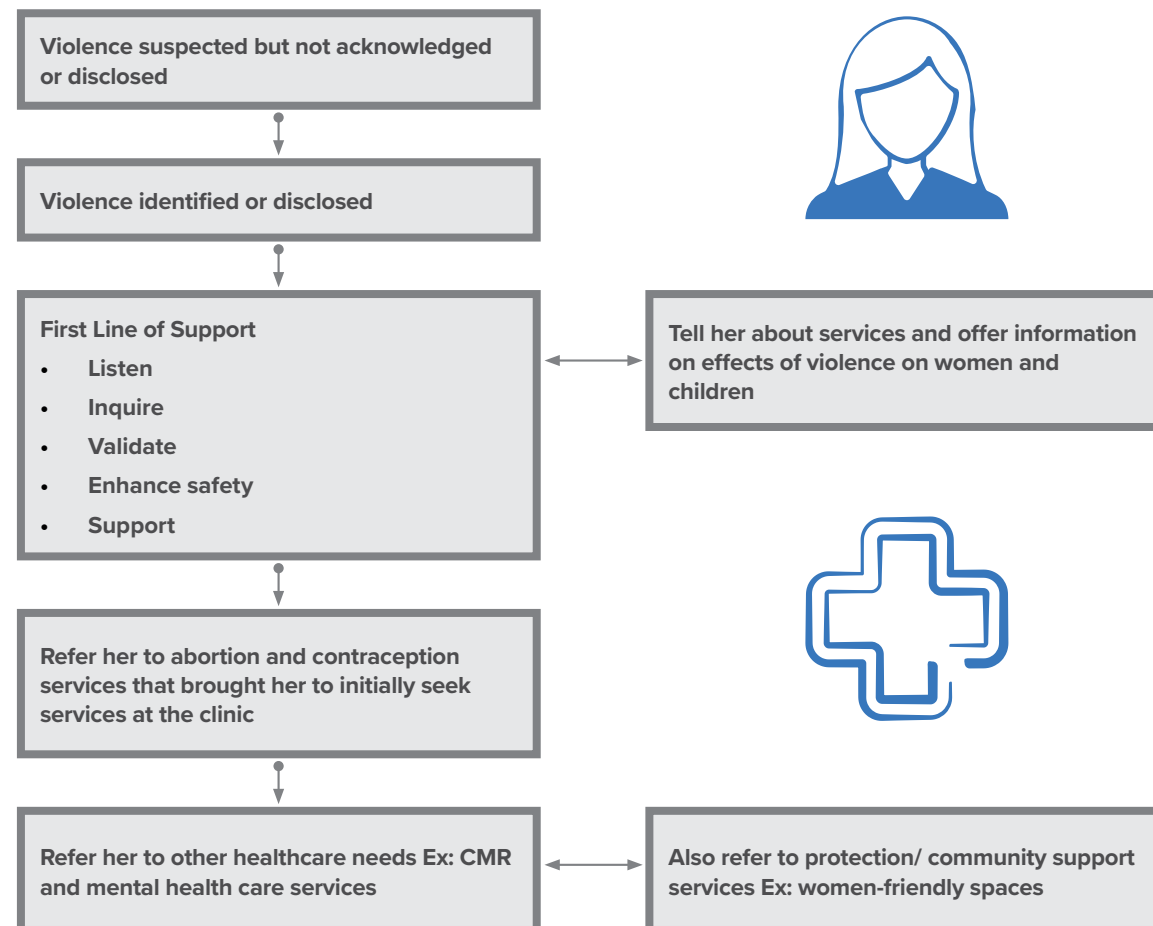
What are examples of referral pathways between sectors for adolescent clients?

Understanding referral pathways in a complex humanitarian environment can be challenging. Below is an illustrative case study and graphical representation of referral pathways for providing multi-sectoral services. Remember, a flexible referral pathway safely links survivors to supportive and quality services that can include any or all of the following support mechanisms: health, MHPSS, security and child protection, legal/justice, and/or economic reintegration support.

A 16-year-old Rohingya adolescent girl visits the camp clinic for an abortion. She is in her first trimester and is requesting an abortion. In Bangladesh, abortion is defined as menstrual regulation before 13 weeks. As her provider, you notice she has scars on her body and vaginal area. The adolescent patient discloses her trauma.

What interventions would be most appropriate? As her provider, you deliver survivor-centered care and use the LIVES method referenced in [Counseling Considerations for Adolescent Survivors of GBV](#). The adolescent consents to receiving an abortion and post-abortion contraceptive services—as well as CMR medications (eg PEP) and a referral to a primary health facility that provides these SRH services. You also make a referral for her to child protection services provided by a partnering agency. As the provider, you recognize the importance of abiding by established safety and ethical standards when referring GBV survivors. You also understand that revealing the identity of the survivor creates a security risk to the survivor, family, and community.

Figure O: First Line of Response; Referral Pathway for Survivor-Centered Care



Tools for Establishing Referral Pathways

Listed below are common tools utilized for coordination and referrals. These tools should be adapted for each context. The Toolkit has modified some of the tools (referral forms) for adolescent considerations.

- [3/4/5 Ws template](#): maps out partner information, who is doing what and where, as well as service delivery data.
- Multi-sectoral referral forms: provide documentation that outlines the services needed for clients and humanitarian actors.
 - The IASC provides standard forms for making referrals for MHPSS cases across all humanitarian sectors. The Toolkit has adapted these forms for referring adolescent clients to different services between sectors. These include forms for the agency making the referral, the client receiving the referral, and the agency receiving the referral request. The forms are included in [Annex N: Referral Form for Referring Agency Copy](#), [Annex NN: Referral Form for Client Copy](#), and [Annex NNN: Referral Form for Receiving Agency Copy](#).





CHAPTER 7: DATA FOR ACTION

This chapter discusses the importance of collecting and using data to inform, measure, and adjust your adolescent sexual and reproductive health (ASRH) programming, as well as sharing the evidence with others. Data should not be gathered only to be left behind to collect dust. It should be used to take action! As seen throughout the Toolkit, there are many areas in ASRH that further evidence is needed. This chapter provides guidance on how to conduct Data for Action activities—alongside adolescents and youth and throughout the program cycle and humanitarian continuum—to help expand the evidence base for ASRH.

Chapter 7 Learning Objectives

After reading this chapter, readers should be able to:

- Describe how to involve adolescents in assessment, program design, monitoring, and evaluation of humanitarian activities
- Understand the principles of conducting research with adolescents
- Identify tools and methods for collecting and monitoring ASRH data
- Explain what Data for Action is and why it is important to ASRH programming

This chapter links to [Chapter 5: Assessment, Monitoring, and Evaluation](#) in the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM) and includes tools that are responsive to and inclusive of adolescents and is in line with [Standard 7: Data and Quality Improvement](#) of the Global Standards for Quality Health-Care Services for Adolescents from the World Health Organization (WHO). It provides guidance and tools programmers can use throughout each phase of the program and humanitarian cycle.

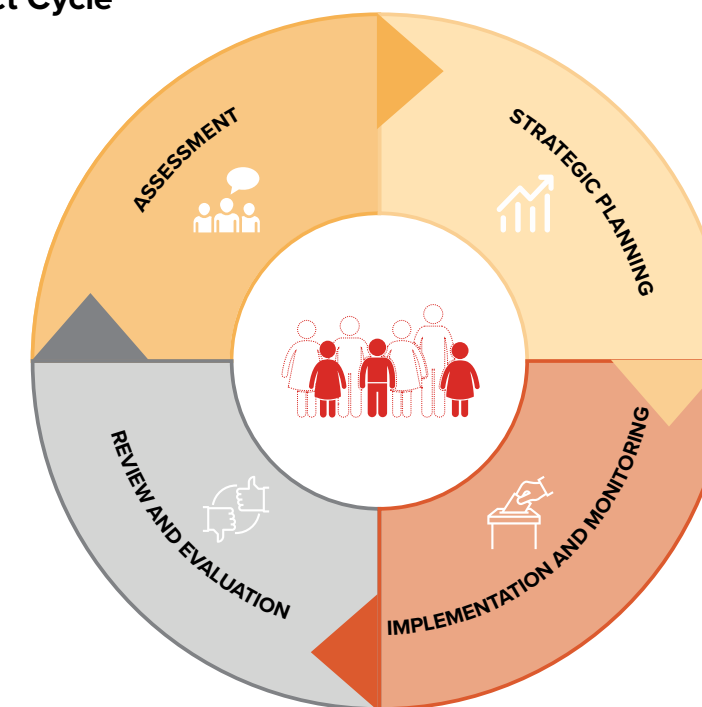
How can we implement Data for Action activities during different parts of the program and humanitarian cycle?

Often, programmers think about monitoring and evaluation (M&E) activities during just one phase of the project: the end. However, data should be used throughout all phases of the project, specifically to inform the design of the project, during implementation to monitor and adapt activities, and at the end to measure impact, build evidence, and/or adjust programming for future work. Similarly, data should also be used throughout the humanitarian response—not just at the beginning for conducting needs assessments. Data should be gathered, discussed, and used to improve programming during preparedness, response, and early recovery efforts. Echoing a common theme throughout the Toolkit, adolescent and community engagement is crucial during each of these phases of the program cycle and humanitarian continuum. Involving adolescents and community members in the design, monitoring, and evaluation of sexual and reproductive health (SRH) services or programming, including in accountability mechanisms, helps to better respond to adolescents' needs while also empowering them to actively inform change. Including adolescents and community members in the decision-making and leadership positions at every stage of humanitarian action, such as during Humanitarian Needs Overview and Humanitarian Response Plan processes, can help ensure that adolescent needs are understood, reflected, and included in relevant sectors' planning.

Figure P shows how the humanitarian program phases operate with involvement from adolescents and community members throughout the process. The next four parts of this chapter will walk you through how to implement Data for Action activities—in partnership with adolescents and community members—during assessments, program design, implementation and monitoring, and evaluation of your project.

To note, this is a graphic representation of humanitarian operational phases. It does not represent reality. As we know, no humanitarian emergency is the same and they do not follow a continuous line or circle. See [Figure D: The Continuum of an Emergency](#) for more information.

Figure P: Project Cycle



Source: Adapted from IAFM's [Chapter 5: Assessment, Monitoring, and Evaluation](#) (IAWG, 2018).

What is an assessment?

An assessment is a method for understanding and responding to needs or gaps identified between current and desired conditions, as well as factors that contribute to those identified gaps. Thus, the purpose of conducting ASRH assessments is to identify the needs of adolescents and barriers they face, as well as determine the capacity of the existing services and health system to respond to those needs. Throughout the humanitarian continuum and the life of a program, we can use periodic assessments to evaluate the program's progress toward achieving its ASRH objectives. Collecting data should be guided by what you need to know, instead of what questions you can ask or what would be nice to know. Thus, all data collected should have a clear purpose and usage.

Why are needs assessments important?

In a humanitarian crisis, it is critical to understand the situation of different subgroups of adolescents to respond to their specific SRH needs. We use assessment, monitoring, and evaluation at different stages during a humanitarian response in order to:

- Understand and quantify the needs of populations of concern and contributing factors and influences, as outlined in the Social-Ecological Model in [Figure C](#)
- Identify programmatic barriers and enablers
- Ensure effective and efficient use of resources
- Determine the success or failure of a program
- Determine the intended and unintended positive and negative consequences of the project
- Provide accountability and transparency to donors, beneficiaries, and other stakeholders
- Inform future programming and contribute to building the evidence base

What should we know before conducting assessments with adolescents?

Before beginning any assessment or research with adolescents, SRH managers should comply with the following DOs and DON'Ts:

DOs ✓	DON'Ts ⊘
<p>The information is collected from adolescents or individuals near their age.</p> <p><i>Adults/parents are not always aware of the conditions that adolescents are facing. Adults may provide information based on what they perceive instead of reality. Speaking to young adults or youth who are closer to the age of adolescents (if you are not able to speak with adolescents) will provide more accurate information.</i></p>	<p>NEVER conduct an assessment if the process or results could put adolescents or interview teams at risk.</p> <p><i>Questions to answer: Will participating in this study likely jeopardize the adolescents' personal safety? Is the study likely to cause emotional or psychological harm to the adolescents? If you answer "yes" to either question, do not conduct the assessment.</i></p>
<p>The information is necessary and justified.</p> <p><i>Only ask questions where you can use the information obtained (eg improving services, advocacy, resource mobilization, etc).</i></p>	<p>DO NOT collect information that can be obtained elsewhere.</p> <p><i>Before initiating primary data collection, review existing (secondary) data that might be available to answer what is needed to know about adolescents' needs and priorities. This includes already existing desk reviews and preparedness plans that can provide an analysis of the situation prior to the emergency, including specific at-risk adolescent groups, vulnerability factors, and/or lessons learned from previous emergencies. Inter-agency needs assessments, needs overviews, or response plans may provide further sector-specific information about adolescents. Disseminated situation reports and existing government data may also provide information to inform programming. Practitioners should also consider what data proxies can be used for ASRH. For example, data on food insecurity and distance to water sources can be used as a proxy for girls' vulnerabilities to gender-based violence (GBV), including sexual violence. Existing data from government, cluster members, displacement tracking, and sectoral assessments that differentiate by age, gender, disability, and socioeconomic status can provide valuable information as well.</i></p>
<p>The benefits to adolescents outweigh the risks.</p>	
<p>The resulting interventions will directly benefit adolescents.</p>	



If your research complies with the above [DO's and DON'Ts](#), the next thing to consider are the minimum requirements for conducting assessments and/or research with adolescents, outlined in this Toolkit. All staff conducting assessments with adolescents should receive training on the below items included in the [Checklist for Conducting Assessments with Adolescents](#). The [ASRH in Emergencies Training of Trainers' \(TOT\) package](#) from the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) provides guidance on how to train others on Data for Action. Practitioners can consult WHO's [Guidance on Ethical Considerations in Planning and Reviewing Research Studies on Sexual and Reproductive Health in Adolescents](#) for additional recommendations and information on conducting ASRH research. The [Reproductive Health Response in Conflict Consortium](#) (RHRC) also provides guidance on developing survey questions and a handbook for training interviewers. Additionally, the [Reproductive Health Assessment Toolkit for Conflict-Affected Women](#) from the United States Agency for International Development (USAID) and Centers for Disease Control and Prevention (CDC) provides guidance on data entry, cleaning, analysis, and suggestions for how to use the data.

Checklist for Conducting Assessments with Adolescents

- Approvals:** Approval to conduct assessments should be obtained from the coordinating agency, as well as the local government and health authorities, local community leaders, and partner organizations. Ethical review or ethical approval may also be required in some countries or by some agencies and institutions depending on the type of assessment.
- Privacy:** Data should be collected in a setting where visual and auditory privacy can be ensured and where adolescents feel comfortable. Adults should not be present during the assessments to allow for open discussion among adolescents; however, if the adolescent requests the presence of a caregiver during an assessment, the caregiver should be allowed but properly coached beforehand to understand their role. Trusted adults are permitted to see adolescents but are not to be within earshot of the discussion among adolescents.
- Security:** The security of the beneficiary population should always be the top priority. If conducting an assessment could put the participants or the study team at risk, then it should not be conducted. Staff should receive a security briefing prior to conducting any assessment to understand the specific risks and security protocols for that area, particularly if you are bringing in third-party individuals for the assessment (translators, vendors, etc).
- Child safeguarding:** All staff involved (whether a part of your organization or a third-party individual) should receive child safeguarding orientation to understand what your organization does to keep children (and the information obtained from children) safe. It is also recommended to conduct a background check for all staff involved prior to working with adolescents or their data. Staff should also have experience working with adolescents or receive training on adolescent considerations.
- Inclusive:** To the extent possible, at least one member of the assessment team should be of the same gender and speak the same language as participants. All assessment staff should be of an age that is contextually appropriate to discuss SRH-related issues with adolescents. When possible, assessments should be pre-tested to ensure the language is understood and appropriate for the participants. If you need to hire a translator, you must make sure they receive appropriate training, including security and child safeguarding protocols. Assessment team members should consult community members on what terminology is contextually appropriate to avoid stigma.
- Referrals:** Appropriate resources or referral services must be available before any assessment is conducted. All assessment staff need training on how to respond to adolescent needs, should an assessment result in services requested by an adolescent. For example, assessment staff must know the correct referral mechanism (and bring appropriate forms) to ensure linkages to medical and psychological treatment or support are available for any participant who reports that he, she, or they is/are a survivor of sexual violence.
- Assent/Consent:** Each individual involved in the assessment must be fully informed of the purpose of the assessment (in language/terminology they can understand). This includes the purpose of the assessment, methods that will be used, the nature of the questions that will be asked, the risks and benefits of participating prior to giving assent/consent to participate, how participants were selected, and what steps will be taken to safeguard their privacy and confidentiality. SRH managers should also explain that the adolescent can disallow the use of their data before results are published. SRH managers should comply with local laws regarding consent. Where possible, verbal assent and consent should be collected so as not to record the persons' identifiable information (eg their signature).



- **Consent:** refers to giving permission for something to occur. In research, informed consent is the formal process for getting permission before a person can participate in research. Refer back to the [Principle of Capability](#), which states that an adolescent—who identifies that they want SRH services and voluntarily requests SRH care, such as maternal care, contraception, sexually transmitted infection (STI) care, or to terminate the pregnancy—is capable of consenting to services. Humanitarian staff must always comply with local laws regarding consent. When the laws/policies/governmental statutes do not include guidance on managing ethical and legal conflicts, practitioners should act in the best interests of the child. If parental consent is required, humanitarian staff should ensure they receive consent from the adolescent’s caregiver, as well as the adolescent’s assent.
- **Assent:** refers to “the willingness to participate in research, evaluations, or data collection by persons who are by legal definition too young to give informed consent...but who are old enough to understand the proposed research in general, its expected risks and possible benefits, and the activities expected of them as subjects.” Assent gives adolescents who are not of legal age (according to local laws where the adolescent resides) the ability to take ownership of their participation and make their own decision as to whether or not they want to participate. Assent is crucial to conducting research activities with adolescents, as they are empowered to make their own decision on whether or not they want to participate in the activity. Even if an adolescent’s caregiver provides consent, an adolescent is free to not provide their assent and should not be forced to participate in the assessment.
- **Voluntary Participation:** Participation is completely voluntary and any participant may decline to answer any question or may decide to withdraw from the assessment at any time. The individuals or the agency conducting the study must respect the wishes of the adolescent and must not pressure them to respond to any question. Ideally, assessment staff should not use incentives to pressure participation. If incentives are used, they should be aligned with local living standards. Adolescents should also be informed that they can withdraw without losing any benefits or services.
- **Confidentiality & Anonymity:** Confidentiality and anonymity must be maintained at all times. Maintaining confidentiality means that only certain people involved in data collection can link responses to a specific participant. Any data collection that includes personal information, such as a registration form, should be kept separate and have no clear links to other data. Protecting anonymity means that there will not be any identifying information of individual participants recorded (name, place of residence, etc). Members of the assessment team must sign confidentiality agreements and not discuss any aspect of the study with anyone except the study supervisor. Adolescent participants’ identities should not be shared with anyone outside the study team and should not be linked to their response. Where possible, data should be de-identified from the participant. Ideally, their name or other personally identifiable information is not linked to the participants at all. If it is linked to the participants during the survey collection, the personally identifiable information must be destroyed following the end of the survey.
- **Data storage:** should be done to ensure that no one else may access the data. For data stored on computers, folders and files should be password protected. For paper-based data, files should be kept in a drawer or cabinet with a lock. All personally identifiable data should be destroyed once data analysis is complete if there is any risk that the questionnaires could pose a risk to participants or staff. Program managers should also take into consideration the cyber-security data privacy related to confidentiality and safety of providers, health facilities, and adolescents.

- **Use the Data!** Debrief after the assessment with the assessment team and determine how best to use the data to improve SRH outcomes for adolescents. Your team should be consulting with adolescents, as well as community members, without breaking confidentiality. Recommendations generated from the assessment should be shared through appropriate humanitarian coordination mechanisms (SRH Working Group, Health Cluster, etc) to ensure other partners can also adjust programming to better address the SRH needs of adolescents. For multi-sectoral and sectoral assessments, SRH managers should collaborate in designing and conducting the assessments to jointly advocate for the inclusion of adolescents. Make sure all data shared cannot be linked to an individual. Data should be shared with adolescents and community members in an accessible, appropriate format.

How are adolescents different from other beneficiaries we collect data from?

How data is collected should be adapted for adolescent populations. Typical modes of data collection, such as in-person surveys, may not be appropriate for all adolescents for a variety of reasons, especially when discussing sensitive topics. Practitioners should meet the adolescent where they are, whether that is through individual interviews, storytelling methodologies, photo elicitation, or other methods. Below are some considerations for conducting assessments with adolescents:

- Adolescents may have a shorter attention span than adults, making it difficult to stay engaged for a long survey or group activity. Surveys should be piloted and kept as succinct as possible, and group activities should be kept to one hour.
- Adolescents may be more adept with technology than adults, making it possible to conduct self-administered surveys using platforms such as [Audio Computer-Assisted Self-Interviewing](#).
- Adolescents may feel shy to discuss issues related to SRH in front of a large group of peers. Smaller group activities or discussions (4–5 participants) may be more comfortable than standard focus group discussions of 10–12 participants. Moreover, to ensure active participation, group sessions—to the extent possible—should be gender specific.

How do we discuss SRH values with adolescents?

As discussed in other parts of the Toolkit, the social norms, taboos, and sensitivity regarding SRH in some contexts or among some individuals can have an impact on activities, services, and information delivered to adolescents. This is also true with assessments. The team’s strengths and weaknesses (related to values, attitudes, skills, and experience) when assigning roles and tasks is therefore a key consideration when planning for adolescent and community participation.

Who Should Conduct Assessments?

Assessment teams can be big or small, depending on how thorough the assessment is, the area the assessment covers, the size of the population the team is consulting, how accessible and/or secure conditions are, and the methods your team plans to use. Generally, it is comprised of a few different specialties—clinical, research, management, and public health. The team should have appropriate technical skills, training, and experience in conducting assessments. They should be skilled at communicating with adolescents in the local language(s) they speak, including communicating about SRH topics. Finally, they should understand how to analyze and interpret the findings and use the data accordingly.

SRH managers can help mitigate risks when conducting assessments by:

- Making the assessment team members aware of their prejudices and their power, and enabling team leaders to challenge such views (see [VCAT Tools](#) for more information).
- Ensuring that your team has a range of backgrounds, including age, ethnicity, religious affiliation, physical ability, and social status.
- Ensuring that your team has an appropriate balance of genders. For example, it might be taboo for a man to ask a married adolescent girl about her reproductive history.
- Ensuring all staff engaged are trained and provided ongoing supportive supervision on SRH for adolescents and young people, what services they have access to (including services your organization does not provide), and how to refer adolescents to those services—should anything arise during their participation.
- Training team members in specific methods to engage with adolescents and communities in an appropriate way, including understanding nuances in language around sensitive topics such as sex and sexuality (see [Community Participation](#) for more information).
 - When possible, it is good practice to engage adolescents in the assessment teams (unless it makes other adolescent participants and/or community member participants uncomfortable).

What types of assessments should we use with adolescents and youth and when?

There are several types of assessments humanitarian responders can use to understand adolescents' needs, barriers, and experiences, as well as opportunities to engage with them. The purpose of the assessment and the phase of the emergency it is being conducted in will determine what kind of assessment you use and when.

The MISP Does Not Wait for Assessments!

It is important to remember that the [Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations](#) (MISP) is implemented without any prior assessments. The initiation of the MISP should never be delayed while waiting for results of any assessment, including the initial rapid assessment.

[Table 6](#) provides information on when you can use these different assessments throughout different phases of the program and humanitarian cycle, how to involve adolescents in different assessments, and examples and tools to consult when using the assessments. It includes several participatory methodologies as well, including body and participatory mapping, ranking exercises, score cards, transect walks, and storytelling. The purpose of participatory methods is to make the assessment process as inclusive as possible. Community organizations led by members of the affected population and informal groups of different subpopulations within the affected population, such as adolescent clubs or youth networks, should be engaged and involved throughout the process. [Table 6](#) will be referenced throughout the chapter, as several of the assessments can be used during multiple phases of the program cycle and humanitarian continuum. *Note: This table is not an exhaustive list of all the assessment tools and methods that can be used for collecting data on ASRH.*

For all assessments, it is important that humanitarian responders understand the principles of collecting data from adolescents and youth, including ethical considerations, which are discussed next.

Table 6: ASRH Assessments, Timing & Tools

Assessment Tool	Purpose & Timing	Tools & Additional Information
Needs Assessments & Analyses		
Initial rapid assessment (IRA)	<p>An IRA is conducted during the first 72 hours of an acute emergency and is used to collect demographic information and identify life-saving issues that must be addressed urgently to ensure the well-being of the beneficiary population. It is critical to ensure adolescent SRH concerns are included in the needs assessment at the very onset of an emergency. Needs assessments can also be done as part of emergency preparedness efforts.</p> <p>Adolescent-inclusive needs assessments should answer questions related to the main SRH concerns of adolescents; the SRH priority needs of adolescents (puberty, contraception, etc); how adolescents' needs differ based on age, marital status, and other key variables; how current services are responding to SRH needs of adolescents; what barriers exist for adolescents accessing/using SRH services; and which community members to involve in SRH activities.</p>	<p>The sample IRA in Annex O: IRA for ASRH cannot be used as a standalone tool but provides an overview of the SRH data that should be collected and can be used as a complementary tool to other rapid assessment formats. For multi-sector IRAs, see guidance from the Inter-Agency Standing Committee (IASC).</p>
Detailed needs assessment	<p>Following the IRA, humanitarian responders should conduct a detailed needs assessment on ASRH (most often a few weeks into the emergency). This assessment helps better understand the needs and priorities of adolescents, in coordination with other humanitarian actors (eg Health Cluster, SRH Sub-Working Group, and the GBV Sub-Cluster).</p>	<p>ActionAid has a detailed needs assessment checklist and report template available online that practitioners can adapt to collect more detailed information on ASRH.</p>

Community capacity and needs assessment	<p>Community capacity and needs assessments (also called “self-assessments”) are analyses of chosen capacities compared to existing capacities and provide a systematic way to gather data and information on the community’s capacity.</p> <p>These assessments help communities identify their strengths and areas for improvement on a given topic or issue, which humanitarian practitioners can use to support their capacity development response with community members. These assessments can be used during preparedness and response phases of the emergency, including to develop response strategies or emergency funding appeals. They support communities in determining priority focus areas, in addition to helping prepare community members to play active roles in their communities.</p> <p>The community capacity and needs assessment information can be gathered using a number of techniques outlined in this table, such as household surveys, focus group discussions (FGDs), participatory mapping, role-playing, transect walks, secondary sources, and seasonal diagramming.</p>	<p>Several organizations have examples of community capacity and needs assessments—all with different domains for capacity and/or needs. These capacity domains should be related to what the community needs or wants to achieve, and thus change with each context and community.</p> <p>Save the Children has a Community Capacity Strengthening Guide, along with their actual assessment tool, the Community Self-Assessment Tool.</p> <p>International Federation of the Red Cross has a Vulnerability and Capacity Assessment tool and related material on how to conduct one.</p> <p>The Ready to Save Lives: SRH Care in Emergencies preparedness toolkit also has guidance and resource tools for community capacity needs assessments.</p> <p>WHO has an Introductory Guide for Community Health Needs Assessments, including guidance for practitioners and for trainers.</p>
Situational analysis	<p>A situational analysis helps humanitarian responders understand the context of affected populations (legal, political, cultural, and socio-economic factors) and how these contextual factors impact their SRH needs and availability of services. Situational analyses should include questions on how the crisis or contextual factors have affected different subpopulations, including adolescents and subgroups of adolescents (eg pregnant adolescents).</p>	<p>The Toolkit has updated the situational analysis from the 2009 version of the ASRH Toolkit for use with several assessments. SRH managers can use Annex P and Annex Q for questions to use with adolescents, providers, or community members, including community health workers, when collecting information.</p> <p>The IAFM provides guidance on how to review literature and indicators as part of the MISP assessment in Section 5.5 of the IAFM.</p> <p>RHRC Consortium provides situational analysis guidelines as well.</p>

Environmental scan	<p>Environmental scans examine and analyze data to identify threats and opportunities that could influence your programming decisions. They include questions around the legal context (laws/policies affecting SRH use among adolescents) and governmental support for ASRH; services that are currently provided to adolescents; training offered to service providers on delivering services to adolescents; where and how adolescents access services available to them (public, private, etc); challenges/barriers adolescents face accessing SRH information and services; decision-makers for ASRH; other partners, associations, and stakeholders working on SRH; and what type of data has been collected and/or used for ASRH. These scans should be completed prior to and/or during program design.</p>	<p>Women’s Refugee Commission (WRC) provides an example of the questions they used for an environmental scan of ASRH programming in humanitarian settings from 2009–2012.</p> <p>The Coalition for Adolescent Girls provides an example of how they engaged adolescent girls in conducting their environmental scan in Kenya’s Kibera slum.</p>
Gender analysis	<p>A gender analysis looks at the relationships between people of all genders. It examines their roles, their access to and control of resources, and the constraints they face relative to each other. A gender analysis should be integrated in the humanitarian needs assessment and in all sector assessments or situational analyses.</p>	<p>IASC developed a handbook with guidance on gender analysis, planning, and actions to ensure that the needs, contributions, and capacities of women, girls, boys, and men are considered in all aspects of a humanitarian response. It also offers checklists to assist in monitoring gender equality programming.</p> <p>Several organizations have examples of gender analyses. Here is an example of a recently completed gender analysis by CARE and the International Rescue Committee (IRC) during the Coronavirus Disease (COVID-19) pandemic.</p>
Other analyses (stakeholder, risk, conflict)	<p>These analyses are necessary to implement prior to starting your project/as part of your program design process. The stakeholder analysis helps managers understand the interests of different groups, including adolescents, youth clubs, and community members, and strategize ways to gain support from these groups for your programming while mitigating risks from those who may not fully support your activities/projects. Risk and conflict analyses, as well risk and resource mapping, help identify risk factors and/or conflict dynamics, opportunities, resources, or strategies to overcome, and/or mitigate the risks and dynamics of the context.</p>	<p>Foreign, Commonwealth & Development Office (FCDO; replacing Department for International Development [DFID]) and European Civil Protection and Humanitarian Aid Operations (ECHO) provide guidance on conducting stakeholder, risk, and conflict analyses.</p>

Interviews & Discussions		
Individual interviews	<p>Individual interviews, or in-depth interviews, generate qualitative data from adolescents by asking open-ended questions on specific topics, such as SRH and rights.</p> <p>These interviews can be conducted with adolescents and youth during all phases of the program cycle; however, in a humanitarian response it is not appropriate to conduct individual interviews at the onset of an emergency. It is advised to conduct individual interviews as you transition to comprehensive SRH programming and/or during protracted emergencies to help design activities, better implement programming, and measure impact of the project upon adolescents.</p> <p>Adolescents and youth can also be consulted regarding who else should be interviewed and what information would be most useful to learn from them.</p>	<p>Individual interview questions can be asked in a structured (a set of questions asked in a specific order), semi-structured (a set of questions and suggested probes that can be changed or adapted during the course of an interview), or unstructured format (a list of guiding topics used for inductive, open-ended questioning). These interviews ask adolescents about pre-existing conditions and SRH practices, the current situation, changes in practices since the onset of the emergency, adequacy of current SRH services, and their priority SRH needs.</p> <p>WHO and USAID provide examples of interview guides that have been used with adolescents and youth, which you can use to adapt for your project and context.</p>
Focus group discussions (FGDs)	<p>FGDs generate qualitative data about adolescents' beliefs and attitudes on a particular SRH issue or problem. FGDs differ from individual interviews as they allow for interaction among all the members of the group. While FGDs require a significant amount of planning and preparation, they can offer in-depth insights to a given issue.</p> <p>FGDs can be conducted during any phase of a project; however, it is advised to conduct FGDs in protracted crises and while transitioning to comprehensive SRH programming to design, better implement, and effectively evaluate your programming. If the situation presents itself to conduct FGDs in the acute phase, this method is a great way to begin collecting data and informing programmatic decisions.</p> <p>FGDs can also use creative approaches (body mapping, photo elicitation, and storytelling) to talk to adolescents about their beliefs, attitudes, and experiences.</p>	<p>The Toolkit has provided a tip sheet for conducting FGDs, included in Annex R.</p> <p>FGDs can use a standard guide with questions, beginning with more general questions and slowly transitioning to the subject matter to discuss. Annex RR provides an example of an FGD conducted by Save the Children's Yemen team with adolescents—including adolescent girls who are married, adolescent girls who are unmarried, and adolescent boys. The FGD guide provides considerations and adjustments for each of the questions depending on the audience, as well as guidance for how to introduce, transition between topics, and close the FGD session.</p> <p>RHRC Consortium provides FGD guidelines as well.</p>

Mapping & Participatory Exercises		
<p>The Toolkit provides a few examples of these methods, but more can be found in the Regional Network for Equity in Health in East and Southern Africa's Methods Reader and Ipas's Young Women and Abortion: A Situation Assessment Guide, which are referenced throughout this section.</p>		
Body mapping	<p>Body mapping is a participatory activity that enables girls and boys to explore and express how different risks, hazards, conflict, or crisis events affect their lives, experiences, views, and feelings through a visual method. Participants create an outline of a person's body and use the structure to show how internal and external factors have impacted their lives. For example, looking at the head of the body image, assessment staff could ask how a particular event has affected the participants' minds, the way they think, and their learning.</p> <p>This method is especially useful for gathering information on sensitive and conversational topics, which can be hard to put into words. The method can be used to assess needs and barriers when designing your project or for monitoring and accountability mechanisms throughout your programming.</p>	<p>The Centre for Support and Social Integration Brazil and Centre for Spanish-Speaking Peoples developed a body mapping guide for researchers, which can be tailored to fit your context. As well, the Regional Network for Equity in Health in East and Southern Africa and partners put together a methods reader to inform, motivate, and strengthen participatory action research. The guidance document provides additional information on body mapping and includes examples.</p>
Participatory mapping methods	<p>In participatory mapping methods, adolescents and other participants are asked to draw maps of their area/community to identify example service points or hazards and risks. This includes risk and hazard maps, which identify risks and resources—including safe and unsafe places—in the community from the perspective of adolescent girls and boys of different ages.</p> <p>This method can be used to assess needs and barriers when designing your project or for monitoring and accountability mechanisms throughout your programming.</p>	<p>The Regional Network for Equity in Health in East and Southern Africa and partners put together a methods reader to inform, motivate, and strengthen participatory action research. The guidance document provides additional information on participatory mapping and includes examples.</p>
Social mapping	<p>This is similar to participatory mapping but is more focused on social characteristics (population, social group, health, and other characteristics). This includes assets, well-being, and vulnerability mapping of adolescents. This mapping can be used to identify key social groups and processes, needs, preferences, and other health information. Social maps—the product of this exercise—provide up-to-date household listings that programmers can use for health programming and decision-making.</p>	<p>The Regional Network for Equity in Health in East and Southern Africa and partners put together a methods reader to inform, motivate, and strengthen participatory action research. The guidance document provides additional information on social mapping and includes examples. IRC also provides an example of a social mapping exercise with adolescents.</p> <p>RHRC Consortium and IRC provide community mapping guidelines as well.</p>

Ranking exercises	<p>There are several types of ranking exercises, including diamond ranking, well-being ranking, preference ranking, matrix ranking, and pair-wise ranking. These exercises are used to compare and value different services, priorities, barriers, or other items, such as comparing different contraceptive methods or adolescents valuing/ranking their satisfaction with services. Comparisons are made through scoring or by grouping or positioning items.</p> <p>These exercises can be used during the design phase to understand adolescents' preferences, barriers, and priorities, as well as monitoring the performance of your program's services.</p>	<p>The Regional Network for Equity in Health in East and Southern Africa and partners put together a methods reader to inform, motivate, and strengthen participatory action research. The guidance document provides additional information on ranking methods and includes examples.</p> <p>The Child Protection Center Learning Network (CPC) provides a participative ranking methodology guide, and Save the Children has a how-to guide for using participatory action research with adolescents in humanitarian contexts.</p> <p>RHRC Consortium provides pair-wise ranking guidelines as well.</p>
Transect walks with adolescents	<p>Transect walks, or participatory observational surveys, are an observation-based assessment where observers (humanitarian programmers) walk through the community with participants (adolescents or community members) to examine the features, resources, barriers, and overall conditions in the area.</p> <p>Transect walks can supplement formal maps and data, but in cases where these do not exist, they are an excellent tool for creating a record of environmental conditions, such as the barriers or risks faced by adolescents seeking SRH information and services. They can be helpful for understanding conditions, assets, services, and barriers from an adolescent's point of view.</p> <p>The walk can take less than one hour or last up to three hours, but advance planning is important to identify objectives and methods. This method can be used to assess barriers and needs in designing activities to benefit adolescents, as well as for monitoring and accountability mechanisms later in the project.</p>	<p>The Regional Network for Equity in Health in East and Southern Africa and partners put together a methods reader to inform, motivate, and strengthen participatory action research. The guidance document provides additional information on transect walk/participatory observational surveys and includes examples.</p>

Photo elicitation	<p>Photo elicitation is when photographs, cartoons, public displays (graffiti), pictures, or images are used to elicit discussion. Assessment staff must carefully select the photograph or picture/image, which they show to adolescents and ask them about their feelings upon seeing the photo, as well as to reflect on situations, conditions, or problems brought out from viewing the photograph or image.</p> <p>This method can encourage open discussion and help bring back memories. The method can be used to assess barriers and needs in designing activities to benefit adolescents, as well as for monitoring and accountability mechanisms later in the project.</p>	<p>The Regional Network for Equity in Health in East and Southern Africa and partners put together a methods reader to inform, motivate, and strengthen participatory action research. The guidance document provides additional information on photo elicitation/picture codes and includes examples.</p> <p>Gender and Adolescent Global Evidence provides examples of using photography, as well as visual storytelling (discussed next) as participatory research methods to reach young people in emergency settings.</p>
Storytelling	<p>Storytelling—including life histories, Most Significant Change technique, and narratives—involve inviting adolescents to create a story around a topic. Storytelling can help researchers and implementers gain a better understanding of emotions and issues that might have been missed or misunderstood during other conversations. It can also bring together individual stories into a group story for additional conversations and study, as well as encourage shared experiences, develop compassion for one another, and find common ground. It can help participants think about a solution to a problem, uncover their attitudes toward the topic, and/or discover how they react to a situation.</p> <p>Typically, assessment staff will provide participants with a situation and the materials and scenes to build a story. This method can be used to assess barriers and needs in designing activities to benefit adolescents, as well as for monitoring and accountability mechanisms later in the project.</p>	<p>The Regional Network for Equity in Health in East and Southern Africa and partners put together a methods reader to inform, motivate, and strengthen participatory action research. The guidance document provides additional information on storytelling examples.</p> <p>CARE, Oxfam, Lutheran World Relief, and Ibis supported a guide to using the Most Significant Change technique.</p>

Monitoring & Accountability Mechanisms		
Monitoring checklist for MISP	<p>The SRH Coordinator implements the MISP for SRH Monitoring Checklist to monitor service provision in each humanitarian setting as part of overall health sector/cluster M&E. In some cases, this might be done by verbal report from SRH managers and/or through observation visits. At the onset of the humanitarian response, monitoring is done weekly and reports should be shared and discussed with the overall health sector/cluster. Once services are fully established, monthly monitoring is sufficient.</p> <p>The tool is used to discuss gaps and overlaps in service coverage during SRH stakeholder meetings and with the health sector/cluster coordination mechanism to find and implement solutions. It is important for all health partners to understand how to use and contribute to this monitoring tool.</p>	IAWG provides this monitoring checklist as part of the IAFM . It is available in English and French.
Exit interviews (at service points)	<p>Patient exit interviews are conducted after an adolescent has received services. They provide an opportunity to obtain information from the adolescent's perspective on the services received that day—a perspective often very different from that of the healthcare worker. SRH managers can also add mystery patients or staff who pose as an adolescent patient to see how the patient was treated. These assessments can be used for monitoring or evaluating program activities.</p> <p>Exit interviews are not only used for health facility services, but can be used with other sectors to ensure high quality standards are met.</p>	<p>United Nations Population Fund (UNFPA) provides an example of an exit interview form, as well as resources for conducting interviews with providers about service delivery. SRH managers should adapt their exit interview form to their audience, programming, and context.</p> <p>RHRC Consortium provides an example client feedback form as well.</p> <p>WHO has developed a web-platform for the M&E of national quality standards for adolescent healthcare services, which includes several exit interview tools.</p>
Score card methodologies	There are several score card methodologies for SRH services and policy advocacy. Overall, these methods allow users (could be joint discussions with adolescents and other community members/health professionals or targeted discussions with one population) to discuss a specific topic; identify barriers, needs, and other information; compare perspectives from one group to another; agree on evaluation indicators (eg satisfaction of SRH services); and propose solutions to address any identified issues. These methodologies are useful to employ when designing your program to identify needs and barriers and joint solutions, as well as to monitor performance of the project.	International Planned Parenthood Federation (IPPF) , CARE , and several other organizations provide examples of different score card methodologies they have used with adolescents in emergency settings.

Health facility assessments	These tools are used to help program managers assess how well their facility is delivering services to beneficiaries and identify gaps or areas for improvement. There are several different kinds of facility assessments that include quality standards for ASRH.	In Facility Quality Improvement Tools, the Toolkit provides an adapted health facility checklist for assessing, monitoring, and evaluating how friendly and responsive your facility is in meeting the SRH needs of adolescents.
Process monitoring tools	Process monitoring looks at how effective, efficient, and quickly your organization is implementing activities. This includes all actions, systems, and processes your organization uses to provide services to adolescents (including human resources, financial processes, M&E, technical, etc). Organizations can use qualitative or quantitative indicators for monitoring their processes. During program design, your organization should agree upon process indicators to use throughout the duration of the timeline and decide how often you will look at these indicators. Looking at these indicators on a regular basis allows organizations to identify problems and opportunities early to respond to them.	The Sphere Project provides example indicators for process monitoring.
Surveys and Evaluations		
Knowledge, attitudes, and practices (KAP) surveys	<p>This type of survey is a uniform approach to conducting surveys regarding the knowledge, attitudes, and practices (KAP) from a specific population (adolescents) about a particular topic (eg SRH issues). KAP surveys are a type of household survey. Household surveys are questionnaires provided to a sample of households in a population. These surveys would be targeting adolescents in a specific area; they are the primary data collection tools used in the Demographic and Health Surveys (DHS) Program.</p> <p>In most KAP surveys, data are collected orally by an interviewer using a structured, standardized questionnaire. KAP studies can be conducted during any phase of a project. However, it is advised to conduct KAP studies in protracted crises and while transitioning to comprehensive programming to design, better implement, and effectively evaluate your programming. If the situation presents itself to conduct KAP studies in the acute phase, this method is a great way to begin collecting data and informing programmatic decisions.</p>	<p>WHO developed a questionnaire to use when asking adolescents about their SRH behaviors, which you can use for creating your own KAP survey. As well, the Toolkit includes several questions to ask adolescents about their attitudes, knowledge, beliefs, and behaviors regarding SRH in Annex P and Annex Q.</p> <p>WHO completed a KAP survey with individuals above age 15 to evaluate their KAP and examine related, associated socio-demographic variables. Their study includes the KAP survey questions and analyses.</p> <p>WHO provides examples of larger household surveys conducted, as well as other data collection assessments, on their Health Statistics and Health Information Systems resource page.</p>

<p>Process evaluation</p>	<p>Process evaluations, or formative evaluations, look at the process of a program's implementation and are conducted during implementation to show what is working well, how efficiently, and where improvements can be made.</p> <p>These evaluations look at the types, quantities, beneficiaries of, and resources used to deliver your program's services, as well as issues encountered and how your organization overcame those barriers.</p> <p>These assessments can be completed during the middle of a project (if in a protracted crisis) to help with course correction or at the end of a project as part of other evaluation activities.</p>	<p>WHO provides a handbook on conducting different evaluations, including process or formative evaluations.</p> <p>IAFM also provides MISP process evaluation tools.</p>
<p>Program impact evaluation/assessment</p>	<p>This evaluation or assessment looks at what and how much change occurred (at program or population level) that can be attributed to the program or intervention.</p> <p>These assessments should be completed at the beginning (to collect baseline information) and at the end (to collect endline data) of a program or when you need to demonstrate impact (to justify continued funding).</p>	<p>USAID's MEASURE Evaluation project provides a manual for programmers to use for conducting a program impact evaluation. The project also provides a separate manual, called Evaluating Family Planning Program with Adaptations for Reproductive Health, which includes how to conduct an impact assessment/evaluation, as well as how to identify appropriate indicators and data sources for evaluation and how to design an evaluation plan.</p>
<p>Program outcome evaluation</p>	<p>A program outcome evaluation assesses the effectiveness of your program in affecting long-term changes. While impact evaluations assess the immediate effects of a program, outcome evaluations look at longer-term effects of the intervention, which should relate to the project's overall goal.</p> <p>These assessments should be completed at the beginning (to collect baseline information) and at the end (to collect endline data) of a program.</p>	<p>WHO provides guidance and ways to conduct program outcome evaluations, including randomized control trials, quasi-experimental designs, before-after studies, and several others.</p> <p>WHO developed a handbook for implementing evaluation practices, which takes users from planning for the evaluation, to conducting the evaluation, through to reporting and communicating results.</p> <p>In addition, WHO has specific guidance on how to conduct post-project evaluations of ASRH projects.</p>

What are other sources of ASRH information we should consult?

Reviewing existing data and information (eg Ministry of Health data) should always be done as part of program design, prior to primary data collection. If your organization supports health facilities, health facility registers provide a significant amount of information on SRH service use among adolescents. This is discussed further in [Implementation and Monitoring](#).

Secondary data can also be extremely useful throughout Data for Action activities to supplement primary data. Secondary data can help to contextualize program data and provide additional comparison points to assess whether or not the intervention is achieving its intended objective. Secondary data should be used with the understanding that it may not be representative of the population affected by conflict or displacement, particularly if it is national-level data.

The following are some sources of ASRH data:

- [Demographic and Health Surveys \(DHS\)](#): The DHS Program has collected, analyzed, and disseminated accurate and representative data on population, health, HIV, and nutrition through more than 400 surveys in over 90 countries. USAID provides an overview paper on [Youth Data Collection in DHS Surveys](#).
- [Multiple Indicator Cluster Surveys \(MICS\)](#): Over 300 MICS have been carried out in more than 100 countries, generating data on key indicators on the well-being of children and women and helping shape policies for the improvement of their lives.
- [World Population Dashboard](#): The World Population Dashboard showcases global population data, including fertility rate, gender parity in school enrollment, information on SRH, and more. Numbers come from UNFPA and other UN agencies and are updated annually.
- The [Adolescent Data Hub](#): The Adolescent Data Hub is a global portal to share and access data on adolescents living in low- and middle-income countries. It is home to the world's largest collection of data on adolescents and serves as a resource to facilitate data sharing, research transparency, and a more collaborative research environment to drive continued progress for adolescents.

How can we involve and engage adolescents/youth in conducting assessments?

At minimum, adolescents should be consulted on their needs, their preferred activities prior to starting the SRH program or activities, their views on the program as it is being implemented, and their feedback on the data results and what those results mean for future similar projects. Programmers can use the assessments described in [Table 6](#) to consult adolescents on these topics throughout the program cycle and humanitarian continuum.

Beyond involving adolescents as the study participants, SRH managers can also engage adolescents and youth in helping design, assist, and lead Data for Action activities—with the appropriate level of resources and supervision (see [Engaging adolescents/youth as first responders](#) under Community-Based Services for further guidance). Youth volunteers from the Philippines provide a case study of how humanitarian organizations utilized youth as first responders in Data for Action activities during Typhoon Washi and Typhoon Haiyan response efforts. More guidance on how to engage adolescents as first responders in Data for Action activities during program design, implementation and monitoring, and evaluation and documentation is discussed next.

KEY MESSAGE

Remember, if you can find the information you need about adolescents from another source (needs assessment, sector report, secondary data), you should not be conducting the assessment with adolescents (see [DO's and DON'Ts list](#) from above).

CASE STUDY

Leadership of Youth Volunteers in the Philippines Typhoon Washi & Haiyan Response Efforts

In the aftermath of Typhoon Washi in the Philippines, youth volunteers were involved from the start of the response. This was possible because there was an active presence of pre-existing youth groups, including youth volunteers, that were immediately galvanized to support the response. The volunteers were mostly older adolescents (17–19 years) and young people between 18–24 years old. Within the first days of the response, these volunteers received on-the-spot training to collect information for rapid assessments and to enter this information into a database. In the subsequent rounds of trainings, efforts were made to include more of the displaced youth at increased risk and who were not pre-existing peer educators. They also received training on distribution of UNFPA dignity kits. Because many of them were already trained youth leaders in ASRH, they were able to conduct information sessions on several topics including: menstrual hygiene for young girls when handing out the dignity kits; GBV and GBV prevention; and where to access health services. During the distribution, they were also able to identify vulnerable adolescents and refer them to mobile health clinics or child protection services.

After the success of using youth volunteers during the Typhoon Washi response, a TOT on the ASRH Toolkit (2009 version) was held for national and regional government officials—as well as the UN and other key (international and national) non-governmental organizations (NGOs)—which ultimately contributed to preparedness efforts for the next emergency.

In fact, in the next big response, which was Typhoon Haiyan in 2013, ASRH was automatically a standing agenda item of each regional Reproductive Health Working Group. Some regions even invited adolescent participation at the weekly Working Group meetings. Previously trained youth volunteer networks were re-activated and harnessed. Assessments were conducted by young people with adolescents. FGDs were held in the early stages of the emergency and informed proposal design, and when funds were received, their input helped to design the programs.

Program Design

Humanitarian responders should be utilizing assessment tools outlined in [Table 6](#) to inform their program design throughout the program cycle and humanitarian continuum. This section pulls from evidence in the field to provide guidance on the key steps and considerations for designing and planning for ASRH programming, including provision of priority ASRH activities in emergency settings (outlined in [Chapter 4](#)). The steps included in this section are not intended to be exhaustive, nor are all of the steps mandatory to implement; we encourage innovation and creative methods to strengthen ASRH care in humanitarian contexts.

What steps should we take in designing an ASRH program or integrating ASRH activities into existing health programming?

The Toolkit recommends consulting and/or completing the following steps (below). Throughout all of these steps, humanitarian responders should be thinking about how to involve adolescents. Engaging adolescents as team members of the assessment and design team from the onset can help develop an inclusive and holistic program that is participatory and responds to the needs of their peers in their communities. Adolescents can be actively engaged on numerous fronts: designing and conducting the assessments, and partaking in project design by supporting the development of clear goals, objectives, indicators, and activities. For detailed guidance on the best practices for engaging adolescents/youth as first responders, please see [Chapter 6: ASRH Services & Interventions under Community-Based Services and Outreach Platforms](#).

Steps for Program Design:

1. Become familiar with all of the factors affecting the adolescents' ability to access and utilize SRH information and services by using the [Social-Ecological Model](#)
2. Review and/or collect information about SRH needs among adolescents via assessments, mapping, and scan exercises
3. Consult community members, existing partners, and ASRH stakeholders during program design
4. Develop and/or use theory(ies) of change to underpin your ASRH strategy and how you plan to reach your goals
5. Develop indicators in line with your theory(ies) of change, strategy, and goals

What does the social-ecological model have to do with designing an ASRH program?

Program design should be used in conjunction with the Social-Ecological Model to ensure your program is addressing not only the immediate concerns (as identified from the [IRA](#) and other assessments), but also the broader behavioral- and social-norm changes required to achieve the intended outcome(s). When using the Social-Ecological Model for ASRH program design and activities, humanitarian responders may implement social and behavioral change (SBC) strategies when introducing comprehensive SRH care. SRH managers should plan for their program based on what is relevant and appropriate for their context. It is important to remember that program planning is an iterative process and not rolled out in a linear manner.



What information should we consult to design an ASRH program?

SRH managers should conduct and/or consult a previously completed [needs assessment](#) and [environmental scan](#) to inform the project design/planning and desired outcomes. Needs assessments and environmental scans help us identify which adolescents we need to reach and understand what their needs and priorities are—providing critical answers we need to examine when designing an ASRH program and/or integrating ASRH into existing health programming. The results of the environmental scan also allow us to build on existing SRH programming, determine entry points for cross-sector integration, and start planning for comprehensive and sustainable programming early on in the project design phase (eg understanding the key players, identifying existing stakeholders, and understanding and addressing any gaps).

As always, SRH managers should be consulting secondary sources and existing assessments completed by other health partners, as well as non-health sector assessments that collect data on adolescents. If the situation allows, conducting FGDs, individual interviews, and other participatory action and mapping exercises is recommended, though these assessments may not be feasible directly following an acute humanitarian emergency. Refer to [Table 6](#) for tools that you can utilize to adapt to your context.

Identify, Coordinate, and Establish Partnerships

Developing and fostering relationships with partners, community members, and adolescents are critical to the successful roll-out of your program or activity. Coordinating with all partners during program design lays the groundwork for all phases of the program cycle and humanitarian continuum. As outlined in [Objective 1 in the MISIP](#), coordination and partnerships are important to ensure a robust response initiative is implemented efficiently and effectively among all stakeholders. Utilizing a [3/4/5 Ws template](#) is an effective tool to map out stakeholders, partnerships, and intervention strategies. Moreover, coordinating with stakeholders prior to program design will inform the design of your program by identifying what interventions worked and what has failed. Refer to the [Building Multi-Sectoral Linkages](#) for detailed guidance on coordination.

How can we connect our program design strategy to our intended goals?

Once you have established what the needs are (through consultations/assessments with adolescents), humanitarian responders can then begin developing their goals and ways to reach them. Humanitarian responders can link their strategies, approaches, and activities to their intended goals by grounding them in a theory of change at the onset of the program design phase. Theories of change describe how an organization plans to create the change they are seeking—showing the causal links between what you do and what you are trying to achieve. This theory should include:

1. a description of the nonprofit's target population
2. intended outcomes
3. codified program activities
4. indicators
5. measurement tools
6. uses of data

Theories of change help provide a foundation for understanding why your organization or program exists, what success looks like, how your organization adds value in its community (and specifically for adolescents), and how your organization uses the data collected to achieve its goals. The theory of change articulates the linkages between strategy and anticipated outcomes that support an organization's mission. Your theory of change should relate back to the social-ecological factors you identified in the first step of program design to ensure your program is addressing as many levels of influence affecting ASRH service access and use.

There are many different theories of change to use for ASRH programming and activities. Johns Hopkins University provides an [implementation kit](#) for thinking through how to develop an ASRH program underpinned in a theory of change (and how to know what theory of change to use!).

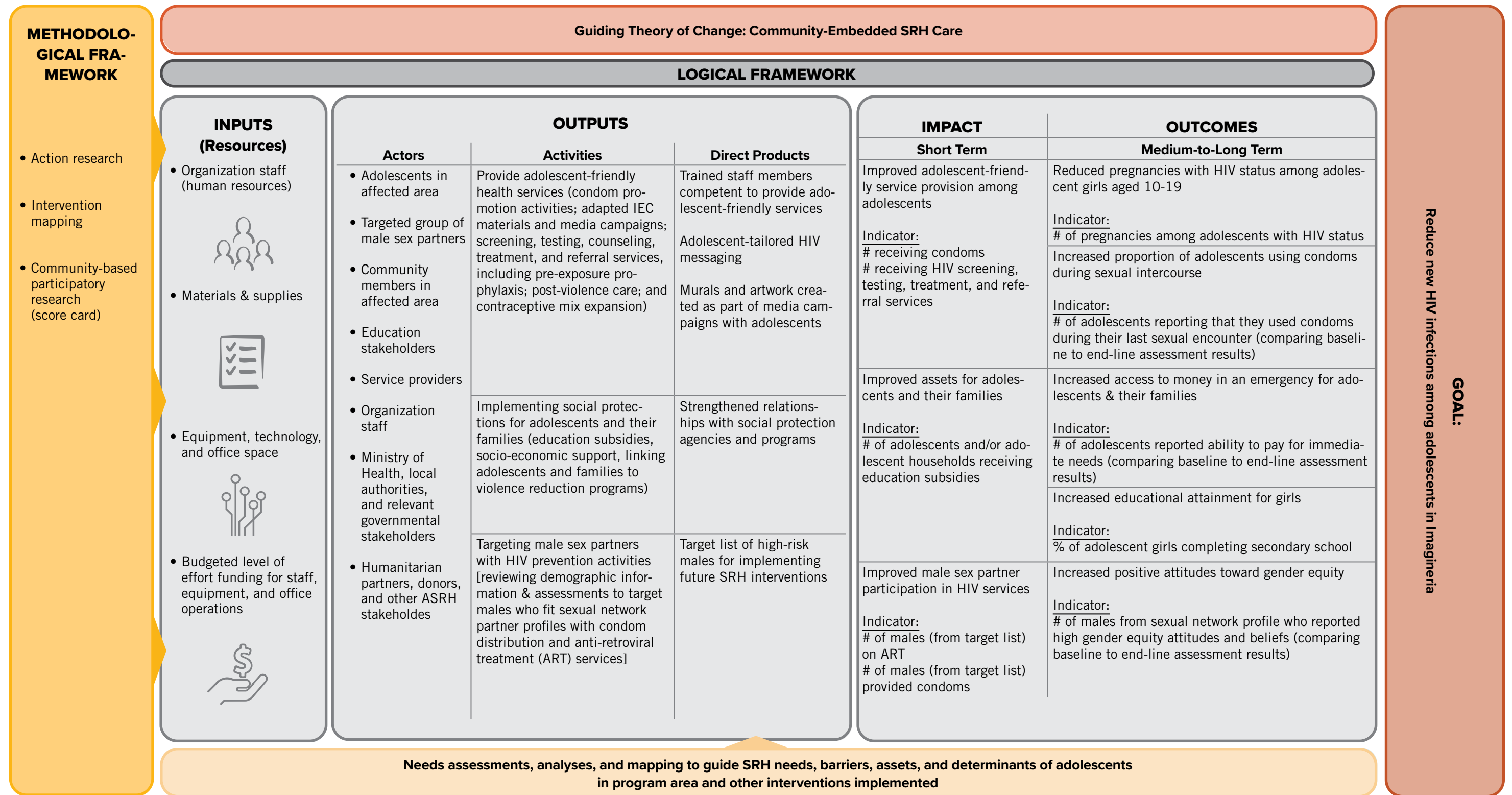
Everything is connected! Regardless of what theory of change your organization uses, the SRH manager needs to make sure their planning tools link to this theory of change. Humanitarian responders can utilize different planning tools to link to their theory of change. The one highlighted in the Toolkit is called a “logical framework” (included in [Figure Q](#)). The Toolkit also includes [guiding questions](#) to consider when developing your theory of change and completing your logical frame and/or other planning tool.

For additional resources on logical frameworks, the United Nations Office on Drugs and Crime outlines how to develop a [logical framework](#) in their Toolkit to Combat Trafficking in Persons. As well, Humanitarian Capacity Building shows humanitarian responders how to build a logical framework through their [YouTube video](#).



Figure Q: Logical Framework for ASRH

The below figure is an illustrative example created from several intervention examples. This illustrative HIV intervention in the humanitarian setting of Imagineria shows how their theory of change, research strategy methods, and assessments all inform the logical framework of the project. They developed their own theory of change called “Community-Embedded SRH Care,” which utilizes action research (conducting a baseline and endline assessment to measure progress against objectives), intervention mapping (conducting environmental scans and stakeholder analyses), and community-based participatory research (using score card methodologies to understand adolescents’ needs and preferences). These strategies, along with other data available from needs assessments, situational analysis, etc., will help the organization achieve their desired goal of reducing new HIV infections among adolescents in Imagineria. This example only provides a few activities and indicators, but provides an idea as to how SRH managers/evaluation teams can complete a logical framework.



Guiding Questions for Developing a Theory of Change

1 Identifying long-term goals.

- Design team should be thinking about “What behaviors need to change or happen to strengthen or expand the provision of ASRH care?”

2 Backwards mapping and connecting the preconditions or requirements necessary to achieve that goal and explaining why these preconditions are necessary and sufficient.

- Design team should be thinking about what factors are affecting adolescents’ access and use of SRH information and services at the individual, interpersonal, community, and structural levels.

3 Identifying your basic assumptions about the context.

- Design team should recognize what assumptions they are making about adolescents and their environment, including their own biases, attitudes, and beliefs towards ASRH.

4 Identifying the interventions that your initiative will perform to create your desired change.

- Design team should be consulting other organizations/partners in the area to understand what has been done in the past, as well as other evidence or literature on the effectiveness of the proposed activities/program upon adolescents’ SRH outcomes.

5 Developing indicators to measure your outcomes to assess the performance of your initiative.

- Design team should be utilizing existing, standardized, and tested indicators when possible and relevant.

6 Writing a narrative to explain the logic of your initiative.

- Design team should be able to explain to team members and community members (including adolescents), as well as donors, partners, and other ASRH stakeholders, how their program intends to achieve the desired outcomes.

What are ASRH indicators and how do I develop them for ASRH programs?

Indicators measure the implementation and effectiveness of the project. By collecting data on each outcome, organizations can identify what is or is not happening and find out why. For ASRH initiatives, make sure your indicators are disaggregated by age and gender (discussed further in [Implementation & Monitoring](#)). All indicators should have clear definitions, with all staff understanding what these definitions mean (eg how is basic knowledge of SRH defined?). Organizations should only be collecting data on the SRH domains in which they are providing services to adolescents to maximize efficiency and to be able to use the data.

Implementing organizations should create indicators in line with their program’s objectives and capacity for measuring progress and results. Additional resources with ASRH indicators can be found in the following

resources: [MEASURE Evaluation Database](#), [Sexual and Reproductive Health and Rights Indicators for the SDGs](#), UNFPA’s [Community Pathways to Improved ASRH: a conceptual framework and suggested outcome indicators](#), and EMpower’s [Designing Programs for Adolescent Girls](#). WHO is also developing guidance for standardized SRH indicators, as well as how to collect this data, which will be released in late 2020.

The indicators outlined below are a small handful of initial suggestions:

- Number of adolescent patients seeking services at health facility (disaggregated by type of SRH service, age, gender, and other sub-groups)
- Proportion of adolescents who use a modern method of contraception
- Proportion of adolescents with adequate knowledge of puberty and fertility
- The degree to which adolescents report they felt they were meaningfully engaged in the program cycle (could be a qualitative indicator for program improvement purposes)
- Adolescent birth rate (among adolescent girls aged 10–14, 15–17, and 18–19)
- Proportion of births to adolescent girls younger than 20 years that were unintended
- Proportion of young men and women aged 15–24 with basic knowledge about SRH and rights
- Number of healthcare workers who are technically competent to deliver quality ASRH services (according to best practices) at targeted health facilities
- Number of targeted health facilities that are adolescent-friendly according to best practices
- Number of outreach activities completed that specifically target adolescents

Now that you have designed your project and received community buy-in, project activities can begin! Before implementation starts, though, make sure you have set up a simple information system to collect SRH

Implementation & Monitoring

data required for monitoring the implementation of the [MISP](#), as well as any other additional donor-required indicators. See [Table 6](#) for the tool IAWG uses for monitoring implementation of the MISP. As the humanitarian emergency changes and organizations begin implementing comprehensive SRH services, your monitoring requirements and indicators should be adjusted accordingly.

What is monitoring?

Monitoring is “the ongoing, systematic collection and analysis of data as a project progresses. It is aimed at measuring progress towards the achievement of program milestones and objectives.” Assessments are not a one-time occurrence at the start or end of a project; they should be used throughout the project. Regularly collecting, documenting, and reviewing SRH data is critical to understanding the performance and quality of the services your program is providing to adolescents. Monitoring allows your program to identify changes in adolescents’ conditions and make timely adjustments.





Don’t Recreate Systems or Processes

It is recommended to work through the country/context’s existing healthcare system, when possible and appropriate. Reporting and referral systems should align with the existing system, but may not always be possible in all emergency situations; thus, further advocacy may be required to guarantee inclusion of affected populations.

There is so much work and so little time. Why should we prioritize monitoring and reviewing data?

There are many reasons organizations and staff do not prioritize monitoring, reviewing, and using the data they have collected. Below, we have included some of the common barriers and/or pitfalls regarding the process of data collection, with information on how Data for Action helps overcome them.

Common Barriers & Pitfalls to Data Collection & How to Overcome Them

 <p>Collecting data for the sake of collecting data</p> <p><i>Often, data collection is seen as a mandated activity and is done to tick a box. Staff may not get feedback on the data they have collected, reducing their engagement or understanding as to why the data is being collected in the first place. This can result in overburdening staff and participants with data collection activities.</i></p>	<p>Planning for how data will be used before it is collected helps to ensure that we only collect information that we will use to improve programs.</p>
 <p>Limited staff capacity for data collection and analysis</p> <p><i>Staff do not feel they have the right skills to monitor and review data or that this work is solely for the M&E person. They may also be unsure or unable to find practical, realistic answers for using the data to propose actionable steps.</i></p>	<p>The more data and information are utilized for action, the more valuable they are to your organization. Showing how services and programs are informed by data helps make the case for capacity building of field staff to better collect and utilize data in a meaningful way. Reviewing the data should also be presented as a creative opportunity in a safe environment, where staff can propose different ideas without fear of rejection or judgment. M&E is the whole team's responsibility—not just the responsibility of designated M&E staff. Everyone should engage with deciding the best indicators and reviewing data on a regular basis. The RAISE Initiative developed several learning modules on data use for staff to understand how to use data to increase quality and impact of their SRH program.</p>
 <p>Weak data collection and poor quality data</p> <p><i>Data collection is often conducted with underdeveloped or inappropriate tools or methods, resulting in data that is of poor quality or, worse, inaccurate. This may be due to the two above-mentioned pitfalls (collecting data for the sake of collecting data and limited staff capacity) and failing to account for how data will be utilized.</i></p>	<p>Thinking through how data and information will be used for programming and advocacy throughout the design of tools, selection of methods, and collection of data is essential. Supervisors must provide appropriate support to staff, reviewing data for inaccuracies/incompleteness, providing constructive feedback on how to collect and report the information correctly, and acknowledging/rewarding staff who are providing accurate and timely data. This mentorship also reinforces to staff that someone is paying attention to the data and work they are doing, increasing their motivation and prioritization.</p>
 <p>Overstating successes and hiding failures</p> <p><i>When evaluating an intervention, we, of course, hope to see that it was a success. It may be disappointing to see that there was no change as a result of our intervention, or, worse, that our intervention resulted in unanticipated negative outcomes.</i></p>	<p>Learning from failures is just as important as learning from successes; documenting what does not work and understanding why it did not work can meaningfully inform future interventions in order to better meet adolescents' SRH needs. This openness also creates a better work and learning environment, where staff feel comfortable bringing up ideas on how to adjust programming or overcome obstacles to performance.</p>

Throughout the project cycle, it is critical to collect and analyze data to be able to adapt the response to meet the needs of adolescents. It is therefore important to allocate adequate resources to M&E and to train staff on the importance of collecting data and what to do with it. Translating Data into Action can mean, for example, fine-tuning the approaches and changing direction of the program, or it can mean taking the information and turning it into advocacy messages to support further investments in ASRH.

For more resources on how to train others on Data for Action, please see the [IAWG ASRH in Emergencies TOT materials](#) for SRH managers (which has an entire session dedicated to Data for Action). Additionally, the [Reproductive Health Assessment Toolkit for Conflict-Affected Women](#) and the [Gender-Based Violence Research, Monitoring, and Evaluation with Refugee and Conflict-Affected Populations](#) resources both provide guidance on how to collect, analyze, and use data.

What should I be tracking with ASRH programming?

Setting objectives and indicators that track the impact and outcomes of the program for adolescents is critical for effective program implementation and to be able to monitor, evaluate, and adapt as the program progresses. Targets should provide a clear definition of what the program aims to achieve, and indicators should tell us exactly how we will measure results. Indicators will serve as a guide when implementing and monitoring activities, as they inform what data and information needs to be collected. Thinking through how targets will be measured is a key part of the monitoring process. Refer to the [theory of change](#) guiding questions and guidance on how to develop indicators for program design, monitoring, and evaluation.

Disaggregated data (by age and gender) is a condition for effective reporting on gaps and results for adolescents towards the objectives, and it is the foundation of more targeted, intentional programming with and for adolescents. At minimum, data should be disaggregated by age and gender. This data is available in health facility registers, but is often not reported to separate adolescents from other children. By disaggregating data into smaller groups, you can better examine and discuss patterns, potential barriers or opportunities, and provide a more tailored approach for that population. Age groups may be adjusted based on local context, but here are examples of different groupings of adolescents based on age and gender:

- Younger adolescent girls (10–14)
- Older adolescent girls (15–19)
- Younger adolescent boys (10–14)
- Older adolescent boys (15–19)

Beyond age- and gender-disaggregated data, consider consulting separately with other groups with specific needs, including but not limited to:

- Married adolescent girls
- Pregnant adolescent girls
- Adolescent mothers (and adolescent fathers, where relevant)
- Adolescents associated or formerly associated with fighting forces
- Unaccompanied and separated adolescents in kinship or foster care
- Adolescents with a disability

How can you tailor monitoring activities for ASRH programming?

Chapter 5 of the IAFM provides comprehensive guidance on monitoring and evaluating SRH programming in humanitarian responses. The IAFM's guidance applies to overall SRH emergency programming, which is why we have included some special considerations for adapting monitoring tools and ensuring/establishing accountability mechanisms for adolescents; the guidance for both of these considerations also includes ideas for how to involve/engage adolescents in monitoring and accountability activities of your project.

Adapting Monitoring Tools

The first consideration relates to the type of monitoring data we collect. Monitoring is conducted to ensure that program implementation is on track and to make real-time adjustments to services and activities.

Table 7 describes how monitoring data is collected and used and considerations for adapting monitoring tools for use with adolescents, including some ideas for how to meaningfully engage adolescents directly in monitoring activities.

Table 7: Tailoring SRH Monitoring Activities for Adolescents

Source of monitoring data	Use	Adaptations for use with adolescent populations
Patient records and charts	Used to monitor utilization of SRH services	<ul style="list-style-type: none"> Ensure data is disaggregated by age and gender when providing regular reports Collect additional information on method discontinuation or method mix
Participant or patient registers	Used to record socio-demographic characteristics of patients or participants, enabling you to ensure that the service or program is reaching adolescents	<p>Registers can collect information that is relevant to the intervention</p> <ul style="list-style-type: none"> Ensure data is disaggregated by age and gender when providing regular reports Beyond age and gender, you may wish to include educational status, household composition, and/or disability status in registration forms
Attendance lists	Used to monitor attendance to ensure that registered participants are in fact participating in the program	<ul style="list-style-type: none"> Attendance lists should be linked to registers to identify any patterns or trends in drop-out and retention
Activity records and reports	Used to keep track of service provision or content being shared with program participants and frequency of activities	<ul style="list-style-type: none"> Activity records and reports should be informed by adolescents and should include satisfaction with programming
Observation tools and checklists	Used to monitor the capacity of program staff to deliver high quality services or programming	<ul style="list-style-type: none"> Observation tools and checklists should be in line with guidance on adolescent-friendly services Criteria should reflect input from adolescents regarding their definition of quality

Ensuring/Establishing Accountability Mechanisms

Ensure internal and external accountability processes are in place throughout any data collection activities and during program implementation activities. Individual participants (regardless of age and gender) should be able to give feedback and complaints to program staff about the process, including the attitudes and behaviors of staff, and trust that their feedback will be acted upon. Adolescent feedback is particularly important when monitoring coordination and referral efforts across sectors. At minimum, adolescents can provide their views on the program as it is being implemented, with the design team remaining flexible to advocate internally and within the humanitarian coordination system for course-corrections to ensure the needs of adolescents are met. Refer to Accountability Tools in Table 6 (exit interviews and score card methodologies).

How do we translate this data into action?

The numerous data and analysis resources in the assessment section may feel initially overwhelming; however, it does not need to be challenging to translate primary and secondary data into action and positive change. While the Toolkit provides guidance for using rigorous analysis methods, your program does not have to adopt all methods to successfully monitor, analyze, and use the data. Tracking the progress of program activities does not have to be sophisticated. Microsoft Excel can be utilized to create your data templates for data entry and analysis for internal and external reporting. Often, the SRH Sub-Cluster, other partners, and donors have specific donor reporting templates to utilize and document your programmatic work. DHIS2 is an open source software that many ministries of health use around the world as a real-time indicator performance-tracking tool. We have identified some simple steps for translating data into action:

1. Review baseline data from primary (eg health facility registers) and secondary data sources (eg DHS).
2. Review indicator data (from monthly/quarterly monitoring logs or reports) on a regular basis (monthly/quarterly) and compare to baseline data to identify the gaps and changes over time.
3. For identified gaps, brainstorm solutions to course-correct within your organization and, when relevant, with other health partners. For positive trends, explore ways to reinforce program activities (and potentially expand coverage/reach).
4. Implement proposed actions (in coordination with other health partners, adolescents, and community members).
5. Report data to the SRH Sub-Cluster, organizational leadership channels, and donors.
6. Continue data entry and monitoring activities.
7. Repeat.





Case Scenario to Demonstrate Data for Action

To help illustrate how to use Data for Action, the Toolkit has provided an exercise for readers to review, brainstorm, and discuss. This is a fictional humanitarian SRH program designed to help readers become more comfortable with reviewing and analyzing data, as well as proposing solutions to adjust programming.

SRH Project in Imagineria: This is a two-year project focused on improving the SRH of all adolescents in the camp and host community of Imagineria and to guarantee free SRH services for all adolescents. It included outreach activities in the camp and support to the five health facilities. Educational activities were carried out with adolescents in youth centers and advocacy activities were geared towards both community leaders in the target areas and leaders at the national level. This is the data you have available after one year of the program (Imagineria SRH Achievements) and the score card shows the past quarter (three months) of data (Imagineria SRH Data Snapshot).

What to look for: As the SRH program manager for this project in Imagineria, you need to review this information from your field officers. You have to prepare a quarterly report for your donor. Based on this information, what questions would you ask your field officers to address some of the gaps and data quality issues you have identified? And beyond the quarterly report, what suggestions would you make for solutions or next steps to improve the outcomes and/or advocacy messages and to mobilize political and financial support for the future of the project?

Imagineria SRH Data Snapshot (from past three months of programming)

	Girls 10-14	Girls 15-19	Boys 10-14	Boys 15-19
Total visits to clinics	220	670	20	70
Received counselling on contraceptives	1	450	0	45
Received STI testing	0	300		0
Average score in exit poll (using score card)				

Imagineria SRH Achievements (after one year of programming)

- Pregnancies among in-school children decreased by 40% in the targeted communities
- 70% of adolescent girls chose a long-acting and reversible contraception method, 15% chose oral contraceptive pills
- 3 health facility managers were trained on ASRH
- 5 health facilities were equipped with supplies
- STIs have increased by 7%

Below are some examples of questions and proposed actions to take in response to the above data points:

- A box should never be empty; questions arise as to whether the data point is a 0 or if someone forgot to fill it in—what happened in the registry?
- Why has only one 10–14-year-old girl been counseled on contraceptives?
- How come so few boys come to the clinic in comparison and why have they not received STI testing?
- Boys seemed happier with the services they received—what kinds of experiences are they having compared to the girls, who report sad or neutral faces?
- STIs increased but pregnancies went down—what does that say about contraceptives received?
- Only three out of five program-supported facilities received capacity building of staff, and that was only the facility managers. Why have so few staff received training?

The above questions and reflections provide a glimpse into some of the ways SRH managers (and other staff members) can use data to improve the quality of services. The main point from this exercise is that reviewing and analyzing data does not require sophisticated software or highly trained staff. It does require staff time, supervisor support, and flexibility to adjust programming.

Evaluation & Documentation

As you design your program, the [theory of change](#) will support the development of an evaluation protocol, narrative reporting, and documentation of your intervention for publication, which can be disseminated via communities of practice. Resources and tools outlined in [Table 6](#) will support efforts to design, plan, and execute an evaluation. At the end of this chapter, you will find future areas to pilot ideas and research, as well as programmatic tools.

What is evaluation?

Evaluation is “a process for determining whether a program has met expected objectives and/or the extent to which changes in outcomes can be attributed to the program.” The evaluation should be designed during project development or before you begin the project. Utilizing the initial theory of change model and [logical framework](#) for designing the evaluation protocol will enable SRH program managers to determine whether the SRH program met defined objectives and whether or not the intervention resulted in any changes among participants or the community. The evaluation compares program activities and services (outputs) with benefits (outcomes) and public health impact (goals).

Why do we need to document ASRH evidence?

To date, there are minimal implementation science publications on ASRH. However, this provides humanitarian responders ample opportunities to pioneer efforts to document ASRH initiatives in humanitarian responses. A pool of open-access, evidence-based programming would provide all stakeholders with a basis of understanding on what works, what does not work, what the gaps are, and what needs to be done next. The section at the end of the chapter—[Closing the Gap between Implementation and Research for Practitioners](#)—provides a list of technical areas for practitioners and researchers to delve into and subsequently contribute to the limited evidence pool for ASRH initiatives in humanitarian responses.

How do we involve adolescents in evaluation, documentation, and dissemination?

There are a number of programmatic and research avenues through which to meaningfully involve adolescents in your day-to-day evaluation, documentation, and dissemination activities. Opportunities to engage adolescents in evaluation and documentation activities of SRH programs include:

- **Evaluation design:** The application of user-centered design processes in developing an evaluation protocol allows adolescents to provide input on what outputs and outcomes are measured by the evaluation, what groups of adolescents are being reached—or not reached—and what SRH-related needs are being met or not met. Adolescents providing feedback on M&E results strengthen the implications for future similar projects and create an environment of inclusion and buy-in.
- **Planning and timing:** Evaluations, which should be planned at the beginning of the project, require a sufficient amount of time to measure program outcomes and impacts. Therefore, evaluations are not appropriate in acute situations. In contrast, ongoing assessments and monitoring can provide feedback on emergency actions in acute, protracted settings, and comprehensive SRH programming.
- **Documentation and dissemination:** Developing a documentation and dissemination strategy is essential when implementing ASRH programs in humanitarian emergencies. Involving adolescents in this work ensures that the information is accessible to everyone. Additionally, adolescents are creative and particularly adept with social media and other technologies. Their unique capacity to develop and create approaches will help translate data into key messages and into various technological formats that are relevant and most understandable to adolescents and key stakeholders.

Planning for Comprehensive SRH Care in Evaluation Phase

In line with [Objective 6 of the MISP](#) with planning for comprehensive SRH care, practitioners should aim to document baseline information in the acute phase; this in turn will support efforts to use data to inform programming when the situation stabilizes and when you are able to compare endline data and implement evaluation plans. As you plan and design more complex and comprehensive ASRH programming during the acute phase of the response, it is important to build in the framework for evaluations.

What is required to conduct a successful ASRH program evaluation?

To implement a successful program evaluation, practitioners should adequately plan and budget for it during the program design phase. The prior work completed during assessments (conducting needs assessments, mapping, and consulting secondary resources and ASRH stakeholders), program design (establishing theory of change, developing indicators, creating logical framework), and implementation and monitoring (tracking indicators and adjusting programming) will provide the main inputs for your program evaluation—whether it is a simpler evaluation (baseline/endline comparison) or more sophisticated evaluations (impact/outcome evaluations). Choosing an appropriate time to conduct the evaluation is crucial.

In planning for an impact evaluation, it is important to begin ideally a year in advance to have enough time to develop a scope of work for the evaluation team, identify core members of the evaluation team, and inform/coordinate with stakeholders. International NGOs should prioritize partnering with local research institutions for an outcome evaluation, and your organization may need additional time to demonstrate achievement of medium-to-long-term outcomes. At the beginning of your project, your organization should develop an evaluation protocol, which includes specific evaluation criteria, to feed into your evaluation assessments (see [Table 6](#)).

What is an evaluation protocol and how is it used with ASRH programming?

An evaluation protocol “is a detailed document that defines and sets forth practices and sequence of activities for analyzing and examining the project by certain evaluation criteria. This document aims to determine project effectiveness and efficiency through tracking progress on each objective, completion of activities, and dates of completion.” Evaluations measure intended and unintended positive and negative outcomes. A concrete evaluation protocol with standard evaluation criteria is an evaluation practice that will help bridge the evidence gap in ASRH humanitarian programming and ensure the rights of children are upheld. UN Women released a new approach for the Sustainable Development Goals era called [Inclusive Systemic Evaluation for Gender Equality, Environments and Marginalized Voices](#). This approach shows how each intervention can be used as a learning opportunity to influence social change, including gender equality, sustainability, human rights, and peace. It also provides a shift from viewing evaluations as an accountability measure and toward acceptance that “we do not know what we do not know.”

What is typically included in an evaluation protocol?

The Toolkit recommends using MEASURE Evaluation’s evaluation protocol template. It is highly recommended to develop protocols in a participatory manner, involving all study partners, including implementing partner staff, the organizations responsible for designing and conducting surveys, local and international research partners, and implementing partner project staff. The below content components provide a guide for developing your organization’s detailed protocol. Your research questions and study design will determine the final outline and content of your study-specific protocol. Practitioners should consider all sections outlined below and adapt accordingly when some sections or headings may not be relevant for the planned evaluation and/or other sections may need to be added. For instructions on filling out each content section, please consult MEASURE Evaluation’s [website](#).

EVALUATION PROTOCOL CONTENT COMPONENTS		
• Abbreviations	• Logical Framework	• Dissemination Plan
• Study Background	• Essential Survey Indicators	• Study Limitations
• Tables	• Methods	• Study Management
• Figures	• Data Collection	• Study Timeline
• Study Objectives	• Human Subjects, Confidentiality, and Security	• References
• Theory of Change		• Appendixes

What evaluation criteria is recommended?

When designing your evaluation protocol, it is important to refer back to your [theory of change](#) and establish evaluation criteria that helps address the below seven criteria areas:

- **Coordination:** (eg Is your organization coordinating effectively with ASRH stakeholders throughout the program cycle?)

- **Performance:** (eg Did your program achieve its ASRH objectives?)
- **Effectiveness:** (eg Did your organization provide timely services and maximize resources for adolescents?)
- **Relevance:** (eg Did your program involve adolescents, including their preferences, in program design and implementation?)
- **Impact:** (eg Did your program contribute to improved SRH outcomes for adolescents?)
- **Sustainability:** (eg Did your program increase support for ASRH activities among service providers, parents, and community stakeholders?)
- **Quality:** (eg Have the quality of services for ASRH improved in intervention sites?)

Answers to these questions will help reveal if the strategies implemented by your program contributed to achieving the desired program objectives. These answers will also identify if there are unmet needs that this program did not address and if these types of strategies are sustainable in addressing and improving health-seeking behaviors and quality at the service-delivery level. The data sources from an evaluation can also serve as an action plan for subsequent implementation and/or interventions.

CASE STUDY

Girl-led Global Action Research CEFM Study during COVID-19

In 2019, the WRC and Plan International launched a multi-country action research study consisting of girl-led and community grounded participatory mixed-methods to explore the needs and priorities of adolescent girls in two diverse humanitarian settings. The overall research aim is to develop an evidence-based, multi-sectoral program model to prevent child, early, and forced marriage (CEFM) from occurring and to better respond to the needs of married girls in humanitarian settings.

WRC and Plan International utilized [SenseMaker](#) to conduct their research with adolescent girls and community members. SenseMaker is a mixed-method research and analysis tool that allows people to exchange stories about their experiences based on a story prompt. After participants share their stories, they answer a series of questions by placing their response on a visual scale to give meaning to their own story. As with other humanitarian organizations, the COVID-19 pandemic forced WRC and Plan International to adapt their research activities in 2020, but also presented an opportunity to apply their innovative research method in a mobility-restricted environment. WRC and Plan International were able to complete their research in the Philippines prior to COVID-19 limitations and restrictions—engaging adolescent girls and community members in a co-design workshop to inform the SenseMaker research tool and collecting more than 2,000 stories from adolescent girls and community members. For the co-analysis workshops planned after data collection, WRC and Plan International are preparing virtual workshops with various stakeholders, including ASRH experts. For the upcoming data collection in food-insecure communities in Zimbabwe, WRC and Plan International are using SenseMaker to understand how COVID-19 has perpetuated or mitigated factors driving CEFM, the impact it has had on service delivery, and how humanitarian actors can adapt to better meet the needs of adolescents. Key informant interviews with key stakeholders will be administered via WhatsApp, Skype, and telephone, instead of in-person.

The two organizations plan to work together in a further phase of the project—testing the delivery of their program model in diverse settings. Findings from the pilots will be used to further update and adapt their program model—together with adolescents, their families and communities and service providers.

What other resources are there for conducting evaluations on SRH?

The following resources by Measure Evaluation: [How Do We Know if a Program Made a Difference? A Guide to Statistical Methods for Program Impact Evaluation](#) and [Evaluating Family Planning Programs with Adaptations for Reproductive Health](#) provide best-practice guidance on how to evaluate ASRH programs. Additionally, USAID has an [online learning lab](#) to guide evaluation planning and documentation.

Closing the Gap between Implementation and Research for Practitioners

While data indicates that adolescents are impacted and vulnerable in crises, they tend to be overlooked in the design, implementation, and documentation of humanitarian responses. This section aims to bring to the forefront the urgent need to address some of the identified priority gaps, build on existing knowledge, invest in better evidence generation, and include adolescents in research and response efforts in meaningful ways. Such evidence generation and improvements to humanitarian responses would assist in generating funding in country settings, but also globally through IAWG ASRH work. For example, the IAWG mapping exercise that looked at ASRH humanitarian programming from 2009–2012 highlighted the immense gaps in ASRH funding, implementation, and prioritization. Findings from this exercise allowed IAWG ASRH Sub-Working Group members to advocate for additional funding for ASRH in emergencies through a two-year project between IAWG and the Dutch Ministry of Foreign Affairs from 2018–2020. The Toolkit has identified future areas for research development, as well as implementation tool testing and piloting to advance the evidence base for ASRH in emergencies and, ultimately, provide more responsive programming to address adolescents' SRH needs.

Research Opportunities—Closing the Gap

Future areas of research identified from the Toolkit throughout different chapters include:

- Conduct an updated mapping of ASRH programming in humanitarian settings (the [last mapping exercise](#) was completed in 2012)
- Research the markers that improve SRH services for adolescents outlined in the MISP and cross-sector interventions, as well as their distinctive effects on adolescent subgroups—disaggregated by gender and age
- Explore, pilot, and document interventions that employ GBV screening measures for adolescents to understand potential benefits and/or harm to adolescents
- Explore, pilot, and document interventions utilizing adolescents in community-based SRH care, such as providing emergency contraception
- Explore, pilot, and document self-care approaches for abortion and contraceptive methods in humanitarian settings with adolescents
- Document innovative approaches for reaching at-risk subgroups of adolescents beyond very young adolescents (VYAs) (eg lesbian, gay, bisexual, transgender, queer, intersex, and asexual+ [LGBTQIA+] adolescents, adolescents with cognitive and physical disabilities, etc)
- Explore, pilot, and document disability inclusion of adolescents in the MISP humanitarian response and accountability to affected adolescents
- Explore, pilot, and document disability and intersectionality in resilience-based programs with disability disaggregated data for gender and age
- Identify and document adolescents' coping strategies and empowerment in moments of crises

- Explore, pilot, and document the effectiveness and impact of meaningful engagement approaches, including participatory approaches, in humanitarian activities
- Document the SRH outcomes for adolescent patients at health facilities that engaged adolescents in service delivery approaches (see [Facility-Based Services](#) for the list of activities to involve adolescents)
- Explore the direct effects of telemedicine on SRH outcomes and SRH uptake among adolescents
- Examine the efficacy of engaging adolescents/youth as first responders/peer educators/youth volunteers in humanitarian contexts
- Document the effectiveness of larger organizations in capacitating youth-led and/or community-based organizations serving young people in humanitarian activities
- Gather evidence for providing multi-sectoral programming to improve SRH outcomes for adolescents in humanitarian settings
- Explore, pilot, and document ASRH referral mechanisms along the continuum of care from community to facility, as well as multi-sectoral referral systems for ASRH
- Document the effectiveness of adapted resources and tools provided in the revised 2020 ASRH Toolkit for Humanitarian Settings

Developing and Piloting ASRH Programmatic Tools—Closing the Gap

Each chapter of this Toolkit is accompanied with associated tools aimed to support SRH managers with their ASRH programming. However, there were difficulties in finding specific tools for ASRH programs in humanitarian settings. As a result, the Toolkit identified several areas for future development of implementation tools to share with the ASRH community of practice. The Toolkit proposes future exploration into development of:

- Tools and examples of conducting ASRH preparedness activities, particularly around engaging adolescent/youth networks and adolescents/youth as first responders before the crisis occurs
- Standard information, education, and communication (IEC) materials tailored for adolescents and youth that can be adapted for different humanitarian settings (and available in multiple languages)
- Additional tools for community health workers on how to facilitate dialogues with community members/gatekeepers about ASRH
- Additional examples/tools for how community health workers can identify at-risk subgroups of adolescents (eg adolescent mothers, orphaned adolescents, migrant adolescents, etc)
- Additional multi-sectoral intervention examples and integration tools for ASRH in humanitarian settings
- Additional examples/templates of participatory research activities and/or M&E activities completed with adolescents in humanitarian settings
- Additional ASRH job aids for service providers



Photo: Médicos Sin Fronteras



CHAPTER 8: MANAGER GUIDANCE NOTES & TOOLS

We have navigated our way through the Adolescent Sexual and Reproductive Health (ASRH) Toolkit Roadmap. We have grasped the multifaceted and interrelated programmatic considerations for sexual reproductive health (SRH) managers to prioritize at the onset of a crisis and technical guidance to incorporate throughout preparedness and response interventions along the humanitarian continuum. This chapter provides SRH managers with guidance on how to apply this technical knowledge in a humanitarian crisis.

Chapter 8 Learning Objectives

After reading this chapter, readers should be able to:

- Describe the role and responsibilities of SRH coordinators and/or managers
- Explain the main components and considerations in developing an ASRH proposal and/or adding ASRH components to a larger health/SRH proposal
- Describe typical costs associated with ASRH programs and provide justification for those costs
- Discuss importance of supportive supervision and provide examples of program implementation tools for ASRH programs

What are the roles and responsibilities of an SRH manager?

A large component to prioritizing ASRH programming involves seeking funding, subsequently managing ASRH programs, and building and monitoring program quality. Program managers are expected to lead or assist in proposal development, including developing monitoring and evaluation (M&E) frameworks and budgets. Once funding is secured, managers recruit and supervise project staff. Through the duration of the project, managers monitor implementation through work plans, monthly and quarterly reporting, and tracking of spending—budgeted versus actual spending. During both resource mobilization and project implementation, managers coordinate with other sector managers to ensure a more integrated approach to serving beneficiaries and to maximize impact using available resources.

SRH managers also play an important role in advocating for [meaningful participation](#)—both internally within their agencies and externally. This is especially true of ASRH activities in emergency settings, where often the case still has to be made for the urgency and need of ASRH programs given other competing health priorities.

SRH managers wear numerous and simultaneous hats on a day-to-day basis. The primary roles and functions of SRH managers are:



1. **Coordination**
2. **Strategy Development**
3. **Resource Mobilization & Proposal Development**
4. **Program & Budget Management**
5. **Documentation & Dissemination of Evidence**
6. **Technical Advocacy & Representation**
7. **Technical Support & Capacity Development of Implementing Partners**
8. **Staff Recruitment, Support & Management**
9. **Procurement of Reproductive Health Commodities & Supplies**

The primary roles and functions of SRH managers are:

- **Coordination:** In line with [Objective 1 of the Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations \(MISP\)](#), SRH managers should coordinate with health, SRH, protection, and gender-based violence (GBV) stakeholders within the cluster system to collate and share data and information, design their organization's SRH response strategy and plans, and liaise and establish equitable partnerships with local community-based organizations (CBOs), including youth-led organizations and donors.
 - Represent organization's work and ASRH activities in Health Cluster, Reproductive Health Working Group, and GBV Sub-Working Group meetings, as well as other coordination meetings with the Ministry of Health. Advocate for representation of adolescents and other young people at coordination and decision-making tables.
 - Network with key donors, such as the United States Agency for International Development (USAID) [Bureau of Humanitarian Assistance](#) (BHA; replacing the Office of U.S. Foreign Disaster Assistance [OFDA]), United States' State Department's [Bureau of Population, Refugees, and Migration](#) (BPRM), [Foreign, Commonwealth & Development Office](#) (FCDO; replacing Department for International Development [DFID]), and [European Civil Protection and Humanitarian Aid Operations](#) (ECHO) at cluster and working group meetings. Submit proposals with specific adolescent considerations/funding to the flash appeal.
 - Coordinate with other sector responses within organization (health; water, sanitation, and hygiene [WASH]; shelter; food; GBV; disaster risk reduction [DRR], etc) to ensure a multi-sector approach to ASRH.
 - Coordinate with all appropriate organizational departments, such as communications and global technical teams (if applicable), on ASRH programming and developments.
- **Strategy Development:** SRH managers should work with emergency response team members to develop a strategy for integrating ASRH into emergency programming, including linkages with specific sectors. For example, in distributing clean delivery kits, condoms, and newborn kits through non-food item (NFI) distribution, SRH managers could develop a dissemination strategy to reach adolescents with information on where to find SRH commodities and services. It is also important for SRH managers to develop an exit and handover strategy for partners and local stakeholders, as this ensures communities in fragile settings are equipped to remain resilient, thrive, and take ownership of the interventions and commit to meeting quality standards for ASRH service delivery.
- **Resource Mobilization & Proposal Development:** The SRH manager must remain proactive in establishing funding requirements for SRH/ASRH activities, identifying and mapping out funding opportunities, and integrating ASRH into proposals with other technical sectors for emergency response and for transitioning toward comprehensive SRH programming and early recovery efforts. It is imperative for SRH

KEY MESSAGE

Within the SRH Sub-Cluster, SRH managers should advocate for ASRH to be a standing agenda item and invest in adolescent leadership to engage in humanitarian and technical coordination and decision-making.

KEY MESSAGE

SRH managers should work with SRH stakeholders to convene discussions with adolescents on financial barriers in resource mobilization, and utilize inputs from adolescents to inform fundraising strategies.

managers to advocate for ASRH funding and network with donors to make funding available and/or increase funding for ASRH. Refer to [Resource Mobilization](#) for detailed additional guidance.

- **Program & Budget Management:** The SRH manager is responsible for the SRH programmatic and financial portfolio, liaising with other members on the senior management team, and coordinating with partners and donors to ensure implementation of the [MISP](#). This includes providing technical leadership to program staff to support the preparation of proposal narratives, budget, and associated narrative and budget reports to donors. The Toolkit provides standard template tools for budgeting ASRH programming in [Budget Guidance & Design](#).
- **Documentation & Dissemination of Evidence:** These two components are fundamental responsibilities of SRH managers during all phases of the program cycle and humanitarian continuum. Documentation and dissemination require SRH managers to be proactive and diligent to ensure data is shared with and used by all ASRH stakeholders. If you do not have M&E staff to support this scope of work, refer to [Chapter 7: Data for Action](#) for detailed step-by-step guidance. Key responsibilities for documentation and dissemination of ASRH evidence include:
 - Determining ASRH needs and programmatic gaps to ensure ASRH is included in all organization proposals, regardless of the proposal's focus (health, protection, education);
 - Adapting and/or developing primary data tools—alongside adolescents/youth—so that they are relevant, friendly, and inclusive for all adolescents/youth;
 - Orienting staff and partner agency staff on the significance of utilizing and documenting ASRH activities;
 - Analyzing M&E data to propose areas of improvement and support future initiatives to assess gaps, challenges, and solutions for meeting adolescents' SRH needs; and
 - Disseminating data via donor reports and/or use for journal articles, campaigns, and advocacy strategies.
- **Technical Advocacy & Representation:** During an emergency, SRH managers advocate for initiatives aimed at ensuring women and girls have access to life-saving SRH services in line with core humanitarian principles and human rights standards. Managers need to liaise with donors within the cluster system, government line agencies, local stakeholders, and within their own organization to ensure ASRH activities are integrated into emergency response plans and initiatives. Managers may utilize the [Advocacy Toolkit: A Guide to Influencing Decisions That Improve Children's Lives](#) from the United Nations Children's Fund (UNICEF) and CARE's [Emergency Toolkit](#) to provide additional guidance on effectively advocating for ASRH in emergency settings. The [Advocacy in Emergencies](#) resource from the United Nations High Commissioner for Refugees (UNHCR) and [ASRH in Emergencies Fact Sheet](#) from the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) also provide several advocacy tips. **As a manager, representation and advocacy does make a difference to influence senior management and leadership to allocate funds! Keep persisting and use ASRH facts to pursue your case!**

- **Technical Support & Capacity Development of Implementing Partners:** Local and/or implementing partners are resilient and well versed in understanding their community. It is SRH managers' responsibility to provide their partners with accompaniment, supervision, and support to execute their assigned roles. This includes providing technical resources, tools, training, and supportive supervision to ensure program activities are implemented in a collaborative and successful approach. Refer to the section below for detailed guidance.

KEY MESSAGE

Per [Sphere Standards](#), all staff and implementing partners should be trained on child safeguarding and prevention of sexual exploitation and abuse (PSEA) standards and protocols. For examples of these standards and protocols, see [Save the Children's Policy of Child Safeguarding](#) and the UN's [Protocol on Allegations of Sexual and Exploitation and Abuse Involving Implementing Partners](#).

- **Staff Recruitment, Support & Management:** One of the priorities of an SRH manager is creating a high-functioning and supportive SRH team. An essential set of activities for recruitment, support, and management include:
 - Developing tailored job descriptions based on priorities outlined in their SRH emergency response strategy. The job description in [Annex S](#) can be adapted to ensure it is context specific and addresses the organizational standard operating procedures for humanitarian programming. In addition, [Annex L](#) outlines essential characteristics of supervisors to implement, support, and manage ASRH programming;
 - Disseminating the job descriptions, as well as developing a short-list of candidates to interview and conducting the interviews; and
 - Providing new staff with tailored onboarding plans, training, and ongoing supportive supervision. Refer to [Staff Recruitment, Support, and Responsibilities](#) for further guidance.

- **Procurement of Reproductive Health Commodities & Supplies:** There are 12 designed and pre-packaged Emergency Reproductive Health kits associated with each of the [six objectives of the MISP](#). You can refer to the [MISP Cheat Sheet](#) and [Inter-Agency Reproductive Health Kits for Crisis Situations manual](#) for a detailed description of the life-saving SRH medical drugs, commodities, and supplies. These kits are intended to speed up the procurement channels and thereby provision of reproductive health services in humanitarian settings.

KEY MESSAGE

SRH managers should strengthen SRH commodity supply lines to ensure the full range of contraceptive methods and safe abortion methods—approved by the World Health Organization (WHO)—are available to adolescents. Managers should also transition from Inter-Agency Reproductive Health Kits to non-governmental organization or United Nations Population Fund (UNFPA) procurement channels to avoid additional costs and wastage.

As you can see, SRH managers wear many hats. This chapter provides further guidance on staff recruitment, resource mobilization, and program implementation, as well as tools and resources to consult for additional information.

Staff Recruitment, Support, and Responsibilities

The foundational requirements of creating a robust and sustainable ASRH team in humanitarian contexts involves four important responsibilities of SRH managers:

KEY MESSAGE

SRH managers should prioritize recruitment of local staff to build local capacity and create ownership of SRH services and activities, in addition to avoiding high turnover of staff.

1. **Staff recruitment:** While it may be unlikely to recruit a position specific to ASRH, it is recommended to ensure that recruited SRH staff have some ASRH training or experience or that the organization has plans to train those staff on ASRH. [Annex S](#) provides a sample job description for a key ASRH position—an ASRH Coordinator—who will be responsible for the overall implementation of the project. Staff recruitment in humanitarian settings needs to be swift, as project timelines tend to be short and recruitment is competitive.
2. **Onboarding:** In emergencies, especially in new emergencies, high staff turnover is common. An onboarding plan is a standard tool used to efficiently and effectively orient staff to an organization and set them up on a path for success. An onboarding plan should encompass organizational standard operating procedures and the wide-range of technical, programmatic, and training aspects of their roles. It should be adapted accordingly to the strengths and areas of growth for that staff person. Refer to [Annex T](#) for an onboarding template.
3. **Staff training:** Trainings are often an essential first step of programming and an ongoing professional development process to equip staff with the knowledge and skills to initiate and sustain an ASRH project (see [Training and Capacity Building of Staff](#) for training materials and tools).
4. **Supportive supervision and mentoring staff:** Supportive supervision has been mentioned throughout the Toolkit because it is an important approach to support staff in continuously improving their work—rooted in a culture that promotes learning, teamwork, and reporting without fear. Supportive supervision and mentoring are approaches that can be utilized internally with staff but also programmatically. Refer to [Program Implementation](#) for additional guidance on supportive supervision.



Resource Mobilization

The consequences of the funding gap for women and girls in humanitarian crises is alarming. Global estimate analyses by UN Women in [Figure R](#) provide information on the funding levels required for women and girls in humanitarian crises, per sector. Additionally, as mentioned earlier, the [IAWG mapping exercise](#) completed in 2012 revealed poor prioritization of SRH programming for adolescents.

Resource mobilization is critical to SRH preparedness and response plans in humanitarian crises because:

1. SRH services are often not at the forefront of humanitarian interventions;
2. Mobilizing resources is crucial to meeting the SRH needs of adolescents;
3. Mobilizing resources enables the scale-up and improvement of SRH services and activities for adolescents along the humanitarian continuum; and
4. Mobilizing resources to support ASRH interventions facilitates long-term sustainability by empowering local communities to remain resilient, engage actively, and respond to the SRH needs of their community, including adolescents.

What is resource mobilization?

The term resource mobilization refers to “all activities undertaken by an organization to secure new and additional financial, human, and material resources to advance its mission. Inherent in efforts to mobilize resources is the drive for organizational sustainability.” The [RESOURCE Mobilization Implementation Kit](#) by John Hopkins University and Management Sciences for Health provides SRH managers with detailed guidance and templates on the resource mobilization process. The Toolkit has extracted key steps from this resource for SRH managers to use when mobilizing resources for ASRH.

What are the steps for ASRH resource mobilization?

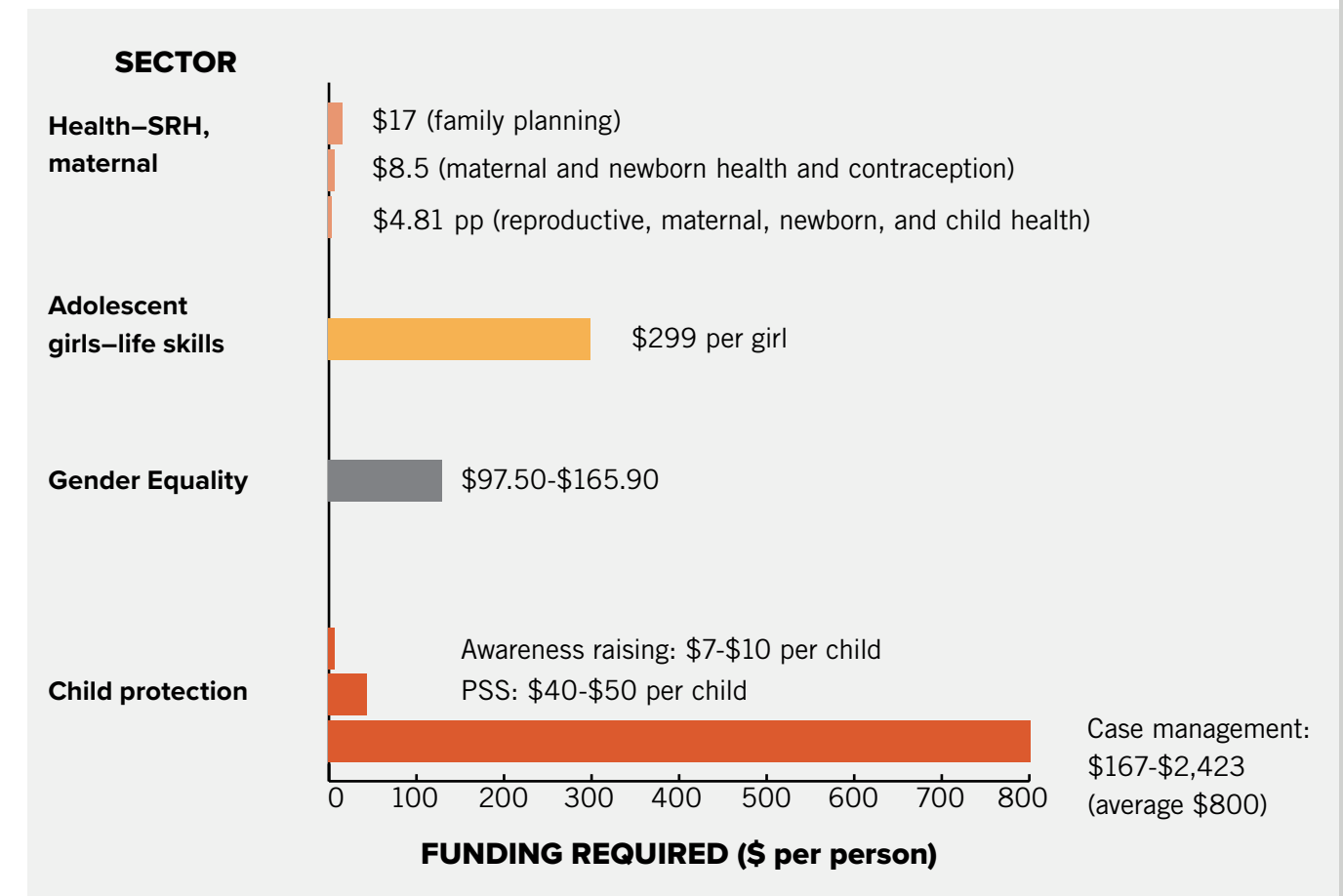
Identify donors and funding opportunities: Scan, track, identify, and respond to requests for proposals on ASRH. While coordinating within the cluster system during the initial onset of an emergency, SRH managers should understand and make use of the following funding mechanisms (which may vary depending on the emergency): the UN Office for the Coordination of Humanitarian Affairs (OCHA) [Flash Appeal](#), [Central Emergency Response Fund](#) (CERF), OCHA’s [Humanitarian Needs Overview](#) (HNO), OCHA’s [Humanitarian Response Plan](#) (HRP), and other institutional funding mechanisms. Note that funding opportunities may not be specific to SRH, but the MISP and ASRH standards outlined in this Toolkit can be integrated by the SRH manager into health, nutrition, gender-based violence (GBV), protection, etc proposals.

As the response continues, it is the SRH manager’s responsibility to remain proactive by identifying new donors and diversifying their organization’s donor base. Developing a resource mobilization/donor mapping tool can help track and manage the organization’s resource mobilization strategy, activities, and can analyze trends (see RESOURCE kit templates [here](#)). This approach can also be utilized as part of the organization’s disaster risk reduction and preparedness strategies before crises. A donor mapping tool can assist SRH managers in ensuring that funding is earmarked and allocated specifically for ASRH and provide flexibility in delivering SRH services, as outlined in the MISP and ASRH Toolkit.

KEY MESSAGE

An SRH manager should diversify their organization’s donor base as part of their preparedness (and/or recovery) strategy to help secure and earmark funding to respond ASRH needs at the onset of a crisis and support program sustainability along the humanitarian continuum.

Figure R: Humanitarian Funding Levels for Women & Girls



Network with donors: Donors are critical partners in reaching adolescents in emergency settings. It is crucial for SRH managers to advocate for the SRH needs of adolescents in crises and ensure funding does not lag behind any further. Utilizing the evidence gathered through assessments and mapping exercises outlined in [Chapter 7: Data for Action](#) can help SRH managers reinforce the realities on the ground and spark an interest with donors to fund ASRH work and distribute calls for proposals. Regularly meeting with donors also provides SRH managers and their organizations visibility and positions them to be informed of progress, areas for improvement, and expansion of activities.

Engage SRH and ASRH stakeholders: Coordination—as outlined in [Objective 1 of the MISP](#) within the SRH sub-cluster, overall cluster system, and SRH stakeholders—is imperative for identifying collective funding opportunities, mapping out response activities, and creating localized partnerships for the implementation of the MISP. Mobilizing partnerships through the cluster system, inter-agency mechanisms (such as IAWG and Inter-Agency Standing Committee at the global- and country-level, particularly SRH Sub-Working Groups) before

and throughout a crisis is crucial for ensuring the MISP and ASRH priority activities are implemented from the onset of an emergency. It is important for SRH managers to engage in these coordination mechanisms and establish partnerships to ensure participation in funding allocations and logistics, specifically supply chain and procurement, and resource allocations for emergency reproductive health kits, as outlined in the MISP and [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings](#) for each of the priority activities. SRH managers should utilize and build upon existing networks, platforms, and technical working groups for ASRH programming, including those established prior to the emergency situation.

Contribute to proposal writing and budget development: After funding opportunities are identified, managers are expected to contribute to proposal writing and budget development. Donors have different proposal and budget templates that require strict adherence. SRH managers can use information from [Budget Guidance & Design](#) to develop an ASRH proposal and/or integrate ASRH activities into a larger humanitarian proposal. This section also provides tips to managers on proposal language for ASRH programs, sample activities, indicators, and timelines.

IMPLEMENTATION CONSIDERATION

ASRH Integration

It is unlikely that proposals, especially during the acute emergency phase, will be submitted solely for ASRH. There is a greater possibility for ASRH to be integrated into a wider health proposal, a general SRH proposal, or even a protection proposal (such as GBV or child protection). Remember, it is also important to diversify your donor base as much as possible!

Please find two examples of proposals/appeals for ASRH resource mobilization in Annex U and Annex V. [Annex U](#) provides guidance on what to include in different sections for a stand-alone ASRH project proposal. [Annex V](#) provides guidance on what to include in the different sections of an OCHA Flash Appeal proposal template.

Budget Guidance & Design

A critical component to ensuring implementation of high-quality ASRH programming is to adequately budget for staffing and activities.

KEY MESSAGE

Even when ASRH programming intersects with other health or protection programs, it is imperative to include separate budget lines for ASRH so there is no compromise to the level of staffing, trainings, logistics, community meetings, and other routine activities that are required to positively impact ASRH outcomes.

Programs should use the findings from ASRH assessments to design their staffing structure and budget. [Annex W](#) provides a table of guiding questions from the International Rescue Committee for using ASRH assessment findings to determine staffing and budget needs.

[Annex X](#) provides a sample budget for an ASRH program. The table includes some of the essential budget categories and budget line items to submit for a new ASRH project. To note, Annex X contains the minimum proposed budget lines. ASRH project budgets will increase or decrease based on the amount of funding available and the scope of the project.

Along with the budget, SRH managers will need to provide budget notes (also called narratives or justification), which usually accompany budgets to describe the budget line and costs. Depending on the donor, there may be a requirement to explain each budget line or category and provide justification for the inclusion of budget line items in the ASRH budget. [Annex Y](#) provides a sample of budget notes for a new ASRH project, with brief explanations of budget categories for the budget provided in Annex X. The budget notes provide guidance on line items and their associated costs.

KEY MESSAGE

Per the [MISP](#), SRH managers should plan and budget for comprehensive SRH services, including services for adolescents, into primary healthcare interventions. This means SRH managers should assess how to provide the full comprehensive package of ASRH services, including violence prevention and care; sexually-transmitted infection (STI) prevention and care; antenatal, intrapartum, and postpartum care; comprehensive sexuality education; contraception counseling and provision; prevention of harmful tradition practices; and safe abortion care.



Photo: Save the Children

Program Implementation

SRH managers should support their implementing partners in receiving training and tools to successfully implement an ASRH program. The success of an ASRH project, as with most projects, lies in planning and coordination. At the start of the ASRH project or when initiating new ASRH activities, SRH managers should organize a program kick-off meeting to facilitate an open and productive discussion on the deliverables and what form of ASRH technical support they may need. The two conventional interrelated approaches of strengthening the quality of program activities are training and supportive supervision of implementing partners (eg clinical health providers, community health workers, or CBOs).

Trainings are often conducted at the start of a project, as well as repeated throughout the project via refresher trainings. Trainings are an essential first step to equipping practitioners with knowledge and skills to initiate an ASRH project (see [Training and Capacity Building of Staff](#) for training materials, tools, and training strategies). Evidence shows that through routine supportive supervision, the most impactful form of teaching and learning is accomplished.

Supportive supervision is a process of helping staff of implementing partners to improve their own work performance continuously. It is carried out in a respectful and non-authoritarian way with a focus on using supervisory visits as an opportunity to improve knowledge and skills of staff working at different levels of the [Social-Ecological Model](#). Experiences in various and diverse countries, including Chad, the Democratic Republic of the Congo, Pakistan, Somalia, and Yemen, have demonstrated success in using supportive supervision to enhance service provision.

Many contexts use the traditional, authoritarian style of supervision, which is more control-driven. The differences between a control approach and a supportive approach to supervision are outlined in Table 8. Supportive supervision encourages open, two-way communication, builds team approaches, and facilitates problem-solving. In other words, **“supportive supervision is helping to make things work, rather than checking to see what is wrong.”** More guidance on supportive supervision is provided in [WHO’s Training for Mid-Level Managers](#) curriculum. Table 8 also provides further guidance on the different approaches to supervision; the Toolkit advocates for the supportive approach.

Table 8: Control Versus Supportive Approaches

CONTROL APPROACH	SUPPORTIVE APPROACH
<ul style="list-style-type: none"> • Focus is on finding faults with individuals • Supervisor is like a police person • Episodic problem solving • Little or no follow-up • Punitive measures are taken 	<ul style="list-style-type: none"> • Focus is on improving performance and building relationships • More like a teacher, coach, or mentor • Use of local data to monitor program performance and solve problems • Provide regular follow up • No punitive measures taken—only support provided to improve behavior

Supportive supervision checklists are essential tools for program implementation. The ASRH Health Facility Checklist—introduced in Chapter 6 with [Annex H](#) and [Annex I](#)—can be used as an initial assessment and as a supervision checklist on a routine basis (recommended to complete every six months). Managers can also consult IRC’s [Supportive Supervision Checklist](#) for another tool for conducting supervision visits. The Toolkit also provides a sample Action Plan Form in [Annex Z](#) that can be used during supervision visits, as well as for developing, conducting, and implementing program activities.

KEY MESSAGE

In fragile and restricted settings, SRH managers must remain creative in identifying how supportive supervision activities can be achieved when in-person support cannot be provided. Working with available technology and sharing and documenting information across the region and internationally are all helpful and cost-effective tools for achieving these objectives.

What is an Action Plan?

An action plan allows ASRH program staff and implementing partners an outline for developing and planning ASRH programming. SRH managers can then refer to their action plan to track progress and highlight specific activities that need extra attention (this may include additional trainings for staff; procurement of additional supplies; and increased community engagement). Activities included in action plans should be time-bound—meaning they include dates by when staff will accomplish them. An action plan also states the team member responsible for the activity, so an SRH manager can follow up directly with the assigned staff on progress or challenges. The Toolkit’s Action Plan in [Annex Z](#) has a column for adolescent participation—a theme that has been highlighted throughout the Toolkit and which is critical to all activities, including program design and monitoring. SRH managers should develop their action plans with health providers, community health workers, and community representatives, including adolescent/youth representatives, to ensure collective ownership and accountability of the project’s progress and durability.



Photo : Tom Pillston

CHAPTER 9: CONCLUSION

Sexual and reproductive health (SRH) managers have made substantial progress in raising the profile and prioritization of adolescent SRH (ASRH) information and service provision in humanitarian emergencies—as evidenced by the sheer number of guidance documents, resources, and tools captured in this Toolkit. However, there is still much work to be done in accomplishing the main aim of this Toolkit: for SRH managers to deliver inclusive and holistic SRH programming for all adolescents—in partnership with adolescents and their communities—throughout the program cycle and in every phase of the humanitarian continuum.

The guidance, resources, and tools included in this Toolkit provide stepping stones for practitioners to continue enhancing the community of practice on how to successfully meet the unique SRH needs of adolescents in emergency settings. To fully [close the gaps](#) identified in this Toolkit, the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) ASRH Sub-Working Group calls on humanitarian organizations, youth organizations and networks, donor and government agencies, and global SRH advocacy and rights-based bodies to continue to aim higher. Continue generating more evidence on ASRH interventions in humanitarian emergencies, continue pushing boundaries in creatively and meaningfully engaging and capacitating adolescents and youth, and continue working to move the needle toward expanding adolescents' access to quality SRH services—no matter where they live.

ANNEXED TOOLS

Annex A: WHO Global Standards for Quality Health Care Services for Adolescents	Annex NNN: Referral Form for Receiving Agency Copy
Annex B: Principles for Young People's Participation	Annex O: IRA for ASRH
Annex C: Basic Requirements for Planning Young People's Participation and Engagement	Annex P: Assessment Questions to Use with Adolescents
Annex D: Key Actions to Increase Young People's Engagement in the Project Cycle	Annex Q: Assessment Questions to Use with Community Members and Providers
Annex E: Sample VCAT Exercise for ASRH	Annex R: FGD Tip Sheet for ASRH
Annex F: WHO Health Service Referral Form Example	Annex RR: FGD Guide for ASRH
Annex G: SRH Service Mapping Tool	Annex S: Sample Job Description for ASRHR Coordinator
Annex H: How-To Guide for Using ASRH Health Facility Checklist	Annex T: ASRH in Emergencies Onboarding Plan
Annex I: ASRH Health Facility Checklist	Annex U: Sample ASRH Standalone Project Proposal
Annex J: GATHER CHECKLIST, Adapted for Humanitarian Settings	Annex V: OCHA Flash Appeal Template
Annex K: Additional Resource Catalog for Providing GBV Care to Adolescent Survivors	Annex W: Guidance for Programmatic Considerations
Annex L: Essential Characteristics of Supervisors	Annex X: Sample Budget for ASRH Project
Annex M: Multi-Sectoral Tool for Integrating ASRH in Emergency Responses	Annex Y: Sample Budget Notes for ASRH Project
Annex N: Referral Form for Referring Agency Copy	Annex Z: Action Plan Form
Annex NN: Referral Form for Client Copy	

ANNEX A: WHO Global Standards for Quality Health Care Services for Adolescents

This is a tool referenced in [Chapter 2: Roadmap for Using the ASRH Toolkit](#). WHO facilitated a global consensus building process for development of global standards for quality health-care services for adolescents. Each of the eight agreed-upon global standards defines the required level of quality in the delivery of services.

Adolescents' health literacy	Standard 1: The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Community support	Standard 2: The health facility implements systems to ensure that parents, guardians, and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Appropriate package of services	Standard 3: The health facility provides a package of information, counseling, diagnostic, treatment, and care services that fulfills the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.
Providers' competencies	Standard 4: Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect, and fulfill adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude, and respect.
Facility characteristics	Standard 5: The health facility has convenient operating hours, a welcoming and clean environment, and maintains privacy and confidentiality. It has the equipment, medicines, supplies, and technology needed to ensure effective service provision to adolescents.
Equity and nondiscrimination	Standard 6: The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation, or other characteristics.
Data and quality improvement	Standard 7: The health facility collects, analyzes, and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Adolescents' participation	Standard 8: Adolescents are involved in the planning, monitoring, and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

Source: [Global Standards for Quality Health-Care Services for Adolescents](#) (WHO, 2015).

ANNEX B: Principles for Young People's Participation

This is a tool referenced in the [Participation Tools](#) section of Chapter 3: Meaningful Participation. This resource supports humanitarian implementers in planning for adolescent participation and outlines key principles to guide adolescent engagement.

PRINCIPLES	MEANING
Transparent and informative	Young people must be informed of their right to freely express their views with the expectation that those views will be given due consideration. The form their participation will take, along with its scope, purpose and potential impact, should be provided in full, using accessible, diversity-sensitive and age-appropriate language.
Voluntary	Young people should never be coerced into expressing views against their wishes, and they should be informed that they can cease involvement at any stage.
Respectful	Young people's views have to be treated with respect, and they should be provided with opportunities to initiate ideas and activities.
Relevant	Opportunities must be available for young people to express their views on issues of real importance to their lives and enable them to draw on their knowledge, skills, and abilities.
Young people, friendly environments, and working methods	Adequate time and resources should be made available to ensure that young people are adequately prepared and have the confidence and opportunity to contribute their views. Those working with young people should be mindful of their age and evolving capacities.
Inclusive	Engagement and participation must avoid existing patterns of discrimination, model cultural sensitivity to young people from all communities and background, and encourage opportunities for particularly vulnerable young people of all genders to be involved.
Supported by training	Adults need preparation, skills, and support in areas such as listening, collaborating with young people, and engaging young people, according to their evolving capacities so they will be equipped to effectively facilitate young people's engagement.
Safe and sensitive to risk	Expression of views may involve risks. Adults have a responsibility to the young people they are working with, and must take every precaution to minimize the risk to young people of violence, exploitation, or any other negative consequence of their participation. Working with families and communities can build understanding of the value of engagement and minimize risks to which young people may otherwise be exposed.
Accountable	A commitment to follow-up and evaluation is essential. Young people are entitled to clear feedback on how their participation has influenced any outcomes. Wherever appropriate, they should be given the opportunity to participate in follow-up processes or activities. Whenever possible, monitoring and evaluation of adolescents' participation needs to include adolescents themselves.

Source: [Adolescent and Youth Engagement Toolkit](#) (No Lost Generation, 2018).

ANNEX C: Basic Requirements for Planning Young People's Participation and Engagement

This is a tool referenced in the [Participation Tools](#) section of Chapter 3: Meaningful Participation. This checklist provides requirements and corresponding questions to help humanitarian implementers plan for adolescent engagement.

1. Participation is transparent and informative

- Do young people have enough information about the project to make an informed decision about whether and how they may participate?
- Is information shared with young people in language that they can understand?
- Are the roles and responsibilities of everyone involved clearly explained and understood?

2. Participation is voluntary

- Is young people's participation voluntary?
- Have the young people been given enough information and time to make a decision about whether they want to participate or not?
- Can they stop participating at any time they wish without suffering from negative consequences as a result of their withdrawal?

3. Participation is respectful

- Have young people been involved in selecting the issues in order to ensure they are relevant to their lives? Do the ways of working with young people consider and build upon local cultural practices?
- Has support from key adults in young people's lives been gained to ensure respect for young people's participation?

4. Participation is relevant

- Are the issues being discussed and addressed of real relevance to young people's own lives?
- Do young people feel any pressure from adults to participate in activities that are not relevant to them?

5. Participation is young people-friendly

- Are young people-friendly approaches and methods used?
- Do the ways of working build self-confidence among young people of different ages, genders, and abilities?
- Are young people-friendly meeting places used? Are such places accessible to working children, refugees, girls, and young people with disabilities?

6. Participation is inclusive

- Are young people of different ages, genders, and backgrounds, including young people with disabilities, or from different ethnic groups, given opportunities to participate?
- Is the process inclusive and non-discriminatory?
- Are young people encouraged to address discrimination through their participation?

7. Participation is supported by training for adults

- Are the staff and partners youth people-friendly?
- Does the staff have confidence and skills to facilitate young people's participation?
- Are staff members able to effectively support young people's participation in their community?
- Do the staff have opportunities to improve their capacity in working with young people?

8. Participation is safe and sensitive to risk

- Are the young people aware of the impact or potential consequences of participation?
- Do young people, including young women and other vulnerable groups, feel safe when they participate?
- Have risks and ways to keep young people safe been identified?
- Do young people know where to go for help if they feel unsafe while participating in the project?

9. Participation is accountable

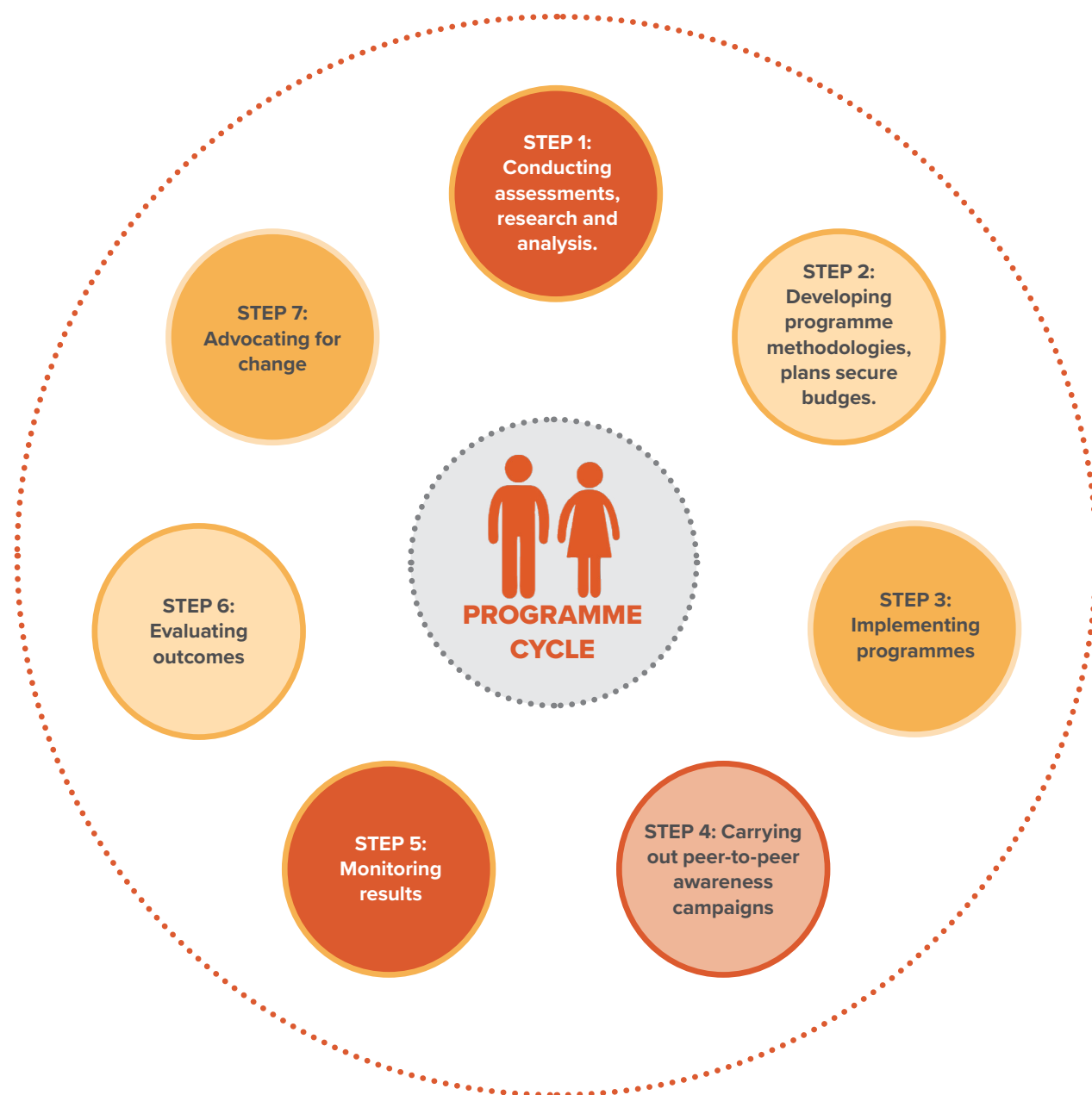
- Are young people supported to participate in follow-up and evaluation processes?
- Do adults take young people's views and suggestions seriously and act upon them or offer adequate justification for why they cannot be actioned?
- Are young people given feedback from the relevant organizations about any of their requests and follow-up?

Source: [Adolescent and Youth Engagement Toolkit](#) (No Lost Generation, 2018).

ANNEX D: Key Actions to Increase Young People's Engagement in the Project Cycle

This is a tool referenced in the [Participation Tools](#) section of Chapter 3: Meaningful Participation. This resource outlines the steps needed to increase youth engagement in the project cycle.

Key Actions To Increase Young People's Engagement In The Project Cycle



STEPS	INDICATORS
Step 1: Conduct assessments, research, and analysis	<ul style="list-style-type: none"> Conduct an analysis of your (proposed) target group with a focus on the desirability, feasibility, and extent of young people's engagement, as a whole and per programme component Support young people-led research of programmes aimed at, and including, adolescents and youth Support ongoing research and the pursuit of evidence relevant to developing effective young people-appropriate programmes and services Data should be disaggregated by age, sex, and ability. The assessment should also look at the extent that existing programs and services have benefitted different vulnerable groups of young people. Assess specific needs—including a gender lens—by consulting and mobilising young people wherever they are
Step 2: Develop program methodologies, plans, and secure budgets	<ul style="list-style-type: none"> Consciously build ownership of all programme components among young people. Determine which components are more conducive to young people's engagement for your target group, and start with those. Review and adjust as you go, always keeping in mind that it is a long, but worthwhile, process. Earmark (through a budget line) a fixed amount or percentage of annual funds to young people's engagement. Identify at least one person in the programme/organisation as the "go to person". This person is tasked with promoting young people's engagement in the organization (organise/conduct training, assess levels of young people's engagement, incorporate young people's engagement into the Constitution). Avoid abusing the agenda to access cheap, docile human resources. Plan and budget in consultation with young people to ensure transparency Create common open spaces for young people and humanitarian partners to meet, listen to young people, and make the programme relevant to them Consider giving a delegation of young people a seat in program meetings, and/or forming a group/taskforce of beneficiaries to regularly brainstorm on ideas for new activities
Step 3: Implement programmes	<ul style="list-style-type: none"> Involve young people in the implementation of programmes as volunteers, paid staff, and youth groups
Step 4: Carry out peer-to-peer awareness campaigns	<ul style="list-style-type: none"> Support young people to conduct peer-to-peer awareness campaigns, based on action research and planning that involved young people Could also be linked to a broader advocacy agenda

STEPS	INDICATORS
Step 5: Monitor results	<ul style="list-style-type: none"> Document, assess, and adjust the elements of young people's engagement in the programme. Determine current and desired levels per component and develop plans of action for improvement—including tools and mechanisms, key partners, tasks, and timelines. Revisit the level of young people's engagement regularly. Expect different and changing levels in terms of capacity, readiness, and enthusiasm to cooperative approaches.
Step 6: Evaluate outcomes	<ul style="list-style-type: none"> Support young people-led evaluations of programmes aimed at, and including, adolescents and youth
Step 7: Advocate for change	<ul style="list-style-type: none"> Young people's engagement will develop best in a conducive environment where key stakeholders—including donors, programme management, and staff members—actively promote it.

Source: [Adolescent and Youth Engagement Toolkit](#) (No Lost Generation, 2018).

ANNEX E: Sample VCAT Exercise for ASRH

This is a tool referenced in the [Tools for Clarifying Values](#) section of Chapter 6: ASRH Services & Interventions. In order to create an enabling environment, Values Clarification and Attitude Transformation (VCAT) activities and workshops can be conducted with wide range of stakeholders in various training formats and meetings. You may adapt this VCAT activity to reflect the contexts of any humanitarian setting and refer to Ipas' VCAT toolkits for additional VCAT activities.

Values Clarification Exercise: Agree or Disagree?
<p>Introduction</p> <p>This activity is designed to help participants reflect on their level of comfort discussing, advocating for, and/or providing adolescent-friendly services. Participants are encouraged to reflect on their life experiences that influenced these attitudes and comfort levels and how they relate to norms on adolescent sexual and reproductive healthcare.</p>
<p>Objectives</p> <p>By the end of this activity, participants will be able to:</p> <ul style="list-style-type: none"> Articulate their beliefs about adolescents accessing reproductive health services Defend and respectfully explain other, sometimes conflicting, points of view Explain different values underlying a range of beliefs on adolescent reproductive health Discuss ways to ensure a professional standard of high-quality adolescent-friendly services, regardless of personal beliefs Materials: <ul style="list-style-type: none"> Wall signs or handwritten signs labeled “Agree” and “Disagree” in separate corners of the room Tape (for attaching signs to the wall)
<p>Timeline: One hour</p>
<p>Instructions:</p> <p>The person facilitating the VCAT should:</p> <ol style="list-style-type: none"> Explain that the purpose of the exercise is to explore feelings, attitudes, and values regarding adolescents' sexual and reproductive health (ASRH), and how those values might influence how healthcare workers provide ASRH care for adolescent patients. Put up the two signs (Agree, Disagree) on the wall or floor. Explain that you will read five statements, one at a time. After each statement, participants should move to the side of the room based on whether they agree or disagree with the statement. Participants should be honest about their feelings and resist being influenced by where other participants move.

4. Begin the exercise using **Content: Values Clarification Statements**. Use the following process for each of the five statements:
 - a. Read statement aloud and ask participants to move to the side of the room based on whether they agree or disagree with the statement.
 - b. Ask one participant from each side of the room to explain the reason for their response and facilitate a brief discussion after each statement to encourage further reflection. Please note that the point is to encourage participants to think about how the values they hold might impact access to and quality of services but should not make anyone feel defensive about their response. If any participants would like to move to the other side of the room based on someone else's point, they may.
 - c. As the facilitator, you should remain cognizant that the responses to each of the five statements may vary if you adapt the statements for different subgroups of adolescents.
5. After the five statements have been read, ask participants to sit down and then lead them in a discussion using **Content: Discussion Questions**.

Content: Values Clarification Statements

1. Adolescents should not have sex.
2. Adolescent girls should never have an abortion for any reason.
3. Parents of an adolescent who is receiving any sexual and reproductive health (SRH) service should be informed, whether the adolescent agrees or not.
4. Adolescent counseling should focus on ensuring that youth abstain from sex.
5. If I provide contraception, it is as if I am encouraging the adolescent to have sex again.

Content: Discussion Questions

The purpose of this exercise is not to persuade others to adopt certain positions, but rather to listen and reflect on what we think and feel about various issues.

- What observations do you have about your own responses to these statements?
- What about your responses or others' responses to these statements surprised you?
- How would you have responded differently if these statements were discussing access to SRH services for boys or diverse Sexual Orientation and Gender Identity and Expression (SOGIE) populations?
- What is the relationship between your attitudes to these statements and your ability to provide high-quality and compassionate care to adolescents?
- Use these questions to probe participants to reflect further on how the beliefs reflected in these statements might affect providers' ability to offer compassionate care to adolescents.
 - Reading statement #1: If an adolescent does have sex, either by choice or by coercion, what role can the provider play in ensuring that she/he/they remains healthy?
 - Reading statement #2: Why do you think some adolescents might seek SRH services? Do you think that a provider's view on SRH should prevent him/her/them from treating a patient who needs services and life-saving treatment? How can providers help adolescents to prevent future unintended pregnancies?

- Reading statement #3: What do you think will encourage your patients to trust you and come back to the health facility? If a provider tells the adolescent's parents, will this damage the trust that the adolescent has in the provider/facility?
- Reading statement #4: It can be difficult or impossible for a young person to abstain for various reasons. How can we ensure that young people remain healthy when they are not able to abstain? How can providers ensure adolescents have the information and services needed to make their own decisions?
- Reading statement #5: Research shows that providing accurate information and contraception does not lead to increased sexual activity among young people. It only ensures that they are protected if they choose to have sex. How can you, as a provider, ensure that the adolescent lives a healthy life?
- How can you be a better provider of SRH services and other services to adolescent patients? How can you ensure that adolescents' right to comprehensive sexual and reproductive healthcare is respected and fulfilled?

Key Messages

Individuals' discomfort with some women's reasons (for having sex, unintended pregnancy, and abortion) results in the implementation of reproductive health policies, laws, and service delivery systems that deny certain women access to safe, high-quality reproductive healthcare. This can lead to adolescents risking their health and lives to procure a possibly unsafe SRH practice or being hesitant to access available services. In other words, it creates health disparities and often-tragic health outcomes.

Ensure participants grasp that this disparity in access to reproductive healthcare (family planning, post-abortion care, sexually transmitted infection [STI] screening and treatment, etc) is often based on individual, subjective beliefs about what are "acceptable" versus "unacceptable" reasons for pregnancy and reproductive health.

We have a professional responsibility to ensure adolescents receive quality counseling and SRH services. If we are uncomfortable with counseling or providing services, we should refer women to safe services.

Adolescents may avoid safe SRH services because they are afraid of being mistreated by healthcare providers or staff. As providers/healthcare staff, we should ensure that we treat women professionally and with respect, regardless of their reasons for terminating a pregnancy—even if their reasons may challenge our personal beliefs.

Sources: Adapted from [Youth-Friendly Postabortion Care Supplemental Training Module](#) (PAC Consortium, 2012) and [Abortion Attitude Transformation: Values Clarification Activities Adapted for Young Women](#) (Ipas, 2013).

ANNEX F: WHO Health Service Referral Form Example

This is a tool referenced in the [Facility-Based Services](#) section of Chapter 6: ASRH Services & Interventions. An effective referral system—one where all levels of the health system work together and in which the humanitarian cluster and coordination system is involved—is critical to ensure people receive the life-saving services they need. WHO's referral template provided below may be adapted and utilized for different humanitarian contexts.

Referral Form				
Name of facility:		original / copy		
Referred by:	Name:	Position:		
Initiating Facility Name and Address:			Date of referral:	
Telephone arrangements made:	Yes	No	Facility Tel No.	Fax No.
Referred to Facility Name and Address:				
Client Name				
Identity Number		Age:	Sex: M	F
Client address				
Clinical history				
Findings				
Treatment given				
Reason for referral				
Documents accompanying referral				
Print name, sign & date	Name:	Signature:	Date:	
Note to receiving facility: On completion of client management, please fill in and detach the referral back slip below and send with patient or send by fax or mail.				

Back referral from Facility Name		Tel No.			Fax No.
Reply from (person completing form)	Name:			Date:	
	Position:		Specialty:		
To Initiating Facility: (enter name and address)					
Client Name					
Identity Number		Age:	Sex: M	F	
Client address					
This client was seen by: (give name and specialty)					on date:
Patient history					
Special investigations and findings					
Diagnosis					
Treatment / operation					
Medication prescribed					
Please continue with: (meds, Rx, follow-up, care)					
Refer back to:				Refer back to:	
Print name, sign & date	Name:	Signature:			Date:

Source: Adapted from [Management of health facilities: Referral systems](#) (WHO).

ANNEX G: SRH Service Mapping Tool

This is a tool referenced in the [Facility Quality Improvement Tools](#) section of Chapter 6: ASRH Services & Interventions. This tool provides an example and notes on how to fill out the below SRH service mapping tool adapted from Women’s Refugee Commission.

No.	Name of Service Provider/Facility	Services, Programs & Activities Provided	Whom Do They Serve?	Barriers to Adolescent Inclusion	Quality of SRH services	Notes
	[provide information on the organization, location, and name of clinic/facility/provider]	[provide as much detail as you can on the SRH services or programming offered at this site]	[describe which populations can access the services at this site]	[since we are focused on adolescent SRH services, list any challenges adolescents may face in receiving the full package of SRH services at this site]	[as stated in the Facility Tools section, use quality standard checklists for assessing the quality of SRH services provided at this location]	[any other suggestions or follow-up step information can be included in this column]
1	UNFPA’s Health Post 1 in Fantasia District, Fantaziland	Provides contraceptive counseling & commodities; STI & HIV screening, treatment, and prevention services; essential maternal and newborn care services	Newborns Children Adolescents Youth & young people Women Men	Local laws require parental consent for all unmarried adolescent girls under 18 years of age; no post-abortion care services are provided at this clinic and only short-term contraceptive methods are available	Service providers have been trained on how to provide services to adolescents, but lack knowledge on where to refer additional services, such as PAC and where to obtain LARC contraceptive methods	Need to follow-up with UNFPA leadership to understand if PAC and/or LARC methods should be available at this clinic, if not, then ensure this clinic knows where to refer

Source: [Service Provision Mapping Tool: Urban Refugee Response](#) (WRC, 2016).

ANNEX H: How-To Guide for Using ASRH Health Facility Checklist

This is a tool referenced in the [Facility Quality Improvement Tools](#) section of Chapter 6: ASRH Services & Interventions. The ASRH Health Facility Checklist ([Annex I](#)) can serve as a proxy for assessing the quality of ASRH services provided in the facility; however, organizations should be using quality standard checklists on a regular basis as well.

<p>Purpose: This checklist is for SRH managers and health facilities managers to use to assess how responsive the clinic or facility is in meeting the SRH needs of adolescents. This checklist can also be used for supervision visits to monitor the progress of next steps and action plans following the initial facility assessment, as well as to inform program design and initial budgeting for a new project.</p> <p>Limitation: This tool has not been tested for use with rigorous research. It is intended for SRH managers to use for gaining a sense of ASRH service gaps, but only captures observations made during one point in time—thus is subject to reporting bias.</p>
<p>Timeline: At the onset of the humanitarian response, monitoring (using the checklist) should be completed monthly for the first three months of programming and quarterly thereafter in the initial year of site set-up. In subsequent years, monitoring can be completed on a bi-annual basis.</p>
<p>Instructions: SRH managers and/or health facility managers must answer all questions on the form to know their facility’s score for the assessment, propose recommendations, and implement the appropriate actions. For all questions, you will mark a “✓” in the “yes” or “no” column, depending on your answer. Some questions have follow-up questions if you answer “yes”, which you will provide the answer for in the comments section.</p>
<p>Scoring: For every “yes”, mark one point. Add together all of the points from each of the three sections to see your total score and what level of SRH care you are providing to adolescents at your facility.</p> <p>Minimum: 16–24 points <i>The facility provides the minimum level of requirements for addressing the SRH needs of adolescents. The facility must aim higher to meet the holistic needs of adolescents and take additional efforts to involve adolescents in programming.</i></p> <p>Good: 25 - 34 points <i>The facility provides a good level of SRH information and services, in addition to involving adolescents in some of the facility operations.</i></p> <p>Exceptional: 35 - 44 points <i>The facility provides an exceptional level of SRH information and services. Adolescents are highly involved in facility operations, accountability measures, and SRH outreach efforts.</i></p>

Section-specific guidance: Below are instructions and examples for certain questions on the facility checklist that might require additional guidance or explanation to fill out the survey.

Health Facility Characteristics:

Question #9 on accountability/compliance mechanisms: We are talking about transparent, confidential mechanisms for adolescents to submit complaints or feedback, which includes having a form available for adolescents to fill out and submit anonymously on their experience at the facility/clinic; having a hotline available for adolescents to call in to provide feedback or complaints; and/or a voluntary exit interview with a staff member that does not record the person’s name or any identifying information.

Provider Characteristics:

Question #1 on provider training on ASRH: The checklist is asking if your service providers/facility staff members have been trained on how to counsel/talk to adolescents—which is different from how you counsel or provide services to adults. If there is no special training or guidance provided to staff on how to talk to adolescents, please answer “no” to this question.

Question #3 on respectful care: For this question the SRH manager or health facility manager should have discussions with service providers and ask questions to understand if staff provide all information to adolescents, regardless of age, and do not attempt to influence adolescents into making certain choices based on the provider’s experiences/attitudes. Respect for adolescents and their choices means that staff are providing comprehensive counseling, speaking about all the choices available to adolescents, and delivering the services that the adolescent requests (even if the adolescent’s choice is not what the provider thinks the adolescent should do).

Question #6 on allowing sufficient time for adolescent appointments: For this question, the SRH manager or health facility manager should have discussions with service providers about how much time they allow for their appointments. Does the provider only allow a few minutes for counseling with adolescents? Or do they allow for flexibility in their appointment times so that they can answer questions from patients, particularly adolescents?

Program Characteristics:

Question #2 on community mobilization activities: When discussing youth volunteers, the checklist is asking if there are adolescents, youth, or young people available at the facility to talk to adolescents so that they have someone who is close to their age and can relate to their experiences. These youth do not have to be formal peer educators or counselors.

Source: Adapted from [ASRH Toolkit for Humanitarian Settings](#) (UNFPA, Save the Children, 2012).

ANNEX I: ASRH Health Facility Checklist

This is a tool referenced in the [Facility Quality Improvement Tools](#) section of Chapter 6: ASRH Services & Interventions. The ASRH Health Facility Checklist helps humanitarian staff assess their facility's characteristics, policies, and actions in responding to adolescents' SRH needs.

Health Facility Characteristics				
		Yes	No	Feasible suggestions for improvement and/or comments
1.	Is the facility accessible and located within walking-distance proximity of a place where adolescents—of all genders—congregate (youth center, adolescent-friendly space, school, market, etc)? <i>Note: Define accessibility and proximity with your local team before using the checklist and agree on what is appropriate for the context. For example, consider insecurity or infrastructure issues that might affect access.</i>			
2.	Is the facility open during hours that are convenient for adolescents of all genders (particularly in the evenings or on the weekend)? <i>Note: If only males or only females are congregating, mark "no".</i> <i>Please verify hours of school for adolescents and facility hours.</i>			
3.	Are there specific clinic times or spaces set aside for adolescents and are drop-in patients welcomed (without appointments)? <i>Note: If only males or only females are able to access the facility, mark "no".</i>			
4.	Does the clinic conduct any mobile medical camps and/or outreach activities for SRH services for adolescents? <i>Note: If yes, describe the specific set of activities, how often, and if services are provided free of charge.</i>			

5.	Are SRH services offered for free to adolescents?			
6.	Are waiting times very short (less than 30 minutes) or short (less than one hour)? <i>Note: Mark "yes" if the waiting time is less than one hour. Specify if on average the wait time is less than 30 minutes or an hour.</i>			
7.	If both adults and adolescents are treated in the facility, is there a separate, discreet space for adolescents to ensure privacy?			
8.	Do counseling and treatment rooms allow for privacy (both visual and auditory)?			
9.	Is there an accountability/ compliance mechanism regarding feedback about SRH services at the facility?			
10.	Is there a data management system (eg health management information system) that includes age-disaggregated data, as outlined in international adolescent group standards (eg data broken up by different age groups: 10–14, 15–19 years old)? <i>Note: Ask for the monthly health facility reports submitted to the Ministry of Health (MOH)/non-governmental organization (NGO) or other entity that operates the facility.</i>			
11.	A. Is the staff collecting data on people living with disabilities? <i>Note: This can be done using the Washington Group Questions.</i> B. Is the clinic accessible for those with disabilities (eg have a wheelchair ramp)? <i>Note: Mark "yes" if answers to both A & B are "yes". A person with disability is defined as a person who has a physical or mental impairment that substantially limits one or more major life activity/ies. For example, does the facility have ramps or other aids to ensure mobility for disabled people, including adolescents, within the facility services?</i>			

12.	Do the SRH services enable young men to access services? <i>For example, are SRH services available outside of the maternity ward?</i>			
13.	Are male condoms available to young people of all genders, including in discreet locations, such as bathrooms? <i>Note: Select “no” if male condoms are only available to boys or only available to girls. Or if male condoms are only available from providers directly.</i>			

At minimum:

Answer “yes” to questions 5, 8, 9, 10, and 13.

Provider Characteristics

		Yes	No	Feasible suggestions for improvement and/or comments
1.	In the last year, how many providers have been trained on how to provide SRH services to adolescents, which includes non-judgmental attitudes, empathic language, active listening, and age-appropriate counseling?			
2.	In the last year, have all staff members (receptionist, security guards, community health workers, cleaners, etc) been oriented to provide confidential, adolescent-friendly services?			
3.	Based on your observations during this visit, do staff members demonstrate respect for adolescents and their choices?			
4.	Based on your observations during this visit, do the providers ensure the patients’ privacy? <i>Note: If yes, state how they ensure privacy in the comments section.</i>			

5.	Based on your observations during this visit, do the providers ensure the patients’ confidentiality?			
6.	Do the providers set aside sufficient time for patient-provider interaction, including ensuring all of the patient’s questions are fully answered?			
7.	Are there both male and female providers available to provide SRH services at this facility?			
8.	In the last year, have health providers been assessed using quality standard checklists?			

At minimum:

Answer “yes” to questions 3, 4, and 5.

Program Characteristics

		Yes	No	Feasible suggestions for improvement and/or comments
1.	Do adolescent representatives join monthly health facility staff meetings, if they exist?			
2.	Are community mobilization activities on ASRH linked to the health facilities (community health workers, youth volunteers, etc)?			
3.	Are adolescents involved in quality assurance mechanisms to improve adolescent health outcomes? <i>For example, are adolescents involved in collecting data and evidence and/or reviewing qualitative and quantitative data?</i>			
4.	Are adolescents involved in the design or implementation of feedback mechanisms? <i>For example, do adolescents help with collecting or reporting feedback for the facility?</i>			

5.	Is there written guidance visible at the health facility that indicates adolescents do not require parental consent to receive SRH services? <i>Note: Make sure there are adequate consent forms available in contexts where parental consent is mandatory.</i>			
6.	Can adolescents be seen for all SRH services in the facility without the consent of their parents or spouses? <i>Note: These services include all forms of contraception, post-abortion care, safe abortion care, STI/HIV screening and treatment, maternal and child health (MCH) services, and gender-based violence (GBV).</i>			
7.	Does the facility have the commodities for at least three modern contraceptive methods (including one long-acting method)? <i>For example, are SRH commodities, including family planning methods, available at education centers, safe spaces, bathrooms, and other places youth congregate?</i>			
8.	Are modern contraceptive methods and counseling offered to adolescents at this facility? <i>Note: If yes, please provide how many adolescent patients have received services in the last three months in the comments section. Modern contraceptive methods include condoms, emergency contraception, pills, injectables, implants, and intrauterine devices.</i>			
9.	Are STI treatment and prevention services offered to adolescents at this facility? <i>Note: If yes, please provide how many adolescent patients have received services in the last three months in the comments section.</i>			

10.	Are HIV counseling and testing services offered to adolescents at this facility? <i>Note: If yes, please provide how many adolescent patients have received services in the last three months in the comments section.</i>			
11.	Are ante- and post-natal care services offered to adolescents at this facility? <i>Note: If yes, please provide how many adolescent patients have received services in the last three months in the comments section.</i>			
12.	Are maternal delivery care services offered to adolescents at this facility? <i>Note: If yes, please provide how many adolescent patients have received services in the last three months in the comments section.</i>			
13.	Are safe abortion care, including post-abortion care, services offered to adolescents at this facility? <i>Note: If yes, please provide how many adolescent patients have received services in the last three months in the comments section.</i>			
14.	Does the facility maintain, at minimum, a three-month supply of SRH commodities? <i>Note: This includes modern contraceptive commodities, abortion commodities and equipment, delivery supplies and equipment, and STI commodities (post-exposure prophylaxis [PEP], antiretrovirals [ARVs], etc).</i>			

15.	Are written clinical protocols for providing adolescent-specific health and SRH services available in the facility? <i>For example, clinical protocols that provide guidance for providers outlining country legal policies, clinical quality standards for serving adolescents, and guidance for contraceptive and abortion conscientious objectors.</i>			
16.	Are there SRH educational materials, posters, or other job aids/information, education, and communication (IEC) materials tailored to an adolescent audience? How are these distributed? <i>For example, are adolescents featured in the posters or flipbooks used for health education?</i>			
17.	Are there functional referral mechanisms in place between health, safe abortion care, and child protection services, including mental health and psychosocial support (MHPSS) and Clinical Management of Rape (CMR) for GBV cases? <i>For example, does the facility use referral cards specifically for adolescents?</i>			
18.	Are there functional referral mechanisms in place between health services and education?			
19.	Are there functional referral mechanisms in place between health and nutrition services?			
20.	Are there functional referral mechanisms in place between health and MHPSS services?			

21.	Are there functional referral mechanisms in place between health services and lesbian, gay, bisexual, transgender, queer, intersex, and asexual+ (LGBTQIA+) organizations?			
22.	Are there functional referral mechanisms in place between health services and persons living with disabilities organizations?			
23.	Are there functional referral mechanisms in place between community platforms, health services, and GBV services for abortion cases?			
<p>At minimum:</p> <ul style="list-style-type: none"> • Program should include adolescents in at least one component of the program cycle (design, implementation, evaluation): relates to questions 1, 2, 3, and 4 (at minimum should have answered "yes" to one of the four questions). • Answer "yes" to questions 7, 8, 9, 12, 13, 14, and 17. 				

Sources: Adapted from [ASRH Toolkit for Humanitarian Settings](#) (UNFPA, Save the Children, 2012), [Clinic Assessment of Youth Friendly Services Tool](#) (Pathfinder International, 2002), and field experience from the [IAWG ASRH Sub-Working Group](#). Disability information: [What is the definition of disability under the ADA?](#) (ADA National Network, 2020) and [Question Sets](#) (Washington Group on Disability Statistics, 2020).

ANNEX J: GATHER CHECKLIST, Adapted for Humanitarian Settings

This is a tool referenced in the [Counseling Tools & Resources](#) section of Chapter 6: ASRH Services & Interventions. There are many different types of counseling tools similar to the GATHER checklist that can be adapted further to meet the needs of adolescents. This tool included below is for counseling on contraceptive services, but can be adapted for other SRH services. It has been adapted to include considerations for service providers to use for adolescent patients.

Checklist For Adolescent Contraception Counseling

- To be used by the service provider as a learning guide for practice
- To be used by the trainer at the end of the course for skill assessment
- To be used by the supervisor during supportive supervision in the health facilities

Place a “✓” in patient box if step/task is performed satisfactorily, an “✗” if it is not performed satisfactorily or if not observed, “N/A” if the step is not required. Lines are provided below survey for writing any additional comments or observations.

Satisfactory: Performs the step or task according to the standard procedure or guidelines.

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines. (Many of the following steps/tasks should be performed simultaneously)

Service provider name:						
STEP/TASK	PATIENTS (P) [eg patient 1 = P1]					COMMENT
	P1	P2	P3	P4	P5	
[enter date below each patient number]						
GREET						
1. Greets respectfully and with kindness, introduces self to adolescent patient. <i>Provider ensures that they have adequate time (more time) for adolescent patient.</i>						
2. Engages the adolescent in conversation with some easy & welcoming questions, not related to the purpose of the visit: <i>How are you? How is your family? What do you like to do for fun?</i>						
3. Asks patient(s) how they can help them.						
4. Reassures the adolescent that information discussed during the consultation is private and confidential and explains in a simple way what that means. <i>For example, "What you say in this room will stay between us". Encourages the adolescent to talk freely about any concerns.</i>						
5. Explains what will happen during the visit.						
ASK						
6. Listens actively—showing interest in the adolescent. <i>This includes sitting in a position where the adolescent can choose to establish eye contact. Provider should be maintaining eye contact at all times.</i>						
7. Uses gender-neutral and non-stigmatizing language. <i>Does not provide judgmental comments, ask irrelevant questions, or show a negative nonverbal attitude when the adolescent is talking.</i>						
8. Asks adolescent what they know about contraception and whether they have ever used a contraceptive method; if so, how they used the method and if they have any concerns about it. <i>If the patient is a very young adolescent, you might start with if they understand what changes are happening in their body, instead of what family planning/contraception is.</i>						

9. Asks adolescent about life goals and then about their reproductive goals—and lets them know how contraception can help with both their goals: <ul style="list-style-type: none"> • What would they like to do in the future? Do they plan to go to school? For how long and for what career? • If they do not have children: do they want to have children? • If they have children: how many (more) children do they want? • Are they interested in spacing pregnancies (if so, for how long) or preventing them completely? 						
10. Checks for medical complications (history taking, last menstruation date, etc), uses Medical Eligibility Criteria correctly, and refers adolescent for medical evaluation if necessary.						
11. Asks about any concerns adolescent would like to share.						
TELL						
12. Briefly provides general information about all contraceptive methods available, including effectiveness, possible problems or complications, side effects and their management, advantages and disadvantages, possible needs for protection against STIs/HIV, and the difference between reversible and permanent contraception. <i>Provider explains that contraceptive methods are safe and effective for adolescents.</i>						
13. Uses photos/cue cards/visuals to counsel and explain contraceptive methods when possible, speaks in terms that are suitable for adolescents, and avoids technical terminologies during the discussion.						
HELP						
14. Encourages adolescent to ask questions. Answers them.						
15. Identifies and addresses the fears and misinformation the adolescent may have regarding contraception and other sexual and reproductive health issues.						

EXPLAIN						
16. Reassures adolescent about minor side effects they may experience and treats them if appropriate.						
17. Asks whether adolescent has any final questions.						
18. Provides method/arranges procedure (if chosen).						
RETURN VISIT						
19. Makes a return appointment for adolescent if necessary and reassures adolescent that they can come back to visit for any reason.						
Enter the total of “✓”						
Enter the total of steps (remove the “N/A”, if any)						
<p>SCORE Calculate the percentage:</p> $\text{Score} = \frac{\text{Total of “✓”}}{\text{Total of steps} \times 100} = \dots\%$						

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REMINDER		
EXCELLENT	GOOD	FAIR
checklist score >= 90%	90% > checklist score >= 80%	checklist score < 80%

Source: Adapted from [GATHER Guide to Counseling](#) (Population Reports, 1998).

ANNEX K: Additional Resource Catalog for Providing GBV Care to Adolescent Survivors




This annex is referenced in the [Counseling Considerations for Adolescent Survivors of GBV](#) section of Chapter 6: ASRH Services & Interventions. In addition to the [MISP](#) and [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings](#), this resource catalog provides a variation of additional evidence-based resources humanitarian responders can utilize for providing gender-based violence (GBV) services to adolescent survivors. **Note: This catalog is not a comprehensive list of all available resources.**

Description	Source
Clinical Care for Sexual Assault Survivors is an online educational program to improve clinical care and general treatment sexual assault survivors.	IRC (2014)
Convention on the Rights of the Child is a human rights treaty that outlines the civil, political, economic, social, health, and cultural rights of children.	UN (1989)
GBV Responders' Network's Caring for Child Survivors provides field-tested guidelines and tools for health and psychosocial staff working with child survivors of sexual abuse in humanitarian settings.	IRC (2014)
Gender-Based Quality Assurance Tool: Health care for women subjected to violence. A clinical handbook aims to provide standards for the provision of high-quality post-violence care in health facilities.	WHO (2018)
Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action include information on reducing risk, promoting resilience, and aiding recovery provides entry points for GBV integration into other humanitarian sectors.	IASC (2019)
Inclusion of Persons with Disabilities in Humanitarian Action guidance aims to provide guiding principles for better inclusion of persons with disabilities in humanitarian action.	IASC (2019)
IASC GBV Minimum Standards include some guidance for gender-based violence (GBV) services for people of diverse Sexual Orientation and Gender Identity and Expression (SOGIE) as well as specific guidance for child survivors and adolescent girls and boys.	IASC (2019)
IRC Inclusion Guidance Note is a component of the GBV Emergency Response and Preparedness model from the International Rescue Committee (IRC), and this guidance note provides approaches for women and girls of diverse SOGIE populations.	IRC (2019)

The Minimum Standards for Child Protection in Humanitarian Action is set of standards that should be adhered to in coordination activities and referral services by SRH actors.	The Alliance for Child Protection in Humanitarian Action (2019)
Providing Inclusive Services and Care for LGBT People is a guide to help health care staff provide an affirmative, inclusive, and respectful environment for all clients, with a focus on lesbian, gay, bisexual, and transgender (LGBT) people.	National LGBT Health Education Center (2016)
Psychological First Aid: Guide for Field Workers from the World Health Organization (WHO) provides tools and information on how to provide PFA responsibly to those affected by crises.	WHO (2011)
Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO clinical and policy guidelines is intended for healthcare providers to use when responding to intimate partner violence and sexual violence against women.	WHO (2013)
Save the Children's Psychological First Aid Training Manual for Child Practitioners is aimed at developing skills and competences that will help child protection staff reduce the initial distress of children who have recently been exposed to a traumatic event.	Save the Children (2013)
Strengthening Health Systems to Respond to Women Subjected to Violence: A manual for health managers aims to strengthen and enable health systems to provide confidential, effective, and women-centered services of violence.	WHO (2017)
Universal Declaration of Human Rights is a milestone human rights document for the protection of all humankind.	UN (1948)
Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights provides foundational guidelines on GBV and SRH.	WHO (2018)
WHO Clinical Guidelines: Responding to children and adolescents who have been sexually abused aims to provide evidence-based recommendations for quality clinical care for children and adolescents who have, or may have, been subjected to sexual abuse.	WHO (2017)
WHO Clinical Handbook for Providers on Sexual Violence provides healthcare workers best practices for providing care to GBV survivors.	WHO (2013)

ANNEX L: Essential Characteristics of Supervisors

This annex is referenced in the [Community-Based Services and Outreach Platforms](#) section of Chapter 6: ASRH Services & Interventions. International Planned Parenthood Federation (IPPF) outlines the essential characteristics of supervisors for mentoring youth. Equally important to recruiting the right supervisors is also making sure organizations are implementing appropriate child safeguarding policies and measures, as well as other provisions to guarantee the safety and protection of adolescents.

 Knowledge/experience on the following issues/areas	 Skills needed in the following areas	 Attitudes to address/nurture
<ul style="list-style-type: none"> • Quality services • Young people’s needs • SRH issues • Gender issues • Rights-based approaches 	<ul style="list-style-type: none"> • Program development • Inspiring young people • Coaching/mentoring skills • Creativity—thinking outside the box • Sense of humor • Ability to work with youth from different cultural, socioeconomic and ethnic backgrounds and from different sexual orientations • Excellent communication and facilitation skills 	<ul style="list-style-type: none"> • Proactiveness, positive attitude • Respect for young people • Non-judgmental attitude • Commitment to the program’s goals and objectives

Source: [Included Involved Inspired: A Framework for Youth Peer Education Programmes](#) (IPPF, 2007).

ANNEX M: Multi-Sectoral Tool for Integrating ASRH in Emergency Responses

This is a tool referenced in the [Tools for Building Multi-Sectoral Linkages](#) section of Chapter 6: ASRH Services & Interventions. IAWG developed a multi-sectoral tool to assist SRH managers with identifying ways to integrate ASRH activities across all humanitarian sectors and identify strategies for reaching adolescents. This tool provides examples of ASRH activities that SRH managers should advocate for integrating within each humanitarian sector. The tool also provides specific activities for reaching [adolescents at increased risk](#) with SRH information and services (**in bold**). Below the table of multi-sectoral examples is a template for SRH managers to use when discussing ASRH opportunities with other sector staff, including questions to use for guiding those conversations (at the top of the template).

Purpose	This tool is intended to assist SRH managers with identifying ways to integrate ASRH activities across all humanitarian sectors, including ways to reach subgroups of adolescents at increased risk.
Guidance	This tool provides examples of ASRH activities that SRH managers should advocate for integrating within each humanitarian sector. The tool also provides specific activities for reaching adolescents at increased risk with SRH information and services (in bold). Below the table of multi-sectoral examples is a template for SRH managers to use when discussing ASRH opportunities with other sector staff, including questions to use for guiding those conversations (at the top of the template).
Vulnerability of Adolescents	<p>Adolescents are a heterogeneous group of individuals that have unique needs and concerns and can face discrimination based on their age, sex, gender identity, disability, sexual orientation, and bodily diversity. Thus, ASRH programs must be tailored to the individual needs and risk factors of adolescents in need of SRH assistance. A “one size fits all” mentality will not be effective in addressing the SRH needs of adolescents, particularly those in the most difficult of circumstances—a humanitarian crisis. ASRH programs should aim to reach all adolescents, with particular attention on subgroups of adolescents that are at increased risk during humanitarian emergencies. These include, but are not limited to:</p> <ul style="list-style-type: none"> • Pregnant adolescents • Adolescents with disabilities • Adolescents with diverse SRH needs (including indigenous groups, those living with Human Immunodeficiency Virus [HIV], those identifying as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual+ [LGBTQIA+]) • Adolescent heads of households

Examples of Multi-Sectoral Activities by Humanitarian Sector	
Sector	ASRH Integration Activities
All Sectors	<ul style="list-style-type: none"> • Ensure all staff know what SRH services are offered to adolescents, where they are offered, and how to refer services that are unavailable to other facilities/organizations • Ensure information sharing and referral mechanisms are in place between health and other sectors • Train all staff on 1) the sensitivities of SRH information, particularly for adolescents; 2) impact of judgmental language, behavior, and bias on ASRH uptake; and 3) assurance of privacy and confidentiality in delivery of ASRH services • Ensure staff are meaningfully engaging adolescents and community members prior to initiating activities • Staff should share relevant ASRH data collected during focus group discussions or assessments with health staff • Educate staff on discreet locations for adolescents to receive SRH services (eg adolescent entrances, condoms in bathrooms) • Create partnerships with local youth-led organizations and community-based organizations that are addressing needs of adolescents and provide that information to relevant sector staff <p>Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> • Ensure humanitarian facilities are accessible for adolescents with disabilities (eg providing ramps)
Health	<ul style="list-style-type: none"> • Work with all health staff to implement Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (MISP) components <ul style="list-style-type: none"> • Coordinate with other health organizations and local government to understand where ASRH services are available to coordinate referral mechanisms and avoid duplication (MISP Objective 1) • Ensure everyone has access to condoms; provide condoms in consultation rooms, throughout facilities, as well as in discreet locations (such as bathrooms) <ul style="list-style-type: none"> • Ensure that community distributions of condoms are always accompanied by demonstrations on how to use them • Educate health staff on other sector services that benefit adolescents in your organization’s program areas • Develop and disseminate ASRH messages to share at other sector entry points • Work with non-health sector staff to design outreach services to increase ASRH service uptake <ul style="list-style-type: none"> • Consider how sexually transmitted infection (STI) services, including HIV, can be integrated into health system and facilities versus having separate, vertical structure for patients to obtain MHPSS services • Conduct anonymous/confidential exit interviews with adolescents to ensure quality service provision • Pilot test activities with adolescents to ensure they are appropriately tailored (eg have adolescents provide feedback for draft information, education, and communication [IEC] materials) <p>Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> • Create tailored SRH messages, including pictorial messages, for adolescents with hearing impairments and low literacy • Map adolescent subgroups at increased risk (eg pregnant adolescents, orphaned adolescents, etc) within coordination groups/meetings to understand needs & barriers

<p>Cash and Voucher Assistance</p>	<ul style="list-style-type: none"> • Ensure cash-for-health programs include access for SRH services • Ensure minimum expenditure baskets for multi-purpose cash (MPC) assistance include the cost of SRH and menstrual hygiene goods and services <p>Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> • Ensure adolescents at increased risk (pregnant adolescents, adolescent heads of households, adolescent survivors of gender-based violence [GBV], etc) are prioritized and eligible for MPC • Ensure adolescents at increased risk (pregnant adolescents, adolescent heads of households, adolescent survivors of GBV, etc) are prioritized in cash-for-health programs
<p>Education</p>	<ul style="list-style-type: none"> • Make SRH services and information available in formal and non-formal schools and educational and vocational centers • Establish relationships between health staff/providers and education staff to ensure issues affecting adolescents are addressed, as well as opportunities to increase engagement/coordination between education and SRH • Tailor sexuality education and life skills curricula or programs to ensure they are age, developmentally, and culturally appropriate, as well as addressing gender diversity and inclusion <ul style="list-style-type: none"> • Discuss with community members which SRH commodities might be possible to have available at education structures for adolescents (eg female hygiene supplies or condoms in bathrooms at an education center) • Teachers could have health staff visit classrooms/education spaces to deliver SRH messages and/or provide demonstrations to adolescents and young people <p>Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> • Include supportive messaging for young mothers to continue education after marriage and/or childbearing • Create understanding among education staff about needs of LGBTQIA+ • Jointly research, respect, and promote traditional health practices that are helpful and strive to eliminate harmful traditional practices that adversely affect the health of adolescents, particularly adolescents at increased risk (eg adolescents from indigenous groups)
<p>Food & Livelihoods</p>	<ul style="list-style-type: none"> • Ensure adequate food and nutritional services/programs are available for adolescents • Ensure health and hygiene messages (including SRH messages and menstrual hygiene messages) are provided at cash/food/voucher distributions • Integrate SRH information into livelihood programs, especially life skills content that easily bridges both topics • Work with food and livelihoods staff to expand availability of food and cash opportunities beyond male heads of households <p>Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> • Prioritize adolescents at increased risk in distribution lines (eg pregnant adolescent girls, adolescents with disabilities, adolescent heads of households, etc)

<p>Nutrition</p>	<ul style="list-style-type: none"> • Consider how nutrition programs/services can be integrated into health system and facilities (eg outpatient therapeutic programs in health centers; stabilization centers in hospitals; infant and young child feeding [IYCF] programs) • Ensure SRH messages are promoted, when appropriate, during nutrition consultations • Jointly (with adolescents/youth) develop social behavior communication (SBC)/IEC materials that support nutrition needs and behaviors of adolescents <p>Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> • Integrate pre-/post-natal consultations with nutrition services to address needs of pregnant adolescent girls • Simulate or do role-playing exercises during trainings on how to provide IYCF counseling/services to adolescent mothers
<p>Protection/ MHPSS</p>	<ul style="list-style-type: none"> • Consider how MHPSS services can be integrated into health system and facilities versus having separate, vertical structure for adolescents to obtain MHPSS services • Make sure that MHPSS consultation rooms are far enough away from other rooms to allow for confidentiality and privacy for adolescents • Encourage adolescent participation in any multi-sectoral GBV prevention task force • Facilitate community dialogues and action plans where a key group of stakeholders—including adolescents/youth representatives—meet regularly to discuss challenges facing adolescents, including GBV, and develop and implement a plan to address at least one of the identified challenges <p>Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> • Consider placement of child-, girl-, and women-friendly centers close to SRH services to increase access for adolescent girls • Ensure child-, girl-, and women-friendly centers provide areas/space for SRH-related activities for adolescent girls • Place social workers/other protection staff trained on counseling adolescent survivors of GBV at health facility • Utilize safe spaces to collect information on barriers to health services for adolescents at increased risk (eg adolescent survivors of GBV, adolescents selling or exchanging sex for other goods or services, etc) • Ensure MHPSS services are available for adolescents formerly associated with armed groups and adolescents who formerly perpetrated GBV

Shelter and Camp Management	<ul style="list-style-type: none"> Ensure consultation with shelter advisor on design and construction of temporary/rehabilitation of health clinics and other health structures to provide adequate privacy and space for adolescents to the extent possible (eg privacy curtains) <ul style="list-style-type: none"> Enable opportunities for adolescents to speak about barriers and issues with camp management and coordination, including during design and construction of humanitarian infrastructure Provide sustainable lighting throughout camp to ensure personal security of adolescents <p>Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> Ensure all adolescents have opportunity to provide input, feedback, and concerns regarding personal safety, security, and management of the camp or humanitarian setting, including adolescent girls, LGBTQIA+ adolescents, adolescents with disabilities, etc
Water, Sanitation, and Hygiene (WASH)	<ul style="list-style-type: none"> Ensure safe, sex-specific hygiene facilities are available for adolescents Consider including ASRH messages at WASH facilities, such as on the back of bathroom doors Work with protection team to understand WASH concerns affecting adolescents' ability to use WASH facilities <p>Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> Ensure appropriate washing facilities are available and accessible, including to adolescents with disabilities Ensure adolescent girls have access to culturally appropriate, sustainable menstrual products and tools, as well as convenient sites for disposal of sanitary materials Ensure separate girl-friendly latrines are available

Sources: This tool was adapted based on guidance from the [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings](#) (IAWG, 2018) and supplemental materials from the [ASRH Toolkit for Humanitarian Settings](#) (UNFPA, Save the Children, 2012).

Template for Multi-Sectoral Integration of ASRH Activities	
Sector	ASRH Integration Activities
Questions to ask during consultations with other sectors	<ul style="list-style-type: none"> Where and when do you come in contact with adolescents? What services do you offer them? Do this sector's staff know what and where SRH services are provided to adolescents by your organization? And for services not provided by your organization, do they know where to refer adolescent patients? Are you aware of opportunities for providing ASRH messages or services at your facility (eg food distribution point, livelihood program, education center)? <ul style="list-style-type: none"> Do your program's benefits apply to ASRH services (eg can cash programming be used for ASRH services)? <p>Questions for Reaching Adolescents at Increased Risk:</p> <ul style="list-style-type: none"> Do you know what subgroups of adolescents are at increased risk in your organization's program areas? Does your programming give priority to pregnant adolescents or adolescent heads of households?
Cash and Voucher Assistance	
Education	
Food Security & Livelihoods	

Health	
Nutrition	
Protection/ MHPSS	
Shelter and Camp Management	
WASH	

Sources: This tool was adapted based on guidance from the [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings](#) (IAWG, 2018) and supplemental materials from the [ASRH Toolkit for Humanitarian Settings](#) (UNFPA, Save the Children, 2012).

ANNEX N: Referral Form for Referring Agency Copy

This is a tool referenced in the [Tools for Establishing Referral Pathways](#) section of Chapter 6: ASRH Services & Interventions. The Inter-Agency Standing Committee (IASC) provides standard forms for making referrals for mental health and psychosocial support (MHPSS) cases across all humanitarian sectors. The Toolkit has adapted these forms for referring adolescent clients to different services between sectors, such as nutrition, gender-based violence (GBV), water, sanitation, and hygiene (WASH), etc. These include forms for the agency making the referral, the client receiving the referral, and the agency receiving the referral request. This tool is specifically a referral form for the referring agency.

Referring Agency copy Routine Urgent Date of Referral (DD/MM/YY): _____

Multi-Sector Referral Form for Adolescent Clients

Referring Agency	
Agency/Org:	Contact:
Phone:	Email:
Location:	

Receiving Agency	
Agency/Org:	Contact (if known):
Phone:	Email:
Location:	

Adolescent Client Information	
Name:	Phone (if available):*
Age:	
Identified Gender:	Address/Location (if available):*
Language:	
Notes:**	

**If the adolescent client is not comfortable sharing this information, it is not required to complete the referral. Use discretion when asking questions and utilize Toolkit resources for talking to adolescents (see [Five Principles for Creating a Trustful Atmosphere for Adolescent Counseling](#)).*

***Use this space for including any additional information necessary and/or useful for the receiving agency, such as capacities of the adolescent client that may affect their ability to access or receive the SRH services (e.g. cognitive impairments, physical disabilities, etc.)*

Background Information/Reason for Referral: problem description, duration, frequency, etc. and services already provided	
Has the adolescent client been informed of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No* (if no, explain below)	Has the adolescent client been referred to any other organizations? <input type="checkbox"/> Yes* (if yes, explain below) <input type="checkbox"/> No

**Use this space if the client did not consent for referral due to being unconscious and in need of emergency life-saving services.*

Consent to Referral & Release Information (read with adolescent client and answer any questions before they sign below)

I, _____ (adolescent client name), understand that the purpose of the referral and sharing this information with _____ (receiving agency) is to ensure my safety and to make sure I receive the services I need. The service provider, _____ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be shared. By signing this form, I authorize this referral and exchange of information.

Signature of Adolescent Client: _____

Date (DD/MM/YY): _____

If required by local laws, * signature of Adolescent Caregiver: _____

Date (DD/MM/YY): _____

**Providers and referring agencies should document consent to the full extent of local laws. If no policy exists regarding consent, international standards for documenting consent should be adhered to. [Note: International Standards do not require consent from an adult to receive services.] Refer to [Facility-Based Services](#) and [Data for Action](#) sections on consent and assent to find more detailed guidance.*

Services Requested*

<input type="checkbox"/> General health services	<input type="checkbox"/> Camp management services	<input type="checkbox"/> Food & Livelihoods services
<input type="checkbox"/> SRH services	<input type="checkbox"/> Cash & voucher assistance services	<input type="checkbox"/> Legal assistance services
<input type="checkbox"/> GBV services	<input type="checkbox"/> Shelter services	<input type="checkbox"/> MHPSS services
<input type="checkbox"/> MHPSS services	<input type="checkbox"/> Child protection services	<input type="checkbox"/> WASH services
<input type="checkbox"/> Nutrition services	<input type="checkbox"/> Education services	<input type="checkbox"/> Other (please explain below)

Please explain any requested services: _____

**Some referrals may have overlapping services and/or may not be available in all contexts. Check all relevant boxes.*

Details of Referral

Does the adolescent client consent to follow-up communications after their referral visit? Yes No
If yes, what mode of communication does the adolescent client prefer? (explain below) _____

Referral delivered for adolescent client via:
 Phone (emergency only) E-mail Electronically (eg App or database) In Person

Follow-up communications expected between referring agencies via:
 Phone E-mail In Person

By date (DD/MM/YY): _____

Referring agencies agree to exchange during follow up call/appointment: _____

Name and signature of recipient: _____ Date received (DD/MM/YY): _____

Source: [Inter-Agency Referral Form and Guidance Note](#) (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2017).

ANNEX NN: Referral Form for Client Copy

This is a tool referenced in the [Tools for Establishing Referral Pathways](#) section of Chapter 6: ASRH Services & Interventions. The Inter-Agency Standing Committee (IASC) provides standard forms for making referrals for mental health and psychosocial support (MHPSS) cases across all humanitarian sectors. The Toolkit has adapted these forms for referring adolescent clients to different services between sectors, such as nutrition, gender-based violence (GBV), water, sanitation, and hygiene (WASH), etc. These include forms for the agency making the referral, the client receiving the referral, and the agency receiving the referral request. This tool is specifically a referral form for the adolescent client.

Client copy Routine Urgent Date of Referral (DD/MM/YY): _____

Multi-Sector Referral Form for Adolescent Clients

Referring Agency

Agency/Org:	Contact:
Phone:	Email:
Location:	

Receiving Agency

Agency/Org:	Contact (if known):
Phone:	Email:
Location:	

Adolescent Client Information

Name:	Phone (if available):*
Age:	
Identified Gender:	Address/Location (if available):*
Language:	
Notes:**	

**If the adolescent client is not comfortable sharing this information, it is not required to complete the referral. Use discretion when asking questions and utilize Toolkit resources for talking to adolescents (see [Five Principles for Creating a Trustful Atmosphere for Adolescent Counseling](#)).*

***Use this space for including any additional information necessary and/or useful for the receiving agency, such as capacities of the adolescent client that may affect their ability to access or receive the SRH services (e.g. cognitive impairments, physical disabilities, etc.)*

Background Information/Reason for Referral: problem description, duration, frequency, etc. and services already provided

Has the adolescent client been informed of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No* (if no, explain below)	Has the adolescent client been referred to any other organizations? <input type="checkbox"/> Yes* (if yes, explain below) <input type="checkbox"/> No

**Use this space if the client did not consent for referral due to being unconscious and in need of emergency life-saving services.*

Consent to Referral & Release Information (read with adolescent client and answer any questions before they sign below)

I, _____ (adolescent client name), understand that the purpose of the referral and sharing this information with _____ (receiving agency) is to ensure my safety and to make sure I receive the services I need. The service provider, _____ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be shared. By signing this form, I authorize this referral and exchange of information.

Signature of Adolescent Client:

Date (DD/MM/YY):

If required by local laws, * signature of Adolescent Caregiver:

Date (DD/MM/YY):

**Providers and referring agencies should document consent to the full extent of local laws. If no policy exists regarding consent, international standards for documenting consent should be adhered to. [Note: International Standards do not require consent from an adult to receive services.] Refer to [Facility-Based Services](#) and [Data for Action](#) sections on consent and assent to find more detailed guidance.*

Services Requested*

- | | | |
|--|---|---|
| <input type="checkbox"/> General health services | <input type="checkbox"/> Camp management services | <input type="checkbox"/> Food & Livelihoods services |
| <input type="checkbox"/> SRH services | <input type="checkbox"/> Cash & voucher assistance services | <input type="checkbox"/> Legal assistance services |
| <input type="checkbox"/> GBV services | <input type="checkbox"/> Shelter services | <input type="checkbox"/> WASH services |
| <input type="checkbox"/> MHPSS services | <input type="checkbox"/> Child protection services | <input type="checkbox"/> Other (please explain below) |
| <input type="checkbox"/> Nutrition services | <input type="checkbox"/> Education services | |

Please explain any requested services:

**Some referrals may have overlapping services and/or may not be available in all contexts. Check all relevant boxes.*

Details of Referral

Does the adolescent client consent to follow-up communications after their referral visit? Yes No
If yes, what mode of communication does the adolescent client prefer? (explain below)

Referral delivered for adolescent client via:

- Phone (emergency only) E-mail Electronically (eg App or database) In Person

Follow-up communications expected between referring agencies via:

- Phone E-mail In Person

By date (DD/MM/YY):

Referring agencies agree to exchange during follow up call/appointment:

Name and signature of recipient: _____ Date received (DD/MM/YY): _____

Source: [Inter-Agency Referral Form and Guidance Note](#) (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2017).

ANNEX NNN: Referral Form for Receiving Agency Copy

This is a tool referenced in the [Tools for Establishing Referral Pathways](#) section of Chapter 6: ASRH Services & Interventions. The Inter-Agency Standing Committee (IASC) provides standard forms for making referrals for mental health and psychosocial support (MHPSS) cases across all humanitarian sectors. The Toolkit has adapted these forms for referring adolescent clients to different services between sectors, such as nutrition, gender-based violence (GBV), water, sanitation, and hygiene (WASH), etc. These include forms for the agency making the referral, the client receiving the referral, and the agency receiving the referral request. This tool is specifically a referral form for the receiving agency.

Referring Agency copy Routine Urgent Date of Referral (DD/MM/YY): _____

Multi-Sector Referral Form for Adolescent Clients

Referring Agency	
Agency/Org:	Contact:
Phone:	Email:
Location:	

Receiving Agency	
Agency/Org:	Contact (if known):
Phone:	Email:
Location:	

Adolescent Client Information	
Name:	Phone (if available):*
Age:	Address/Location (if available):*
Identified Gender:	
Language:	
Notes:**	

**If the adolescent client is not comfortable sharing this information, it is not required to complete the referral. Use discretion when asking questions and utilize Toolkit resources for talking to adolescents (see [Five Principles for Creating a Trustful Atmosphere for Adolescent Counseling](#)).*

***Use this space for including any additional information necessary and/or useful for the receiving agency, such as capacities of the adolescent client that may affect their ability to access or receive the SRH services (e.g. cognitive impairments, physical disabilities, etc.)*

Background Information/Reason for Referral: problem description, duration, frequency, etc. and services already provided	
Has the adolescent client been informed of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No* (if no, explain below)	Has the adolescent client been referred to any other organizations? <input type="checkbox"/> Yes* (if yes, explain below) <input type="checkbox"/> No

**Use this space if the client did not consent for referral due to being unconscious and in need of emergency life-saving services.*

Consent to Referral & Release Information (read with adolescent client and answer any questions before they sign below)

I, _____ (adolescent client name), understand that the purpose of the referral and sharing this information with _____ (receiving agency) is to ensure my safety and to make sure I receive the services I need. The service provider, _____ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be shared. By signing this form, I authorize this referral and exchange of information.

Signature of Adolescent Client:

Date (DD/MM/YY):

If required by local laws, * signature of Adolescent Caregiver:

Date (DD/MM/YY):

**Providers and referring agencies should document consent to the full extent of local laws. If no policy exists regarding consent, international standards for documenting consent should be adhered to. [Note: International Standards do not require consent from an adult to receive services.] Refer to Facility-Based Services and Data for Action sections on consent and assent to find more detailed guidance.*

Services Requested*

- | | | |
|--|---|---|
| <input type="checkbox"/> General health services | <input type="checkbox"/> Camp management services | <input type="checkbox"/> Food & Livelihoods services |
| <input type="checkbox"/> SRH services | <input type="checkbox"/> Cash & voucher assistance services | <input type="checkbox"/> Legal assistance services |
| <input type="checkbox"/> GBV services | <input type="checkbox"/> Child protection services | <input type="checkbox"/> Shelter services |
| <input type="checkbox"/> MHPSS services | <input type="checkbox"/> WASH services | |
| <input type="checkbox"/> Nutrition services | <input type="checkbox"/> Education services | <input type="checkbox"/> Other (please explain below) |

Please explain any requested services:

**Some referrals may have overlapping services and/or may not be available in all contexts. Check all relevant boxes.*

Details of Referral

Does the adolescent client consent to follow-up communications after their referral visit? Yes No
If yes, what mode of communication does the adolescent client prefer? (explain below)

Referral delivered for adolescent client via:

- Phone (emergency only) E-mail Electronically (eg App or database) In Person

Follow-up communications expected between referring agencies via:

- Phone E-mail In Person

By date (DD/MM/YY):

Referring agencies agree to exchange during follow up call/appointment:

Name and signature of recipient: _____ Date received (DD/MM/YY): _____

Source: [Inter-Agency Referral Form and Guidance Note](#) (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2017).

ANNEX O: IRA for ASRH

This is a tool referenced in [Table 6](#) in Chapter 7: Data for Action. An initial rapid assessment (IRA) is conducted during the first 72 hours of an acute emergency and is used to collect demographic information and identify life-saving issues that must be addressed urgently to ensure the well-being of the beneficiary population. This sample IRA for cannot be used as a standalone tool but provides an overview of the ASRH data that should be collected and can be used as a complementary tool to other rapid assessment formats.

Initial Rapid Assessment for Adolescent Sexual and Reproductive Health		
Number of adolescents (10–14 years), disaggregated by males & females	[females]	[males]
Number of adolescents (15–19 years), disaggregated by males & females	[females]	[males]
Number of unaccompanied adolescents (10-14 years), disaggregated by males & females	[females]	[males]
Number of unaccompanied adolescents (10-14 years), disaggregated by males & females	[females]	[males]
Number of pregnant adolescents per age bracket	[10–14 years]	[15–19 years]
Number of married adolescents (10–14 years old), disaggregated by males & females	[females]	[males]
Number of married adolescents (15–19 years old), disaggregated by males & females	[females]	[males]
Are there national or local laws in place that might restrict adolescents' ability to access SRH and rights services?	Yes	No
	Comments:	
Are adolescent- and gender-sensitive SRH and rights services currently being provided in the community/project area? (If yes, specify where)	Yes	No
	Comments:	

Are adolescent- and gender-sensitive mental health and psychosocial support currently being provided?	Yes	No
	Comments:	
Are sex-segregated toilets and bathing facilities located in well-lit areas?	Yes	No
	Comments:	
Do toilets and bathing facilities have doors that can be locked from the inside?	Yes	No
	Comments:	
Identify sites for adolescent-friendly contraception distribution [specify location(s)]		
List any adolescent groups or organizations active in the community		

Source: Adapted from [ASRH Toolkit for Humanitarian Settings](#) (UNFPA, Save the Children, 2012).

ANNEX P: Assessment Questions to Use with Adolescents

This is a tool referenced in [Table 6](#) in Chapter 7: Data for Action. These questions, while not an exhaustive list, can be used and/or adapted for collecting information from adolescents via several assessments, such as situational analyses, focus discussion groups (FGDs), individual interviews, and knowledge, attitudes, and practices (KAP) surveys. As a reminder, practitioners should adapt questions based on the context, as well as for different adolescent population groups. We have added [\[specify all subgroups\]](#) for questions we recommend adapting for different subgroups of adolescents, as well as examples of adapted questions for adolescents with disabilities (including cognitive impairments and physical disabilities) and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual+ (LGBTQIA+) adolescents.

Sample Questions for Conducting Assessments with Adolescents	
Introductory questions	<p>A reminder to always start with introductory, softer questions when working with adolescents to create a trustful, friendly environment (see Five Principles for Creating a Trustful Atmosphere for Adolescent Counseling).</p> <p>Sample questions to ask adolescent and respond to as facilitator to create dialogue and comfortable atmosphere:</p> <ul style="list-style-type: none"> • How are you? • How is your family? • What do you like to do for fun? • Who do you spend your time with? • What do you like to do with your friends? • What educational grade are you in?
KAP questions on Puberty & Menstruation	<p><i>Puberty & Menstruation</i></p> <ul style="list-style-type: none"> • Have you noticed changes in your body recently? What do you think it means? • What is puberty? <i>Note: If they do not know the term, explain the term.</i> How does puberty affect boys? How does puberty affect girls? • What is menstruation? <i>Note: If they do not know the term, explain the term.</i> How does menstruation affect girls? Do girls go to school when they are menstruating? Are girls permitted to stay in their home? If not, where do girls stay and for how long? • What is a wet dream? <i>Note: If they do not know the term, explain the term.</i> How does a wet dream affect boys? • What is masturbation? Is it only for boys or for all genders? <i>Note: If they do not know the term, explain the term.</i>
KAP questions on Relationships & Sexual Activity	<p><i>Relationships</i></p> <ul style="list-style-type: none"> • Who do you like to spend time with? Do you like someone as more than a friend? Are you in a relationship with anyone? <ul style="list-style-type: none"> • If adolescent answered “no” to being in a relationship: Do you have feelings for anyone? Have you talked to your friends about your feelings? • What does it mean to be in a relationship? What kind of relationships do you see (girls and boys, girls and girls, boys and boys)?

<p>KAP questions on Relationships & Sexual Activity</p>	<ul style="list-style-type: none"> • What do people in relationships do with each other? Do they kiss? What else do they do? <ul style="list-style-type: none"> • If adolescent answered “yes” to being in a relationship: What do you like to do with your partner? Have you talked about sex? • If adolescent answered “no” to being in a relationship: Do you talk to your friends about sex? • Can substitute or add as a follow-up question: What do girls and girls OR boys and boys OR adolescents with disabilities do when they are in a relationship? • Who makes the decision in a relationship to have sex? • Would your partner reject you if you insisted on him wearing a condom? • Can a girl get pregnant after having sex once? Can a girl with disabilities get pregnant? Can a boy with disabilities impregnate a girl? • If a girl gets pregnant, who takes care of the baby? • At what age do girls get married? Whom do they marry? • At what age do boys get married? Whom do they marry? • Who makes the decision of whom a girl will marry? Who makes the decision of whom a boy will marry? • What are some of the influences (provide examples of influences: cultural, religious, family pressure, monetary, etc) that encourage girls to get married at a younger age? • What are some of the influences (provide examples of influences: personal goals, mentors, family values, etc) that prevent girls from getting married at a younger age? <p><i>Sexual Activity</i></p> <ul style="list-style-type: none"> • What different kinds of sexual activity are girls and boys having in the community? Are adolescents with disabilities and LGBTQIA+ adolescent populations involved in sexual activity? • Do you know of any adolescents having sex in the community? If yes, what do you think of it? At what age do boys start? At what age do girls start? Who are their partners? Are there boys who have sex with boys? Are there girls who have sex with girls? Are girls or boys with disabilities having sex and with whom are they having sex? • Have girls or boys [specify all subgroups] started having sex more, less, or about the same since the emergency began? Have their partners changed since the emergency began? • What are all the different reasons that adolescents have sex? • If your partner withdraws before ejaculating, can you get pregnant? • Can a girl get pregnant after having sex only one time? • What can happen after having sex? • What are ways to prevent becoming pregnant? • Are many girls becoming pregnant in the community? What are some reasons that girls in the community become pregnant? What are some of the influences (provide examples: personal goals, education, etc) that prevent girls from becoming pregnant? • Which kinds of sex are the most risky or dangerous? Why?
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<p>KAP questions on Relationships & Sexual Activity</p>	<ul style="list-style-type: none"> • Do you know any adolescents who have had sex for money, protection, or food? With whom do they have sex? What do you know and think about this kind of situation? Has this changed since the emergency began? • Have any of your friends had sex with someone who sells or exchanges sex for other goods or services? If yes, how many (a few, many, most, or all)? • Do you know of girls/boys [specify all subgroups] who were forced to have sex with others (soldiers, teachers, others in position of authority)? Has this changed for girls/boys since the emergency began?
<p>KAP questions on SRH services</p>	<p><i>Availability & Accessibility of SRH Services</i></p> <ul style="list-style-type: none"> • Have you seen (art, billboards, murals, pamphlets, etc) or heard (via radio and/or TV) any SRH information for adolescents specifically? • Have your teachers, parents, or health providers approached you to discuss matters related to you growing up, specifically in relation to puberty and general sexual and reproductive health? • What type of community adolescent and youth activities are you involved in? • Do you have sufficient access to menstruation products and contraceptive methods? If yes, where? • Do you find that your local health facility is accessible? Are the facility and the providers welcoming? If yes, why? If not, why not? Additional prompts: Do you need to pay for health services? Do you find your local facility accessible to adolescents with disabilities and LGBTQIA+ adolescents? If yes, why? If not, why not? • If you had a question about sexual or reproductive health, what would you do? Would you talk to someone about it? If yes, whom do you feel most comfortable discussing it with? If not, why not? • Where do you prefer to get information about sexual or reproductive health? • If you had a sexual or reproductive health problem, what would you do? Would you go to see someone? If yes, who would it be? If not, why not? <p><i>Quality of SRH Services</i></p> <ul style="list-style-type: none"> • Have you visited a health clinic to receive services in the last three months? • If yes, what types of services did you seek and/or receive? Where do you prefer to get health services? Why? How was your experience? <ul style="list-style-type: none"> • Was the receptionist nice to you? • Did you have to wait a long time for services? • How did the service provider treat you? • <i>Note: Look at additional Quality of Service questions from Annex 1: ASRH Health Facility Checklist.</i> • If no, why have you not visited a health clinic? <p><i>Contraceptive, Maternal & Newborn Health Services</i></p> <ul style="list-style-type: none"> • Where do girls go to get supplies to prevent pregnancy? Are the services free? Is it difficult or easy to get the supplies? • Is emergency contraception available in your community? If yes, where can you get it? • What type of supplies can girls use for contraceptive methods? What contraceptive methods can boys use? • Are girls with disabilities forced into sterilization? <i>Note: Explain term if adolescent is not familiar.</i>

KAP questions on SRH services

- If a girl has a baby, what health services are available? Where do they go?
- Are there programs or groups available to help girls with babies?
- Do girls understand the danger signs with their pregnancy and know when and where to seek care?

Abortion

- What do you think leads girls into having unwanted pregnancies during an emergency?
- Sometimes girls get pregnant when they do not want to. What do girls do when they are pregnant but do not want to be?
 - Are there traditional ways? What about other ways? Where do they access care?
 - How do community members feel about girls who want to end their pregnancy?
 - Does the local health facility or pharmacy provide abortion methods? If yes, do you know what methods they provide?
 - How do service providers feel about girls who want to end their pregnancy?
- Do girls in the community seek abortion services for unwanted pregnancies? Why or why not?
- Do girls in the community seek care for post-abortion complications? Why or why not?
- Are girls with disabilities in the community forced to get abortions?
- What role do you think boys or young men have in unwanted pregnancies and abortions?

STI Services

- What else can happen when you have sex with someone?
- Do you know of any infections one can get by having sexual intercourse? What kinds? Is there anything that a girl/boy can do to avoid getting these infections?
- If your partner withdraws before ejaculating, can you get a sexually transmitted infection (STI) or Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS)? *Note: Other terms for HIV/AIDS may be used depending on the context, consult with local organizations and community members to use appropriate terminology.*
- Do you think that girls and boys in the community are at risk of getting STIs? Why or why not?
- Have you heard about HIV/AIDS? Do you believe it exists? What can be done to prevent HIV/AIDS?
- Do you know what a condom is used for? What about a female condom?
- Have you been taught how to use a condom?
- Are condoms available for adolescents who are having sex [specify all subgroups]? If so, from where? Are adolescents using them? Do girls use them? Do boys use them? If not, why not? *Note: If adolescent is in a relationship and answered “yes” to having sex, ask if they use a condom and why or why not.*

KAP questions on SRH services

GBV Services

- What roles do girls have in your family and community? What roles do boys have? What roles do adolescents with disabilities and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual+ (LGBTQIA+) adolescents have in your family and community? *Note: Explain each of the terms if the adolescent is not familiar with any of the terms a part of LGBTQIA+. Do girls and boys both go to school?*
- What is violence? Are there different forms of violence? Has violence increased during the emergency or has it remained the same or decreased?
- Who are perpetrators of violence in a relationship? And in the wider community/ camp setting?
- Can someone touch another person without asking? Would you feel obligated to say “yes”? Or are you comfortable saying “no”?
- Can someone be forced to have sex? What is that called? *Note: If they are not familiar with the term “rape”, explain the term.*
- If a girl or boy was raped here, would she/he/they tell anyone? If yes, who? If not, why not? Would s/he/they go to anyone for help? If yes, who? If not, why not?
- If a girl or boy is hurt by someone else, where do they go? Whom do they talk to about it? Why or why not? Are there child safe spaces or female-friendly spaces that children and girls can go to?
- Are LGBTQIA+ adolescents and adolescents with disabilities in more danger of violence?
- Have girls or boys been trafficked since the emergency? *Note: If they are not familiar with the term “trafficked”, explain the term.*
- Whom do you talk to when you are sad, angry, or frustrated? Do you talk to health workers? Why or why not?
- Do you ever use tobacco, drugs, or alcohol? If so, where did you use them? With whom did you use them? How did you use them? (Smoked, inhaled, took pills, injected, chewed)

Sources: Adapted from [ASRH Toolkit for Humanitarian Settings](#) (UNFPA, Save the Children, 2012); [Young Women and Abortion: Situation Assessment Guide](#) (Ipas, 2011); [Guidelines for Disability Situation Analyses](#) (UNICEF, 2013); and [Situational Analysis of the Sexual and Reproductive Health of Women with Disabilities](#) (UNFPA, 2009).

ANNEX Q: Assessment Questions to Use with Community Members and Providers

This is a tool referenced in [Table 6](#) in Chapter 7: Data for Action. These questions are not an exhaustive list, but can be used and/or adapted for collecting information from parents, community leaders, and health workers via several assessments, such as situational analyses, focus groups discussions, individual interviews, and knowledge, attitudes, and practices (KAP) surveys. As a reminder, practitioners should ask different stakeholder groups questions pertaining to different adolescent population groups and adapt questions accordingly. We have added [\[specify all subgroups\]](#) for questions we recommend adapting for different subgroups of adolescents, as well as examples of adapted questions for adolescents with disabilities (including cognitive impairments and physical disabilities) and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual+ (LGBTQIA+) adolescents.

	Parents	Community Leaders	Health Workers
Knowledge, attitudes and behaviors of adolescents	<ul style="list-style-type: none"> Which family members or other adults can adolescents go to for support and advice? How would you start discussing SRH issues (puberty, menstruation, sex, and deciding when to have babies by using contraception or accessing abortion care) with your children? Can adolescents with disabilities get pregnant or impregnate someone? Do children with disabilities need SRH counseling and services? If yes, why? If no, why not? Do you have a child with disabilities? If yes, are you supported by family members, the community, and/or health facility to ensure your child has access to SRH care? If yes, what type of support do they provide? 	<ul style="list-style-type: none"> What is the community's attitude towards SRH programs for adolescents that are either currently being implemented or were implemented in the past? What is the average age of marriage for girls in the community? For boys? Has this changed since the emergency began? What are the reasons for marriage? How would you talk to an adolescent [specify all subgroups] who came to you with questions about SRH? What types of stigma do adolescents with disabilities and/or LGBTQIA+ adolescents face in the community? Can adolescents with disabilities get pregnant or impregnate someone? Do children with disabilities need SRH counseling and services? If yes, why? If no, why not? Are there children in the community with disabilities? If yes, is the family supported by the community and health facility to ensure children have access to SRH care? If yes, what type of support do they provide? 	<ul style="list-style-type: none"> How do you feel about providing SRH services to adolescents? Do you feel confident? Do you feel you have enough training? How do community members feel about you providing SRH services to adolescents? And adolescents with disabilities? Do you think adolescents are mature enough to make decisions about having sex and using contraceptive methods? Do you think adolescents with disabilities have the capacity to make decisions about their reproductive health needs? How do you feel about adolescents [specify all subgroups] using contraception, including emergency contraception? What about very young adolescents using long-term contraceptive methods? How would you describe adolescents' knowledge about correct condom use? Where do adolescents in the community seek treatment for STIs? Contraception? Prenatal care? Delivery care? Unwanted pregnancy? Post-abortion care? What do you do when an unmarried adolescent presents to the clinic with an STI? For Human Immunodeficiency Virus (HIV) counseling and testing? For contraception? For prenatal care? For delivery care? For an unwanted pregnancy and an abortion? For post-abortion complications? After a sexual assault? What do you do when a married adolescent patient comes to the facility for SRH services? What do you do when an unmarried adolescent patient comes to the facility for SRH services? How do you provide support to adolescents with disabilities who come to the facility for SRH services? Prompt: Are adolescents with disabilities forced into having abortions and sterilization?

	Parents	Community Leaders	Health Workers
Adolescent risks	<ul style="list-style-type: none"> • What can be done to reduce the number of adolescents [specify all subgroups] getting pregnant? • Are adolescents [specify all subgroups] in the community at risk for sexually transmitted infections (STIs)? Why or why not? • What kinds of traditional rites of passage or ceremonies are practiced in the community (female genital mutilation or cutting, forced marriage, abduction, wife-inheritance, etc)? Do these put adolescents at any risk? Why or why not? 	<ul style="list-style-type: none"> • Are adolescents [specify all subgroups] in the community at risk of STIs? Are they at risk of pregnancy? Why or why not? • How do adolescents in the community resolve conflicts? • Which adolescent populations are at risk of experiencing gender-based violence (GBV) in the emergency? Has this increased, stayed the same, or decreased? • Are girls at risk of being trafficked? • What additional risks do adolescents with disabilities and LGBTQIA+ adolescents face in relation to SRH needs and services? 	<ul style="list-style-type: none"> • Are you treating many adolescent girls for post-abortion complications due to unsafe abortions? If yes, why do you think this is happening? • What is the average age of first childbirth in the community? • Are adolescents with disabilities at increased risk for GBV? • What additional risks do adolescents with disabilities and LGBTQIA+ adolescents face in relation to SRH needs and services? • What kinds of rites of passage or traditional ceremonies are practiced in the community (female genital mutilation or cutting, forced marriage, abduction, wife-inheritance, etc)? What are the health impacts of these?
Accessibility and availability of ASRH information and services	<ul style="list-style-type: none"> • Where do adolescents [specify all subgroups] get information about SRH? • Where do you think that they should get this information? • Where can adolescents [specify all subgroups] go to get SRH services, including contraception and safe abortion care? • How do you feel about adolescents [specify all subgroups] having access to contraceptives and condoms? • How do you feel about adolescents [specify all subgroups] having access to safe abortion care? • What are the reasons that adolescents [specify all subgroups] might not seek care for SRH problems? 	<ul style="list-style-type: none"> • Where can adolescents [specify all subgroups] get SRH information and services including contraception? • Where do you think that adolescents [specify all subgroups] should get information about SRH? • Do adolescents [specify all subgroups] have access to contraception, emergency contraception, and condoms? How do you feel about this? • What are reasons that girls might choose not to have a baby? • Do adolescents [specify all subgroups] have access to safe abortion care? How do you feel about this? • What are the reasons that adolescents [specify all subgroups] might not seek SRH information and services? • What are the barriers to accessing SRH care for adolescents with disabilities and LGBTQIA+ adolescents? 	<ul style="list-style-type: none"> • How should the SRH needs of adolescents [specify all subgroups] in the community be addressed? • What health programs or opportunities have been designed to reach adolescents [specify all subgroups]? By whom were they designed? • What are the reasons that adolescents [specify all subgroups] might not seek care for SRH problems? • Outside of your health facility where else can adolescents' access SRH commodities and services? • If an adolescent [specify all subgroups] comes to your facility asking for a safe abortion, what do you do?

Sources: Adapted from [ASRH Toolkit for Humanitarian Settings](#) (UNFPA, Save the Children, 2012); [Young Women and Abortion: Situation Assessment Guide](#) (Ipas, 2011); [Guidelines for Disability Situation Analyses](#) (UNICEF, 2013); and [Situational Analysis of the Sexual and Reproductive Health of Women with Disabilities](#) (UNFPA, 2009).

ANNEX R: FGD Tip Sheet for ASRH

This is a tool referenced in [Table 6](#) in Chapter 7: Data for Action. In addition to the guidance for conducting assessments, below are some tips for conducting focus group discussions (FGDs) based on the [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings](#) and program experience.

Preparation & Planning

- **Train assessment team appropriately:** The assessment team should receive training on how to conduct an FGD with adolescents and youth, and the training should include having time to practice conducting FGDs. Asking questions to adolescents, similar to counseling, requires a different set of skills. The assessment team should use terminology that adolescents understand, provide easier questions to start the discussion, and be ready to provide information and/or referral to other services offered (particularly for gender-based violence [GBV] services, should a survivor disclose information and/or request those services).
- **Develop question guide/materials:** Prior to conducting the FGD, assessment team members should determine the objective of the discussion and how they plan to conduct the FGD. If using a question guide, develop the question guide ahead of time. The ideal number of questions to be asked during an FGD is 10–12. For other FGD methods (body mapping, photo elicitation, story-telling), make sure to bring all materials and have the discussion questions prepared.
 - For all FGD methods, assessment team members should ensure there is adequate time set aside for introductions, asking questions, allowing for in-depth discussion, and closing the discussion. If too little time is allocated or too many questions are asked, the information obtained from the FGD may be superficial and of little benefit to the program. In general, a minimum of two discussions should be held with each focus group and discussions should be held with additional participants within each focus group until no new information is obtained.
- **Obtain approvals and bring all materials:** The assessment team should ensure they have the correct approvals, bring all materials (including FGD guide for all staff), assent/consent forms, and decide who will be asking which questions.
 - At minimum, the team should have one person facilitating the discussion and one person taking notes. If you are not able to secure an assessment team member who speaks the same language as the participants, your team would also include a translator that has been trained in child safeguarding, security, and FGD protocols.
- **Select participants carefully:** Participants in a focus group should be of similar age and gender, have comparable levels of education, speak the same language, and be from similar socio-economic backgrounds. Discussions conducted as part of an assessment for an ASRH program, for example, may be held with separate focus groups of adolescent boys, unmarried adolescent girls, married adolescent girls, separated boys, etc. Be flexible to rearranging the groups—some adolescents may self-identify and choose to be a part of a different discussion group than you had planned (eg a very young adolescent [VYA] that is pregnant may choose to be with other pregnant adolescents/adolescent mothers, versus with other VYAs). The ideal number of participants per FGD is 8–10 persons. At minimum, there should be more participants than assessment team members.
- **Find a good space:** Choose a space where you can ensure audio and visual privacy. While preferred, indoor spaces are not always required if you can find spaces that still provide privacy to the participants.

Conducting the FGD

- **Introductions & purpose:** Make sure all staff introduce themselves, including the note taker and/or translator, prior to explaining the purpose of the FGD (including that their participation is voluntary and their responses will be kept confidential and anonymous). This creates a welcoming atmosphere for the adolescent participants. Obtain assent/consent. Establish some ground rules, including respect for each other's thoughts and views, and that everything shared in the discussion stays within this group.
- **Be careful with your words:** Do not make promises you cannot fulfill. If you are not sure when you will be able to return to talk again, do not provide false ideas of returning.
- **Promote inclusion:** As assessment team members, you are trying to make sure all participants feel welcome to share their point of view. If you notice one participant is more vocal than others, you can use techniques to encourage other people to share. Be careful not to force anyone to participate. Adolescents' input to these discussions is voluntary. Instead of asking a quieter adolescent to respond to the question, you might ask them what they think of the response of another participant. You can also bring items in that promote inclusion, such as a ball that adolescents pass to each other when they want to speak.
- **Use open-ended questions:** Avoid using yes/no questions. This is a discussion, not a survey. You want to encourage conversation among the participants. Also, remember to pause and allow time for silence. Participants may need time to reflect upon what you have asked or what others have said.
- **Come prepared for questions:** Should an adolescent need referral to other services, you should be prepared to tell them about those services and provide the necessary referral on site.
- **Ensure enough time to close:** The note taker should also be monitoring the time to provide the assessment team member who is facilitating the FGD a warning when they are reaching the end of the time. You want to make sure you have enough time to wrap up the discussion, provide a summary, and say goodbye.

After the FGD

- **Safeguard the data:** As discussed earlier, ensuring confidentiality and anonymity is paramount to conducting assessments with adolescents. You should make sure the notes, transcripts, audio tapes, consent/assent forms, and all other materials used during the FGD are kept under lock and key, and safely destroyed after they are no longer being used by the team.
- **Debrief and analyze results:** Debrief about the FGD in a private space. Understand that some of the findings may be difficult for staff to process and discuss, so be prepared to refer staff to the appropriate mental health services. Work with your team to analyze the results, discuss common themes (particularly if you completed multiple FGDs to compare against), and prepare a report with your findings.
- **Use the data:** You collected this data to serve a specific objective. Make sure to use the data, including adjusting programming or advocating for additional funding and/or expanding coverage. Your team should be consulting with adolescents, as well as community members (without breaking confidentiality).
- **Share your data appropriately:** Make sure you are coordinating information sharing with other agencies, including government staff, as appropriate. Your findings and/or recommendations could help inform other health, SRH, GBV, etc clusters and/or working groups, and should be shared through relevant humanitarian coordination mechanisms. Data should also be shared with adolescents and community members in an accessible, appropriate format.

Source: [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings](#) (IAWG, 2018); Programmatic experience from the [IAWG ASRH Sub-Working Group](#).

ANNEX RR: FGD Guide for ASRH

This is a tool referenced in [Table 6](#) in Chapter 7: Data for Action. Focus groups discussions (FGDs) can use a standard guide with questions, beginning with more general questions and slowly transitioning to the subject matter to discuss. This tool provides an example of an FGD conducted by Save the Children's Yemen team with adolescents—including adolescent girls who are married, adolescent girls who are unmarried, and adolescent boys. The FGD guide provides considerations and adjustments for each of the questions depending on the audience, as well as guidance for how to introduce, transition between topics, and close the FGD session.

To note: this in an example of an FGD from Save the Children's Yemen team. They did not use all of the questions listed below during their discussion with different adolescent groups, but these questions helped guide them in their discussion.

Selected FGD areas: Tuban, Hota, Radfan and Yafe. Tuban and Hota resemble urban populations and the socio cultural make up is similar. Radfan and Yafe represent rural populations. However, Radfan and Yafe do not have similar environments. The idea is to conduct one FGD for each of the mentioned areas. Each focus group can have a mixture of adolescents and youth.

Introduction: Thank you for participating in this discussion today. Your participation is voluntary. This means that you choose if you want to participate or not. If you decide you do not want to participate during the discussion, please feel free to leave at any time. [Instruction to facilitator: take consent form from Sheik before starting FGD.]

Today we will be talking about your experiences with health services in the community. We are interested in hearing about your opinions on health services and information offered to adolescents/youth in your community. There are no right or wrong answers to any of the questions. I will not ask about your personal experiences, but if you would like to share something that you feel may be of interest and are comfortable doing so, it may help our research. In addition, if there are any questions you do not feel comfortable answering, you are free to not answer. The ideas and opinions of everyone in the group are important to us. We ask that you respect each other's opinions. This means that we let each person speak and listen to what they have to say. We also ask that you keep everything that is said in this discussion private and that you do not share anything that is said in the discussion outside of this room. As I mentioned before, your name will not be written down and all answers will be kept confidential. The reason we are collecting this information is to understand your experience with health services our organization and other organizations offer to adolescents and youth and, where possible, make improvements to our services in response to the things you share with us.

Before we get started, does anyone have any questions? Great, thank you. Let us get started.

Introductory Questions

1. Could everyone go around and tell me your name and what you like to do for fun?
2. What is your typical day like?
 - a. Other ways of phrasing: how do you spend your day?
3. What do you want to do when you grow up? What are your goals?

Health Questions

4. When you get sick, what do you do?
 - a. Probe: Who do you talk to? Do you talk to your friends? Where do you find information about health?
5. Have you had any questions about your health or your body changing? If so, ask what questions.
6. Where do you go when you get sick?
7. Have you had to access services at the health clinic?
 - a. Probe: What for? What was your experience like (ask about service providers, safety getting to the clinic, can they get there without a caregiver)? Did you have to take someone with you to the clinic? If yes, who accompanied you to the health facility? Were you comfortable and able to ask your questions or was the discussion with the service provider done by the person who accompanied you?
 - b. If you have not gone to the health clinic to access services, why not?
8. What do you know about the changes going on in your body?
 - a. Probe - **Girls**: How does a girl's body change as they grow from a girl to a woman? What do these changes mean?
 - b. Probe - **Boys**: How does a boy's body change as they grow from a boy to a man? What do these changes mean?
9. Who do you go to when you want advice on issues with your body changing? Where do you access information on these topics? Probe further – Do you speak to peers/ friends for your information and advice? Do you check media or the internet? Please explain.

Early Marriage Questions

10. For asking **adolescent girls**: what roles do girls and women typically have in your community? What roles do boys and men have in your community? Have any of these roles changed recently or in the past years? Is there a change of roles for accessing health care services? Do you get permission readily to leave the house for services?
 - a. Use following questions for asking **adolescent boys**: What roles do boys and men have in your community? What roles do girls and women typically have in your community? Have any of these roles changed recently or in the past years? Is there a change of roles for accessing health care services?
11. What age do people usually get married in your community?
 - a. Probe: **Girls** – What age do girls in this area usually get married?
 - b. Probe: **Boys** – What age do boys in this area usually get married?
12. Do you know of girls and boys who get married before turning 18 years old? If so, why? Why do you think those boys or girls married? Was the decision his or hers or up to someone else?
13. What do you think of girls and boys getting married before 18 years old? Do you think it was a good idea for you to get married when you did? Would you prefer to get married later?
 - a. Use following questions for asking **unmarried adolescent girls**: Do you think this is a good practice or would you say that young girls should not get married at this age? What if the girl is getting married to an older man with resources? Is it a good idea then?
 - b. Use following questions for asking **adolescent boys**: Do you think boys getting married before 18 years old is a good practice or would you say that getting married before 18 years old should not happen? What if a young girl (below 18 years old) is married to an older man (20 years or older)? Is it a good idea then?
14. For **married adolescent girls**: how does getting married at a young age affect girls and boys in this area? Describe your life as a young married girl?
 - a. Use following questions for asking **unmarried adolescent girls**: If you get married at a young age, how does this affect your goals? Can you continue going to school if you get married young?
 - b. Use following questions for asking **adolescent boys**: If you get married at a young age, how does this affect your goals? Can you continue going to school if you get married young?

Conclusion: This concludes our focus group discussion. Thank you so much for coming and sharing your thoughts and opinions with us. As we said before, we hope to use the information you all provided today to improve health services for you and other adolescents and youth in this community. If you have any questions, please let us know.

Source: Focus Group Discussion for Adolescents in Yemen (Save the Children, 2019).

ANNEX S: Sample Job Description for ASRHR Coordinator

This is a tool referenced in the [Staff Recruitment, Support, and Responsibilities](#) section of the Chapter 8: Manager Guidance Notes & Tools. The job description is for the role of Adolescent Sexual and Reproductive Health and Rights (ASRHR) Coordinator.

Position Title:	ASRHR Coordinator
Employee Type:	Full-time
Supervisor Title:	Reproductive Health Manager

Role Purpose

<Name of Organization> is in the process of implementing an Adolescent Sexual and Reproductive Health & Rights (ASRHR) program in <Name of Location> in partnership with Ministry of Health and the Sexual and Reproductive Health (SRH) Sub-Cluster. This program is expected to address the ASRHR needs of young people, specifically improving their access to information and services to promote positive health and protection outcomes during and after <Name of Humanitarian Emergency> emergency. It is also expected the evidence from project implementation will inform policies and guidelines on ASRHR and support scale-up of ASRHR programming for adolescents and youth.

Scope Of Role

The ASRHR Coordinator will be responsible for ensuring smooth implementation of daily ASRHR project activities in <Name of Location> and to ensure that the goals and objectives of the program are met. This person will provide supervision to the ASRHR project team to ensure the project meets its objectives. The project will be supported closely by Health, Education and Child Protection programs to ensure holistic, high-quality services are offered to promote the well-being of adolescents in <Name of Location>.

Key Areas Of Responsibility:

Project Implementation

- Conduct meetings with community members, including with adolescents/youth, and key program stakeholders to secure buy-in and support for project implementation
- Conduct quarterly ASRHR Community Dialogue Sessions for the project
- Conduct trainings for health workers and Ministry of Health representatives on providing ASRH services
- Engage relevant stakeholders, including adolescents/youth, to identify ways to make health facilities and other service delivery points more adolescent/youth friendly

- Conduct outreach activities involving community health workers to provide mobile ASRH services, specifically targeting hard-to-reach adolescents and those at increased risk, such as married adolescents, pregnant adolescents or adolescent mothers, and adolescents with disabilities.
- Support recruitment, training, and supervision of youth volunteers to provide ASRHR information in schools, child-friendly/adolescent-friendly/girl-friendly spaces through IEC materials, games, and drama activities.

Partnerships for social mobilization

- Contribute to formation and operationalization of an ASRHR Technical Working Group to oversee and support provision of ASRH services in <Name of Location>.
- Develop and nurture partnerships with key Ministry stakeholders at national and county levels to ensure close collaboration with the government.
- Support meetings with Ministry of Health and other relevant ministries, such as Ministry of Education, to advocate for implementation of ASRH services and use project results to share learnings and, where relevant, update ASRHR policies and/or implementation of ASRHR activities.
- Develop partnerships with religious groups, women's groups, health care providers, community health workers, adolescent/youth groups, and other relevant community groups to orient them on the project goals and to solicit their involvement in project implementation.

Monitoring and evaluation

- Work with monitoring and evaluation colleagues and local research partners to conduct monitoring and evaluation activities, including conducting assessments, completing monitoring reports, and preparing documents and lessons learned.
- Ensure routine monitoring takes place and corrective action is taken where necessary, with adherence to the regulations set under each intervention.
- Support the development and implementation of adolescent participation and accountability mechanisms during the project.
- Facilitate dissemination of lessons learned, best practices, and operational research findings both within the organization and externally with adolescents/youth and community members in <Name of Location>; relevant government bodies; SRH Sub-Cluster partners; other international and local SRH organizations.

Grants management and reporting

- Oversee the implementation of the project work plan, including developing weekly/monthly action plans to stay on track of project implementation.
- Participate in grant review meetings.
- Prepare activity spending plans, and ensure project activities and outputs are completed.
- Oversee project activities and budget expenditures. Ensure expenditures are allowable and allocable according to organizational and donor regulations. Review monthly budget compared actual spending and expenditure sheets. Collaborate with the finance department to ensure accurate expenditures and reporting.

- Actively participate in generation of quarterly, semi-annual, and annual program performance reports.

Qualifications and Experience

- Bachelor of Science/Bachelor of Arts in Public Health, Community Health, Social Science, or related degree.
- Minimum five years of relevant professional work experience in the development, planning, and management of SRH projects with practical experience in overseeing, monitoring, and reporting on project outcomes, as well as operational research.
- Experience in community mobilization and implementing principles of adolescent engagement.
- Experience in developing effective working relationships with senior stakeholders from government agencies, international organizations, donors, NGO, academics, and opinion-leaders.
- Expertise in training health workers and community groups on ASRHR topics.
- Excellent communication and facilitation skills, including fluency in written and spoken English and strong interpersonal skills.

Competencies

- Possess high-level communication skills, including writing and formal public speaking skills.
- Ability to work effectively in a multicultural environment.
- Translates strategic direction into plans and objectives.
- Maintains and extends an effective network of individuals within the organization, as well as partnerships with government and development agencies.
- Proven ability to work as a team.

Source: Adapted from [IAWG ASRH Sub-Working Group](#) members' job description templates.

ANNEX T: ASRH in Emergencies Onboarding Plan

This is a tool referenced in the [Staff Recruitment, Support, and Responsibilities](#) section of the Chapter 8: Manager Guidance Notes & Tools. We collated a compendium of highly used resources in month one of the onboarding plan, but staff may refer to resources in later months, as needed for their work and responsibilities.

	Week one	Week two	Week three	Week four
Self-Reading	<p>Organization Mission and Country Strategy</p> <ul style="list-style-type: none"> [Placeholder for organizational resources, such as PowerPoints, capability statements, strategic documents, etc.] [Placeholder for organizational global and national ASRH mission, technical, and programmatic resources] [Placeholder for child safeguarding and prevention of/protection from sexual exploitation and abuse standard operating procedures] <p>Global ASRRH Resources and Tools</p> <ul style="list-style-type: none"> ASRH Toolkit for Humanitarian Settings and ASRH in Emergencies advocacy video <p>ASRH Programmatic Documents and Tools</p> <ul style="list-style-type: none"> Disseminated assessments via cluster system on www.humanitarianresponse.info website National ASRH policies and data statistics Prior agency proposals, work plans, and budgets (if applicable) Data forms–logbook templates, site baseline and site progress reports, and community engagement activities 	<p>Global ASRH Resources and Tools</p> <ul style="list-style-type: none"> Continue reading the ASRH Toolkit for Humanitarian Settings Begin reading/reviewing Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings Educate yourself/review Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (MISP) & MISP cheat sheet. Complete MISP distance learning course. Participate in ASRH in Emergencies training and/or go over IAWG ASRH Training Resources. <p>ASRH Programmatic Documents and Tools</p> <ul style="list-style-type: none"> Continue reviewing agency's ASRH proposals, work plans, budgets, and reports Continue reviewing local national SRH and ASRH policies and statistics Review existing ASRH training resources at the national level (if applicable), but also organizational ASRH training resources 	<p>Global ASRH Resources and Tools</p> <ul style="list-style-type: none"> Continue reading ASRH Toolkit for Humanitarian Settings Continue reading Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings Deep-dive into health system and/or community engagement content and evidence-base resources on SRH (e.g. Emergency Obstetric and Newborn Care [EmONC] and safe abortion care clinical guidance) <p>ASRH Programmatic Documents and Tools</p> <ul style="list-style-type: none"> Deep dive into local national clinical protocols (e.g. contraception and clinical management of rape guidelines and protocols) 	<p>Global ASRH Resources and Tools</p> <ul style="list-style-type: none"> Continue reading ASRH Toolkit for Humanitarian Settings Continue reading Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings Continue deep-dive into health system and/or community engagement content and evidence-base resources. (e.g. EmONC and safe abortion care clinical guidance) <p>ASRH Programmatic Documents and Tools</p> <ul style="list-style-type: none"> Deep dive into local national clinical protocols (e.g. contraception and clinical management of rape)
Activities	<ul style="list-style-type: none"> Meet with SRH Program Manager—short introduction to ASRH program and introduce the onboarding plan and go through relevant chapter sections of ASRH Toolkit with staff, as relevant to their position (e.g. providers—reviewing facility & counseling) Meet with Monitoring & Evaluation Manager—review country office data systems and ASRH data management plan and tools 	<ul style="list-style-type: none"> Check in meeting with SRH Manager—supportive supervision discussion looking at data and particularly looking at data to determine ASRH needs Seek out opportunity to observe/participate in an SRH clinical training or ASRH Values Clarification and Attitudes Transformation (VCAT) activity/training Meet with other technical response leads to understand their programmatic strategy and activities 	<ul style="list-style-type: none"> Check-in meeting with SRH Manager Attend SRH Sub-Cluster meeting at national and/or subnational level Field visit to intervention sites Meet with implementing partners Continue to seek out opportunity to observe an ASRH clinical training and/or VCAT trainings If applicable, support proposal development processes, create report narratives, conduct assessments, and disseminate content to stakeholders 	<ul style="list-style-type: none"> Check in meeting with SRH Manager Continue meetings with implementing partners Continue field visit to intervention sites If applicable, adapt training packages, facilitate workshops

Source: Adapted from [IAWG ASRH Sub-Working Group](#) members' onboarding tools.

ANNEX U: Sample ASRH Standalone Project Proposal

This is a tool referenced in the [Resource Mobilization](#) section of Chapter 8: Manager Guidance Notes & Tools. This tool provides guidance on what to include in different sections for a standalone ASRH project proposal.

<p><NAME OF PROJECT ON ADOLESCENT SEXUAL & REPRODUCTIVE HEALTH IN HUMANITARIAN SETTINGS></p> <p><NAME OF ORGANIZATION></p> <p><Start & End Dates of Proposed Project></p>
<p>Context</p> <ul style="list-style-type: none"> Describe, in one or two lines, the overall context of the current humanitarian emergency. Describe, in one or two lines, the conditions adolescents are facing during this emergency; for example, adolescents are experiencing displacement, loss of family, destruction of educational and recreational facilities, and lack of health services, etc. Describe, in two or three lines, the specific risks adolescents are facing due to the emergency; for example, adolescents are at increased risk of gender-based violence (GBV) and trafficking. Include pre-emergency indicators and data, if available, especially if these relevant indicators will impact ASRH in the current emergency; for example, existing high rates of child, early, and forced marriage or adolescent pregnancy may be heightened during the emergency.
<p>Proposed Intervention</p> <ul style="list-style-type: none"> State, in one or two lines, the proposed intervention and why the intervention is important given the above context. <ul style="list-style-type: none"> For example, “<NAME OF AGENCY> recognizes the threats adolescents face in <NAME OF EMERGENCY>. To address their dire health and protection risks, <NAME OF AGENCY> will provide critical ASRH services, including <NAME SERVICES AGENCY WILL PROVIDE>, in <NAME OF LOCATION(S)> over the course of <LENGTH OF PROJECT>.” Indicate, in one line, if the project will include other partner agencies, including any partnerships with government agencies. Explain how the project will meaningfully engage adolescents/youth, as well as community members, during the program cycle (design, implementation, and monitoring and evaluation).
<p>Project Goal</p> <ul style="list-style-type: none"> In one line, provide statement about the expectation of what should happen as a result of your program (the desired result). The project goal provides the foundation for developing your program objectives. <p>Examples include:</p> <ul style="list-style-type: none"> <NAME OF AGENCY> aims to decrease the unmet need for contraception among adolescents in <PROGRAM AREA> by <INSERT PERCENTAGE>.

Project Objectives & Activities

- Donor templates usually specify how objectives and activities should be outlined in the proposal. Pay close attention to their formatting and content requirements.
- Objectives describe the results your program aims to achieve and how they will be achieved. You typically need more than one objective to reach your project goal. Objectives should be SMART, or specific (includes who, what, and where), measurable (how much change is expected), achievable (realistic with program resources, planned implementation, and context), relevant (relates to program/activity goals and preferences of adolescents/youth), and time-bound (specifies when objective will be achieved).
- Examples of proposed objectives & activities are as follows:
 - Objective 1: By <MONTH/YEAR>, an increase of <PERCENTAGE> of adolescents and youth will use SRH services in <PROGRAM LOCATION> within <TIME PERIOD>.
 - Activities:
 - Collect baseline information from health facility on service uptake among adolescents and youth prior to implementing program activities
 - Consult adolescents and youth to develop and disseminate youth-friendly ASRH information materials, as well as provide feedback on ways to make service delivery points more adolescent/youth friendly
 - Identify adolescent-oriented distribution points for condoms, SRH information, and other SRH commodities adolescents request
 - Train and supervise health workers on providing health services responsive to adolescents’ needs
 - Implement recommendations from adolescents/youth to make health facility more adolescent/youth-friendly
 - Identify and train community health workers to ensure they link adolescents at increased risk (eg adolescents with disabilities, pregnant adolescents, etc) to health facilities for SRH services

Donors usually require a timeline in which activities will be completed. An example of a timeline is presented below this table.

Proposed Outputs

Output (or process) indicators measure activities conducted to complete specific outcomes.

Examples of proposed outputs include:

- XX health providers trained on ASRH
- XX health facilities that disaggregate data by age and gender
- XX referrals per month by community health workers trained on referring adolescents to health facilities

Proposed Outcomes

Outcome (or performance) indicators measure changes resulting from program activities, such as knowledge, attitudes, behaviors, or availability of services.

Examples of proposed outcomes include:

- Number of adolescent patients who received a form of modern contraception
- Number of adolescent patients with an unmet need for contraception
- Number of adolescent patients who received treatment for sexually transmitted infections
- Percentage of adolescent survivors of GBV receiving post-exposure prophylaxis

(For more examples of ASRH indicators, please see [Program Design](#) under Chapter 7: Data for Action.)

Example of Timeline:

This timeline is for SRH managers to use for implementation of activities. SRH managers should be also utilizing monitoring tools throughout the project. Monitoring tools and guidance can be found in the [Implementation & Monitoring](#) section of Chapter 7: Data for Action.

TIMELINE								
ACTIVITY	November				December			
	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
Conduct ASRH assessment								
Develop ASRH materials								
Distribute ASRH materials								
Train health workers on adolescent-friendly health services								
Establish youth-friendly health services								
Identify community health workers to refer pregnant adolescents to health facilities								
Monthly monitoring visits to youth-friendly health facilities								

Source: Adapted from [IAWG ASRH Sub-Working Group](#) members' project proposals.

ANNEX V: OCHA Flash Appeal Template

This is a tool referenced in the [Resource Mobilization](#) section of Chapter 8: Manager Guidance Notes & Tools. This tool provides guidance on what information and content to include in the different sections of a UN Office for the Coordination of Humanitarian Affairs (OCHA) Flash Appeal proposal template. While each donor has their own proposal guidelines, the guidance from this template may be helpful for completing other donor templates.

Appealing Agency(ies)	<Name of agency or names of agencies in consortium>
Project Title	Adolescent Sexual and Reproductive Health (ASRH) in the <Name of humanitarian emergency>
Project Code	XXX-XXXX <A code generated by OCHA or by your organization> [Look at proposal guidelines for filling out this section]
Sector or cluster	Health [You may be using a different sector than health, particularly if you are adding ASRH to a larger OCHA flash appeal]
Objective(s)	<ul style="list-style-type: none"> To increase availability of and access to adolescent sexual and reproductive health (ASRH) services in the affected area(s) To increase demand/awareness of ASRH services through community mobilization To meaningfully engage adolescents and community members in ASRH services
Beneficiaries	TOTAL: <Total number of beneficiaries> Children: <Total number of child beneficiaries> Women: <Total number of women beneficiaries> Other group (specify): <Provide the number of adolescents/youth and specify the age range> [Indicate the total number of beneficiaries your program aims to reach. OCHA may ask you to specify the number of child beneficiaries, women beneficiaries, or other groups, such as adolescents]
Implementing Partner(s)	<List all implementing partners your project aims to work with during the program period> [Depending on the donor guidance, this can be partners the agency will coordinate with or partners the agency will subcontract with. As this is an OCHA template, the guidance is to list partners to whom the agency will subcontract to as it is assumed that the agency will coordinate with partners in the humanitarian coordination system, such as partners working within the cluster system, Ministry of Health, other non-governmental organizations, etc.]

Project Duration	<Length of project>
Location	<Location(s) project will take place>
Priority	<Priority target group, intervention, or sector> [Based on the proposal guidance, this can refer to priority target group (girls between ages 15-19 years old); priority type of intervention (menstrual hygiene management); or priority sector (health, child protection, education)]
Project Contact Name:	<Provide contact information of Country Director or Team Lead> [In humanitarian settings, staff assignments can change quickly. You should provide contact information for someone with a more permanent role.]
Project Contact E-Mail:	<Provide an email address of Country Director or Team Lead> [In humanitarian settings, staff assignments can change quickly. You should provide email address for someone with a more permanent role.]
Project Contact Phone:	<Provide phone number of Country Director or Team Lead> [In humanitarian settings, staff assignments can change quickly. You should provide phone number for someone with a more permanent role.]

Needs:

<This must be tailored to the specific emergency. The OCHA proposal template should stipulate a word or page limit. Please see below for generic language that can be used for most ASRH proposals.>

Half of the 1.4 billion people living in countries affected by crises and fragile conditions are below 20 years of age. Today, with many of the current protracted crises lasting several years, adolescents can remain displaced or in need of humanitarian assistance for up to 20 years, extending well into adulthood and affecting their educational, economic, and health outcomes. Adolescents (and children who age into adolescence during a crisis) are tremendously impacted by humanitarian emergencies and require critical SRH services to prevent unwanted pregnancies and unsafe abortions; sexual violence, sexual exploitation, and physical abuse; mental health disorders; sexually transmitted infections (STIs); and overall morbidities and mortalities.

As they transition from childhood to adulthood, adolescents typically benefit from the influence of adult role models, social norms, and structures and community groups (peer, religious, or cultural). However, during natural and human-made humanitarian emergencies, these support systems are disrupted significantly—affecting adolescents’ ability to protect themselves and engage in safe and healthy practices, including SRH behaviors. During emergencies, adolescents are also exposed to a range of risks and hazards with which they are ill-prepared to cope. Adolescents can also have overlapping vulnerabilities, risks, and barriers based on a number of factors, including their living conditions. Humanitarian crises represent an additional layer of vulnerability for adolescents, who may already face risks or barriers due to their age, sex, gender identity, sexual orientation, health status, developmental stage, marital status, socio-economic conditions, and contextual and environmental factors.

In crisis situations, adolescents—especially girls—are at higher risk of sexual violence and sexual exploitation at the hands of fighting forces, community members, humanitarian workers, and uniformed personnel because of their lack of power, their lack of resources, and the use of rape as a strategy of warfare. Many adolescents, including younger adolescents, resort to selling sex to meet their own needs or their families’ needs. They may also be at risk of forced recruitment into armed forces or groups, which can increase their risk of sexual exploitation and abuse, STIs, and unwanted pregnancies due to high mobility and an increase in risk-taking behaviors—such as alcohol/drug abuse. Adolescents who live through crises may not be able to visualize positive futures for themselves and may develop fatalistic views about the future. This may also contribute to high-risk sexual behaviors and poor health-seeking behaviors.

Needs (Continued):

The needs, risks, and barriers of adolescent subgroups are exacerbated during emergencies and they require special attention. This is true of very young adolescents; pregnant adolescent girls, adolescents with disabilities; adolescents separated from their families (parents or spouses) and adolescent heads of households; survivors of sexual violence and other forms of gender-based violence; and adolescents selling or exchanging sex. Regardless of the source of their vulnerability, all at-risk subgroups of adolescents require particular attention and targeted interventions to ensure that their reproductive health needs are met.

Activities

SRH interventions save lives and are critically important during all phases of the humanitarian continuum. This project aims to ensure that the implementation of the Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (MISP) addresses the urgent SRH needs of adolescents. Adolescents are creative, passionate, resilient, and capable of exploring creative solutions in difficult situations; they have tremendous capacities that, when utilized appropriately and effectively, can play an instrumental role in their health outcomes. Thus, this project will meaningfully engage adolescents during each phase of the project. This project will also be carried out in close coordination with community members and the SRH Sub-Cluster under the Health Cluster.

- Consult with adolescents, youth, and community members on SRH needs and barriers affecting adolescents and youth in program location(s)
- Sensitize community health workers and health providers on ASRH needs and effective ways of working with adolescents—including recommendations from adolescents and youth from consultations—to ensure that SRH services offered to affected populations are responsive to adolescents’ needs and preferences;
- Support the availability of health personnel specializing in ASRH in outreach clinics and other facilities;
- Support community health workers in linking adolescents to health facilities, particularly for pregnant adolescents, adolescent mothers, and adolescents survivors of sexual violence;
- Mobilize youth volunteers and youth leaders to raise awareness of ASRH issues among their peers and refer them to specialized services;
- Utilize other entry points and distribution points for disseminating ASRH information and commodities—based on consultations with adolescents, youth, and community members;
- Alongside adolescents/youth, develop and disseminate adolescent/youth-friendly SRH information materials that target various adolescent subgroups.

Outcomes

- <NUMBER OF> health providers and community health workers trained on ASRH
- <NUMBER OF> community health workers trained on referring adolescents to specialized services
- <NUMBER OF> adolescent referrals from community health workers for ASRH services
- <NUMBER OF> adolescents who received SRH services prior to program activities compared to
- <NUMBER OF> adolescents who received SRH services at end of project
- <NUMBER OF> youth volunteers and youth leaders involved in outreach among their peers
- <NUMBER OF> SRH information materials and commodities distributed to <NUMBER OF> adolescents

To ensure adolescents are utilizing reproductive health services, the following key ASRH indicators will be monitored in the framework of this project:

- Number and percentage of STI patients treated <=19 years old (disaggregated by gender)
- Number and percentage of facility deliveries <=19 years old
- Number and percentage of new contraception users <=19 years old
- Method mix of contraception users <=19 years old
- Number and percentage of post-abortion care patients treated <=19 years old
- Number and percentage of safe abortion care patients treated <= 19 years old
- Number and percentage of sexual assault survivors receiving clinical care within 72 hours <=19 years old

Source: Adapted from [IAWG ASRH Sub-Working Group](#) members' project proposals.

ANNEX W: Guidance for Programmatic Considerations

This is a tool referenced in the [Resource Mobilization](#) section of Chapter 8: Manager Guidance Notes & Tools. This tool provides a table of guiding questions from the International Rescue Committee (IRC) for using ASRH assessment findings to determine staffing and budget needs.

Goal	Questions
<p>To determine whether you should budget for an ASRH focal point/ officer / manager</p>	<p>Based on the findings of your assessment, do any of your existing staff have the required knowledge, skills and supportive attitudes towards the provision of ASRH?</p> <p>Does the project team, in its current structure, have the capacity to coordinate and implement additional facility, community, and monitoring and evaluation activities necessary to implement ASRH programming? Or is additional support and/or staffing needed?</p> <p>Ideally, a new ASRH project would have ASRH staff dedicated to the project to ensure high-quality programming. If funding is restricted, staff working on SRH can be trained on ASRH and have part of their time dedicated to the ASRH project.</p> <p>IMPLEMENTATION CONSIDERATION: HIRING ASRH STAFF</p> <p>While having a dedicated ASRH person on all projects would help ensure prioritization and implementation of ASRH activities, this is not always feasible within program budgets and staffing structures. Be realistic with your budget. If your organization does not have sustained funding to support an ASRH position, think about instead advocating for a portion of time to be dedicated to ASRH from an SRH position. This person can be trained (using tools and resources from this toolkit) on how to provide SRH programming that is responsive to adolescents' needs.</p>
<p>To determine training needs</p>	<p>Based on the findings from your assessment, what additional trainings will health providers need? Your own agency staff, including those from other sectors? Community health workers? Community leaders? Adolescents? Local stakeholders?</p>

To determine health provider support	Does the project design integrate activities aimed at improving health provider attitudes and are these activities budgeted for? Are ASRH supportive supervision and data review activities included? Beyond the initial phase of the emergency, has your organization assessed social and gender norms that influence ASRH?
To determine what community-level activities are needed	What community level activities should be implemented for adolescents? For their parents and other adult influencers? Can they be integrated into existing community mobilization strategies and platforms?
To meaningfully integrate adolescent participation in the design, implementation and evaluation of the project	What are the costs associated with ensuring adolescent participation in initial assessments and project design meetings? If a participatory framework will be used, are the required participation, outreach, and coordination activities budgeted for?

Source: ASRH Program Guidance Note (IRC, 2019).

ANNEX X: Sample Budget for ASRH Project

This is a tool referenced in the [Budget Guidance & Design](#) section of Chapter 8: Manager Guidance Notes & Tools. This table provides a sample budget for an ASRH program. The table includes some of the essential budget categories and budget line items to submit for a new ASRH project. ASRH project budgets will increase or decrease based on the amount of funding available and the scope of the project. This illustrative ASRH project budget is for a 12-month project period and will provide ASRH activities in two locations. *Note: This sample budget for an ASRH project does not contain all potential ASRH activities SRH managers could implement during a humanitarian setting—only examples of some activities. It also does not contain overhead or indirect costs.*

Budget Line Item	Cost per unit	# of units	# of months	Total Cost
STAFFING				
ASRH Manager/Coordinator (100%)	<Salary per month>	1	12	<Cost per unit multiplied by # of units by # of months>
Two ASRH Officers (100%)	<Salary per month>	2	12	<Cost per unit multiplied by # of units by # of months>
Health Advisor (20%)	<Salary per month>	0.2	12	<Cost per unit multiplied by # of units by # of months>
Logistics Manager/Coordinator (10%)	<Salary per month>	0.1	12	<Cost per unit multiplied by # of units by # of months>
Logistics/Procurement Officer (15%)	<Salary per month>	0.15	12	<Cost per unit multiplied by # of units by # of months>
M&E Manager/Coordinator (10%)	<Salary per month>	0.1	12	<Cost per unit multiplied by # of units by # of months>
M&E Officer (15%)	<Salary per month>	0.15	12	<Cost per unit multiplied by # of units by # of months>

Driver (40%)	<Salary per month>	0.4	12	<Cost per unit multiplied by # of units by # of months>
PROGRAM COSTS				
Adolescent & Community Participation	Cost per unit	# of units	# of months	Total Cost
Community entry meetings	<Venue rental, materials, refreshments, stationery, & certificate costs per meeting>	4	2	<Cost per unit multiplied by # of units (number of meetings) by # of months>
Adolescent meetings	<Venue rental, materials, refreshments, stationery, & certificate costs per meeting>	2	12	<Cost per unit multiplied by # of units (number of meetings) by # of months>
Community Reporting & Feedback Hotline	<Cost of hotline technology, phone, and monthly service charge>	1	11	<Cost per unit multiplied by # of units (number of hotlines) by # of months>
End-of-project-results sharing meeting	<Venue rental, materials, refreshments, stationery, and certificate costs per meeting>	2	1	<Cost per unit multiplied by # of units (number of meetings) by # of months>
Trainings	Cost per unit	# of units	# of months	Total Cost
Venue	<Venue cost per participant>	115	1	<Cost per unit multiplied by # of units (number of participants and trainers) by # of months>
Refreshments & Meals	<Catering cost per person>	115	4	<Cost per unit multiplied by # of units (number of people per training – participants & trainers) by # of months>

Stationery	<Paper for participants to take notes cost>	100	1	<Cost per unit multiplied by # of units (number of stationery pads) by # of months>
Printing and photocopying	<Printing costs>	5	1	<Cost per unit multiplied by # of units (number of paper reams) by # of months>
Trainer per diem	<Per diem for each trainer>	15	1	<Cost per unit multiplied by # of units (number of trainers) by # of months>
Participants per diem	<Per diem for each participant>	100	1	<Cost per unit multiplied by # of units (number of participants) by # of months>
Information, Education, and Communication (IEC) Materials	Cost per unit	# of units	# of months	Total Cost
Consultant/graphic designer fees	<Cost for graphic designer contract>	1	1	<Cost per unit multiplied by # of units by # of months>
Printing & reproducing materials	<Printing costs>	2,500	3	<Cost per unit multiplied by # of units (number of IEC copies) by # of months>
Pilot testing of materials	<Per diem and transport for consultant & ASRH officers>	3	1	<Cost per unit multiplied by # of units (number of people) by # of months>
Distribution costs	<Transport stipend for youth volunteers>	40	10	<Cost per unit multiplied by # of units (number of youth volunteers) by # of months>

Youth-friendly health facilities	Cost per unit	# of units	# of months	Total Cost
Minor rehabilitation	<Installing privacy curtains costs>	2	1	<Cost per unit multiplied by # of units (privacy curtains) by # of months>
Furniture	<Chairs, tables, etc>	5	1	<Cost per unit multiplied by # of units (number of furniture pieces) by # of months>
Equipment & Supplies	<Cost of SRH commodities>	250	12	<Cost per unit multiplied by # of units (SRH commodities, eg contraception, menstrual pads, etc) by # of months>
Printing & reproducing forms (clinic forms & registers, patient charts, referral slips)	<Printing costs>	200	12	<Cost per unit multiplied by # of units (number of paper reams & printer cartridges) by # of months>
ASRH information/support group sessions	<Cost of refreshments, materials, and transport stipend>	2	9	<Cost per unit multiplied by # of units (number of groups sessions) by # of months>
Fuel for generator	<Cost of fuel per month>	0.50	12	<Cost per unit multiplied by # of units (fuel cost per month cost shared with other projects) by # of months>
Fuel for ambulance	<Cost of ambulance fuel per month>	0.50	12	<Cost per unit multiplied by # of units (fuel cost per month, cost-shared with other projects) by # of months>
Maintenance costs for generator & ambulance	<Cost of fuel maintenance per month>	0.50	4	<Cost per unit multiplied by # of units (maintenance cost per month, cost shared with other projects) by # of months>

Community Outreach	Cost per unit	# of units	# of months	Total Cost
Meetings with community health workers	<Refreshments cost per participant>	35	12	<Cost per unit multiplied by # of units (number of community health workers) by # of months>
Visibility materials	<T-shirts and backpacks>	70	1	<Cost per unit multiplied by # of units (number of t-shirts and backpacks) by # of months>
Transport costs	<Cost of monthly transport stipend per person>	35	12	<Cost per unit multiplied by # of units (number of community health workers) by # of months>
Stationery	<Paper for staff to take notes>	70	1	<Cost per unit multiplied by # of units (number of stationery pads) by # of months>
Printing SRH forms (CHW forms, referral forms)	<Printing costs>	350	10	<Cost per unit multiplied by # of units (number of printed forms) by # of months>
Youth Volunteers	Cost per unit	# of units	# of months	Total Cost
Bi-monthly meetings with youth volunteers	<Refreshment costs per meeting for 40 volunteers and ASRH officer>	4	12	<Cost per unit multiplied by # of units (number of meetings) by # of months>
Visibility materials	<T-shirts and pens>	80	1	<Cost per unit multiplied by # of units (number of t-shirts & pens) by # of months>

Stationery	<Paper for volunteers to take notes>	80	1	<Cost per unit multiplied by # of units (number of stationery pads) by # of months>
Printing & reproducing forms (attendance sheets, referral forms)	<Printing costs>	250	10	<Cost per unit multiplied by # of units (number of printed forms) by # of months>
Refreshments for peer education sessions	<Catering costs per person>	25	10	<Cost per unit multiplied by # of units (number of people) by # of months>
Outreach day events	<Cost per event for flyers, radio announcement, refreshments, venue rental, and materials>	2	4	<Cost per unit multiplied by # of units (number of events) by # of months>
Youth dance & theater	<Cost per event for flyers, radio announcement, refreshments, venue rental, costumes, and materials>	2	4	<Cost per unit multiplied by # of units (number of events) by # of months>
Youth representation at RH Working Group Meetings	<Transport stipend per person>	2	11	<Cost per unit multiplied by # of units (number of youth volunteer representatives) by # of months>
Monitoring & Evaluation	Cost per unit	# of units	# of months	Total Cost
Baseline Focus Group Discussions	<Costs of refreshments, printing, stationery, recording devices, local interpreters per discussion>	4	1	<Cost per unit multiplied by # of units (number of discussions) by # of months>

Monitoring visits	<Staff per diem and transport per visit>	2	10	<Cost per unit multiplied by # of units (number of monitoring visits) by # of months>
Mid-term evaluation	<Costs for refreshments, materials, and local interpreters>	1	1	<Cost per unit multiplied by # of units by # of months>
End of project evaluation	<Costs for refreshments, materials, and local interpreters>	10	1	<Cost per unit multiplied by # of units by # of months>
Project results dissemination workshop	<Costs for venue rental, refreshments, interpreter, materials, and certificates>	1	1	<Cost per unit multiplied by # of units by # of months>
TOTAL PROJECT COST				<Sum all costs>

Source: Adapted from [IAWG ASRH Sub-Working Group](#) members' project proposals/budget plans.

ANNEX Y: Sample Budget Notes for ASRH Project

This is a tool referenced in the [Budget Guidance & Design](#) section of Chapter 8: Manager Guidance Notes & Tools. This table provides a sample of budget notes for a new ASRH project, with brief explanations of budget categories for the budget provided in [Annex X](#). The budget notes provide guidance on line items and their associated costs.

ASRH Project Budget Notes & Justification
<p>Staffing</p> <p>The project will primarily be implemented by an ASRH coordinator and two ASRH officers, with technical support from the health advisor and operational assistance from logistics, monitoring and evaluation, and other support staff. The ASRH coordinator and two ASRH officers will be full-time. One ASRH officer will be solely dedicated to managing youth volunteers, while the other ASRH officer will be assigned to supervision of health facilities and community health workers. Due to the level of procurement and logistics involved with the project, the logistics manager/coordinator and the logistics officer will support the project at 10% and 15%, respectively. A driver will be covered at 40% of this project and cost-shared with other health projects. The monitoring and evaluation (M&E) manager/coordinator and M&E officer will be covered at 10% and 15%, respectively, to support routine field-monitoring activities, as well as the operational research and final project.</p>
<p>Program Costs</p> <p>Adolescent & Community Participation: The project will be initiated with adolescent and community meetings, and this budget line covers preparation of the adolescents and community meetings through radio mobilization; in-person meetings; invitations to adolescents and community representatives and, when applicable, through pamphlets; the cost of venue and refreshments for adolescents and members of the community who attend the meetings; printing of consent forms; stationery and recording devices to document the meetings; and provision for miscellaneous expenses, such as hiring interpreters, vehicle rental, or projector rental.</p>
<p>TIP FOR COMMUNITY MEETINGS</p> <p>Community meetings can hold a lot of surprises! Try to be as prepared as possible for any outcome. For example, there may be a lot of curious onlookers who decide to join the meeting. This is generally a good sign as more community participation is better than less involvement. It is important to ensure all who attend are comfortable during the meeting with adequate seating, refreshments and sign consent forms to participate. If laptops and projectors are being used, ensure there is a back-up source of power supply.</p> <p>A community and reporting feedback hotline will be established through a cellular network service. This budget line covers the cost of initiation for the hotline, the phone, and the monthly service charges.</p> <p>At the end of the project, results of the project will be shared with the community, with one meeting per community. This line, similar to the community participation budget line, covers cost of preparation for the meetings, cost of venue, refreshments, stationery, certificates, and provision for miscellaneous expenses.</p>

Trainings

Three major trainings will be held for three days each. The remaining trainings will be provided through supportive supervision and on-the-spot guidance. The first training will be for 20 health workers (10 from each community) and five representatives from the Ministry of Health for a total of 25 participants. The second training will be held for a total of 35 community health workers and the third training will be for 40 youth volunteers, 20 from each community. Training budget will cover cost of venue, refreshments and meals, stationery, printing and photocopying of materials, and any necessary per diems for participants and trainers (such as transport per diems).

IEC Materials

A consultant and graphic designer will be contracted to co-produce—alongside adolescents and youth—locally and culturally relevant information, education, and communication (IEC) materials. These materials will be pilot-tested with adolescents and youth, revised based on their feedback, and reproduced and distributed through bulk order, once every quarter (except for the first quarter of the project, as this time will be spent in developing the IEC materials) to ensure consistent supply of materials through the project.

Adolescent/Youth-Friendly Health Facilities

To ensure the health facility is responsive to adolescents' needs and meets the criteria for provision of discreet and confidential services, minor rehabilitation will be provided along with furniture, equipment, and supplies for the assigned health facilities at the two locations. The minor rehabilitation includes installing two curtains to increase privacy for adolescent health consultations. Stationery and reproducing of essential forms and registers—such as patient charts, ASRH register, clinic forms, referral slips, etc—will be provided on a quarterly basis to both health facilities. Support group and information sessions for adolescents will be held at the health facility to encourage adolescents to access clinic services for a total of 9 sessions, held approximately once a month. This budget line will cover refreshments, materials to share with the adolescents, and a small transport stipend if needed. This project will cost-share with other health projects to sustain the monthly supply of fuel for the clinics' generators to ensure 24-hour power supply and fuel for the ambulances at both sites. Likewise, cost-sharing will also apply for the maintenance of the generators and ambulances once a quarter.

Implementation Consideration

It is good practice for program implementation and for donor support to demonstrate cost-sharing of indirect costs wherever possible.

Community Outreach

Meetings will be held with community health workers once a month at both locations and this budget line will cover refreshments for the meetings. Visibility materials such as T-shirts and backpacks will be procured in lumpsum for 35 community health workers. Transport stipends will be distributed during the monthly meetings to ensure community health workers are able to access remote communities, as well as make frequent visits to health facilities to coordinate with health workers on referrals and targeted visits to new mothers and high-risk adolescents. Stationery supplies will be provided on a quarterly basis and forms such as referral sheets will be reproduced and distributed to the community health workers also on a quarterly basis.

Youth Volunteers

The ASRH Officer will hold meetings twice a month with youth volunteers at each of the two locations and this budget line will cover refreshments for the meetings. Visibility materials such as T-shirts and pens will be procured in lumpsum for the 40 youth volunteers. Stationery supplies will be provided on a quarterly basis, and forms such as attendance sheets and referral forms will be reproduced and distributed to the youth volunteers also on a quarterly basis. Refreshments will be procured every quarter for peer education sessions and stored in an agreed location for youth volunteers to access whenever peer education sessions are conducted. At each of the two locations, youth volunteers will conduct four outreach day events, approximately one per quarter for a total of eight events, and will also hold four youth dance and theater performances at each location, approximately one per quarter for a total of eight events. These budget lines cover costs for flyers; radio announcements and other publicity; rental of venue if needed; refreshments; and costumes. During the course of the project, two adolescents, one from each location, will be nominated by their peers to represent them at the monthly SRH Sub-Cluster meetings. These two adolescents will receive a transport stipend to attend the monthly meeting for the duration of the project (budgeted for 11 months, assuming the first month of the project will be when the adolescents are nominated).

Monitoring & Evaluation

Baseline focus group discussions will be held at the start of the project with four focus groups per location. This budget line covers refreshments for participants; printing of consent forms; stationery and recording devices to document the session; and hiring local interpreters if needed. Monitoring visits will be conducted by the M&E officer once a month at both locations for ten months, assuming the first month will be dedicated to gathering baseline information and the final month of the project will be end-of-project evaluation and results-sharing. A mid-term and end-of-project evaluation will be conducted, and these budget lines will cover a participatory approach to the evaluations, including refreshments for participants, interactive materials for participant involvement, and local interpreters if needed. The operational research will be conducted by an independent body, either consultants or university researchers, and will cover the costs of their fees, transport, accommodation, materials, and supplies required to conduct the research, enumerators, and interpreters, if needed. A one-day final project results-dissemination workshop will be held and attended by representatives from the Ministry of Health; nominated community members, including parents and teachers, community health workers and clinic health workers; nominated youth volunteers and adolescent representatives; and project staff. This budget line covers the cost of venue, meals and refreshments, local interpreter if needed, stationery for participatory exercises on next steps, and certificates.

Source: Adapted from [IAWG ASRH Sub-Working Group](#) members' project proposals/budget plans.

ANNEX Z: Action Plan Form

This tool is referenced in the [Program Implementation](#) section of Chapter 8: Manager Guidance and Tools. This sample Action Plan can be used during supervision visits, as well as for developing, conducting, and implementing program activities.

Activity	Target population	Required inputs, resources, approvals	Adolescent engagement	Monitoring activities & schedule	Time period	Impact/Outcome
Example: conduct ASRH training	Service providers at [insert name] clinic	Materials, staff time, approval from supervisors, venue fee, catering costs Work with finance team to develop budget for costs	Contact youth working group about reviewing training curriculum and/or participating in the training	Conduct assessment of health facilities every three months Look at facility registers to track uptake of ASRH services Schedule refresher training at one-year mark	April – May : plan for training, gather support and approval, prepare materials and budget Target date: June 2019	<ul style="list-style-type: none"> Increased knowledge and skills among service providers Improved quality of services for adolescents Increased uptake of ASRH services

Source: Adapted from [IAWG ASRH Sub-Working Group](#) members' actions plans.

RESOURCE TABLE

The Resource Table provides a list of all resources cited within the Toolkit by chapter. For a full list of all of the citations from each chapter, go to the [IAWG ASRH Toolkit website](#).

PREAMBLE & CHAPTER 1: INTRODUCTION		
Resource	Organization (Year)	Description
Convention on the Rights of the Child	United Nations Human Rights Office of the High Commissioner (1990)	The United Nations Convention on the Rights of the Child is a human rights treaty, which sets out the civil, political, economic, social, health, and cultural rights of children.
Genderbread Person	Killermann (2017)	A teaching tool for breaking the big concept of gender down into bite-sized, digestible pieces, using a figure of a gingerbread person and identifying the four components of gender.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (Chapter 3: MISP)	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.

CHAPTER 2: ROADMAP FOR USING THE ASRH TOOLKIT		
Resource	Organization (Year)	Description
Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings	UNFPA & Save the Children (2012)	The ASRH Toolkit for Humanitarian Settings provides information and guidance to advocate for ASRH and implement adolescent-inclusive SRH interventions. The toolkit is a Companion to the 2010 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.
IASC Guidelines on Working with and for Young People in Humanitarian and Protracted Crises	Task Force 1 of The Compact for Young People in Humanitarian Action (2020)	An easy-to-use field programming tool with principles, tips, and examples for how to plan, design, implement, and monitor interventions with and for young people along the humanitarian program cycle.

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (Chapter 6: ASRH)	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (Chapter 3: MISP)	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.

CHAPTER 3: MEANINGFUL PARTICIPATION		
Resource	Organization (Year)	Description
Adolescent and Youth Engagement Toolkit	No Lost Generation (2018)	This is a context-specific “how to” guide to support the engagement of young people within humanitarian and development programming within the Middle East and North Africa. It also outlines tools to promote and monitor adolescent and youth-led civic, social and economic engagement. Both sets of tools provide specific monitoring tools and promising practices.
Community Mapping ASRH	IRC (2018)	Community mapping example from IRC for adolescents groups, which was adapted from the IRC’s Participatory Action Research Guide for Adolescent Sexual and Reproductive Health.
Community Score Card	CARE (2013)	The Community Score Card is a two-way and ongoing participatory tool for assessment, planning, monitoring and evaluation of services. It is easy to use and can be adapted into any sector where there is a service delivery scenario. It is an exciting way to increase participation, accountability and transparency between service users, providers and decision makers.
Families Make the Difference: Parenting Implementation Guide	IRC (2016)	This is a “how-to” guide for implementing the Families Make the Difference Parenting Skills Program. It provides step-by-step guidance on how to set up and implement the program. This guide is based on the IRC’s experience of implementing parenting programs in Burundi, Liberia, Syria, Tanzania, and Thailand.

The Flower of Participation	CHOICE for Youth and Sexuality and YouAct (2017)	The Flower of Participation is a tool that uses the metaphor of a blooming flower to describe the different forms of meaningful youth participation and how meaningful youth participation can grow and flourish. The flower figure is based on the theory of the 'Ladder of Participation,' as developed by Roger Hart. (Roger Hart, Children's Participation – From Tokenism to Citizenship, UNICEF, 1992).
Girl Shine Caregiver Curriculum	IRC (2018)	The dedicated Girl Shine Caregiver Curriculum has been designed to be implemented with both female and male caregivers of unmarried adolescent girls. It provides complementary support to the Girl Shine Life Skills Curriculum.
I'm Here Approach	WRC (2016)	A series of steps and complementary field tools to help humanitarian actors reach the most vulnerable adolescent girls and be accountable to their safety, health, and well-being from the first days of a response to crisis.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (Chapter 3: MISP)	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Participatory Action Research for ASRH	IRC	This resource from IRC is one models for meaningful adolescent and community participation that could be used in humanitarian settings.
Partnership Defined Quality for Youth (PDQ-Y)	Save the Children (2011)	Partnership Defined Quality for Youth (PDQ-Y) is an approach for improving the quality and accessibility of services whereby young people are involved in defining, implementing, and monitoring the quality improvement process. The PDQ-Y process involves youth, health care providers, and other stakeholders working together to overcome the inadequacies of health services for youth.
Practical Tips on Engaging Adolescents and Youth in the COVID-19 Response	UNICEF (2020)	This brief provides practical tips for UNICEF country offices, partners and young people themselves on engaging adolescents and youth as part of the COVID-19 preparedness and response.

Safe Healing and Learning Spaces Toolkit	IRC (2016)	A Safe Healing and Learning Space (SHLS) is a secure, caring and predictable place where children and adolescents living in conflict and crisis settings can learn, develop and be protected. The SHLS Toolkit provides child protection and education practitioners with all of the content needed to initiate an SHLS program.
Session Plan for Participatory Meeting with Community Members Session Plan for Participatory Meeting with Parents	IRC (2018)	Guidance documents for program managers/community mobilizers on how to facilitate an interactive meeting with community leaders and parents on ASRH. These tools were adapted from IRC's They Know Best operational research study and Supporting Adolescents and their Families in Emergencies (SAFE) program model and resource package.
Shifting Power to Young People—How Young People Can Lead and Drive Solutions in Humanitarian Action	ActionAID & Restless Development (2019)	This report identifies lessons and good practice to shift power to young people in humanitarian action. The findings come from a collaboration between ActionAid and Restless Development.
Social Mapping ASRH	IRC (2018)	Social mapping example from IRC for adolescents groups, which was adapted from the IRC's Participatory Action Research Guide for Adolescent Sexual and Reproductive Health.
Supporting Adolescents and their Families in Emergencies (SAFE) Project Brief	IRC (2019)	SAFE is a protection and psychosocial support program model to strengthen the capacity of front-line actors so that adolescent girls and boys (ages 10-19) are safer, more supported, and equipped with positive coping strategies in acute emergencies. This website also links to SAFE's resource package.
They Know Best - Testing intervention packages to improve adolescents' access to and use of sexual and reproductive health services in emergencies	IRC (2020)	To respond to the need of adolescents in humanitarian settings, the IRC drew upon evidence-based best practices, as well as its experience in humanitarian settings, to test two different packages of interventions aimed at increasing access, use, and quality of ASRH services in two different chronic complex emergency settings in Nigeria and South Sudan.

Young People Advancing Sexual and Reproductive Health: Toward a New Normal	YIELD Project (2018)	In an effort to better understand the state of the field, the Youth Investment, Engagement, and Leadership Development (YIELD) project findings offer a stakeholder-led identification of promising practices, a description of multi-level impacts, and recommendations for the future. The Youth Participation Process Map (which the Toolkit adapted for Figure G) can be found on page 7 of YIELD's report, Figure 2.
Youth Participation Guide: Assessment, Planning and Implementation	Family Health International in collaboration with Advocates for Youth (2008)	The Youth Participation Guide seeks to increase the level of meaningful youth participation in RH and HIV/AIDS programming at an institutional and programmatic level. The target audience includes senior and middle management, program managers, staff involved in implementing activities, and youth who may be engaged at all levels of an organization's work. This Guide can also be adapted for use in other types of youth development programs.

Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response	Sphere (2018)	The Sphere Project, now known as Sphere, was created in 1997 by a group of humanitarian non-governmental organizations and the Red Cross and Red Crescent Movement. This fourth edition marks the 20th anniversary of The Sphere Handbook and includes new guidance for working in urban settings, for addressing Minimum Standards in protracted crises, and for delivering assistance through markets as a way to meet the standards. All technical chapters have been updated to reflect current practice, and the harmonized Core Humanitarian Standard replaces the previous Core Standards.
WHO Health System Building Blocks – Monitoring the Building Blocks of the Health Systems: A Handbook of Indicators and Their Measurement Strategies	WHO (2010)	This handbook provides a common monitoring and evaluation framework of health system strengthening efforts and is structured around the WHO framework that describes health systems in terms of six core components or “building blocks”: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance.

CHAPTER 4: PRIORITY ASRH IN EMERGENCIES ACTIVITIES

Resource	Organization (Year)	Description
Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings	UNFPA & Save the Children (2012)	The ASRH Toolkit for Humanitarian Settings provides information and guidance to advocate for ASRH and implement adolescent-inclusive SRH interventions. The toolkit is a Companion to the 2010 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (Chapter 3: MISP)	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Ready to Save Lives: SRH Care in Emergencies Preparedness Toolkit	IAWG (2020)	This toolkit—created by IAWG partners FP2020, IPPF, JSI, WRC, and UNFPA—is a preparedness toolkit for SRH care in emergencies. The purpose of the toolkit is to bring together existing learning and guidance as a starting point for stakeholders to begin SRH preparedness work.

CHAPTER 5: GOING BEYOND HEALTH SERVICES

Resource	Organization (Year)	Description
Adolescent Programming Toolkit	Plan (2020)	The guidance and tools from this resource are based on program evidence, numerous accounts from adolescents and good practices shared by frontline staff globally. It contains four chapters: 1) Why we should invest in adolescents in crisis settings; 2) Theory of Change to support adolescents to learn, lead, decide and thrive in crisis settings; 3) Programmatic Framework which presents our results framework and key interventions; and 4) Step-by-step Guide for programming with and for adolescents in crisis settings, with key considerations for reaching and supporting adolescent girls.
Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings	UNFPA & Save the Children (2012)	The ASRH Toolkit for Humanitarian Settings provides information and guidance to advocate for ASRH and implement adolescent-inclusive SRH interventions. The toolkit is a Companion to the 2010 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Menstrual Hygiene Management (MHM) in Emergencies Toolkit	Columbia University and International Rescue Committee (2017)	The toolkit looks at MHM from a multi-sectoral perspective and aims to give practical, streamlines guidance to humanitarian workers. The toolkit is co-published by 27 leading organizations that work in the humanitarian sphere. The toolkit is available in English, French and Arabic.

CHAPTER 6: ASRH SERVICES & INTERVENTIONS

ADOLESCENT-FRIENDLY HEALTH SERVICES

Resource	Organization (Year)	Description
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Menstrual Hygiene Management (MHM) in Emergencies Toolkit	Columbia University and International Rescue Committee (2017)	The toolkit looks at MHM from a multi-sectoral perspective and aims to give practical, streamlines guidance to humanitarian workers. The toolkit is co-published by 27 leading organizations that work in the humanitarian sphere. The toolkit is available in English, French and Arabic.
Ready to Save Lives: SRH Care in Emergencies Preparedness Toolkit	IAWG (2020)	This toolkit—created by IAWG partners FP2020, IPPF, JSI, WRC, and UNFPA—is a preparedness toolkit for SRH care in emergencies. The purpose of the toolkit is to bring together existing learning and guidance as a starting point for stakeholders to begin SRH preparedness work.

TRAINING AND CAPACITY BUILDING OF STAFF

Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences	Ipas (2014)	This toolkit is a resource for trainers, program managers and technical advisors who organize or facilitate training events and advocacy workshops in the field of sexual and reproductive health. It provides experienced trainers with the background information, materials, instructions, and tips necessary to effectively facilitate abortion values clarification and attitude transformation interventions.
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Abortion Attitude Transformation: A Values Clarification Toolkit for Humanitarian Audiences	Ipas (2018)	Ipas produced this online toolkit specifically for fragile and conflict-affected settings, designed to give humanitarian audiences the chance to explore their values, attitudes and knowledge related to abortion—with the goal of helping close the service-delivery gap in abortion care in humanitarian settings. This toolkit is designed to be a flexible resource that can serve training needs for a variety of audiences and settings. It is not a structured curriculum, but rather a collection of activities and materials that can be used individually or in combination, based on the timing and agenda of individual workshops as needed.
Abortion Attitude Transformation: Values Clarification Activities Adapted for Young Women	Ipas (2013)	This publication supplements Abortion care for young women: A training toolkit (Ipas, 2013). It modifies six values clarification and attitude transformation activities to focus specifically on young women and abortion. Facilitators wishing to use these modified activities are encouraged to first familiarize themselves with Abortion attitude transformation: A values clarification toolkit for global audiences and should also have completed training in young people's sexual and reproductive health and rights, or abortion care for young women.
Adolescent Sexual and Reproductive Health in Humanitarian Settings eLearning Course	UNFPA, Save the Children, IAWG ASRH Sub-Working Group (2016)	This one-hour interactive course provides an introduction to adolescents' SRH needs in humanitarian settings. You will be working in the fictional earthquake-stricken country of Loucra. Follow Kim from organization Project Youth as she meets adolescents affected by the earthquake and define which interventions should be put in place for and with them.
ASRH Operational Research Toolkit	IRC	This toolkit provides guidance and supplementary training on ASRH for community health workers.
Brief Sexuality-Related Communication: Recommendations for a Public Health Approach	WHO (2015)	This guideline provides health policy-makers and decision-makers in health professional training institutions with advice on the rationale for health-care providers' use of counselling skills to address sexual health concerns in a primary health care setting.
Comprehensive Reproductive Health and Family Planning Training Curriculum: MODULE 16: REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENTS	Pathfinder (2004)	This training manual is part of the Comprehensive Reproductive Health and Family Planning Training Curriculum for service providers. It is designed to prepare participants to provide quality reproductive health services to adolescents. It is to be used to train physicians, nurses, counselors, and midwives. Parts of the module may be adapted for use with CHWs or auxiliary workers. This module also includes counseling skills assessment checklist.

Core Competencies in Adolescent Health and Development for Primary Care Providers	WHO (2015)	This resource aims to help countries develop competency-based educational programs in adolescent health and development in both pre-service and in-service education. In addition, it provides guidance on how to assess and improve the structure, content and quality of the adolescent health component of pre-service curricula.
COVID-19 Response	IAWG (2020)	IAWG has collated a compendium of resources for COVID-19 response and implementation from numerous SRH humanitarian actors and IAWG sub-working groups.
Effective Training in Reproductive Health: Course Design and Delivery the Reference Manual and Trainer's Manual	Ipas (2011/2012)	The training manual is designed to be a resource for trainers who lead training-of-trainers courses in the field of reproductive health. It is designed to provide trainers with all of the instructions and materials they need to help learners strengthen their training, communication and facilitation knowledge and skills, and to enable them to plan and implement more effective training courses. The trainer's manual is intended for use along with its companion document, Effective training in reproductive health: Course design and delivery – Reference manual.
GREAT Scalable Toolkit	Pathfinder (2013)	The Scalable Toolkit is a set of tools created to bring fun and engaging activities that transform gender and reproductive health outcomes through a three-stage process: review of relevant programs, extensive formative research with adolescents, and the people who influence them, and a pretest of draft materials followed by revisions.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (Chapter 3: MISP)	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Providers as advocates for safe abortion care: A training manual	Ipas (2009)	Organized in four parts, this training manual aims to foster an advocacy perspective in health-care providers who are involved in delivering abortion and/or post-abortion care. The manual will help providers recognize their personal power as advocates and identify different circumstances and means to advocate for comprehensive abortion care to the full limits of the law.

Technical Brief on Strengthening the Capacity of Community Health Workers to Deliver Care for Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health	H4+ - UNAIDS, UNFPA, UNICEF, UN Women, WHO, and the World Bank (2015)	The objective of this technical brief is to orient country program managers and global partners as to key elements for strengthening the capacity of CHWs, including health system and programmatic considerations, core competencies, and evidence-informed interventions for CHWs along the SR/MNCAH continuum of care.
Training of Trainers' Package on ASRH in Emergencies for SRH Managers	IAWG (2019)	Training package to teach SRH managers, specialists, and coordinators about ASRH in Emergencies. The materials can also be adapted for health managers. The package is available in Arabic, English, Spanish, and French, and includes: <ul style="list-style-type: none"> - PowerPoint Slide deck with facilitator notes on each slide - Planning materials for facilitators - Group exercises (including VCAT exercises) and role-playing activities
Training Package on ASRH in Emergencies for Non-Health Staff	IAWG (2019)	Training package to teach non-health staff (such as child protection, education, shelter, etc.). The training is intended for a short session (half-day or less), but can be expanded with the other IAWG training materials to be more comprehensive. The package is available in Arabic, English, Spanish, and French, and includes: <ul style="list-style-type: none"> - PowerPoint Slide deck with facilitator notes on each slide
Training Package on ASRH in Emergencies for Service Providers, CHWs, and Health Support Staff	IAWG (2019)	Training package to teach service providers, CHWs, and health support staff. The package has an instruction sheet on how to modify the package for each of the audiences. The package is available in Arabic, English, Spanish, and French, and includes: <ul style="list-style-type: none"> - PowerPoint Slide deck with facilitator notes on each slide - Planning materials for facilitators - Group exercises (including VCAT exercises) and role-playing activities
Training Partnership Initiative	IAWG (updated continuously)	The IAWG Training Partnership Initiative (IAWG-TPI) was formed in 2006 to address clinical service gaps in the implementation of the MISP. Through the development of training materials and partnerships with key stakeholders and practitioners from within and across crisis-affected countries, the Training Partnership Initiative focuses on an integrated, inclusive, and comprehensive capacity development approach. This decentralized approach ensures the effectiveness and long-term sustainability of capacity development efforts.

Values Clarification and Attitude Transformation: Youth-Friendly Postabortion Care Supplemental Training Module Trainer's Manual	PAC Consortium (2012)	This training module is designed to be a supplemental to a comprehensive PAC health provider training. The goal of this module is to improve providers' abilities to offer high-quality PAC services to adolescent clients aged 10-19.
WHO Medical Eligibility Criteria for Contraceptive Use – Digital Application	WHO (2019)	WHO has launched an App for its Medical Eligibility Criteria for Contraceptive Use. This digital tool will facilitate the task of family planning providers in recommending safe, effective and acceptable contraception methods for women with medical conditions or medically relevant characteristics.
WHO Recommendations Intrapartum Care for a Positive Childbirth Experience	WHO (2018)	This comprehensive and consolidated guideline on essential intrapartum care brings together new and existing WHO recommendations that, when delivered as a package, will ensure good quality and evidence-based care—irrespective of the setting or level of health care. It introduces a global model of intrapartum care, which takes into account the complexity and diverse nature of prevailing models of care and contemporary practice.
FACILITY-BASED SERVICES		
The Abortion Self-Efficacy Scale	lpas (2020)	The Abortion Self-Efficacy Scale (ASES) is a 15-item tool designed to measure abortion self-efficacy at the individual and community level. The tool can be used as part of formative research to inform the design, content and messaging of interventions intended to increase abortion self-efficacy. It can also be used to measure changes in abortion self-efficacy over time. Additionally, ASES scores can be utilized to understand factors associated with abortion self-efficacy.
Adolescent Age and Life-Stage Assessment and Counseling Toolkit	USAID (2016)	The Adolescent Age and Life-Stage Assessment and Counseling tools present a set of tools and counseling cards for use by health providers and health workers who treat and counsel adolescent patients on a one-on-one basis at the health facility. This tool includes a set of 23 supplemental counseling cards on specific SRH topics that healthcare providers can use with adolescent patients for a more in depth counseling session.
Adolescent Job Aid: A Handy Desk Reference Tool for Primary Health Workers	WHO (2010)	The job aid's purpose is to enable health workers to respond to adolescents more effectively and with greater sensitivity. To do this, it provides precise and step-wise guidance on how to deal with adolescents when they present with a problem or concern regarding their health and development.

ASIST GBV Screening Tool	IRC, JHU (updated continuously)	IRC has worked with Johns Hopkins University since 2011 on the piloting, implementation and evaluation of the ASIST-GBV, a GBV screening tool developed by JHU specifically for use among women and older adolescent girls in humanitarian settings. This website includes a GBV screening implementation guide, feasibility and acceptability of universal screening and referral protocol for GBV and a research brief.
The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings (Third Edition)	Population Council (2015)	The Balanced Counseling Strategy Plus (BCS+) toolkit, developed and tested in Kenya and South Africa, provides the information and materials that healthcare providers need to offer complete, high-quality family planning counseling to patients living in areas with high rates of HIV and STIs.
Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings	WHO (2020)	This guide includes detailed guidance on the clinical management of rape and intimate partner violence survivors. It is intended for use by qualified health-care providers in developing protocols for the management of rape and intimate partner violence survivors in emergencies, taking into account available resources, materials, and drugs, and national policies and procedures. It can also be used in planning health-care services and training health-care providers.
Comprehensive Reproductive Health and Family Planning Training Curriculum: MODULE 16: REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENTS	Pathfinder (2004)	This training manual is part of the Comprehensive Reproductive Health and Family Planning Training Curriculum for service providers. It is designed to prepare participants to provide quality reproductive health services to adolescents. It is to be used to train physicians, nurses, counselors, and midwives. Parts of the module may be adapted for use with CHWs or auxiliary workers. This module also includes counseling skills assessment checklist.
Counseling Adolescents on Contraception (Level 2 Counseling for Adolescents)	Save the Children (2020)	Save the Children has developed a training package on the key principles and practices service providers can utilize daily in consultation and counseling sessions with adolescents and includes all materials for groups exercises, role-playing, and use of the GATHER Tool.
Cue Cards for Counseling Adolescents on Contraception	Pathfinder (2016)	The set of cue cards is designed to help a range of community- and facility-based providers to counsel adolescents and young people on their contraceptive options. The cue cards address: combined oral contraceptives, progestin-only pills, emergency contraception, male and female condoms, injectables, implants, intrauterine devices, and the lactational amenorrhea method.

Decision-making tool for family planning patients and providers	WHO (2005)	This is a multipurpose decision-making aid for patients: a decision-making aid for patients, a job-aid and reference manual for providers; a training resource. Its format allows easy interaction with patients – one page faces the patient (with simple information on key issues for the patient to consider) and a corresponding page faces the provider (with key points and detailed reference information). Health-care providers can use it step-by-step to help patients make informed choices that suit their needs.
Family Planning: A Global Handbook for Providers	WHO (2018)	This book, Family Planning: A Global Handbook for Providers, offers technical information to help health care providers deliver family planning methods appropriately and effectively. It incorporates and reflects the Medical Eligibility Criteria and the Selected Practice Recommendations as well as other WHO guidance.
A Guide to Family Planning for Community Health Workers and Their Patients	WHO (2012)	This flipchart is a tool to use during family planning counselling or in group sessions with patients. It can help your patients choose and use the method of family planning that suits them best; give you the information you need for high-quality and effective family planning counseling and care; help you know who may need referral.
Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook	WHO (2014)	This handbook is for health-care providers. It can provide care for women who have been subjected to violence. This can be physical, sexual or emotional violence whether by a partner or in the case of sexual violence by any perpetrator. It includes the LIVES method to support counseling efforts in facilities.
Inclusion of Diverse Women and Girls Guidance Note	IRC (2019)	This guidance note accompanies the IRC GBV Emergency Preparedness and Response model, assessment tools, and training package and is not recommended for use as a standalone resource on diversity and inclusion. This resource addresses a gap in the proactive inclusion of diverse women and girls within GBV response and can be used as part of the GBV emergency response model to support GBV actors to examine their own attitudes, skills and knowledge, and take concrete actions to reach and support diverse women and girls throughout GBV emergency preparedness and response programming.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (Chapter 3: MISP)	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Inter-Agency Standing Committee (IASC) Guidelines for Integrating Gender-Based Violence (GBV) Interventions in Humanitarian Action	IASC (2015)	The Guidelines for Integrating GBV Interventions in Humanitarian Action were developed to assist humanitarian actors and communities affected by armed conflict, natural disasters and other humanitarian emergencies to coordinate, implement, monitor and evaluate essential action for the prevention and mitigation of gender based violence (GBV) across all sectors of humanitarian action.
MISP: A Distance Learning Module	IAWG (2019)	This self-instructional learning module is based on the 2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, “Chapter 3: Minimum Initial Service Package.”
Mobile Health Units: Methodological Approach	ICRC (2006)	This publication presents practical guidelines for setting up the mobile health units to provide this ad-hoc out-patient care. It presents useful lessons learned and best practices and will be of interest to all those responsible for medical programs.
Providing Inclusive Care for LGBTQ Patients: A Resource Guide for Clinical Settings	Essential Access Health	This resource toolkit is designed to assist healthcare agencies in meeting the needs of their lesbian, gay, bisexual, transgender and queer (LGBTQ) patients.
Providing Inclusive Services and Care for LGBT People: A guide to healthcare staff	National LGBT Health Education Center (2016)	This guide has been developed to help health care staff provide an affirmative, inclusive, and respectful environment for all clients, with a focus on lesbian, gay, bisexual, and transgender (LGBT) people.
Referral Systems	WHO	This document contains summary of key processes to guide health services managers in providing health service referrals.
The Referral System Revised	USAID (2012)	This document outlines a referral strategy, covering health system issues as well as roles and responsibilities of both the referral initiating and referral receiving facilities. In addition, the document lays out strategies that are needed for supervision and capacity building that are critical for making the referral mechanism fully functional. The document also highlights the importance of continuous quality improvement, including patient safety and rights within the referral system.

Reproductive choices and family planning for people living with HIV counselling tool	WHO (2007)	This tool is designed to help health workers counsel people living with HIV on sexual and reproductive choices and family planning. It also is meant to help people living with HIV make and carry out informed, healthy, and appropriate decisions about their sexual and reproductive lives. This tool is part of the WHO materials on Integrated Management of Adolescent and Adult Illness.
Standards for improving the quality of care for children and young adolescents in health facilities	WHO (2018)	The standards are based on the eight domains of the framework for improving the quality of care and address the most common conditions that affect children and adolescents in health facilities. The standards delineate what is expected in order to respect children's rights: ensuring child, adolescent, and family-friendly health facilities and services; evidence-based clinical care; availability of child and adolescent-specific appropriate equipment; appropriately trained, competent staff. The standards include health facility measures to facilitate implementation, to track improvement and to monitor performance.
Training Partnership Initiative	IAWG (updated continuously)	The IAWG Training Partnership Initiative (IAWG-TPI) was formed in 2006 to address clinical service gaps in the implementation of the MISIP. Through the development of training materials and partnerships with key stakeholders and practitioners from within and across crisis-affected countries, the Training Partnership Initiative focuses on an integrated, inclusive, and comprehensive capacity development approach. This decentralized approach ensures the effectiveness and long-term sustainability of capacity development efforts.
WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights	WHO (2019)	The purpose of this guidance is to develop a people centered, evidence-based normative guideline that will support individuals, communities and countries with quality health services and self-care interventions, based on PHC strategies, comprehensive essential service packages and people-centeredness.
WHO Quality of Care for Maternal and Newborn Health: A Monitoring Framework for Network Countries	WHO (2019)	This Monitoring Framework provides basic guidance on the monitoring and evaluation (M&E) needs for the Network for Improving Quality of Care for Maternal, Newborn and Child Health (the Network).The Monitoring Framework aligns with the Network goals, strategic objectives, implementation framework and WHO standards for improving maternal and newborn care in health facilities (2016) and the WHO standards for improving quality of care for children and young adolescents in health facilities (2018).

WHO Quality of Care in Contraceptive Information and Services, Based on Human Rights Standards: A Checklist for Health Care Providers	WHO (2017)	This document presents a user-friendly checklist specifically addressed to health care providers, at the primary health care level, who are involved in the direct provision of contraceptive information and services. This checklist also builds on WHO vision document on Standards for Improving Quality of Care for Maternal and Newborn Care and its ongoing work under the Quality, Equity and Dignity initiative. The checklist should be read along with other guidance from WHO and also from partners.
COMMUNITY-BASED SERVICES AND OUTREACH PLATFORMS		
Advocating for Change for Adolescents Toolkit	Women Deliver (2018)	This toolkit—developed by and for young people—provides guidance to youth networks on the design, implementation, and monitoring of an effective national advocacy action roadmap on adolescent health and well-being. It aims to encourage meaningful engagement of youth and drive positive advocacy and accountability efforts to influence national health plans and policy processes.
AMAL initiative: Adolescent Mothers Against All Odds—Unleashing the Power of Adolescents in Fragile Settings	CARE, UNFPA, Syria Relief & Development (2020)	This toolkit has been designed for humanitarian practitioners working in crisis-affected and fragile settings with the goal of supporting married adolescents, particularly pregnant adolescents and first-time mothers, to practice healthy timing and spacing of pregnancies and improve their overall sexual and reproductive health well-being.
Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving CHW Programs and Services	WHO & USAID (2013)	The USAID Health Care Improvement Project created the CHW AIM Toolkit to help ministries, donors, and NGOs assess and strengthen their community health worker programs to improve their functionality. This guide provides an overview of the Community Health Worker Assessment and Improvement Matrix (CHW AIM) implementation process, the functionality model, and the four steps to adapt, plan, conduct, and follow up a CHW AIM program assessment as well as guidance on the contents and use of the toolkit.
DO's & DON'Ts for Engaging Men & Boys	Population Reference Bureau for the Intergovernmental Working Group (2020)	The IFWG developed specific guidance for how to engage men and boys in health promotion and gender equity programming. Now Available in French, Portuguese, and Spanish.

Gender Integration Continuum	Interagency Gender Working Group (2017)	This tool shows how practitioners can go from gender-blind to gender-aware programming—with the aim of equality and better development outcomes.
Girl Empower Impact Evaluation	IRC (2020)	The Girl Empower Impact Evaluation assessed mentoring and cash transfer intervention to promote adolescent wellbeing in Liberia.
Girl Empower Program	IRC (2016)	The Girl Empower program was implemented by the IRC in Liberia in 2016. The program aimed to equip adolescent girls with the skills and experiences necessary to make healthy, strategic life choices and to stay safe from sexual violence. It also tested additional impact of a conditional cash transfer to families, based on girls' attendance at mentorship sessions.
Grand Bargain	IASC (2016)	This agreement between some of the largest humanitarian donors and agencies, signatories gathered with the goal of finding and increasing support for local and national responders. With this agreement, signatories committed to investing in local efforts—including working with local organizations—as much as possible and as necessary, while continuing to recognize the vital role of international actors, in particular in situations of armed conflict.
Included Involved Inspired: A Framework for Youth Peer Education Programmes	IPPF (2007)	This framework is a guide and builds upon, and complements, existing frameworks and provides an IPPF perspective on peer education. It includes numerous tools and can be used by program designers, managers and coordinators, as well as by senior managers overseeing larger peer education initiatives. Supervisors, trainers and other young people can also use this framework in their work, and as a basic reference tool.
Institute for Reproductive Health	Georgetown University (updated continuously)	Through partnership with international and local organizations, the Institute for Reproductive Health (IRH) at Georgetown University strives to expand family planning choices to meet the needs of women and men worldwide; advance gender equality by helping women and men across the lifecycle learn about and take charge of their reproductive health; and involve communities in reproductive health interventions that improve their wellbeing. The website includes a compendium of evidence-based resources, tools and guidance for program implementation.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.

Investing in Youth Impact: A Toolkit on Funding for Youth-Led Organizations	CHOICE for Youth and Sexuality (2019)	This toolkit is for youth-led organizations learning how to fundraise, as well as for youth-serving organizations working with youth-led organizations to understand the issues faced by their partners/grantees.
It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV, and Human Rights Education	Population Council (2009)	This resource is designed primarily for curriculum developers, schoolteachers, and community educators responsible for education in the areas of sexuality or sexual health (including AIDS) and civics or social studies. Users may draw on the guidelines and activities in this kit to meet their needs.
Marriage is Not a Game	Resource Center for Gender Equality in Lebanon & UNICEF (2014)	An animated video to educate adolescents, youth, parents, caregivers, providers, and other audiences on the risks associated with early marriage. The video combines key messages based on field testing and focus group discussions with the story of a young girl who faces the negative outcomes of an early marriage.
Meeting the Sexual and Reproductive Health Needs of Adolescent Girls in Humanitarian Settings (conference presentation)	WRC, UNICEF (2019)	A presentation by WRC on the WRC/UNICEF virtual safe space project. This presentation was provided at the SVRI Conference in Cape Town, South Africa, on October 22, 2019.
Menstrual Hygiene Management (MHM) in Emergencies Toolkit	Columbia University and International Rescue Committee (2017)	The toolkit looks at MHM from a multi-sectoral perspective and aims to give practical, streamlines guidance to humanitarian workers. The toolkit is co-published by 27 leading organizations that work in the humanitarian sphere. The toolkit is available in English, French and Arabic.
MISP: A Distance Learning Module	IAWG (2019)	This self-instructional learning module is based on the 2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, "Chapter 3: Minimum Initial Service Package." The module is currently available in English.
Mitigating Risks Across the Project Cycle: IRC Research Toolkit	IRC	This document provides guidance for those conducting human subjects' research on ways to mitigate risks to participants across the project cycle, from inception to close-out, especially minimizing risks with vulnerable populations involving children.

Ready to Save Lives: SRH Care in Emergencies Preparedness Toolkit	IAWG (2020)	This toolkit—created by IAWG partners FP2020, IPPF, JSI, WRC, and UNFPA—is a preparedness toolkit for SRH care in emergencies. The purpose of the toolkit is to bring together existing learning and guidance as a starting point for stakeholders to begin SRH preparedness work.
Regional Comprehensive Sexuality Education Resource Package for Out of School Young People	UNFPA (2018)	The Regional Comprehensive Sexuality Education Resource Package for Out of School Young People was developed to age and developmentally relevant international standards as a comprehensive set of teaching and learning materials for flexible use in settings outside the formal classrooms of the education sector. Several countries of East and Southern Africa have adapted this regional set of materials for nationally endorsed implementation. The content is also available in French and will soon be available in Portuguese.
SBCC for Emergency Preparedness Toolkit	Johns Hopkins University (2016–2020)	The purpose of the Social and Behavior Change Communication (SBCC) for Emergency Preparedness Implementation Kit is to provide a set of key considerations for SBCC activities in emergency situations.
Sendai Framework	UNISDR (2015)	As the first major agreement of the post-2015 development agenda, this framework provides Member States with concrete actions to protect development gains from the risk of disaster. The United Nations International Strategy for Disaster Reduction (UNISDR) has been tasked to support the implementation, follow-up and review of the Sendai Framework and coordinates action within the UN system around disaster risk reduction to make this happen. The UNISDR has endorsed children’s active participation in disaster risk reduction (DRR) activities.
Series of videos on ASRH messages	CARE (2020)	CARE recently developed a series of videos on ASRH messages for Syrian and Jordanian adolescents living in Jordan to show at community centers and initiate dialogues around adolescent pregnancy, child marriage, puberty, and fertility awareness.
Social Analysis and Action (Ideas and Action: Addressing the Social Factors that Influence SRH)	CARE (2007)	CARE has developed an approach called social analysis and action (SAA), which seeks to address the social, economic and cultural factors that influence health. This booklet—designed for CARE program planners and managers—explains SAA at both a conceptual and practical level.
Strategies Guided by Best Practice for Community Mobilization	Advocates for Youth (2014)	This document summarizes 14 key strategies that are based on best practices in community mobilization, collaborative partnerships, and coalition building. In Part A, grantees will find that many of these strategies overlap with best practices for engaging key stakeholders and best practices for working in diverse communities.

Supply Chain Models and Considerations for Community Based Distribution Programs: A Program Manager’s Guide	JSI (2010)	The purpose of this document is to provide guidance in the design of supply chain model systems for community-based distribution programs. This guide presents four models for these programs, as well as guidance on supply chain functions, including logistics management information systems, inventory control systems, storage, distribution, and capacity building, that can be adapted and applied to a variety of country contexts.
Urban Adolescent SRH SBCC Implementation Toolkit	Johns Hopkins University (2016)	The purpose of the Urban Adolescent Social and Behavior Change Communication Implementation Kit (I-Kit) is to provide a selection of Essential Elements and tools to guide the creation, or strengthening, of sexual and reproductive health (SRH) social and behavior change communication (SBCC) programs for urban adolescents aged 10 to 19.
Whole School Approach for Sexuality Education	Rutgers (2012)	The Whole School Approach manual called ‘We All Benefit’ describes the steps to implement and improve sexuality education at schools, create ownership of all involved and increase the coverage of students. The manual also contains useful checklists, tips and a toolkit to raise the impact of the approach.
Youth-Led Organizations and SRH and Rights: A Step-by-Step Guide to Creating Sustainable Youth-Led Organizations Working on Sexual and Reproductive Health and Rights	CHOICE for Youth and Sexuality (2009)	This guide provides guidance on building a sustainable youth-led SRH organization, examining key lessons learned related to ensuring the sustainability of youth-led SRH organization, and overcoming challenges faced by youth-led organizations.
Youth Peer Education Toolkit: Standards for Peer Education Programmes	FHI 360 (2005)	This guide can be used by program designers and program managers, as well as by top managers overseeing larger peer education initiatives. It is also a basic reference and guidance tool for supervisors, trainers, and peer educators themselves.
Youth Power Community of Practice for Gender and Positive Youth Development	Youth Power (2015, updated continuously)	A community of individuals working to promote integrated youth-centered and gender transformative programming through positive youth development. The Gender and PYD Community of Practice has worked through collaboration, dialogue, and collective sharing and learning about innovative and promising practices, what works, how to measure efforts, and how to support each other in applying what we learned.

Y-PEER	Y-PEER (2011)	The Y-PEER youth peer education network of organizations and institutions, working in the field of sexual and reproductive health in 52 countries throughout the world. Y-PEER's mission is to strengthen and spread high quality peer-to-peer education in the field of ASRH and HIV prevention worldwide. Y-PEER was established to support, provide information and train young people on number of issues, in particular SRH and rights issues.
MULTI-SECTORAL LINKAGES AND REFERRAL PATHWAYS		
3/4/5 W Matrix Template	OCHA Humanitarian Response (2015)	Humanitarian coordination system actively utilizes the WHO does WHAT, WHERE, WHEN and for WHOM (3/4/5 W) matrix template to ensure all activities and services among humanitarian actors and cluster system are coordinated.
Inter-Agency Referral Form and Guidance Note	IASC Reference Group for MHPSS in Emergency Settings (2017)	This document includes a referral form that is intended to be used by humanitarian organizations working with persons with MHPSS problems. The referral form and guidance note are tools to facilitate inter-agency referrals, referral pathways, trainings and workshops, and as a means to document referrals in accordance with minimum standards. The referral form and guide can be used by any service provider for example, by a Doctor working in a primary healthcare center referring a child to a child friendly space.
Sendai Framework	UNISDR (2015)	As the first major agreement of the post-2015 development agenda, this framework provides Member States with concrete actions to protect development gains from the risk of disaster. The United Nations International Strategy for Disaster Reduction (UNISDR) has been tasked to support the implementation, follow-up and review of the Sendai Framework and coordinates action within the UN system around disaster risk reduction to make this happen. The UNISDR has endorsed children's active participation in disaster risk reduction (DRR) activities.
UN Sustainable Development Goals	UN (2015)	The sustainable development goals (SDGs) are the world's shared plan to end extreme poverty, reduce inequality, and protect the planet by 2030. The 17 SDG's are a shared blueprint for peace and prosperity and are an urgent call for action by all countries - developed and developing - in a global partnership. The SDG's recognize that ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality, and spur economic growth—all while tackling climate change and working to preserve our oceans and forests.

CHAPTER 7: DATA FOR ACTION		
Resource	Organization (Year)	Description
Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services	Save the Children, WRC, UNFPA, UNHCR (2012)	This report is a result of an extensive mapping exercise of ASRH services in humanitarian settings and provides technical guidance and documentation of good practices in the field of ASRH in humanitarian contexts.
Adolescent SRH Programming in Humanitarian Settings: Question Guide	WRC (2012)	This annex provides questions WRC used as part of their environmental scan of ASRH programming from 2009–2012.
Appendix B: MISP for SRH monitoring checklist	IAWG (2018)	IAWG provides a health facility monitoring checklist as part of the IAFM. It is available in English and French.
Asking young people about sexual and reproductive behaviours	WHO	This knowledge, attitudes, and practices (KAP) survey is intended to be no more than a point of departure for investigators wishing to study the SRH of young people. It should always be adapted to local circumstances and priorities and, wherever possible, be used in conjunction with qualitative methods of investigation.
Body-Map Storytelling as Research: Methodological considerations for telling the stories of undocumented workers through body mapping	CAIS (2012)	While this facilitation guide can be used by community members, service providers, educators, and other practitioners, it was created for researchers interested in using the one to-one body mapping approach for research purposes.
Community Capacity Strengthening Guide	Save the Children (2014)	This Guide is part of a compendium of capacity strengthening resources, experiences and lessons assembled to guide Save the Children staff in writing proposals and implementing programs that include national partner capacity building as a focus.

Community Health Needs Assessment: An introductory guide for the family health nurse in Europe	WHO (2001)	This document describes how a health needs assessment can identify priority health needs, target resources to address inequalities and involve local people. The document also includes a pack for training the trainers in the use of the assessment tool.
Community Mapping ASRH	IRC (2018)	An example of a community mapping exercise that IRC used with adolescent groups.
Community Pathways to Improved ASRH: A conceptual framework and suggested outcome indicators	UNFPA (2007)	This resource provides a conceptual framework and illustrative outcome indicators to better measure the benefit of community involvement in achieving ASRH outcomes. The framework and indicators may be used as program design tools as well as to provide guidance on developing program evaluations.
The Community Score Card (CSC): A generic guide for implementing CARE's CSC process to improve quality of services	CARE (2013)	The Community Score Card is a two-way and ongoing participatory tool for assessment, planning, monitoring and evaluation of services. It is easy to use and can be adapted into any sector where there is a service delivery scenario. It is an exciting way to increase participation, accountability and transparency between service users, providers and decision makers.
Community Self-Assessment Tool	Save the Children (2011)	Save the Children developed the Resilient & Ready Communities Self-Assessment Tool to encourage and support communities in determining their level of emergency readiness regarding the unique needs of children and families in disasters. The Self-Assessment is designed to be a thought-provoking tool and aid communities in asking an array of questions as they relate to children in emergencies and disasters.
Designing Programs for Adolescent Girls	EmPower	Includes multiple youth development tools for designing programs for adolescent girls. Whether starting a new program, expanding the scope or scale of an existing program, or focusing on the specific needs of adolescent girls in a coed program, these tools provide guidance on the A-Z of program design for adolescent girls.
Detailed Needs Assessment	ActionAid	ActionAid has a detailed needs assessment checklist and report template available that practitioners can adapt to collect more detailed information on ASRH.

Evaluating Family Planning Programs with Adaptations for Reproductive Health	MEASURE Evaluation (1996)	This 104-page manual prepares readers to: 1) differentiate between the main types of program evaluation, program monitoring, and impact assessment; 2) critically evaluate the strengths and limitations of alternative methods for impact assessment; 3) assess and select the types of evaluation most appropriate to a given setting; 4) identify appropriate indicators and data sources for evaluation; and 5) design an evaluation plan outlining study designs, indicators, and data sources that serves as an action plan for subsequent implementation. A Spanish-language version of this manual is also available.
Evaluation Practice Handbook	WHO (2013)	The purpose of this handbook is to complement WHO's evaluation policy (Annex 1) and to streamline evaluation processes by providing step-by-step practical guidance to evaluation in WHO. The handbook is designed as a working tool that will be adapted over time to better reflect the evolving practice of evaluation in WHO and to encourage reflection on how to use evaluation to improve the performance of projects and programs and to enhance organizational effectiveness.
Gaps in Global Monitoring and Evaluation of Adolescents and Youth Reproductive Health	MEASURE Evaluation & USAID (2020)	This report presents recommendations to address gaps in measuring adolescent and youth reproductive health activities and programs across the spectrum of reproductive health categories affecting young people.
Gender-Based Violence Research, Monitoring, and Evaluation with Refugee and Conflict-Affected Populations: A manual and Toolkit for Researchers and Practitioners	The Global Women's Institute, The George Washington University (2017)	This manual and the associated practitioner toolkit form a comprehensive package to support researchers and members of the humanitarian community in conducting ethical and technically sound research, monitoring and/or evaluation (RME) on gender-based violence (GBV) within refugee and conflict-affected populations. The manual's step-by-step approach enables readers to make appropriate ethical and methodological decisions when collecting data with refugee and other vulnerable populations.

Gender-Based Violence Tools Manual: For Assessment & Program Design, Monitoring & Evaluation in Conflict-Affected Settings	RHRC Consortium (2004)	This guidance is aimed at improving international and local capacity to address GBV in refugee, internally displaced, and post-conflict settings. The tools are divided into three major categories: assessment, program design, and program monitoring and evaluation.
Global Gender Analysis for COVID-19	CARE, IRC (2020)	CARE adapted its Rapid Gender Analysis toolkit to develop the Global Rapid Gender Analysis on COVID-19, conducted in consultation with IRC. This report is for humanitarians working in fragile contexts that are likely to be affected by the COVID-19 crisis. It seeks to deepen the current gender analysis available by encompassing learning from global gender data available for the COVID-19 public health emergency.
Guidance on ethical considerations in planning and reviewing research studies on sexual and reproductive health in adolescents	WHO (2018)	This document is intended to inform people involved in SRH research with adolescents and aims to address commonly occurring situations and challenges that one faces in carrying out this research.
Guideline: The Gender Handbook for Humanitarian Action	IASC (2018)	A handbook with guidance on gender analysis, planning, and actions to ensure that the needs, contributions, and capacities of women, girls, boys, and men are considered in all aspects of a humanitarian response. It also offers checklists to assist in monitoring gender equality programming.
A Guide to Using Community Score Cards for Youth-Led Social Accountability	IPPF (2019)	This guide aims to provide a step-by-step approach to implementing youth-led social accountability using the Community Score Card approach as a tool to reach and effectively engage young people to understand and demand their SRH and rights.
Handbook for conducting an adolescent health services barriers assessment (AHSBA) with a focus on disadvantaged adolescents	WHO (2019)	This handbook for conducting an adolescent health services barriers assessment with a focus on disadvantaged adolescents outlines how governments can assess health service equity and barriers at national and subnational levels in order to identify which adolescents are being left behind, and why.

Health statistics and health information systems	WHO (2002/2004)	This webpage provides examples of larger household surveys conducted, as well as other data collection assessments, on their Health Statistics and Health Information Systems resource page.
How Do We Know if a Program Made a Difference? A Guide to Statistical Methods for Program Impact Evaluation	MEASURE Evaluation (2014)	This manual provides an overview of core statistical and econometric methods for program impact evaluation (and, more generally, causal modelling).
How To Evaluate The Programme	WHO	This module describes the process of developing and conducting an evaluation of a drinking and driving program. It is divided into three key sections: Planning the evaluation, choosing the evaluation methods, and dissemination and feedback.
Inclusive Systemic Evaluation for Gender Equality, Environments and Marginalized Voices (ISE4GEMs): A new approach for the SDG era	UN Women	This approach shows how each intervention can be used as a learning opportunity to influence social change, including gender equality, sustainability, human rights, and peace. This guide provides an introduction to the new approach and includes a summary of the key theoretical concepts as well as guidance and tools for applying it in practice. It is now also available in Spanish.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (Section 5.5)	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises. See chapter 5.0 in the IAFM: Assessments, Monitoring and Evaluation as it provides comprehensive guidance on monitoring and evaluating SRH programming in humanitarian response.
Knowledge, Attitude and Practice toward the Novel Coronavirus (COVID-19) Outbreak: A Population-Based Survey in Iran	WHO (2020)	WHO completed a KAP survey with individuals above age 15 to evaluate their KAP and examine related, associated socio-demographic variables. Their study includes the KAP survey questions and analyses.

Learning Lab	USAID (updated periodically)	Includes guidance on the program cycle and three toolkits resources to provide stakeholders with a curated set of resources to plan, implement and integrate monitoring, evaluating and collaborating, learning and adapting practices into their programs.
Logical Framework	UN Office on Drugs and Crime (2006)	A part of UN Office on Drugs and Crime's Toolkit to Combat Trafficking in Persons, this tool outlines how to develop a logical framework.
MEASURE Evaluation: Family Planning and Reproductive Health Indicators Database	MEASURE Evaluation & USAID	The programmatic area on adolescent and youth sexual and reproductive health (AYSRH) within MEASURE Evaluation's Family Planning and Reproductive Health Indicators Database includes indicators, definition, data requirements, data source(s), purpose, issues and—if relevant—gender implications.
Monitoring, Evaluating, and Reporting PEPFAR's Essential Survey Indicators for Orphans and Vulnerable Children Programs Research Protocol Template	MEASURE Evaluation (2018)	The Toolkit recommends using MEASURE Evaluation's evaluation protocol template. It is highly recommended to develop protocols in a participatory manner, involving all study partners, including implementing partner staff, the organizations responsible for designing and conducting surveys, local and international research partners, and implementing partner project staff.
Monitoring Tools for Humanitarian Organizations	ECHO (2008)	The aim of these tools is to help humanitarian organizations with monitoring the different aspects of their operations. It does this by offering a compilation of tools that can be used in monitoring. Each tool provides guidance on how to undertake a different aspect of monitoring work.
The "Most Significant Change" Technique – A Guide to Its Use	CARE, Ibis, Lutheran World Relief, & Oxfam (2005)	This publication is aimed at organizations, community groups, students and academics who wish to use Most Significant Change to help monitor and evaluate their social change programs and projects, or to learn more about how it can be used.
Multi-Sector Initial Rapid Assessment Guidance	IASC (2015)	The Multi-cluster/sector Initial Rapid Assessment (MIRA) is a joint needs assessment tool that can be used in sudden onset emergencies, including IASC System-Wide level 3 Emergency Responses (L3 Responses).

Participative Ranking Methodology: A Brief Guide	Child Protection Center Learning Network (2010)	This is a practical guide to the Participative Ranking Methodology (PRM). PRM is a 'mixed methods' approach to data collection, in which a group of knowledgeable participants are guided in generating responses to a specific question or set of questions.
Participatory Action Research (PAR): A "how to" guide for use with adolescents in humanitarian contexts	Save the Children (2018)	A 'how to' guide for use with adolescents in humanitarian contexts. It provides practical advice that is relevant for anyone considering introducing the PAR approach in their work with adolescents and youth in a humanitarian context.
Participatory Action Research in Health Systems: A Methods Reader	Regional Network for Equity in Health in East and Southern Africa (2014)	The Methods Reader seeks to explain key features of participatory action research and the history and knowledge paradigms that inform it; processes and methods used in participatory research, including innovations and developments in the field and the ethical and methods issues in implementing it; and communication, reporting institutionalization and use of the participatory action research in health systems.
Partners and Allies: Toolkit for Meaningful Adolescent Girl Engagement	Coalition for Adolescent Girls (2015)	A resource for practitioners, policy-makers, advocates, researchers, donors and governments to engage adolescent girls as partners and allies in activities and structures of institutions, programs, and projects. The goal of this toolkit is to enable institutions, programs, and project teams to strategically and meaningfully engage girls as equal and active participants in the leadership and development of their communities, nations, and the world.
The project has ended but we can still learn from it!	WHO (2019)	WHO developed this practical guide for conducting post-project evaluations of ASRH projects.
Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide	UNFPA (2009)	This tool provides a range of resources for SRH assessments, including an exit interview form, as well as resources for conducting interviews with providers about service delivery. Humanitarian practitioners should adapt their exit interview form to their audience, programming, and context.

Ready to Save Lives: SRH Care in Emergencies Preparedness Toolkit	IAWG (2020)	This toolkit—created by IAWG partners FP2020, IPPF, JSI, WRC, and UNFPA—is a preparedness toolkit for SRH care in emergencies. The purpose of the toolkit is to bring together existing learning and guidance as a starting point for stakeholders to begin SRH preparedness work.
Reproductive Health Assessment Toolkit for Conflict-Affected Women	USAID, CDC (2007)	The toolkit can be used to quantitatively assess reproductive health risks, services, and outcomes in conflict-affected women between 15 and 49 years of age. Survey data can be used to compare a population across points in time or to make comparisons across populations.
Sexual and Reproductive Health and Rights Indicators for the SDGs	Guttmacher Institute (2015)	This document provides recommendations for SRH and rights inclusion in the Sustainable Development Goals and the post-2015 development process.
Social and Behavior Change Communication Theory	Johns Hopkins University (2016)	As part of JHU's Urban Adolescent SRH SBCC implementation Kit, this section provides more guidance on SBCC theories of change.
Social Mapping ASRH	IRC	An example of a social mapping exercise IRC used with adolescent groups.
Sphere for Monitoring and Evaluation Sphere for Assessments	Sphere Project (2014/2015)	Sphere for Monitoring and Evaluation together with Sphere for Assessments explains how to integrate key elements of Sphere's people-centered approach into the humanitarian program cycle. These guides indicate the relevant parts of the Sphere Handbook at different moments of the response process and should therefore be used together with the Handbook.
Tools for Development: A Handbook for Those Engaged in Development Activity	Foreign, Commonwealth & Development Office (2003)	This tools draws together a range of techniques to help undertake development activities and interventions of any size and kind. <i>Note: Foreign, Commonwealth & Development Office replaced the Department for International Development (DFID).</i>
Training Materials	RAISE Initiative	List of several learning modules on data use for staff to understand how to use data to increase quality and impact of their SRH program.

Using Visual Participatory Research Methods With Adolescents In Gaza	Gender & Adolescent Global Evidence (2017)	From August to November 2016, thirty-five adolescents (aged 16-19 years old) were part of such a participatory pilot project designed by the GAGE program. This page shares results, lessons learned, and policy implications from the project.
Vulnerability and Capacity Assessment	IFRC	Vulnerability and Capacity Assessment (VCA) uses various participatory tools to gauge people's exposure to and capacity to resist natural hazards. IFRC's website also includes videos, case studies, and other documents on VCA.
A Web Platform to Monitor Global Standards for Quality of Health-Care Services for Adolescents	WHO (2015)	WHO has developed a web-platform for the M&E of national quality standards for adolescent healthcare services, which includes several exit interview tools. The AA-HA! reporting dashboard delivers metrics on the performance of a healthcare facility, district or country against the Global standards to improve quality of health-care services for adolescents, or against national standards if such exist.
Young Women and Abortion: A Situation Assessment Guide	Ipas (2011)	This guide focuses on ways to plan, implement, use and finalize an assessment of how young women and their communities relate to abortion, through locally relevant, community and/or youth-led processes. It is a global resource for community groups, youth groups, peer educators, trainers, administrators, program managers and technical advisors of abortion care programs.

CHAPTER 8: MANAGER GUIDANCE NOTES & TOOLS

Resource	Organization (Year)	Description
Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services	Save the Children, WRC, UNFPA, UNHCR (2012)	This report is a result of an extensive mapping exercise of ASRH services in humanitarian settings and provides technical guidance and documentation of good practices in the field of ASRH in humanitarian contexts.
Advocacy in Emergencies	UNHCR	This document forms part of the 4th edition of the UNHCR Emergency Handbook and was generated from the digital Emergency Handbook system. It provides advocacy in emergency tips related to humanitarian principles and standards, protection risks, key management considerations, and resources and partnerships guidance. This tool can be used to create a job description/terms of reference.

Advocacy Toolkit: A guide to influencing decisions that improve children's lives	UNICEF (2010)	The Advocacy Toolkit provides a broadly accepted definition of advocacy and underscores UNICEF's unique position and experience in advocacy. The heart of the Toolkit provides detailed steps, guidance and tools for developing and implementing an advocacy strategy.
ASRH in Emergencies Fact Sheet	IAWG (2019)	This fact sheet provides key statistics and information on the needs and SRH risks facing adolescents in emergency settings. In addition, the resource recommends four key strategies to prioritize when implementing adolescent-focused SRH programming in humanitarian contexts. Available in Arabic, French, and Spanish.
ASRH Facility Readiness and Supportive Supervision Checklist	IRC	Supportive supervision checklist can be utilized by managers to support staff development and ensure program activities are underway.
Emergency Toolkit	CARE	The CARE Emergency Toolkit (CET) collects what CARE knows about humanitarian response – particularly in acute emergencies, but also in long-term situations. The CET helps you to respond more effectively, to more people, faster. It uses lessons that we have learned from past responses, and good practice from others, to provide you with guidance on what you need to do. It contains forms, protocols, guidelines and tools that you might need.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (Chapter 3: MISP)	IAWG (2018)	The IAFM is the result of a collaborative and consultative process engaging hundreds of representatives from UN agencies and NGOs that make up IAWG. The IAFM continues to be the authoritative source for SRH in crises.
Inter-Agency Reproductive Health Kits for Crises Situations Manual	IAWG (2011)	The IAWG Reproductive Health Kits are complementary to the Interagency Emergency Health Kit, which is designed to meet the primary health care needs of displaced populations without medical facilities and specific kits are designated for each of the six objectives of the MISP 2018 edition. This IAWG resource is a manual on the contents, use, and ordering procedures of the kits.

MISP Cheat Sheet	IAWG (2019)	This document provides a “cheat sheet” from which professionals and those working in the field can quickly reference and recall the objectives and actions included in the Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (MISP).
Protocol on Allegations of Sexual and Exploitation and Abuse Involving Implementing Partners	UN (2018)	This protocol outlines obligations of the United Nations, including its funds and programs, when working with implementing partners, to ensure adequate safeguards and appropriate action related to sexual exploitation and abuse.
RESOURCE Mobilization Implementation Kit (I-Kit) Proposal and Grant Application Templates	JHU, MSH (2016)	Serves as a primer for organizations working in social and behavior change communication and sustainability. The I-Kit Provides SRH managers with detailed guidance and templates for resource mobilization processes.
Save the Children's Policy of Child Safeguarding	Save the Children	Save the Children's policy of child safeguarding outlines key guidance staff and implementing partners must follow when implementing programming.
Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response	Sphere (2018)	The Sphere Project, now known as Sphere, was created in 1997 by a group of humanitarian non-governmental organizations and the Red Cross and Red Crescent Movement. This fourth edition marks the 20th anniversary of The Sphere Handbook and includes new guidance for working in urban settings, for addressing Minimum Standards in protracted crises, and for delivering assistance through markets as a way to meet the standards. All technical chapters have been updated to reflect current practice, and the harmonized Core Humanitarian Standard replaces the previous Core Standards.
Training for Mid-Level Managers	WHO (2008)	Training for mid-level managers (MLM) contains eight modules to support immunization, vaccines and biological programming.
Training for Mid-Level Managers: 4. Supportive Supervision	WHO (2008)	This module will help the mid-level manager to obtain the maximum benefit from every supervisory visit, from the training of supervisors, through managing a system of supervisory visits to following up and solving problems after the supervisory session.

Thank you for the work you
do in service of and in partnership
with the women, girls, boys,
and men affected by crises.

We invite you to join the conversation at
[https://iawg.net/about/sub-working-groups/
adolescent-sexual-reproductive-health](https://iawg.net/about/sub-working-groups/adolescent-sexual-reproductive-health)

You can also email us at
info.iawg@wrcommission.org.



Inter-Agency Working Group on
Reproductive Health in Crises

