Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings

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

Save the Children

UNFPA

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ACRONYMS

AIDS: Acquired Immunodeficiency Syndrome
ART: Anti-Retroviral Therapy
ARV: Anti-Retroviral
ASRH: Adolescent Sexual and Reproductive Health
CAAFAG: Children Associated with Armed Forces and Armed Groups
CBD: Community-Based Distribution
COC: Combined Oral Contraceptive Pill
CRC: United Nations Convention on the Rights of the Child
DDR: Disarmament, Demobilization and Reintegration
EC: Emergency Contraception
ECP: Emergency Contraceptive Pill
FP: Family Planning
GBV: Gender-Based Violence
HCT: HIV Counseling and Testing
HIV: Human Immunodeficiency Virus
IAFM: Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings
IASC: Inter-Agency Standing Committee
IDP: Internally Displaced Person
MARA: Most-At-Risk-Adolescents (refers to HIV/AIDS)
MISP: Minimum Initial Service Package for Reproductive Health in Crisis Situations
MSM: Men who have Sex with Men
NGO: Non-Governmental Organization
OCP: Oral Contraceptive Pill
PEP: Post-Exposure Prophylaxis for HIV
PLHIV: Persons Living with HIV
PMTCT: Prevention of Mother-to-Child Transmission of HIV
POP: Progestin-Only Pill
RH: Reproductive Health
SEA: Sexual Exploitation and Abuse
SRH: Sexual and Reproductive Health
STI: Sexually-Transmitted Infection
UNFPA: United Nations Population Fund
UNHCR: United Nations High Commissioner for Refugees
UNICEF: United Nations Children's Fund
WHO: World Health Organization

Introduction

What is adolescence?

Adolescence is defined as the period between 10 and 19 years of age. It is a continuum of physical, cognitive, behavioral and psychosocial change that is characterized by increasing levels of individual autonomy, a growing sense of identity and self-esteem and progressive independence from adults.

Adolescents are learning to think abstractly, which allows them to plan their futures. Experimentation and risk-taking are normal during adolescence and are part of the process of developing decision-making skills; adolescents are both positively and negatively influenced by their peers, whom they respect and admire. Adults play an important role in this regard and can help adolescents weigh the consequences of their behaviors (particularly risky behaviors) and help them to identify options. The 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.

At one end of the continuum are *very young adolescents* (10 to 14 years of age), who may be physically, cognitively, emotionally and behaviorally closer to children than adults. Very young adolescents are just beginning to form their identities, which are shaped by internal and external influences. Signs of physical maturation begin to appear during this period: pubic and axillary hair appear; girls develop breast buds and may begin to menstruate; in boys, the penis and testicles grow, facial hair develops and the voice deepens. As young adolescents become aware of their sexuality, they may begin to experiment with sex. They also may experiment with substances such as alcohol, tobacco or drugs. Adolescent sexual and reproductive health (ASRH) programs should develop strategies that specifically target very young adolescents, tailoring interventions that are appropriate to their level of maturity, experience and development.

Adolescence is one of life's fascinating and perhaps most complex stages, a time when young people take on new responsibilities and experiment with independence. They search for identity, learn to apply values acquired in early childhood and develop skills that will help them become caring and responsible adults. When adolescents are supported and encouraged by caring adults, they thrive in unimaginable ways, becoming resourceful and contributing members of families and communities. Bursting with energy, curiosity and spirit that are not easily extinguished, young people have the potential to change negative societal patterns of behaviour and break cycles of violence and discrimination that pass from one generation to the next. With their creativity, energy and enthusiasm, young people can change the world in astonishing ways, making it a better place not only for themselves, but for everyone.

From UNICEF: *Adolescence: A Time That Matters. 2002.*

During *middle adolescence* (15-16 years of age), adolescents begin to develop ideals and select role models. Peers are very important to adolescents in this age group and they are strongly influenced by them. Sexual orientation develops progressively and non-heterosexual individuals may begin to experience internal conflict, particularly during middle adolescence.

At the other end of the spectrum are *older adolescents* (17 to 19 years of age), who may look and act like adults, but who have still not reached cognitive, behavioral and emotional maturity. While older adolescents may make decisions independently — they may be employed, their sexual identities are solidified and they may even marry and start families — they still benefit from the influence of adult role models as well as family and social structures to help them complete the transition into adulthood.

Children, adolescents, youth and young people

The terms used to refer to people in the age range of 0 to 24 years vary depending on the context and the source of information. International definitions are summarized in Table 1, but comprehension of the terms varies widely according to countries, cultures and groups.

The United Nations Convention on the Rights of the Child (CRC) encompasses all individuals from birth to 18 years in the category of "children." Therefore, adolescents are covered under the protection of the CRC until they reach 18. The category of "youth" includes older adolescents, aged 15 to 24 years. "Young people" comprise adolescents between 10 and 24. These two terms reflect the continued development and maturation of individuals during the period after 18 years of age, prior to entering adulthood.

Table 1

Term	Age Range	Source
Children	0-18 years	Convention on the Rights of the Child
Adolescent	10-19 years	UNFPA, WHO, UNICEF
Very young adolescent	10-14 years	UNFPA, UNICEF
Youth	15-24 years	UNFPA, WHO, UNICEF
Young people	10-24 years	UNFPA, WHO, UNICEF

Why focus on adolescent sexual and reproductive health?

Although adolescents make up a large proportion of the population in the developing world, where most humanitarian emergencies occur, their sexual and reproductive health (SRH) needs are largely unmet. In 2000, 29% of the population in developing countries was of adolescent age; in the least developed countries, adolescents accounted for 32% of the total population.[1] Worldwide, adolescent females and males are reaching puberty sooner, marrying later and having more premarital sex.[2] The unmet need for contraceptives among adolescents, however, is more than twice that of married women.[3] One third of women worldwide give birth before the age of 20,[4] with deliveries by women under 20 totaling 15 million annually.[5] Pregnant adolescents are at increased

risk of morbidity and mortality due to complications during pregnancy and childbirth, including obstructed labor, preterm labor and spontaneous abortion. Five million adolescents between the ages of 15 and 18 have unsafe abortions each year[6] and 70,000 abortion-related deaths occur among this age group every year.[7] Half of new HIV infections occur in 15-to-24 year olds, and one third of new cases of curable sexually transmitted infections (STIs) affect people younger than 25.[8]

Why is adolescent sexual and reproductive health important in emergency situations?

As they transition from childhood to adulthood, adolescents normally benefit from the influence of adult role models, social norms and structures and community groups (peer, religious or cultural).

> In some settings, the age of marriage is increasing, which has led to prolonged adolescence and a delay in entering the phase of adulthood. In these contexts, it might be appropriate to expand the definition of "adolescence" to include people up to 24 years old.

During natural and man-made humanitarian emergencies, however, family and social structures are disrupted: adolescents may be separated from their families or communities, while formal and informal educational programs are discontinued and community and social networks break down. Adolescents may feel fearful, stressed, bored or idle. They may find themselves in risky situations that they are not prepared to deal with and they may suddenly have to take on adult roles without preparation, without positive adult role models or support networks.

The loss of livelihood, security and the protection provided by family and community places adolescents at risk of poverty, violence and sexual exploitation and abuse (SEA). In crisis situations, adolescents (especially girls) are vulnerable to rape 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 because rape may be used as a method of war. Many adolescents, including younger ones, resort to selling sex to meet their own or their families' needs. They may also be at risk of recruitment into armed forces or groups, which can increase their vulnerability to sexual exploitation and abuse, HIV/STI infection, and unwanted pregnancies due to high mobility and an increase in risk-taking behaviors (including 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.

The disruption of families, education and health services during emergencies, either due to infrastructure damage or to the increased demands placed on health and social-service providers during a crisis, adds to the problem and may leave adolescents without access to SRH information and services during a period when they are at risk.

The lack of access to SRH information, the disruption or inaccessibility of SRH services, and the increased risk of SEA as well as high-risk sexual behaviors among adolescents during emergencies, puts adolescents at risk of unwanted pregnancy, unsafe abortion, STIs and HIV infection.

What sub-groups of adolescents are at particularly high risk and require special attention?

Certain sub-groups of adolescents, including those who are very young, pregnant, or marginalized are considered to be high-risk. Other adolescents fall into high-risk subgroups as a result of the crisis situation.

Sub-groups that are at risk by definition:

- *Very young adolescents (10-14 years), especially girls*, are at risk of SEA because of their dependence, lack of power, and their lack of participation in decision-making processes. Because of their limited life experience, they may not recognize the sexual nature of abusive or exploitative actions.

- *Pregnant adolescent girls*, particularly those under 16, are at increased risk of obstructed labor, a life-threatening obstetric emergency that can develop when the immature pelvis is too small to allow the passage of a baby through the birth canal. Delay in treatment can lead to obstetric fistula or uterine rupture, hemorrhage and death of the mother and child. Emergency obstetric care services are often unavailable in crisis settings, increasing the risk of morbidity and mortality among adolescent mothers and their babies.
- *Marginalized Adolescents*, including those who are HIV+, those with disabilities, non-heterosexual adolescents, indigenous groups and migrants may face difficulties accessing services because of stigma, prejudice, culture, language and physical or mental limitations. They are at risk of poverty. In addition, they are at risk of SEA because of their lack of power and participation.

Sub-groups that become at-risk during a crisis situation:

- *Adolescents separated from their families (parents or spouses) and adolescent heads of household* lack the livelihood security and protection afforded by the family structure, which puts them at risk for poverty and SEA. Separated adolescents and adolescent heads of household may be compelled to drop out of school, marry or sell sex in order to meet their needs for food, shelter or protection.
- *Survivors of sexual violence and other forms of gender-based violence (GBV)* are at risk of unwanted pregnancy, unsafe abortion, STIs including HIV, as well as mental health, psychosocial problems and social stigmatization.
- *Adolescent girls selling sex* are at risk of unwanted pregnancy, unsafe abortion, STIs and HIV. They are at risk of abusing drugs and alcohol and of SEA. For adolescents below age 18 , this is considered to be sexual exploitation of children.
- *Children Associated with Armed Forces and Armed Groups (CAAFAG)*, both boys and girls, are often sexually active at a much earlier age and face increased risk of exposure to HIV. Members of armed forces and groups in general, including adolescents, are at high risk of HIV infection given their age range, mobility, and risk-taking attitudes. Female combatants, girls associated with fighting forces, abductees and dependants also are frequently at high risk, given the widespread sexual violence and abuse. They are at risk of mental health and psychosocial problems as they may have committed or witnessed acts of extreme physical or sexual violence or may themselves be survivors of sexual violence. Girls may have been forced to have sex with commanders or with other soldiers. They are at risk of unwanted pregnancy, unsafe abortion, STIs and HIV infection.

Regardless of the source of their vulnerability, all at-risk sub-groups of adolescents require particular attention and targeted interventions to ensure that their SRH needs are met during times of crisis.

What special considerations should be taken when implementing ASRH programs in emergency settings?

Most of the existing models for ASRH interventions are relevant to the development context; there are few field-tested models for ASRH interventions in emergency situations. This does not mean that development models are not valid in emergencies; in many cases they are, but they must be adapted to the emergency context. In an acute emergency, for example, life-saving interventions are the priority. Even in an emergency, every attempt should be made to involve the beneficiary population in program planning, implementation and monitoring, but the degree of participation that is attainable may be less than in a stable or protracted situation. Once the acute emergency is stabilized, field-tested development-like interventions, with broader participation of stakeholders, should be introduced.

Special considerations for ASRH programs are summarized below. It should be noted that each of these considerations is valid in both the emergency and non-emergency setting, but they may be overlooked in the emergency context. Further details are provided in the Fact Sheets and individual tools.

In this document, the phrases "humanitarian settings", "crisis settings" and "emergency settings" are used interchangeably.

Human Rights, Ethical and Legal Concerns: Under international law, adolescents have rights through the Convention on the Rights of the Child (CRC) until they reach 18 years of age. These include the right to reproductive health (RH) information and services and they provide protection from discrimination, abuse and exploitation. Health staff, adolescents, community members (including parents) and humanitarian workers should be aware of the rights of adolescents and work together to ensure that these rights are protected even in times of crisis.

In addition, certain ethical considerations must be taken into account when designing and implementing interventions with adolescents. Program activities and interventions should demonstrate respect for adolescents and their right to self-determination; the benefits of the interventions should outweigh the risks; and participation of adolescents should be encouraged and their opinions respected.

Finally, local, national and international laws should be followed to the maximum extent possible. In all situations, however, it is important that the best interests of the adolescent are prioritized.

Making Interventions Accessible, Acceptable and Appropriate to Adolescents: Even in non-emergency settings, adolescents face inter-related barriers that prevent them from accessing facility-based RH services. These include: ***individual barriers***, such as feelings of shame, fear or anxiety about issues related to sexuality and reproduction, lack of awareness about the services available, poor health, or advice-seeking behaviors and the perception that services will not be confidential; ***socio-cultural barriers***, such as social norms which dictate the behavior and sexuality of both young men and women, stigma surrounding sexually active adolescents, cultural barriers which limit the ability of women, girls or certain sub-sets of the population from accessing health services, educational limitations, language differences, the attitudes of health care providers towards adolescents or their unwillingness to attend to their RH needs; and ***structural barriers***, such as long distances to health facilities, lack of facilities for clients with disabilities, inconvenient hours of operation, long waiting times, charging fees for services and lack of privacy.

The barriers to accessing services that are experienced by adolescents are increased during a crisis, when health services and infrastructure such as communications and transportation are disrupted, when health services are overburdened by high patient loads, when insecurity leads to restrictions of movement, and when other activities, such as securing food and shelter, take priority over RH concerns.

To reach adolescents during emergency situations, RH programs must take innovative approaches to make services acceptable, accessible and appropriate for adolescents, taking cultural sensitivity and diversity into consideration. Adolescents should be involved as much as possible in the design, implementation and monitoring of program activities, so that programs are more likely to respond to their RH needs and priorities and so that interventions are acceptable to them. Introducing adolescent-friendly health services and involving adolescents in the both the design and monitoring of these services will make facility-based RH services more accessible and acceptable to adolescents. In addition, program managers, together with health providers, adolescents and community members should consider alternative implementation strategies such as community interventions that will make it easier to reach adolescents with RH information and services.

Community and Parental Involvement: Community and parental acceptance and involvement in ASRH programs are crucial for the success and sustainability of the programs. Community members and parents, along with adolescents, should be involved from the earliest stages of program design and if possible, should contribute to program implementation.

Family or Community Re-integration: While not specifically an RH issue, successful re-integration of adolescents into families or the

ABOUT THE ASRH TOOLKIT FOR HUMANITARIAN SETTINGS

The *ASRH Toolkit for Humanitarian Settings* provides information and guidance to advocate for ASRH and implement ***adolescent-inclusive SRH interventions***. The toolkit is meant to accompany Chapter 4 "Adolescent Reproductive Health" of the *Inter-Agency Field Manual on Reproductive Health in humanitarian settings*, IAFM. The tools have been conceived to operationalize this chapter by providing guidance on what should be done to ensure that sexual and reproductive health interventions put into place during and immediately after a crisis are responsive to the needs of adolescents.

While the best way to ensure that ASRH needs are met is to ***mainstream ASRH*** into the emergency RH response, mainstreaming is a process that requires planning and co-ordination and often implementing agencies do not have the time, resources or capacity to do this during an acute emergency.

Recognizing that mainstreaming approaches to mainstreaming ASRH in emergencies have not yet been standardized, this *ASRH Toolkit* has been designed to help program managers at implementing agencies ensure that the sexual and reproductive health needs of adolescents are addressed during all emergency situations, be they natural or man-made. It also provides selected tools specifically for health providers so they can more effectively provide and track services for adolescents at the clinic and community levels. The tools are designed to be user-friendly so that service providers who have never been trained to work with adolescents can feel comfortable treating them during an emergency.

Each humanitarian situation is unique, and it is expected that the tools will be adapted to suit the particular needs on the ground. It is also expected that the Toolkit will be used to raise awareness about the SRH needs of adolescents and as an initial step of mainstreaming ASRH into emergency RH responses.

community is crucial to minimizing their SRH risk. Preventing adolescents from becoming separated from their families is a priority during an emergency situation, and creating safe spaces and beginning education activities during a crisis can minimize idle time among adolescents and aid in preventing them from being abducted or otherwise targeted in an armed conflict. Awareness raising and sensitization sessions on HIV for receiving communities should begin well before reintegration of adolescents commences to counter any stigma or discrimination from the communities. Strong protection measures and strengthening community-based approaches to livelihoods and education can also contribute to the prevention of re-recruitment or harmful behaviors such as selling sex.

Sexual and Reproductive Health Needs of Adolescent Boys: Adolescent girls are most at risk during emergency situations, but addressing the needs of adolescent boys is equally urgent; ASRH programs should recognize the specific SRH needs of adolescent boys. Adolescent boys have an important role to play in improving the health situation for adolescent girls. Including both boys and girls in discussions on power and gender equality can reduce the risk of GBV and can lead to changes in the existing gender norms that contribute to GBV and exclusion of girls from health services. Adolescent boys face high rates of STI and HIV/AIDS (although not as high as females.) By providing boys with information about sexual health and ensuring that they have access to high-quality, adolescent-friendly SRH services, high-risk sexual behavior among adolescent boys may be mitigated. Boys also are targeted for recruitment to armed forces and armed groups, where they are at risk of being subject to and committing exploitation and abuse, in addition to being induced or pressured toward risk-taking behaviors.

SUGGESTED READING:

1. IAWG on the Role of Community Involvement in ASRH. *Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators.* December 2007. http://web.unfpa.org/upload/lib_pub_file/781_filename_iawg_ci.pdf

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A Human and Child Rights Framework

Human rights violations are common in both natural and man-made crisis situations. States are responsible for protecting the human rights of their citizens, but during crises, states may be temporarily incapable of providing protection (in the case of a natural disaster, for example), or may be failed (in the case of an armed conflict). The right to health — including sexual and reproductive health — is not suspended during an emergency, and it is the responsibility of states to ensure that those who are marginalized or most at-risk in the population are provided with safe access to shelter, water, food, cooking fuel and healthcare.

Figure 1 illustrates the sexual and reproductive rights of adolescents in relation to human rights:

FIGURE 1: HUMAN RIGHTS THAT PROTECT THE SEXUAL AND REPRODUCTIVE RIGHTS OF ADOLESCENTS

(from: Ahumada C & Kowalski-Morten S. *A Youth Activist's Guide to Sexual and Reproductive Health.* Ottawa: The Youth Coalition. 2006.)

How are human rights and legal considerations related to adolescent sexual and reproductive health during emergency situations?

The human rights of adolescents, including vulnerable sub-groups, are protected under several declarations and conventions in international law.

The Universal Declaration of Human Rights (UDHR) mentions the right to health under the right to the highest attainable standard of living (UDHR Article 25). **The Constitution of the World Health Organization** defines health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity and declares that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition* (WHO, 1946).

> This was expanded during the **1994 Cairo International Conference on Population and Development**, which defined reproductive health and the right to reproductive health as: *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*

> **The right to reproductive health** includes the right to complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.
>
> *ICPD, 1994*

The 1995 Beijing Women's Conference expanded the definition of reproductive health to include sexuality:

> *The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.*

The UN Convention on the Rights of the Child:

Adolescents are entitled to rights under the Convention on the Rights of the Child (CRC) until age 18. These rights are listed below, with examples of how they relate to ASRH:

- The right to the highest attainable standard of health, *Including the right to reproductive health.*
- The right to impart and receive information and the right to education, *Including complete and correct information about SRH.*
- The right to confidentiality and privacy, *Including the right to obtain RH services without consent of a parent, spouse or guardian. Conducting a virginity (hymen) examination on an adolescent without her consent would also be a violation of this right.*
- The right to be free from harmful traditional practices, *Including female genital cutting and forced early marriage.*

- The right to be free from all forms of physical and mental abuse and all forms of sexual exploitation, *Including sexual violence, domestic violence and sexual exploitation.*
- The right to equality and non-discrimination, *Including the right to access RH services, regardless of age or marital status and without consent of parent, guardian or spouse.*
- All actions taken should be in the best interest of the child. *For example, requiring parental consent for contraception or obstetric care, or refusing services because of age would not be in the best interest of the adolescent.*

Under international humanitarian law and international human rights law, children are protected from recruitment and use by armed forces and groups. The recruitment and use of children under 15 in armed forces and groups are war crimes. In addition to the UN Convention on the Rights of the Child, international and regional instruments including the Optional Protocol to the Geneva Conventions and the Additional Protocols, the Rome Statue establishing the International Criminal Court, and the African Charter on the Rights and Welfare of the Child, offer a legal framework for the protection of children.

Although most adolescents (those between 10 and 18 years of age) are considered to be children under international law, the ***evolving capacity of the child*** is also recognized.[9] Simply stated, as children progress through adolescence and gain life experiences, they become more capable of taking important decisions independently. This is very important when considering issues related to ASRH, particularly in relation to providing ASRH services without requiring the consent of a parent or spouse.

The issue of whether adolescents themselves can provide ***informed consent*** for SRH interventions such as counseling and testing for HIV, clinical care after sexual assault, treatment of STIs and maternity care can be sensitive. In 2003, the UN Committee on the Rights of the Child issued General Comment No. 4, which describes adolescents' rights to health and development in the framework of the Convention on the Rights of the Child (UN Committee on the Rights of the Child, 2003). The comment provides adolescents with the right to information related to SRH, "regardless of their marital status and whether their parents or guardians consent" (paragraph 28). It also states that if parents or guardians provide informed consent, the adolescent should be allowed to express his/her views and those views should be given weight. It recognizes the evolving capacity of the child by giving adolescents who are "of sufficient maturity" the right to provide informed consent "for her/himself, while informing the parents if that is in the 'best interest of the child'" (paragraph 32). Health providers have the obligation to provide adolescents with private and confidential advice so that they are able to make informed decisions about treatment (paragraph 33).

Finally, adolescents with disabilities are protected under the **UN Convention on the Rights of Persons with Disabilities. Ten percent** of the world population lives with disabilities and 80% of people with disabilities live in developing countries (UNFPA, 2007). During emergencies, the number of adolescents with disabilities may increase due to physical or psychological injury or mental health conditions that manifest as a result of crisis.

> **Adolescents with disabilities** include those who have long-term physical, mental, intellectual or sensory impairments, **which in interaction** with various barriers, may hinder their full and effective participation in society on an equal basis with others
>
> *UN Convention on the Rights of Persons with Disabilities*

The disabled are as sexually active as people without disabilities, but they are three times more likely to experience sexual violence, putting them at increased risk of unwanted pregnancy, STIs and HIV. People with disabilities have less access to health (including mental health and psychosocial support) and legal services. Adolescents with disabilities are at increased risk of other human rights violations such as rape, SEA, forced sterilization, forced abortion and forced marriage.

The Convention on the Rights of Persons with Disabilities says that states *shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others. It further states that people with disabilities have the right to the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes* (United Nations, 1997).

How should ASRH programs prevent or address human rights violations in emergency settings?

ASRH programs should engage other sectors to ensure that health staff, adolescents, community members, and other humanitarian actors are aware of the rights of adolescents, particularly as they relate to RH. All efforts should be made to ensure that adolescents, including marginalized groups and those with disabilities, have access to RH information and services and that they are not subjected to human-rights violations. Suspected or known violations of adolescents' human rights during an acute emergency or while providing comprehensive RH services, should be reported to the UN agency overseeing the humanitarian response (the Global Health Cluster, UNOCHA, UNHCR, etc.).

National laws regarding the rights of adolescents may conflict with international law. It is very important that humanitarian staff are familiar with the national laws and that they know how to handle situations that might arise when national and international law do not agree. Remember, the most important factor in taking a decision is to prioritize *the best interests of the child (or adolescent).*

SUGGESTED READING

1. IPPF. *Young Person's Guide to Rights*, (1-page booklet), http://www.ippf.org/NR/rdonlyres/1F0F2AA6-5A35-4771-8222-E002874748F1/0/Ayoungpersonsguide.pdf.
2. United Nations. *Convention on the Rights of the Child*. http://www2.ohchr.org/english/law/crc.htm.
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Meeting Adolescent Sexual and Reproductive Health Needs

The following matrix is intended to be an overview of key interventions for responding to ASRH needs during emergencies. The interventions for each function and sector are organized by:

- Emergency Preparedness
- Minimum Response
- Comprehensive Response

During non-crisis situations, **Emergency Preparedness** actions can be taken. These interventions can facilitate rapid implementation of minimum-response activities in the midst of a crisis. The suggested items in the left column of the matrix summarize key recommended actions for emergency preparedness. Actions that appear in **bold orange** are considered the *minimum standards* and should be prioritized if resources and time are limited.

The middle column corresponds to initial actions to be taken during the height of an emergency. These **Minimum Response** interventions outline priority steps. For certain actions requiring more detailed guidance, links to suggested resources and tools within the ASRH in Crises Package are included. Actions that appear in **bold orange** are considered the *minimum standards* and should be prioritized if resources and time are limited.

In a more stabilized phase of a crisis, the right column suggests steps to be conducted for **Comprehensive Response** of ASRH needs. Implementation details also include links to suggested resources and tools within this package for certain steps.

Meeting Adolescent Sexual and Reproductive Health Needs in Humanitarian Settings			
Functions & Sectors	**Emergency Preparedness**	**Minimum Response** (to be conducted in the midst of emergency)	**Comprehensive Response** (to be conducted when situation has stabilized)
Coordination	• **Determine coordination mechanisms and responsibilities** • **Mainstream ASRH in preparedness and contingency plans** • Map ASRH stakeholders • Identify adolescent-serving/ adolescent-led organizations and focal points • Create referral linkages between adolescent-serving organizations and external services (SRH, mental health and psychosocial support, livelihoods, education, etc.) • Engage in strategic discussions/ planning with humanitarian donors, government entities, NGOs and CBOs	• **Advocate with the Global Health Cluster to ensure ASRH services are accessible to adolescents during implementation of the MISP** (MISP Coordination Fact Sheet) • **Identify the most-at-risk adolescents and ensure that they have access to RH services** (MISP Coordination Fact Sheet) • Use multi-sectoral approaches to identify ASRH needs (MISP Coordination Fact Sheet, RH Entry Points in Adolescent Programs Tool) • Ensure adequate food and nutritional services/programs are available for adolescents • Engage parents and communities in ASRH as soon as possible, as appropriate (Community and Parental Participation Tool) • Engage adolescents in the design, delivery and monitoring of SRH services Adolescent Participation, RH Entry Points in Adolescent Programs Tools) • Engage adolescent-serving/ adolescent-led organizations, humanitarian donors, governmental entities, NGOs and CBOs; build on their services.	• Ensure ASRH is given equal importance when comprehensive RH services are put in place (MISP Fact Sheets, Community-based Distribution Tools, Facility-Based Tools) • Through multi-sector approaches, identify and address ASRH needs of adolescents. (MISP Coordination Fact Sheet) • Engage parents and communities in ASRH (Community and Parental Participation Tools) • Work closely with adolescents to ensure that services are accessible, acceptable and appropriate for all adolescents, including high-risk sub-groups. (Adolescent Participation Tool, RH Entry Points in Adolescent Programs Tool) • Continue engaging government entities on ASRH to ensure national leadership and ownership (MISP Coordination Fact Sheet)

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Meeting Adolescent Sexual and Reproductive Health Needs in Humanitarian Settings			
Assessment and Monitoring	• **Advocate for inclusion of ASRH questions in rapid assessment tools** • Identify at-risk adolescents and discuss how to mitigate threats facing them. • Review national laws and policies addressing ASRH • Map adolescent-serving organizations and their strategies to address ASRH • Advocate for collection and reporting of sex- and age-disaggregated data in clinics and health facilities • Analyze lessons learned, good practices and challenges in addressing ASRH in previous emergencies	• **Identify most-at-risk sub-groups of adolescents** (MISP Fact Sheets, Assessment and Adolescent Participation Tools) • **Advocate for the inclusion of ASRH and adolescent demographic questions in initial rapid assessments** (Initial Rapid Assessment Tool) • Ensure that sex- and age-disaggregated ASRH data are collected and reported from all clinics and health facilities (ASRH Monthly Reporting Form)	• Conduct an ASRH situational analysis(Situational Analysis Tool) • Include ASRH specific questions in comprehensive RH needs assessment (Comprehensive RH Survey Tool) • Collect and report sex- and age-disaggregated ASRH data regularly from all clinics and health facilities and community-based programs (ASRH Monthly Reporting Form, Community-Based Distribution tools) • Establish feedback mechanisms and ensure that adolescents are involved in the implementation, monitoring and evaluation of ASRH programs (Adolescent Participation Tool) • Analyze and share lessons-learned, good practices and challenges (Sharing Lessons Learned Tool)
Facility-based ASRH Services	• **Train health staff on rapid response of ASRH and working with at-risk adolescents.** • Map facility-based ASRH services and providers • Identify resources for adolescent-friendly health service trainings • Ensure that operational guidelines and protocols of adolescent-friendly services include ASRH in emergency situations • Advocate for collection and reporting of sex- and age-disaggregated data in clinics and health facilities	• **Ensure adolescent-friendly health services during MISP implementation** (MISP Matrix and Fact Sheets) • **Ensure adolescents have access to ARV treatment when needed** (MISP Matrix, HIV Fact Sheet) • Ensure that standardized protocols address ASRH (MISP Coordination Fact Sheet) • Establish mental health and psycho-social support services for adolescents (Mental Health and Psychosocial Support Fact Sheet, Adolescent-Friendly RH Services Checklist)	• Train service providers on adolescent-friendly services (Adolescent Friendly RH Services Checklist) • Assess adolescents who come to the health center for psychosocial, protection and RH issues (HEADSSS Assessment Tool) • Ensure adolescents have access to comprehensive ASRH services (Fact Sheets, Adolescent-Friendly Health Services Checklist)

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Meeting Adolescent Sexual and Reproductive Health Needs in Humanitarian Settings			
Community-based ASRH Services	• **Identify where adolescents receive ASRH services (outside of health facilities)** • Identify entry points to discuss ASRH in the community • Engage community leaders, parents and other adults on ASRH in emergencies • Determine menstrual hygiene practices and supply resources	• **Establish adolescent-friendly condom distribution points** (MISP Matrix, HIV Fact Sheet, RH Entry Points in Adolescent Programs Tool) • **Provide sanitary materials to adolescent girls** (RH Entry Points in Adolescent Programs Tool) • Establish or liaise with special treatment and resource centers for at-risk adolescents (Maternal and Newborn Health Fact Sheet, RH Entry Points in Adolescent Programs tool) • Establish or identify safe spaces for adolescents, where appropriate.	• Establish systems for community-based distribution (CBD) of condoms and family planning (FP) methods for adolescents (Community-Based Distribution Tools) • Assess adolescents at community level for psycho-social, protection and SRH issues (RH Entry Points in Adolescent Programs Tool) • Put into place peer-education system for sharing information on ASRH • Engage boys in deconstructing gender norms (RH Entry Points in Adolescent Programs)
Protection and Human Rights	• **Review or establish a code of conduct on SEA and train local and international humanitarian actors** • Ensure that complaints mechanism for SEA is adolescent-friendly • Review national laws, policies and frameworks that ensure adolescent access to SRH services • Train law enforcement personnel on protection of adolescents in emergencies	• **Ensure that all stakeholders are aware of the rights of adolescents** (A Human and Child Rights Framework) • **Strictly enforce a zero-tolerance policy for SEA** (A Human and Child Rights Framework, MISP GBV Fact Sheet)	• Ensure adolescents are included in comprehensive GBV programming (MISP GBV Fact Sheet, Adolescent Participation Tool) • Ensure sex- and age-disaggregated data are included in protection\human rights reporting mechanisms • Ensure that all stakeholders are aware of the rights of adolescents (A Human and Child Rights Framework) • Strictly enforce a zero-tolerance policy for SEA (A Human and Child Rights Framework, MISP GBV Fact Sheet) • Ensure that adolescents are aware of how to access the SEA complaint mechanism

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Meeting Adolescent Sexual and Reproductive Health Needs in Humanitarian Settings			
Information, Education, Communication	• **Strategize on communication channels to reach adolescents at onset of emergencies** • Review, adapt, and develop IEC materials for ASRH in emergencies	• **Provide adolescents information about what SRH services are available and where they can be accessed** (MISP Matrix, Fact Sheets) • Ensure adolescents can access adolescent-friendly information on SRH (Community-based Distribution tools, Adolescent-friendly Health Services tool) • Ensure access to education, both formal and non-formal (MISP Coordination Fact Sheet, RH Entry Points in Adolescent Programs)	• Ensure SRH and HIV education is included in school curricula (RH Entry Points in Adolescent Programs) • Include puberty education for younger adolescents (10-14 years)(RH Entry Points in Adolescent Programs) • Make linkages with HIV life skills trainings and curricula (MISP HIV Fact Sheet, RH Entry Points in Adolescent Programs) • Generate adolescent demand and community support for health service provision (Community-Based Distribution tools)

Endnotes

1 United Nations. *World Population Prospects: The 2002 Revision*. New York: Population Division, Department of Economic and Social Affairs, United Nations, 2003.

2 UNFPA. "Adolescents and Young People: Key Health and Development Concerns." *State of the World Population 2004*. http://www.unfpa.org/swp/2004/english/ch9/page5.htm

3 UNFPA. *Making Reproductive Rights and Sexual and Reproductive Health a Reality for All: Reproductive Rights and Sexual and Reproductive Health Framework*. UNFPA, 2008.

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6 UNFPA. *UNFPA and Young People: Imagine*. UNFPA 2003. http://www.unfpa.org/upload/lib_pub_file/582_filename_unfpa_and_young_people.pdf .

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9 Save the Children, UNICEF, *The Evolving Capacities of the Child*, 2005.

Adolescent-Inclusive Implementation of the MISP for Reproductive Health in Humanitarian Settings

What is the MISP?

In acute emergencies, emphasis is placed on life-saving interventions, such as providing water and sanitation, control of communicable diseases, treatment of injuries and ensuring proper nutrition. RH interventions also save lives and are critically important at all times, including during crises. If particular attention is not paid to RH interventions, however, they can be overlooked or delayed during an emergency situation.

The ***Minimum Initial Service Package (MISP) for Reproductive Health*** is a set of priority interventions that is designed to "reduce mortality, morbidity and disability among populations affected by crises, particularly women and girls."[10] The MISP contains guidelines for providing coordinated RH services during the earliest phases of an emergency (natural disaster or man-made) and guides the planning for comprehensive RH services when the situation has stabilized. Implementation of the MISP has been included in the SPHERE Handbook as a *standard of care* in disaster response.[11]

The MISP has five objectives:

- to ensure SRH coordination;
- to prevent and manage the consequences of sexual violence;
- to prevent excess newborn and maternal morbidity and mortality;
- to reduce HIV transmission;
- to plan for the provision of comprehensive SRH services.

In addition to describing how to establish services that address each of the objectives, the MISP provides information on how to calculate SRH supply needs and procure Inter-agency Emergency RH Kits, which contain the commodities needed to provide SRH services during a humanitarian crisis.

A NOTE ON CULTURAL SENSITIVITY:

During an emergency situation, implementing agencies may be tempted to "jump in" quickly and introduce programs without taking the local cultural context into consideration. While the MISP focuses on *life-saving interventions* and must be implemented without delay, it is important to keep the cultural context in mind, especially when dealing with ASRH - a sensitive issue in some cultures.

Program managers and staff should be aware of the local beliefs and customs related to adolescent sexuality and SRH when introducing ASRH interventions. Promoting dialogue and involving the community, parents and adolescents in the planning, implementation and evaluation of ASRH programs will not only improve program quality, but will also help ensure that sensitive issues, such as GBV, FP, early pregnancy, and HIV, are addressed in ways that are culturally acceptable within the local context.

The introduction of life-saving interventions should never be delayed, but cultural sensitivity is key to community acceptance and uptake of ASRH programs and services.

How does the MISP address ASRH?

The MISP is a guideline for priority RH interventions in emergencies and does not specifically describe how to make services adolescent-inclusive. Agencies should, however, take steps to ensure that the SRH needs of adolescents are addressed during implementation of the MISP.

Each of the MISP components is described in more detail in the MISP matrix and the Fact Sheets that follow in this toolkit. The matrix and the fact sheets provide examples of how to identify and address adolescent SRH needs in the community.[12] Further information about the MISP can be found in the *Minimum Initial Service Package Distance Learning Module*, available at http://misp.rhrc.org.

MISP Services Matrix

The following table outlines SRH services delivered through the MISP and steps to be taken when planning for comprehensive SRH services. This table has been adapted from the table in Chapter 2 of the IAFM. The text in black is taken directly from the table in the MISP chapter. The text in **bold orange** demonstrates interventions that can be incorporated to provide adolescent-inclusive RH services during the implementation of the MISP and while planning for comprehensive RH services.

The table is intended to help the RH Officer appointed by the Lead RH Agency and Health Cluster advocate for adolescent inclusion in RH coordination meetings and to ensure that adolescents are included in MISP interventions. In addition, the table can help program managers ensure that their program interventions - during MISP implementation and while planning for comprehensive RH services - are adolescent-inclusive.

MISP fact sheets

The fact sheets that are included in this section are meant to accompany the MISP Services Matrix. They provide more detail on the key ASRH services that should be provided to ensure adolescent-inclusive implementation of the MISP, and they provide a brief summary of ASRH considerations when planning for comprehensive RH services.

SUGGESTED READING:

1. WHO, UNFPA, UNHCR. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.* Chapter 2, "Minimum Initial Service Package for Reproductive Health," 2009.

2. Women's Refugee Commission. *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: a Distance Learning Module.* http://misp.rhrc.org.

Adolescent-inclusive MISP services Matrix		
Subject Area	**MISP SRH Services**	**Planning for Comprehensive SRH Services**
Family Planning (FP)	Source and procure contraceptive supplies. • *Although comprehensive family planning is not part of the MISP, make contraceptives available for any demand.* • ***Health staff should be aware that adolescents requesting contraceptives have a right to receive these services, regardless of age or marital status.***	• Provide staff training • Establish comprehensive family planning programming • Provide community education • **Ensure that a broad mix of free FP methods is available** • **Provide community information, education and communication (IEC) directed toward adolescents** • **Involve adolescents, parents and community leaders in development of IEC strategy for FP in the community** • **Train staff in adolescent-friendly FP service provision** • **Train adolescents in Community Based Distribution CBD for FP education, condom and oral contraceptive pill (OCP) distribution and referrals to health centers.** • **Promote the use of dual protection (prevention of pregnancy and prevention of STIs, including HIV)**
Gender-Based Violence (GBV)	• Coordinate and ensure health sector prevention of sexual violence • Provide clinical care for survivors of sexual violence • **Provide adolescent-friendly care for survivors of sexual violence at health facilities** • **With the Protection Cluster and GBV sub-Cluster, identify a multi-sectoral referral network for young survivors of GBV** • **Encourage adolescent participation in any multi-sectoral GBV prevention task force** • **Through adolescents, raise awareness in community about the problem of sexual violence, strategies for prevention, and care available for survivors** • **Engage traditional birth attendants (TBAs) and community health workers (CHWs) to link young survivors of sexual violence to health services**	• Expand medical, psychological, social and legal care for survivors • Prevent and address other forms of GBV, including domestic violence, forced/early marriage, female genital cutting, trafficking, etc. • Provide community education • **Involve adolescent leaders, parents and community leaders in the development of strategies to prevent GBV in the community** • **Involve youth in community education on prevention of GBV** • **Raise awareness in community about the problem of GBV, strategies for prevention, and help available for survivors** • **Sensitize uniformed men about GBV and its consequences** • **Establish peer support groups**

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Adolescent-inclusive MISP services Matrix		
Subject Area	**MISP SRH Services**	**Planning for Comprehensive SRH Services**
Maternal and Newborn Care	• Establish 24/7 referral system for obstetric emergencies • Provide midwife delivery supplies, including newborn resuscitation supplies • Provide clean delivery packages • **Provide adolescent-friendly services at health facilities** • **Coordinate with the Health Cluster and other sectors to identify pregnant adolescents in the community and link them to health services** • **Engage TBAs and CHWs to link young mothers to health services** • **Encourage facility-based delivery for all adolescent mothers**	• Provide antenatal care • Provide postnatal care • Train skilled attendants (midwives, nurses and doctors) in performing Emergency Obstetric and Newborn Care (EmONC) • Access to basic EmONC and comprehensive EmONC increased • **Raise community awareness about the risks of early motherhood and the importance of skilled attendant (facility) delivery** • **Integrate mental health and psychosocial support services for adolescent mothers**
STIs, Including HIV Prevention and Treatment	• Provide access to free condoms • Ensure adherence to standard precautions • Assure safe and rational blood transfusions • *Although comprehensive STI programming is not part of the MISP, it is important to make syndromic treatment available for clients presenting for care as part of routine clinical services* • *Although providing anti-retroviral therapy (ART) continuation is not part of the MISP, it is important to make treatment available for patients already taking anti-retrovirals (ARVs) including for prevention of mother-to-child transmission (PMTCT) as soon as possible.* • **Provide discreet access to free condoms at adolescent-oriented distribution points** • **Ensure that adolescent-friendly health services are available for adolescents presenting to facilities with symptoms of STI**	• Establish comprehensive STI prevention and treatment services, including STI surveillance systems • Collaborate in establishing comprehensive HIV services as appropriate • Provide care, support and treatment for people living with HIV • Raise awareness of prevention, care and treatment services for STIs, including HIV • **Raise awareness of prevention and treatment services for STIs/HIV among adolescents** • **Train staff to provide adolescent-friendly STI and HIV-related services** • **Train adolescents in CBD for distribution of condoms, to provide education on STI/HIV prevention and testing and treatment services available and to provide referrals for services** • **Establish programs, including peer education, to adolescents most-at-risk for acquiring and transmitting HIV**

MISP: Coordination Fact Sheet for Adolescent Sexual and Reproductive Health

The implementation of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations requires coordination among humanitarian actors at the local, regional, national and international levels. Effective coordination will help to ensure that resources are used efficiently, that services are distributed equally without gap or duplication, and that information is shared among all of the actors involved.

Some key elements of coordination and examples of how they can be applied to ensure that MISP implementation is adolescent-inclusive are listed below.

Cluster-level coordination:

Coordination of RH activities during an acute emergency is the responsibility of the Global Health Cluster and the Lead RH Agency, which is designated by the Health Cluster. The Lead RH Agency appoints a full-time RH Officer for a minimum period of three months, during which technical and operational support is provided to partners to ensure that RH is prioritized and that there is good coverage of MISP services. The RH Officer oversees the implementation of the MISP and liaises with field-level RH representatives and stakeholders.

The key coordination activities that should take place during MISP implementation are outlined in the following *Terms of Reference (TOR)* for the RH Officer. The table below has been adapted from a table in Chapter 2 of the IAFM. The text in black is taken directly from the table in Chapter 2 and the text in **bold orange** highlights additional responsibilities that should be added to make MISP interventions and planning for comprehensive RH services more adolescent-inclusive. While these ASRH-related interventions should ideally be mainstreamed into the regular responsibilities of the RH Officer, they have been listed separately here to highlight them.

Lead Agency: RH Officer Terms of Reference	
Coordinate, communicate and collaborate:	• Work in close collaboration with the health sector/cluster coordinator(s) and actively participate in and provide information to the health sector/cluster meetings; • Host regular RH stakeholder meetings at relevant (national, sub-national/ regional, local) levels to discuss, problem-solve, strategize and coordinate to ensure the MISP is implemented. • Ensure regular communication among all levels and that key conclusions, issues and activities are reported back to the overall health coordination mechanism to identify synergies and avoid duplication of efforts and parallel structures; • Liaise with other sectors (Protection, GBV, HIV/AIDS) addressing RH; • Procure reference/resource materials and supplies for implementing the MISP; • Provide technical and operational guidance on implementing the MISP and audience-specific orientation on the MISP when and where it is feasible (e.g., for service providers, community health workers, program staff and the beneficiary population including adolescents); • Inform the health sector/cluster lead(s) of issues requiring response (EG, policy or other barriers that restrict the population's access to MISP services); • Disseminate MISP Summary to main stakeholders • Obtain RH funding within the health sector/cluster through humanitarian planning processes and appeals.

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Lead Agency: RH Officer Terms of Reference	

Coordinate, communicate and collaborate: (continued)	• **Advocate for RH attention to adolescents during implementation of the MISP;**
	• **Identify the most vulnerable adolescents through multi-sectoral collaboration and ensure that they are able to access RH services;**
	• **Provide adolescents with information about what RH services are available and where they can be accessed;**
	• **Engage government entities on ASRH to ensure national leadership and ownership;**
	• **During planning for comprehensive RH services:**
	• **Continue multi-sectoral approaches to RH, to ensure that adolescent needs are identified and addressed;**
	  ◦ **Collaborate with other stakeholders (agencies, MOH) to ensure that adolescent RH needs are covered, without duplication of services;**
	  ◦ **Continue engaging government entities on ASRH to ensure national leadership and ownership;**
	  ◦ **Advocate with leadership of uniformed services (police, military) for establishment and enforcement of zero-tolerance policies for GBV**

Identify, familiarize and understand:	• The elements of national and host country policies, regulations and customary laws that support MISP activities; • The elements of national and host country policies, regulations and customary laws that create barriers and restrict access of the affected population to MISP services; • Relevant MOH standardized protocols for selected areas (such as clinical management of rape and referral of obstetric emergencies; and, when planning for comprehensive RH services, syndromic case management of STIs and FP). If MOH policies do not exist, defer to and apply WHO protocols; • **Review and update standardized RH protocols to ensure they address the needs of adolescents.**

Obtain basic demographic and health information:	• Work within the health sector/cluster to ensure collection or estimation of basic demographic and health information of the affected population including:
	  ◦ Total population;
	  ◦ Number of women of reproductive age (ages 15 to 49, estimated at 25 percent of the population);
	  ◦ Number of sexually active men (estimated at 20 percent of the population);
	  ◦ Crude birth rate (estimated at 4 percent of the population);
	  ◦ Age-specific mortality rate (including newborn mortality rate newborn deaths 0 to 28 days);
	• Use MISP checklist to monitor services. Work within context of overall health coordination structure to collect services delivery information, analyze findings, and to respond to identified service-delivery gaps;
	• **Incorporate indicators that capture adolescent demographic data as well as utilization of RH services;**
	• **During planning for comprehensive RH services:**
	  ◦ **Monitor, analyze and report on adolescent RH services using standardized indicators on a monthly basis.**

SRH interventions, including implementation of the MISP, should be discussed in the Health Cluster (or within the health sector, in situations in which the Cluster is not activated). This will allow coordination of activities among NGOs, UN agencies, and national authorities and will ensure coverage of services without duplication or gaps. All RH staff should advocate for inclusion of adolescents during MISP implementation.

ASRH EXAMPLE: CLUSTER-LEVEL COORDINATION

After an escalation in fighting in the region, there is a massive influx of internally displaced persons (IDPs) into a camp where your agency provides health services. Your agency has been designated by the Global Health Cluster to take the lead on RH coordination for implementation of the MISP and you are designated as the RH Program Officer. You have been informed that there is a large number of unaccompanied adolescents among the new arrivals. Knowing that these adolescents are at high risk for RH and social problems, you advocate with the Health and Protection Clusters to designate stakeholders responsible for addressing the needs of the most-at-risk adolescents in the camp.

Multi-sectoral approaches to SRH:

Multi-sectoral approaches to SRH, involving health, protection, mental health and psychosocial support services, community services, camp management and education, promote coordination and increase the likelihood that vulnerable adolescents will have access to RH information and services. SRH (including ASRH) concerns are discussed at multi-sectoral coordination meetings, so that integrated approaches can be identified to address the problems.

ASRH EXAMPLE: MULTI-SECTORAL APPROACHES TO SRH

After recent political elections, there is widespread civil unrest and massive displacement of the population. There are reports that many young girls have been raped during the violent protests that have swept through the villages. A multi-sectoral GBV working group is formed, comprising adolescents and representatives from the various sectors. The working group develops strategies to ensure that adolescent-friendly health services are in place for survivors of sexual assault and establishes an inter-sectoral referral network for survivors. The group works with each sector to identify vulnerable adolescents and ensure that they have information regarding the RH services that are available, and it evaluates prevention measures to ensure that they adequately protect the most-at-risk adolescents.

Orientation to the MISP:

Audience-specific orientations should be conducted to introduce relevant stakeholders, including health workers, the beneficiary population, community service staff and uniformed personnel to the MISP.

ASRH EXAMPLE: MISP ORIENTATION

MISP orientation sessions are held with adolescent clubs, at schools, and other places where adolescents gather, to inform them about the ASRH services being provided and where and how they can be accessed. It also provides a forum for their participation and ability to educate other adolescents on the services available through the MISP as well as informing about potential adolescent-oriented sites for free condom distribution.

Use of standardized RH protocols:

To promote quality service provision, standardized RH protocols should be used (either MOH protocols, or if these do not exist, WHO protocols) and should be revised to meet the specific needs of adolescents. Standardized MISP protocols could include (1) adolescent-friendly clinical services, (2) clinical management of survivors of sexual violence, (3) treatment and referral of clients with obstetric emergencies, (4) standard precautions[13], and (5) condom distribution. As the situation stabilizes, program managers should also review comprehensive standardized protocols to see that they address the specific needs of adolescents and that they reflect adolescents' rights to access to RH information and services.

ASRH EXAMPLE: USING STANDARDIZED RH PROTOCOLS

After the acute crisis has stabilized, the RH program manager reviews the FP protocols at a health facility and notes that they state that *FP services will be available to all married women Monday through Friday from 8 am to 12 pm*. She realizes that this will exclude not only unmarried adolescents, but also those who attend school. After discussion with the clinic director and the RH staff, this is changed to state that *FP services will be available during all hours of clinic operation and are offered to all women and men, including adolescents, regardless of their marital status.*

Monitoring MISP services:

MISP outcomes should be monitored using the MISP service availability checklist, which is available in Chapter 2 of the Inter-agency Field Manual. In addition, the Adolescent-Friendly Services checklist found in this toolkit can be used to assess health facilities.

Further information about the MISP can be found in the MISP chapter *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* and the Minimum Initial Service Package Distance Learning Module, available at www.misp.rhrc.org.

ASRH EXAMPLE: MONITORING MISP SERVICES

As part of its emergency response to an earthquake, an agency monitored the services provided through implementation of the MISP. The program manager found that there was information lacking about adolescent reproductive health services and incorporated the following revisions to the data collection tools:

- *Total population, disaggregated by age and sex:* (under 10 years, 10-14 years and 15-19 years)
- *Number of condoms distributed + Number of condoms distributed at adolescent-friendly locations*
- *Number of sexual violence cases reported in all sectors, disaggregated by age and sex (under 10 years; 10-14 years; 15-19 years; 20 years or above)*

MISP: Adolescents and Sexual Violence Fact Sheet

Why is sexual violence important to consider for adolescents in emergency settings?

During an acute emergency, incidents of sexual violence, including rape, sexual abuse and sexual exploitation, are likely to increase. Adolescents who are faced with poverty or separation from their families or communities as a result of an emergency situation are at risk of sexual violence. They may be coerced to provide sex in exchange for food, clothing, security, or other necessities, or they may sell sex to earn money for what they or their families need. Adolescent girls, especially if they are unaccompanied or have the responsibility of caring for younger siblings, are at risk of rape and SEA because of their dependence on others for survival, because of their limited decision-making power, and because of their limited ability to protect themselves.[14] In addition, young girls may be subject to forced early marriage or trafficking by their families because of economic hardship. Existing sex- and age-related power disparities may become more prominent in an emergency setting. Despite the social upheaval that occurs during a crisis, adolescent girls may be expected to sustain cultural norms, such as modesty and virginity; if they fail to do so, they are at risk of violence from men within their homes or the community.

Adolescent girls are particularly vulnerable to sexual violence:

- during conflict, when rape may used as a method of war;
- during conflict, when adolescent girls may be forced to become child soldiers or sex slaves;
- during displacement from their homes of origin;
- while collecting water or firewood;
- in unsecured or unprotected sanitation or bathing facilities;
- at the hands of military, peacekeepers, humanitarian workers or community members (this includes both sexual assault and sexual exploitation).

Although the majority of GBV survivors are women and girls, men and boys can also be subjected to sexual violence. Marginalized adolescents, such as those with disabilities, migrants, and indigenous adolescents among others are also at risk of SEA.

What are the consequences of GBV among adolescents?

Adolescent survivors of sexual violence are at risk of physical injury, STIs including HIV, unwanted pregnancy and unsafe abortion. In addition to physical injuries, young survivors of sexual violence may suffer severe mental health and psychological problems. It is common for survivors to be blamed for the violence they experience and, as a result, they may experience social stigmatization, be deemed unmarriageable, and be rejected by their own families. In certain cultures, survivors of sexual violence may be seen as having dishonored their families and communities and, therefore, may be at risk of "honor killings" at the hands of their own family members.

What program interventions should be implemented to address adolescent GBV in emergency settings?

It is very important that adolescents be considered and specifically targeted for program interventions as the MISP is implemented. Programs should make efforts to reach out to those sub-groups who are at increased risk of sexual violence in emergencies: orphans, separated adolescents, adolescent heads of household, marginalized adolescents, and children associated with armed forces and armed groups (CAAFAG).

During implementation of the MISP, ASRH program interventions to support the prevention and clinical management of sexual assault in adolescents include:

- *Basic prevention activities:* Firewood and water patrols, well-lit paths to latrines and bathing facilities, and secure and sex-segregated latrine and bathing facilities should be introduced. Safe sleeping arrangements should be ensured, especially for orphans and separated adolescents. Temporary collective centers must be segregated by sex and age.

- *Multi-sector coordination with adolescent participation:* Efforts to prevent and address sexual violence should be coordinated among the health, protection, camp management, community services and security sectors. Examples of multi-sector coordination include:
  - A GBV prevention task force, with representation from the various sectors, community members and adolescents, can identify entry points to reach adolescents and develop prevention messages and strategies that specifically address adolescent vulnerabilities;
  - An inter-sectoral referral system should be developed, so that survivors of sexual violence who present to any sector are referred for health, protection or counseling services, as required;
  - Inter-sectoral meetings should be held on a regular basis to review the numbers, sex and ages of new clients seen by each service and to identify gaps or weaknesses in the referral network.
  - Inter-sectoral efforts should be undertaken to ensure that complaint mechanisms for SEA are in place and are adolescent-friendly.

Adolescent-friendly services: Clinical care for sexual assault survivors should be based on WHO/UNHCR 2004 *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* and should include treatment of physical injuries (or referral, if injuries are severe), post-exposure prophylaxis for HIV (PEP), emergency contraception (EC), presumptive treatment for STIs, hepatitis B and tetanus immunizations, either provision of or referral to mental health and psychosocial support, and voluntary referral to protection and legal services if available. The security of the survivor must always be a priority, and the health or protection sector may need to provide a

CHARACTERISTICS OF ADOLESCENT-FRIENDLY SERVICES FOR SURVIVORS OF SEXUAL VIOLENCE:

- Clinical services for sexual assault survivors should be available 24 hours per day, seven days per week, to avoid delays in treatment; services should be offered free of charge;
- Survivors of sexual violence should be triaged directly to treatment areas to protect their privacy. Alternatively, a separate, discreet entrance to the clinic can be made available, which allows survivors to access the treatment area directly, without passing through registration or the waiting area;
- If possible, the clinical examination of a sexual assault survivor should be conducted by a provider of the same sex. If this is not possible, a person of the same sex should accompany the survivor during the physical examination;
- Vaginal speculum examination may be very traumatic for the immature adolescent and should never be used in pre-pubertal girls. If a speculum examination is indicated (for example, suspicion of a vaginal injury or foreign body), the girl should be referred for specialist care.
- All staff, including registration clerks, guards, and cleaners should be non-judgmental and should be aware of the need to ensure the privacy and respect the dignity of young survivors;
- Services for adolescent survivors of sexual violence should be confidential; parental consent should not be required;
- Health workers should understand that sexual violence may also happen to boys and that male clients should receive the same level of clinical care and respect that female survivors receive.

safe place for the survivor to stay if there is risk of retaliation by the perpetrator and/or re-victimization by the family or community.

- Awareness-raising: All stakeholders, including community members, adolescents, health staff, staff from other sectors, humanitarian agents and security personnel, should be made aware of the problem of sexual violence and the risks faced by women, girls and other high-risk adolescents. Sexual violence prevention strategies should be communicated and information about where help is available and how to access it should be made available. Adolescents should know that confidential services are available for all survivors, regardless of age or marital status.
    - During MISP implementation, this information can be provided through MISP orientation sessions, which should include sessions for adolescents, as well as through IEC materials distributed in the community. Community health workers (CHWs) and traditional birth attendants (TBAs) should also be informed, so that they can link young survivors to services. As the emergency stabilizes, health information and education campaigns can convey these messages with the involvement of adolescents.
    - It is important to raise awareness about SEA among humanitarian personnel, including personnel from UN agencies, peacekeeping forces, and NGOs. **For all humanitarian workers, a zero-tolerance policy for SEA must be enforced.**
    - Other uniformed services (police, military) should be sensitized about GBV and its consequences. The health cluster and the RH Officer should advocate with officials to ensure that zero-tolerance policies are in place for SEA among uniformed personnel.
- Community linkages: ASRH programs should try to link with any networks already existing in the community to reach adolescent survivors and to disseminate prevention messages. For example, CHWs and TBAs can provide information to the community on prevention measures and clinical services available. They may be aware of young survivors of sexual violence in the community and should know how to refer these clients for clinical services as well as legal and psychosocial support. Religious or other community leaders may also be good resources for identifying problems within the community and for disseminating information.

GBV is a broader term that encompasses a wide range of issues, including sexual violence, trafficking, domestic violence, and harmful traditional practices such as female genital cutting (FGC) and forced early marriage. As crisis situations stabilize, other forms of GBV are reported more frequently, although sexual violence continues to be an important problem for adolescents. Once the emergency has stabilized and comprehensive RH services are introduced, multi-sectoral collaboration is important to ensure that:

- GBV awareness-raising and prevention activities are carried out at the community level, with adolescents, with military and peacekeepers, and with humanitarian workers;
- the community and adolescents are involved in developing GBV prevention strategies and improving the mechanisms for handling complaints about SEA;
- staff are trained (or re-trained) in screening for GBV and in sexual violence prevention and response systems;
- appropriate, confidential, ethically-sound data collection, storage, analysis, and dissemination systems have been established;
- the systems to prevent and address GBV that were established during the acute phase are continued and strengthened; and
- the community is involved in referring GBV survivors to health facilities and other support services.

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MISP: Adolescents and Maternal and Newborn Health Fact Sheet

Why are maternal and newborn health important concerns for adolescents in emergency situations?

During emergencies, there are many situations that make adolescent girls vulnerable to early pregnancy. Sexually active adolescents may not have access to information about reproduction or access to FP services and they may engage in unprotected sex. Married adolescents may be expected to become pregnant right away in order to demonstrate their fertility. Adolescent girls are at risk of rape, SEA, or they may be compelled to engage in sex work in order to meet their own needs or the needs of their families. Young female soldiers may be forced to "marry" commanders or have sex with other combatants.

In any situation, young pregnant women are a high-risk group; this is particularly true in the emergency context, when family and social support systems are disrupted and health services may be less accessible than during normal times. A study of countries in sub-Saharan Africa has suggested that maternal mortality is significantly higher in countries with recent armed conflict, as compared to those without recent conflict.[15]

Pregnancy is a leading cause of death among girls aged 15 to 19, most frequently due to complications of delivery and unsafe abortion.[16] Adolescents aged 15 to 19 are twice as likely to die during pregnancy and childbirth — as are those in their twenties — and very young adolescents, under 15 years of age, have a fivefold increase in risk of death during pregnancy and childbirth compared with women 20 and older.[17] Adolescents, particularly girls under 16, have immature pelvises which may be too small to allow a baby to pass through the birth canal. This can result in obstructed labor, a medical emergency requiring an emergency cesarean section. Delay in accessing emergency obstetric care for obstructed labor can lead to obstetric fistula or to uterine rupture, hemorrhage and death of both the mother and the baby.

Adolescent mothers are also more likely to have spontaneous abortion, premature births and stillbirths than older mothers. The infants of adolescent mothers are 50 percent more likely to die during their first year of life than those born to mothers in their twenties,[18] and countries which have experienced recent war or civil unrest have especially high rates of newborn mortality.[19]

Social issues also put adolescent mothers into the high-risk category. Girls who become pregnant are usually forced to leave school. Unmarried pregnant girls are frequently shunned by their families or the community, so they may hide their pregnancies or attempt to terminate their pregnancies using unsafe methods. Without a family or social safety net and faced with the economic burden of providing for a child, young mothers become vulnerable to sexual exploitation. Domestic violence (including physical abuse and "honor killings") may threaten the well-being of both married and unmarried pregnant adolescents and their unborn children.

What program interventions should be implemented in an emergency situation to promote maternal and newborn health among adolescents?

Maternal and newborn health interventions are life-saving interventions that are incorporated into the MISP in the earliest stages of an acute emergency, when the normally-existing health services may be disrupted or inaccessible. The MISP focuses on clean and safe delivery to reduce maternal and newborn deaths. Other aspects of maternal and newborn health (antenatal and postnatal care, FP, etc.) are addressed later, when comprehensive RH services are introduced.

Implementation of the MISP provides clean delivery packages to pregnant women and birth attendants for home deliveries and midwife delivery supplies to health facilities. Basic emergency obstetric and newborn care (EmONC) services should be established at health facilities and should be available 24 hours per day, 7 days per week and referral systems to comprehensive EmONC services should be in place.[20] Program managers should ensure that pregnant adolescents are aware of the risks of early pregnancy and that they are linked to the health system for delivery.

ASRH program interventions to link young pregnant women and mothers to maternal and newborn health services during implementation of the MISP include:

- *Multi-sector coordination:* Coordinate with camp management, protection and community services sectors to identify pregnant adolescents in the community. Raise awareness among staff from all sectors that adolescent pregnancies are a high risk for both the mother and the unborn child and identify ways to link pregnant adolescents with maternal and newborn health services (clean delivery packages, facility-based delivery and referral services). If necessary, health workers should link pregnant adolescents to other sectors, such as protection, for additional support.
- *Adolescent-friendly obstetric services:* Health providers should understand the health risks associated with early pregnancy and the importance of providing confidential obstetric services to adolescents, regardless of their age or marital status and without requiring parental or spousal consent. Health workers should be non-judgmental and should protect the privacy and dignity of the adolescent mother and her child. While health facility delivery should always be encouraged, pregnant adolescents should be provided with clean delivery packages, which can be used at the time of delivery, either in the health facility or at home. Adolescents should be provided with information and access to safe abortion services when legal.
- *Engaging traditional birth attendants or community health workers:* If traditional birth attendants (TBAs) are already active in the community, they can serve as links to facility-based services, identifying pregnant adolescents in the community and informing them about where to seek care if they experience complications during pregnancy or childbirth.
- *Awareness-raising about services available:* Information about the risks of adolescent pregnancy and the adolescent-friendly obstetric services available should be provided during MISP orientation sessions with adolescent groups, in schools or other places where adolescents gather.

After the situation has stabilized, other maternal newborn health interventions can be introduced to link young pregnant mothers with the health system and to encourage delivery in a health facility. Some examples include:

- *Community-based strategies* for ante-natal and post-partum care (using medical outreach teams or community health workers) may make those services more accessible and acceptable to adolescents. Community-based workers can identify young pregnant mothers and link them to appropriate health services.
    - TBAs and pregnant adolescents should be educated about the importance of skilled birth attendance at delivery. Adolescents may be more likely to deliver in a health facility with skilled attendants if they are accompanied by someone whom they trust. TBAs should be taught the danger signs of pregnancy, labor and delivery so that if an adolescent develops a complication during pregnancy or home delivery, the TBA knows to refer her to the health facility immediately.
- *Birth plans* should be developed with young mothers, their partners and their families to avoid unnecessary delays in seeking medical attention when they go into labor.
- *Maternity waiting homes* located near health facilities provide women with a safe place to stay during the final weeks of their pregnancies. Establishing maternity waiting homes and making them available to adolescent mothers may help ensure that these high-risk mothers deliver in EmONC facilities.
- *Family planning* options should be discussed with young mothers during pregnancy and again at the post-partum visit; and referral should be made for FP services, if desired.
- *Breastfeeding support* should be provided to ensure that adolescents use proper feeding practices and infants receive optimal nutrition.
- *Infant care support groups* should be established to help adolescent mothers take care of their babies.
- *Mental health and psychosocial support* must be integrated into maternal and newborn health services.
- *Education programs* should be supported so that adolescent mothers can continue with their education.

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4. WHO, UNFPA, UNHCR. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*., Chapter 6: "Maternal and Newborn Health," 2009.

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6. Women's Refugee Commission. *Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*, RHRC Consortium: July, 2005. http://www.womenscommission.org/pdf/EmOC_ffg.pdf.

MISP: Adolescents and STI/HIV Prevention and Treatment Fact Sheet

Why is prevention and treatment of STIs and HIV in adolescents important during emergency situations?

In emergency situations, the risks of STIs and HIV among adolescents can increase: the social structures that normally influence behavior are broken and power disparities between men and women may increase, which can lead adolescents to engage in consensual or coerced sexual activity at earlier ages. Adolescents are at greater risk of SEA; and although more research is needed on this issue, livelihood insecurity may lead adolescents to engage in sex work in order to meet their survival needs.

What program interventions should be introduced to address STIs and HIV in adolescents during an emergency?

ASRH program responses during the implementation of the MISP should focus on prevention of HIV transmission, although adolescents who present with symptoms of STIs should receive treatment. HIV prevention activities in the MISP are limited to condom distribution, adherence to standard precautions and safe blood transfusions.

- *Condom distribution:* Male condoms (and if available, female condoms) should be available to adolescents free-of-charge at distribution points located in places that are discreet and convenient to access. ASRH program managers may engage selected adolescents in the community to help identify adolescent-friendly distribution points and inform others that condoms are available. In addition, condoms should be offered to any person (regardless of sex, age, or marital status) who requests them or who presents to the health facility with symptoms of STIs.

  It is important that programs supply sufficient number of condoms to provide for the entire sexually active population, including adolescents. Male and female condoms can be obtained from UNFPA through the Inter-Agency RH Kits, from the Ministry of Health, from other donor agencies, or can be purchased on the open market.

  A minimum of three-months' supply of condoms should be procured.[21]

- Other prevention of HIV transmission: Clinical care for survivors of sexual assault should include post-exposure prophylaxis (PEP) for HIV and presumptive treatment of STIs.
- *Standard precautions* to prevent transmission of HIV and other blood-borne infections should be enforced in the health facilities at all times. Equipment and supplies for standard precautions (sharps containers, gloves, etc.) should be among the first items procured when implementing the MISP; health care workers may require refresher training on standard precautions. Blood safety protocols should be introduced to prevent transmission of HIV or other blood-borne pathogens through transfusions.

Non-MISP interventions:

- *ART/PMTCT:* If ART and services for prevention of mother-to-child transmission (PMTCT) of HIV were available before the crises began, they should be continued during the emergency, if possible. If these services weren't previously available, they should be introduced as soon as possible once the emergency has stabilized.
- *Treatment of STIs:* Although comprehensive STI programming is not part of the MISP, any man or woman - regardless of age or marital status- who presents to a health facility with symptoms of STI should be treated appropriately and offered condoms.

Once the emergency situation has stabilized and comprehensive RH services are being planned, ASRH programs should consider ways to provide adolescents with access to prevention and treatment services, with special attention to those sub-groups at higher risk for STI and HIV. Some ASRH program interventions to be implemented as part of comprehensive RH services include:

- *Continuation of MISP interventions:* The prevention, treatment and referral services that were introduced during the acute emergency should be continued and strengthened once the situation stabilizes.

- *Expansion of HIV services:* HIV services should be expanded to include expanded prevention activities, condom distribution, HIV counseling and testing (HCT) and PMTCT; prophylaxis and treatment of opportunistic infections, and care and support for people living with HIV (PLHIV) should also be included. If ART is not available, a system for referring clients requiring ART should be established, if possible.
- *Establish prevention activities and support groups for adolescents living with HIV to* help them plan their sexual and reproductive lives.
- *Community-based strategies* should be considered, such as condom distribution by adolescents trained in CBD, mobile or home-based HCT, and home-based care for PLHIV to make these services more accessible to adolescents who may be afraid, embarrassed or unable to seek care in a health facility.
- *Peer counselors and educators* can be trained to provide information and counseling that is more acceptable to adolescents.
- *Multi-sectoral interventions* for high-risk sub-groups: Multi-sectoral prevention strategies should be developed. A referral network should be established among health, protection and livelihoods to address the needs and develop prevention strategies for all adolescents, with particular focus on high-risk sub-groups.
    - Targeted multi-sectoral intervention strategies for prevention, care and treatment should be developed for those adolescents who are most-at-risk of acquiring and transmitting HIV (MARA), including injection drug users (IDU); adolescents with multiple sexual partners, including those who sell sex and their clients; and adolescent men who have sex with men.
- *Behavioral change communication (BCC):* BCC programs for HIV and STI prevention should be developed specifically for adolescents, with messages that are relevant and in language that is understandable by adolescents. Adolescent and community organizations should participate in the development and dissemination of BCC messages through a variety of media, such as visual materials, radio, dance and drama groups. Peer-to-peer approaches may be particularly effective forms of BCC.
- *Mental health and psychosocial support:* ASRH programs must pay particular attention to the mental health and psychosocial needs of adolescents who are HIV-positive. HIV-positive adolescents may experience depression, fear, stigma and bereavement. These psychological stresses, in addition to the psychological and emotional stress associated with adolescence, can place a great burden on his or her mental health. HIV and AIDS themselves can biologically induce mental health problems such as depression, acute psychotic disorders and dementia. Mental health problems may impair the adolescent's judgment and decision-making capacities, which can have a negative impact on health-seeking behaviors and adherence to drug regimens and may also increase the likelihood that s/he will transmit HIV through high-risk behaviors. Adolescents with existent mental health problems may also have impaired judgment, which puts them at risk of engaging in high-risk activities and acquiring HIV.

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1. *Holmes, W. Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations*, International Rescue Committee, 2003.
2. IASC. *Guidelines for HIV/AIDS Interventions in Emergency Settings*. http://www.who.int/3by5/publications/documents/iasc/en/index.html
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8. Women's Refugee Commission, *Guidelines for the Care of Sexually Transmitted Infections in Conflict-affected Settings,* RHRC Consortium: 2004.

MISP: Adolescents and Family Planning Fact Sheet

Why is family planning for adolescents important in an emergency setting?

In any setting, adolescents have the right to receive accurate and complete information about SRH, including FP. Unfortunately, parents and other adult role models commonly don't want to discuss issues such as FP with adolescents because of cultural or religious norms, which prohibit sexual relations before marriage. In addition, health workers may be unwilling to provide FP information or services to adolescents (particularly those who are unmarried) because of their own personal beliefs or cultural pressures.

Access to FP is particularly important in crisis settings, when adolescents are affected by the loss of normal family and social support structures and when facility- and community-based systems for providing FP information and services may be disrupted. During emergencies, adolescents may be sexually exploited or may engage in high-risk sexual behaviors. This can lead to unwanted pregnancy, which may lead to other negative consequences such as death of the mother and/or the child, unsafe abortion, and social stigmatization of the young mother.

What FP interventions should ASRH programs implement in emergencies?

While comprehensive FP programming is not considered part of the MISP, contraceptives should be available during the acute phase of an emergency to respond to requests for FP. Later, when the situation has stabilized, it is important to consider ways to reach adolescents with FP information and comprehensive services.

- *Provide adolescent-friendly services:* Facility-based services should be "adolescent-friendly," meaning that the facility has been set up in such a way that ensures privacy and confidentiality, and makes adolescents feel comfortable accessing services. To provide adolescent-friendly services, health providers should be aware of the vulnerability of adolescents to early pregnancy and the dangers of pregnancy in adolescence. They must treat adolescent clients with a positive attitude and respect the right of an adolescent to receive confidential FP information and services, regardless of age or marital status and without the consent of a parent or guardian.

Emergency Contraception (EC) can be used by adolescents to prevent pregnancy after either consensual or forced unprotected sexual intercourse. EC can also be used when a regular FP method fails (for example, when a condom breaks, when the adolescent has not taken her OCPs properly, etc.)

The most commonly used EC methods are the combination oral contraceptive pills and progestin-only pills (both are referred to as ECPs). Copper-bearing intrauterine devices can also be used for EC. ECPs are most effective when taken immediately after unprotected sexual intercourse, but they may remain effective in preventing pregnancy when taken up to 120 hours (five days) after unprotected sex.

Adolescents should be aware that EC is available and it should be included in all discussions about FP methods, including during FP counseling. EC should not be considered a "regular" form of FP, as other methods are more effective. If an adolescent presents requesting EC, s/he should receive it, along with counseling about all other forms of FP and encouragement to select a "regular" FP method.

- *Offer a broad-method mix:* ASRH programs should include information and access to a broad mix of FP methods, including EC. It is important to emphasize to the young FP client that s/he may choose whatever method(s) s/he prefers, without feeling as if s/he has been coerced into choosing any specific method.
- *Provide quality counseling:* Provide complete information about all of the methods available and their effectiveness and allow the adolescent to make a choice. Quality FP counseling includes explanation (and demonstration, when appropriate),

of how to correctly use each method. Some considerations for FP counseling include (WHO, 2007):

- All methods of FP are safe for use by adolescents, although permanent methods, such as tubal ligation and vasectomy should be discouraged for adolescents without children.
- Young women may be less tolerant of side effects. It is important to explain possible reactions during FP counseling in order to increase the likelihood that they will continue FP and seek alternative methods if the side effects persist.
- Adolescents have less control over when and with whom they have sex and over contraception than older women, which increases their need for EC. Any adolescent who requests emergency contraception should receive counseling on all methods of FP and should be allowed to take EC with her (see text box).
- Adolescents may prefer more discreet methods (such as injectables or intra-uterine devices) that can be used without drawing attention and would require fewer visits to the health facility.

- *Encourage condom use for dual protection:* Since they may engage in unsafe sexual practices that put them at risk for STIs or HIV/AIDS, adolescents should be strongly encouraged to use condoms for dual protection against pregnancy and STI/HIV.
- *Look for alternative ways to reach adolescents:* Because of the barriers to accessing RH information and services faced by adolescents, it is important that ASRH programs look for alternative ways to reach out to this group.

  Community-based services may be the best way to reach particularly at-risk sub-groups of adolescents, such as married girls, child heads of household and girl-mothers. Training adolescents in CBD can be great resources to the ASRH program by providing community- or home-based FP counseling, distribution of certain methods (typically condoms and oral contraceptive pills - OCPs) and referrals to health facilities for other methods. Adolescents may be more likely to access FP services from adolescents trained in CBD because they feel more comfortable in the home setting and because they feel less intimidated about discussing SRH issues with a peer than they would with an adult.

  In situations where schools are functional, teachers can provide RH orientation sessions, which include discussions on FP. The *Letter Box Approach* (Sharma & Sharma, 1995) is a method through which adolescents can anonymously submit questions via a letter box and teachers respond to the questions during group educational sessions. This method could also be implemented through peer educators. Teachers or other trusted members of the community may also serve as community distributors of condoms and OCPs. (For more information on the Letter Box Approach, please see the reference below.)

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Adolescents, Mental Health and Psychosocial Support Fact Sheet

Why are adolescent mental health and psychosocial support important during emergency situations?

While mental health and psychosocial support are not areas of focus during implementation of the MISP, they are critical components of overall health and are inseparable from physical health. Nevertheless, mental health and psychosocial aspects of health are commonly overlooked in times of crisis. Emergencies create fissures in community and family networks, and the loss of protective support functions can have a disproportionate impact on adolescents. During an emergency, social and psychological problems (e.g., social stigma due to membership within a marginalized group, alcohol abuse, GBV) persist and may be amplified, and new psychological problems such as anxiety, grief, post-traumatic stress disorder and depression can emerge. Within the context of a humanitarian emergency, adolescents may experience extremely stressful and traumatic events, such as witnessing atrocities, being displaced, becoming separated from loved ones, being subject to physical and sexual violence, or being forcefully recruited to serve in fighting forces.

WHAT IS MEANT BY MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT?

Mental health and psychosocial support (MHPSS) is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.

From IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*

Adolescence is a period of tremendous growth and development, and navigating the social, behavioral, cognitive and physical changes under "normal" circumstances, let alone during a crisis, can be extremely challenging. Although not every person will develop psychological problems in a crisis, adolescents are at increased risk of experiencing social and/or psychological problems. Addressing mental health and psychosocial issues can help adolescents to develop resilience, enabling better decision-making capacity and healthier risk-taking behavior. It is therefore important to integrate mental health and psychosocial support into emergency-response mechanisms. Studies show that nearly one in three survivors of GBV develops mental health problems (WHO 2008), underscoring the vital nature of mental health and psychosocial support services for survivors of GBV.

How do mental health and psychosocial support impact reproductive health?

Mental health and psychosocial problems may be both causes and consequences of SRH problems among adolescents. Mental, psychological and emotional barriers are important factors to consider for access and adherence to FP-related services. Mental health and psychosocial issues can impair decision-making capacities and increase high-risk behaviors, such as unprotected sexual intercourse. This, in turn, leads to the risk (and the associated distress) of unwanted pregnancies and to acquiring or transmitting HIV and other STIs.

In the developing world, 1 in 3 to 1 in 5 pregnant women experience a significant mental health problem, such as depression, during pregnancy and after childbirth; in the developed world, 1 in 10 women experience depression during pregnancy or in the post-partum period.[22] Depressed women are less likely to seek and receive prenatal or postpartum care, and perinatal depression is associated with an increased risk of obstetric complications. The mental health of the mother also has an impact on the child's health and survival. A mother's poor mental health is associated with an infant's increased risk of low birth weight, malnutrition, diarrheal disease and infectious illnesses. It is important that pregnant and post-partum women have access to mental health and psychosocial

support services to protect them and their infants from increased morbidity and mortality.

PLHIV, their partners and their families may suffer from mental health and psychosocial problems due to fear, stigma and other stressors; HIV and AIDS themselves can biologically induce mental health problems such as depression, psychosis and dementia. Up to 44 per cent of persons living with HIV suffer from depression (WHO 2008). Mental health and psychosocial problems can also interfere with adherence to treatment regimens. Sexual experimentation is a normal part of adolescence and HIV-positive adolescents require psychosocial support and counseling to help them plan their reproductive lives.

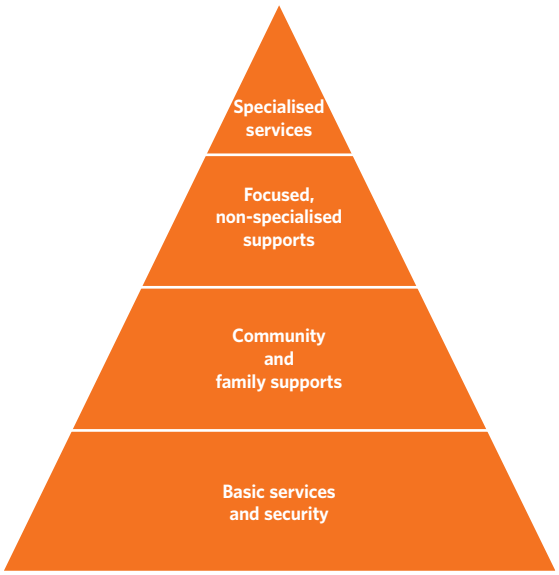
What program interventions should be implemented to address adolescent mental health and psychosocial support in emergencies?

It is important that program personnel, including health workers, are aware of the risks and consequences of mental health and psychosocial problems among adolescents and that they are alert to signs of mental health and psychosocial issues, particularly among high-risk sub-groups. Health staff should be trained to identify mental health and psychosocial problems and to make appropriate interventions and referrals, if needed. Referral networks should be multi-sectoral, involving health, protection, livelihoods, education, social services, etc. Community-based and peer-to-peer support structures (peer counselors, adolescent groups, women's groups, etc.), should be considered once the situation has stabilized. If these networks are already established, they may be helpful in reaching those adolescents with disabilities and those who are marginalized or otherwise unable to access services during an acute emergency.

The core principles of emergency mental health and psychosocial interventions are: (1) Promote respect for human rights and **equity**; (2) Promote community (adolescent) participation; (3) Do no harm; (4) Build on available resources and capacities; (5) Integrate activities and programming into wider systems (such as health programs, education programs, etc); and (6) Develop a multi-layered response (IASC 2007).

The following diagram, from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, shows the suggested "intervention pyramid" for response in emergency settings. This illustrates the multiple layers of mental health and psychosocial interventions in an emergency, which should, ideally, be implemented simultaneously.

FIGURE 2: Intervention pyramid for mental health and psychosocial support in emergencies. Each layer is described below.



- **Specialized services** - provide professional support to the small group of people with severe mental health problems, which cannot be addressed by the other supports. Agencies should either establish a system to refer people for specialized services, or should train health staff to provide these services.
- **Focused, non-specialized supports** - provide supports for smaller groups of people who may require individualized care by trained and supervised workers. An example of this is a program for survivors of sexual violence which combines livelihoods activities with emotional support and protection.

- **Community and family supports** - provide support to a smaller number of people, and may include the activation of social networks (adolescent clubs, women's groups), livelihoods and education activities. An example would be a system of adolescent community outreach workers who link child-headed households with livelihoods activities, health services and education programs.
- **Basic services and security** - ensure the wellbeing and protection of the entire community, including safety, food security, and health. Agencies should take special steps to see that these services are accessible to vulnerable adolescents.

While all SRH programs should integrate mental health and psychosocial support services, no single agency is expected to address all issues related to adolescent mental health and psychosocial support independently. Agencies and the community should collaborate to ensure that adolescents' mental health needs are identified and addressed.

SUGGESTED READING:

1. IASC, *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf.
2. UNFPA. *Emerging Issues: Mental, Sexual and Reproductive Health*. 2008. http://www.unfpa.org/upload/lib_pub_file/764_filename_mhenglish.pdf
3. WHO. *Improving Maternal Mental Health*. 2008. http://www.who.int/mental_health/prevention/suicide/Perinatal_depression_mmh_final.pdf.

Endnotes

[10] IAFM, Chapter 2.

[11] Sphere Handbook, 2004, p. 288.

[12] IAFM, Chapter 2.

[13] The term *standard precautions* refers to infection control measures that reduce the risk of transmission of blood-borne pathogens through exposure of blood or body fluids among patients and health care workers (IAFM, 2009). This term replaces the term *universal precautions*, which was used previously.

[14] IASC. *Guidelines for Gender-Based Violence Interventions in Emergency Settings*, 2005. p. 4.

[15] O'Hare, B and Southall, P. "First Do No Harm: the Impact of Recent Armed Conflict on Maternal and Child Health in Sub-Saharan Africa," *Journal of the Royal Society of Medicine*. Vol. 100, December, 2007. pp. 564-570.

[16] UNFPA. *State of the World's Population 2004*. 2004. http://www.unfpa.org/swp/2004/english/ch9/page5.htm

[17] ibid.

[18] Shane, B. *Family Planning Saves Lives*. Third Ed. Population Reference Bureau. Washington: Jan. 1997. pp 4, 16.

[19] Save the Children. *State of the World's Mothers 2006*. 2006., p.10. http://www.savethechildren.org/publications/mothers/2006/SOWM_2006_final.pdf

[20] MISP Distance Learning Module, p. 39

[21] Formulas for calculating male and female condom needs are available in the IAFM and MISP module.

[22] WHO, *Improving Maternal Mental Health*, 2008.

Participation Tools

Adolescent Participation

Rationale: Adolescents have the right to participate in SRH programs that target them. As demonstrated by many programs elaborated in development settings, adolescents' involvement in the design and implementation of programs as well as in program monitoring are key to ensuring that programs are both acceptable and accessible to them and that their SRH needs are being met.

In addition, adolescent involvement in program evaluation can guide the development of future programming. 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.

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 the emergency circumstances. The following matrix provides some examples of ways that adolescents can participate during implementation of the MISP and comprehensive SRH services.

Participation for ASRH in humanitarian settings		
	During MISP Implementation	**Comprehensive RH Services**
Who to engage	▪ Adolescent leaders[23] ▪ Existing adolescent groups and networks ▪ High-risk adolescents[24] *Female and male adolescents should have equal access to and participate equally in all activities*	▪ Adolescent leaders ▪ Adolescent groups and networks ▪ High-risk adolescents ▪ Adolescent advisory panels *Female and male adolescents should have equal access to and participate equally in all activities*
Needs Identification/ Program Design	▪ Participate in **forums** such as SRH coordination meetings or GBV prevention task forces; ▪ Identify suitable locations for making condoms available to adolescent females and males; ▪ Map out existing adolescent-oriented, gender-sensitive services; ▪ Participate in the design of ASRH strategies and messages.	▪ Continue to participate in activities carried out during MISP implementation; ▪ Through focus group discussions (with inclusion of high risk groups), provide feedback on their needs and assistance in identifying their most-at-risk peers. ▪ Ensure the integration of gender considerations at all stages of the needs assessment and program design.
Program Implementation	▪ Share information with peers about the importance of seeking medical care for survivors of sexual violence and where that care is available; ▪ Inform pregnant adolescents about where to seek skilled delivery care when they go into labor; ▪ Share information with peers about where to access adolescent-friendly, gender-sensitive and confidential SRH services, including contraception and treatment for STIs;	▪ Continue to participate in activities carried out during MISP implementation; ▪ Be trained in CBD and as peer educators and counselors; ▪ Set up clubs that include activities especially targeted at most at-risk adolescents and drama or music groups that disseminate behavior change communication (BCC) messages. ▪ Ensure that program activities are gender-sensitive in terms of their location, timing and participation of male and female adolescents together or separately as culture and social practices dictate. ▪ Establish psychosocial support groups for adolescent survivors of sexual violence and for adolescents living with HIV.
Program Monitoring and Evaluation	▪ Provide feedback on program implementation through participation in SRH coordination, GBV prevention task force, and other similar forums.	▪ Continue to participate in activities carried out during MISP implementation; ▪ Participate in monitoring of quality of RH programs; ▪ Participate in the evaluation of ASRH programs by contributing to the elaboration of the methodology, the analysis and the actual data collection process.

There are several models for adolescent participation that have been used in development contexts and that could be adapted for use in emergency situations. Two examples of field-tested models are described below.

The **Partnership-Defined Quality for Youth (PDQ-Y)** methodology, which is used by Save the Children, engages youth and health workers in a process that identifies adolescent SRH needs, defines quality, explores ways of collaborating, and emphasizes mutual responsibility for problem solving. The process involves meeting with adolescents and health workers separately to explore their perceptions of ASRH needs, quality of care, the strengths and weaknesses of the existing services, and the responsibilities and rights of the clients and health workers. Then, there is a bridging the gap session, during which adolescents and health workers come together to share their ideas and come up with ways to collaborate with the shared vision of improving adolescent-friendly services. In the final step, adolescents and health workers work in partnership to develop and implement action plans, and adolescents are involved in monitoring the quality improvements of health services (Save the Children, 2008).

The Youth-Adult Partnerships (YAP) model, developed by Family Health International and YouthNet, is based on the principles that youths have the right to participate; that participation makes programs more relevant and sustainable; and that participation increases the resiliency and development of young persons. Through this model, adults and adolescents engage not only in dialogue, but also in action as equal partners. The YAP model integrates adolescent perspectives and skills with adult experience and wisdom; offers each party the opportunity to make suggestions and decisions; recognizes and values the contributions of each; and allows youth and adults to work in full partnership envisioning, developing, implementing, and evaluating programs (FHI, 2005). In order for YAP to be successful, adolescents and adults must show mutual respect. Adults must feel confident in the adolescents' abilities to make decisions; they must see the adolescents' assets and recognize the value of what they can contribute to the partnership; and they must be willing to provide the adolescents with additional training, if needed. (Norman, J. Advocates for Youth, 2001).

The participation of high-risk adolescents, including those who are very young, separated from their families, heads of household, CAAFAG, marginalized or have disabilities, is particularly important during crisis situations. The participation of high-risk adolescents can help reduce barriers to accessing SRH information and services and can help programs be sure that the specific needs of these groups are addressed.

SUGGESTED READING:

1. Advocates for Youth. Transitions. Vol. 14, No. 1, October, 2001. http://www.advocatesforyouth.org/storage/advfy/documents/transitions1401.pdf.
2. *Save the Children. Partnership-Defined Quality for Youth: A Process Manual for Improving Reproductive Health Services Through Youth-Provider Collaboration*, Save the Children, 2008. www.savethechildren.org.
3. WHO/UNFPA/UNICEF. *Programming for Adolescent Health and Development: a Report of a WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health*. WHO, 1999. http://www.who.int/child_adolescent_health/documents/trs_886/en/print.html
4. YouthNet, Family Health International. *Youth Participation Guide: Assessment, Planning and Implementation*. FHI, 2005. http://www.fhi.org/en/youth/youthnet/rhtrainmat/ypguide.htm.

Community and Parental Participation

Rationale:
Implementing agencies, health staff and adolescents may embrace ASRH programs, but these programs are unlikely to be sustainable if they do not have the support of the local community, including parents. 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.[25] Even in emergency settings, parents and community members should be involved and consulted from the design phase of ASRH programming.

There are many ways to involve parents and the community in ASRH programming. The models for adolescent participation mentioned in the Adolescent Participation tool (PDQ-Y and YAP) all emphasize the development of adolescent-adult partnerships. These models can be adapted to involve parents and community members in identifying adolescents' SRH needs and developing and implementing programs to address those needs.

The tool illustrated below has been adapted from the conceptual framework developed by the IAWG on Community Involvement in Youth RH and HIV Prevention. The tool can be used in a group encounter with community members, parents, adolescents and health care workers at any stage during the emergency situation, although it is probably most useful after the emergency has stabilized, when planning for comprehensive RH services.

Methods used in this exercise could include brainstorming, small and large group sessions with plenary discussions or debates. Because the goal of the exercise is to identify ways to promote community and parental support for ASRH services and interventions, decisions should be made by consensus to the greatest degree possible.

The steps used in this exercise are listed below.

Step 1: In broad terms, identify the ASRH problems in the community.

Step 2: Using the results of the Initial Rapid Assessment, the Situation Analysis, or the Comprehensive Adolescent Sexual and Reproductive Health Assessment (depending on the phase of the emergency), outline the Baseline ASRH Situation in the community and discuss how this contributes to the ASRH problem.

What factors among adolescents, parents, the community and health services contribute to the ASRH-related problem(s) in the community?

Step 3: Identify the overall goal of the ASRH program.

What would you like to ultimately achieve, in terms of ASRH in the community? What would you like to ultimately achieve, in terms of community support for ASRH? (Note: The goals may go beyond the scope of the program interventions that you will develop.)

Step 4: Identify the individual, structural, and social changes (outcomes) that you would like to see as a result of this program.

Individual: What are the ASRH-related behaviors and beliefs that you want to see in adolescents, parents and community members as a result of these processes?

Structural: What changes do you want to see in health services as a result of these processes? What changes do you want to see in the accessibility of services?

Social: What changes do you want to see at the greater level as a result of these processes? (changes in social norms, age- and gender-equity, accessibility of information, etc)

Step 5: Identify interventions that can be introduced to: (1) Increase awareness in the community of the ASRH problem and (2) promote community support for ASRH interventions.

Identify interventions that will contribute to the desired outcomes (individual, structural and social changes).

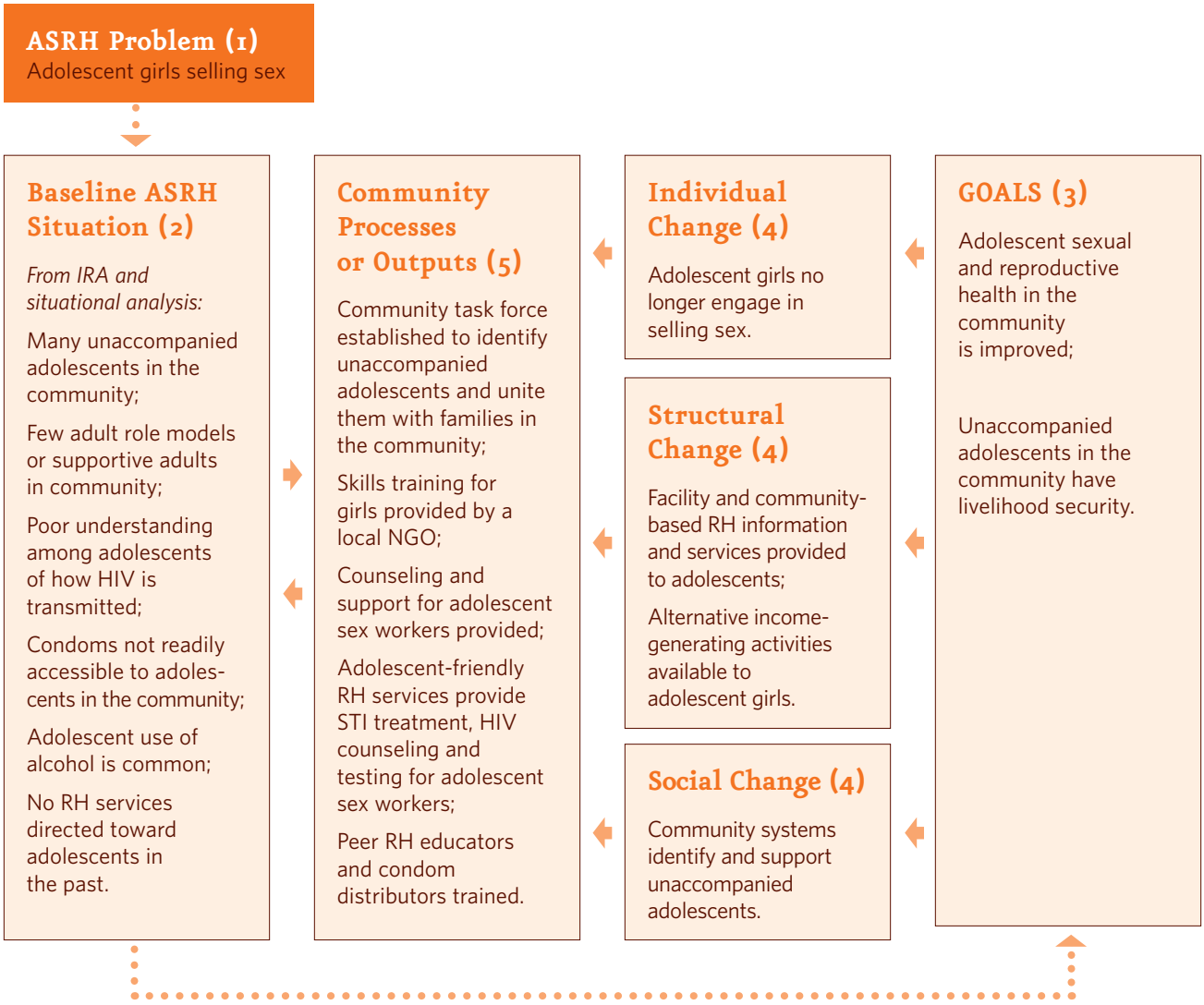
Include interventions that involve collaboration among adolescents, community members and parents.

ASRH Example:
Figure 3 illustrates illustrates the process of consultation with parents, community members, health workers and adolescents in a conflict-affected community to develop a strategy addressing the ASRH problem of *adolescent girls* who are selling sex.

Discussion with community members and adolescents reveals that these girls have been separated from their families as a result of the conflict and have resorted to selling sex in order to survive.

(*Note:* In a real situation, this diagram would likely be expanded to address more than one ASRH problem.)

FIGURE 3



SUGGESTED READING:

1. IAWG on the Role of Community Involvement in ASRH. *Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators*, December, 2007. http://web.unfpa.org/upload/lib_pub_file/781_filename_iawg_ci.pdf

Reproductive Health Entry Points in Existing Adolescent Programs

Rationale:
Because of barriers that prevent adolescents from accessing RH information and services, it is important to look for alternative ways to reach adolescents. The matrix below lists non-RH adolescent programs that may be present in a community after an emergency has stabilized. The matrix suggests entry points that might be accessed or used to provide SRH information to adolescents and link them with SRH services, either in a facility or the community. It may also be useful during RH coordination and multi-sectoral meetings where adolescent SRH issues are discussed.

Type of adolescent program	Reproductive health entry points
Schools	• "Peer" educators offer age-appropriate RH education sessions in schools; • RH outreach staff provide RH question-and-answer sessions to older adolescents in classroom settings; • Teachers or school nurses are trained to deliver health curriculums, including education on puberty and menstruation; gender and sexuality; FP; HIV prevention; GBV; and age-appropriate life skills such as identifying values and understanding consequences of behaviors (for young adolescents) and negotiating relationships and condom use (for older adolescents);[26] • Teachers and peer educators provide RH orientation sessions for adolescents, using such methods as the Letter Box Approach (see FP fact sheet); • Train teachers to identify high-risk adolescents and develop a system linking them with ASRH services; • Teachers or school nurses act as community distributors of condoms and other contraceptives (such as OCPs); teachers distribute sanitary materials for menstrual hygiene.

Adolescent clubs and centers (drama, sports, religious)	• Support drama or music groups to disseminate accurate ASRH information, including information about services available. Organize performances at community events.
	• Invite peer counselors to provide ASRH information sessions for participants before each adolescent sporting event.
	• Train sports coaches to provide and incorporate ASRH information into coaching sessions.
	• Ask group leaders to set aside a private space within their meeting areas and:
	  • Offer HIV counseling and testing at adolescent program activities;
	  • Schedule health/RH clinics during adolescent activities and gatherings;
	  • Invite adolescents trained in CBD to group activities.
	• Offer group counseling for HIV at adolescent meetings or gatherings (ONLY if testing is available - either onsite or at facility)
	• Establish condom distribution points.

Continued ▸

◀ Continued

Type of adolescent program	Reproductive health entry points
Vocational or skills training program; non-formal education programs for out-of-school adolescents	• Using peer counselors, organize monthly "Youth Talk" sessions for out-of-school adolescents to address ASRH topics. • Work with program leaders to establish system linking high-risk adolescents to RH information and services.
Disarmament, demobilization and reintegration (DDR) programs	• Train adult mentors in HIV counseling. Link CAAFAG with HCT services, as well as care and treatment services (including PMTCT) for HIV+ girls and boys. • Work with CAAFAG and adolescents in DDR programs to identify peers who have not been included into DDR program (particularly girls and older adolescents) and identify ways to link them to life skills and SRH education programs and to SRH services • Work with mentors and program leaders to establish system linking high-risk adolescents to RH services • Receiving communities should be prepared for returning children and young people through awareness raising and education; particular attention should be paid to myths that may circulate among communities about returning boys and girls (e.g. reports of real or presumed rates of prevalence of HIV among children) which can lead to stigma or discrimination. • Provide SRH and life skills training for demobilized boys and girls, including HIV prevention, GBV, FP, gender and sexuality, negotiating relationships, condom use.
Media and communications	• Support adolescents to develop and broadcast adolescent-friendly radio "spots" and programs that provide SRH information and inform adolescents of services available and where to access them. • With adolescent participation, publish a newsletter or newspaper that addresses ASRH topics.

SUGGESTED READING:

1. African Youth Alliance. *Reaching Out-of-School Youth with Life-Planning Skills Education: The African Youth Alliance's Behavior Change Communication Efforts in Arusha, Tanzania*. Dar es Salaam, Tanzania: PATH, 2005. http://www.path.org/files/AH_aya_chawakua.pdf.

2. Family Health International. *YouthNet Brief: Zambia, Peer Educators bring RH/HIV messages to the Classroom in Zambia*. http://www.fhi.org/NR/rdonlyres/eajhaq5ugapy4qb5a2slwmykuejfnbofa3vr-j3gfe2mlzd3yhhoapnjk5ekm5zgowyny2wtuyfpzoa/Zambiaclassroompeeredenyt.pdf.

3. INEE Gender Task Team. *Gender Strategies in Emergencies, Chronic Crises and Early Reconstruction Contexts*. "Gender Responsive School Sanitation and Hygiene," www.ineesite.org/uploads/documents/store/doc_1_58_Gender_Strategies_in_ Emergencies.WT2.doc.

4. Specht, I. "Children and DDR." *Seen, but not Heard: Placing Children and Youth on the Security Governance Agenda*. Ed. Nosworthy, D. , Zurich: LitVerlag GmbH &Co., 2009. pp. 191-217. http://se2.dcaf.ch/serviceengine/FileContent?serviceID=21&fileid=A24C89E1-6860-7370-A2F3-97D908B23F29&lng=en.

5. United Nations. *Integrated Disarmament, Demobilization and Reintegration Standard*. Module 5.20: "Youth and DDR," 2006. http://www.unddr.org/iddrs/05/download/IDDRS_520.pdf.

6. United Nations. *Integrated Disarmament, Demobilization and Reintegration Standards*. Module 5.30: "Children and DDR," 2006. http://www.unddr.org/iddrs/05/download/IDDRS_530.pdf.

7. WHO, UNFPA, UNHCR. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. Chapter 4: "Adolescent Reproductive Health." 2009.

Endnotes

[23] Adolescent leaders include those who represent their peers or have leadership roles in social, community or other groups and those who have positive influence over other adolescents.

[24] High-risk adolescents refer to those listed in the introduction: very young adolescents, pregnant girls, marginalized adolescents and sub-groups, such as separated adolescents and adolescent heads of household, survivors of sexual violence, adolescents who sell sex and CAAFAG.

[25] IAWG. *Community Pathways to Improve Adolescent Sexual and Reproductive Health: a Conceptual Framework and Suggested Outcome Indicators*. Oct. 2007.

[26] Teachers, coaches and any other persons interacting with adolescents should be trained in and abide by a *Code of Conduct*, which regulates their interactions. All adults interacting with adolescents should be monitored, and adolescents should be allowed to provide feedback on their interactions.

Assessment Tools

Assessing Adolescent Sexual and Reproductive Health

In a humanitarian crisis, it is important to understand the SRH situation of both male and female adolescents to develop a plan that responds to their specific needs. Information about SRH needs is gathered through assessments conducted during the course of an emergency situation.

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. It is important to remember that the MISP is a life-saving set of interventions that are implemented without prior assessment. The initiation of the MISP should never be delayed while waiting for results of any assessment, including the IRA.

After an emergency situation has stabilized, a *situational analysis* will provide information about the baseline status of RH needs and services, and will help the agency prioritize interventions when comprehensive RH services are introduced. Situational analyses may use several methods of data collection, including secondary data, in-depth interviews, focus-group discussions (sex-separated, if culturally required), community mapping, and facility assessments.

Comprehensive RH assessments are not often conducted in emergency situations because they are time-consuming and they can place additional burdens on precious human and logistic resources. After stabilization of an acute emergency, however, a comprehensive RH assessment of RH knowledge, beliefs and behaviors, can provide valuable information that will help an agency design an SRH program that responds to the specific gendered needs of the beneficiary population.

IMPLEMENTATION OF THE MISP TAKES PRIORITY!

Life-saving interventions are the priority during an acute emergency. For this reason, the MISP is always the first RH intervention to be introduced. The MISP should never be delayed while waiting to conduct an assessment or analyze results.

Ethical and Legal Considerations when Conducting Assessments with Adolescents

Adolescents have the right to the highest attainable standard of health, including sexual and reproductive health, during emergency situations. In both emergency and stable situations, it is often necessary to collect information about the adolescent population, in order to understand their SRH needs and design programs that specifically address those needs. Adolescents should be permitted to contribute to the knowledge base that is used to guide the programs they benefit from. It is essential, however, that care is taken not to cause harm to the adolescent or put him/her at risk for the sake of collecting adolescent data. This is particularly important with regard to ASRH, which may be personally, culturally or politically sensitive.

The WHO Scientific and Ethical Research Group (SERG) has established guidelines for the ethical collection of data from adolescents. These guidelines are summarized as follows:

- Parents and guardians have the legal and ethical responsibility to protect very young and dependent adolescents and to provide them with preventive and therapeutic health care. If the results of the assessment will lead to improved preventive and therapeutic care for the adolescent, then parents and guardians should not be opposed to their participation in the process.

  Generally, parents and guardians do not have the legal power to overrule the decisions of mature (competent) adolescents who wish to participate in an assessment. From a legal perspective, agencies or individuals conducting SRH assessments do not violate the law by involving adolescents who are sexually active (or who are about to become sexually active) in studies when the benefit to the adolescent outweighs the risk. If, however, the local law denies decision-making power to adolescents who are below a certain age (regardless of their competence or maturity), then this law must be respected.

- Ethical considerations that must be taken into account when conducting assessments or research among adolescents.

  1. Agencies conducting research or assessments among adolescents must ensure that:
     - The goal of the assessment is to obtain information that is relevant to adolescents' health needs;
     - The information could not be scientifically gained from adult sources;
     - The risk of conducting the assessment is low in comparison with the benefit that will be obtained from the information;
     - The interventions that are introduced as a result of the assessment will directly benefit adolescents and will be at least as advantageous as any available alternative.

       Special care must be taken when collecting data from very young adolescents. Very young adolescents should not be recruited for the assessment unless the information gained from them cannot be obtained from older adolescents.

  2. Unless the law specifically states otherwise, consent to participate in the assessment should be obtained from the adolescent alone. If the adolescent is mature enough to understand the purpose of the proposed assessment and the level of involvement requested of him/her, then s/he is mature enough to provide informed consent to participate.
  3. Confidentiality must always be observed when conducting research with adolescents.

4. Confidentiality must always be maintained, even when parents (or both adolescents and parents) have provided consent.

5. Institutions conducting assessments involving adolescents must be sensitive to the needs of adolescents and should have the appropriate staff and facilities to care for this population group.

6. In circumstances in which researchers believe they are obligated to report adolescent behavior to any authority, the adolescent subject must be made aware of the possibility of such reporting prior to his/her involvement in the assessment.

Other ethical considerations:

In addition to the above, there are other important ethical issues that must be taken into consideration:

• Approval

Prior to conducting an assessment, it is important to obtain permissions from the body coordinating the emergency response (the Global Health Cluster, for example) as well as from national and local government and health authorities, community leaders and partner organizations.

• Security

The security of the beneficiary population and the staff should be of primary concern. If conducting the assessment could put the participants or the study team at risk, then the assessment should not be conducted.

• Referrals

The assessment (or sections of the assessment) should not be conducted if appropriate referral services are not available. For example, questions regarding sexual assault should not be asked unless there are medical and psychological services available to a participant who reveals that s/he is a survivor of sexual assault.

• Informed consent

Informed consent must be obtained from each individual involved in the assessment. The participant must be fully informed of the purpose of the assessment, the methods that will be used, the nature of the questions that will be asked, and the risks and benefits of participating.

• Participation

Participation in an assessment is completely voluntary. An individual has the right to refuse to participate in the assessment and may decide to withdraw at any time. S/he may also choose not to answer any question without being pressured by the interviewer to respond. It is the obligation of the individuals or agency conducting the assessment to respect the wishes of the participant if s/he decides not to participate.

• Privacy

Data should be collected in a setting where privacy is ensured (both visual and auditory) and where adolescents feel comfortable, so that the participants are more likely to respond freely to questions. Adults or older adolescents must not be allowed in the room during the interview. If the participant is a caregiver of a very young child, it is permissible that the child be in the room during the interview, but it is preferable that other arrangements to care for the child be made if possible.

• Confidentiality

The assessment team has the obligation to maintain the confidentiality of the participants at all times before, during, and after the assessment. Members of the assessment team must not discuss any aspect of the assessment, except with the study supervisor, if clarification is needed. The identities of the participants must be guarded and must not be linked to the responses that they provide. The participants' responses must not be discussed anywhere, with anyone except with the study supervisor if clarification is needed. If questionnaires are used, they must not contain information that could be used to identify the participants, and they should be kept in a locked cabinet; if there is any risk that the questionnaires might endanger the participants or the staff in the future, they should be destroyed once data analysis is complete.

• Institutional Review Boards (IRBs)

Agencies, institutions and governments may have institutional review boards, or IRBs, which have the responsibility to approve, monitor and review any research conducted with human subjects. IRBs are also known as *ethical review boards* (ERBs). The requirements of the agency, government and funding institutions should be reviewed to ensure IRB compliance, prior to conducting any assessment.

SUGGESTED READING:

1. RHRC. *Monitoring and Evaluation Toolkit*. 2004. http://rhrc.org/resources/general%5Ffieldtools/toolkit/index.htm.
2. WHO Scientific and Ethical Review Group (SERG). *Guidelines for Conducting Research on Reproductive Health Involving Adolescents*. http://www.who.int/reproductive-health/hrp/guidelines_adolescent.html.

Initial Rapid Assessment for Adolescent Sexual and Reproductive Health in Emergency Settings

An initial rapid assessment (IRA) is conducted within the first 72 hours of an emergency situation, to collect crucial demographic information and identify key issues within the targeted population that need to be addressed immediately. Initial rapid assessments typically focus on issues related to shelter, food, water and sanitation, health and nutrition of children under five years, and protection in the affected population.

Minimal initial data can also help identify the SRH needs and risk factors of adolescents. The following form provides key indicators that can be used to collect information about ASRH during the acute stage of an emergency situation. This information is intended to supplement the Health, Nutrition and WASH Initial Rapid Assessment and the form should be adapted to fit the context of the crisis. More detailed information is gathered later, through a situational analysis and/or comprehensive RH assessment.

A NOTE ABOUT THIS TOOL:

The data collected with this tool cannot stand alone!

This tool is intended to complement the Initial Rapid Assessment developed by the IASC Health, Nutrition and WASH Clusters, which does not include information that is specific to adolescent SRH. The data must be analyzed in conjunction with the findings from the IRA to draw conclusions about adolescents' immediate SRH needs.

See Inter-Agency Standing Committee. *Initial Rapid Assessment (IRA): Guidance Notes*. 2009.

http://www.humanitarianreform.org/humanitarianreform/Default.aspx?tabid=75

Initial Rapid Assessment for Adolescent Sexual and Reproductive Health			
Number of adolescents (10-14 years), disaggregated by sex	Females		Males
Number of adolescents (15-19 years), disaggregated by sex	Females		Males
Number of unaccompanied adolescents, disaggregated by sex	Females		Males
Number of adolescent-headed households, disaggregated by sex and age	Females		Males
Number of pregnant women who are <16 years old and 16-19 years old	16 years		16 -19 years
Number of married girls, <18 years of age			
Are there national or local laws in place that might restrict adolescents' ability to access RH services?	Yes	No	Comments
Are adolescent-friendly, gender-sensitive SRH services currently being provided in the community? (If yes, specify where)	Yes	No	Comments
Are adolescent-friendly, 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 condom distribution (specify location(s))			
List any adolescent groups or organizations active in the community			

Situational Analysis for Adolescent Sexual and Reproductive Health in Emergency Situations

After an emergency situation has stabilized, a situational analysis will provide information about the baseline status of adolescent RH needs and services and will help the agency prioritize interventions as comprehensive RH services are introduced. Situational analyses may use several methods of data collection, including secondary data, in-depth interviews, focus group discussions, community mapping, and facility assessments.

As mentioned in the introduction to this section, there are certain ethical considerations that must be taken into account when conducting a situational analysis. If all of the ethical requirements cannot be met, then it is inappropriate to proceed with the situational analysis.

Example: Focus group discussions (FGD)

Focus group discussions (FGDs) require a significant amount of planning and preparation. Selection of the discussion participants is important. Participants in a focus group should be of similar age and sex, 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, CAAFAG, separated boys, etc. The ideal number of participants per FGD should be 8-10 persons. In addition to the focus group participants, there should be one discussion leader, who is responsible for asking the questions and guiding the encounter, and one reporter, who is responsible for documenting all that is said during the course of the discussion. The participants, leader and reporter should sit in a circle to encourage equal participation and to discourage the perception that any individual is dominant over another.

Prior to conducting the FGD, the objective of the discussion should be determined and the question guide should be developed. The ideal number of questions to be asked during an FGD is 10-12 and adequate time should be set aside to ask the questions and allow for in-depth 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.

(Additional guidance on how to select participants, conduct FGDs and analyze the data can be found in the "Selected readings," referenced at the end of this section.)

The following matrix illustrates the types of questions that can be asked of stakeholders during focus group discussions to gather information on the RH needs and practices of adolescents. For each focus group, program managers should select a maximum of 10-12 questions from the sample and adapt them to fit the context of the situation.

Situational Analysis Questions Adol. Sex. Repro. Heath in Emergencies Situations				
	Adolescents	**Parents**	**Community Leaders**	**Health Workers**
Knowledge, attitudes and behaviors of adolescents	• Are adolescents in the community having sex? If so, at what age do boys start? At what age to girls start? Has this changed for girls or boys since this emergency began? Who are their partners? Have their partners changed since the emergency began? • What are the ways one can avoid getting pregnant? What are the modern ways? Are there traditional ways? • Can a girl get pregnant the first time she has sex? Can a girl get pregnant if she has sex only once? • 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? • Have you heard about AIDS? Do you believe it exists? What can be done to prevent AIDS? • Are condoms available for adolescents who are having sex? If so, from where? Are adolescents using them? Do girls use them? Do boys use them? If not, why not?	• 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) with your children?	• What is the community's attitude towards sexual and reproductive 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? Have they changed since the emergency began?	• Where do adolescents in the community seek treatment for STIs? Contraception? Prenatal care? Delivery care? Unwanted pregnancy? • What do you do when an unmarried adolescent presents to the clinic with an STI? For HIV counseling and testing? For contraception? For prenatal care? For delivery care? For an unwanted pregnancy? After a sexual assault? • How would you describe adolescents' knowledge about correct condom use? • How do you deal with a married adolescent client who comes to the facility for sexual or reproductive health services?

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Situational Analysis Questions Adol. Sex. Repro. Heath in Emergencies Situations				
	Adolescents	**Parents**	**Community Leaders**	**Health Workers**
Adolescent risks	• What different kinds of sexual activity are adolescents having in the community? Which kinds of sex are the most risky? Why? • What are all the different reasons that adolescents have sex? Are some kinds of sexual partnerships riskier for adolescents? Why? • Do you know any girls or boys 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 been with a sex worker? If yes, how many? (a few, many,most, all). • Do you know of girls/boys 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? • What do you think rape is? If a girl or boy was raped here, would she/he tell anyone? If yes, who? If no, why not? Would s/he go to anyone for help? If yes, who? If no, why not? • Are there boys who have sex with boys? • What are some of the influences that lead adolescents in the community to become pregnant? What are some of the influences that prevent them from becoming pregnant? • Are girls/boys worried about getting AIDS? Do you think that adolescents in the community are at risk of getting the AIDS virus? Why or why not? • Do you think that adolescents in the community are at risk of getting STIs? 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).	• What can be done to reduce the number of adolescents getting pregnant? • Are adolescents in the community at risk for STI or HIV? Why or why not? • What kinds of traditional rites of passage or ceremonies are practiced in the community? (FGM, forced marriage, abduction, wife-inheritance, etc.) Do these put adolescents at any risk? Why or why not?	• Are adolescents in the community at risk of STI or HIV? Are they at risk of pregnancy? Why or why not? • How do adolescents in the community resolve conflicts? • What is the average age of marriage for boys and girls in the community?	• What is the average age of first childbirth in the community? • What kinds of rites of passage or traditional ceremonies are practiced in the community? (FGM, forced marriage, abduction, wife-inheritance, etc.) What are the health impacts of these?

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Situational Analysis Questions Adol. Sex. Repro. Heath in Emergencies Situations				
	Adolescents	**Parents**	**Community Leaders**	**Health Workers**
Accessibility and availability of ASRH information and services	• If you had a question about sexual or reproductive health, what would you do? Would you talk to someone about it? If yes, who? If no, why not? • 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 no, why not? • Where would you go to get contraceptives if you needed them? Anyplace else? Do you have to pay for them? Is it difficult or easy to get contraceptives? • Sometimes girls get pregnant when they don't want to. What do girls do when they are pregnant but do not want to be? What modern things? What traditional things?	• Where do adolescents get information about sexual and reproductive health? Where do you think that they should get this information? • Where can adolescents go to get sexual and reproductive health services, including family planning? • How do you feel about adolescents having access to contraceptives and condoms? • What are the reasons that adolescents might not seek care for sexual or reproductive health problems?	• Where can adolescents get reproductive health information and services including family planning? • Where do you think that adolescents should get information about sexual and reproductive health? • Do adolescents have access to contraception and condoms? How do you feel about this? • What are the reasons that adolescents might not seek care for sexual or reproductive health problems?	• How should the sexual and reproductive health needs of adolescents in the community be addressed? • What health programs or opportunities have been designed to reach adolescents? By whom were they designed? • What are the reasons that adolescents might not seek care for sexual and reproductive health problems?

SUGGESTED READING:

1. FHI. "Focus Group Guide". *HIV Rapid Assessment Guide*. p. 47, 2001. http://www.fhi.org/en/HIVAIDS/pub/guide/RapidAssessmentGuide/index.htm.

2. RHRC. *Monitoring and Evaluation Toolkit*. RHRC, 2004. http://rhrc.org/resources/general%5Ffieldtools/toolkit/index.htm[b1].

Comprehensive Sexual and Reproductive Health Survey for Adolescents in Emergency Situations

Comprehensive SRH assessments are time-consuming and require significant human and logistical resources. They can, however, provide valuable information about adolescents' SRH knowledge, beliefs and behaviors that can be used to guide program design. Comprehensive SRH assessments should be conducted after the emergency situation has stabilized.

When conducting a comprehensive SRH assessment, it is important to be reminded of the ethical issues discussed in the introduction to this section. If any of the ethical requirements cannot be met, then it is inappropriate to proceed with the assessment.

The following questions complement the CDC *Reproductive Health Assessment Toolkit for Conflict-Affected Women* and can be used to collect information about adolescents' knowledge, attitudes and utilization of reproductive health services, as well as their sexual behaviors. When incorporating ASRH services as a part of a comprehensive reproductive health package, these indicators can serve as a baseline to guide programming and assess changes over time.

A NOTE ABOUT THIS TOOL:

The data collected with this tool cannot stand alone!

This tool is intended to complement the CDC *Reproductive Health Assessment Toolkit for Conflict-Affected Women*, the most widely-used RH assessment tool in emergency settings. However it does not include information that is specific to adolescent SRH. The questions in this tool must be asked along with the questions in the CDC *Toolkit* and the data analyzed together, in order to draw conclusions about adolescents' knowledge, attitudes and utilization of sexual and reproductive health services and their sexual behaviors. Please note that the questions included in this tool are intended for both adolescent girls and boys from age 15 and older.

SUGGESTED READING:

1. CDC, USAID. *Reproductive Health Assessment Toolkit for Conflict-Affected Women*, 2007. http://www.cdc.gov/ReproductiveHealth/Refugee/ToolkitDownload.htm
2. Schenk K and Williamson J. Ethical *Approaches to Gathering Information from Children and Adolescents in International Settings: Guidelines and Resources*, Population Council, 2005. http://www.popcouncil.org/pdfs/horizons/childrenethics.pdf.

Part I ASRH Services: Knowledge, Attitudes and Utilization

These questions can be asked after Section 1: Background Characteristics in the CDC Toolkit

No	Questions	Coding Categories	Skip to:
Q101	Is there a place in your community where young people like you are able to visit to talk and find out about relationships, sex, contraception, sexually transmitted infections, HIV/AIDS, etc?	Yes 1 No 2 No response 88 Don't know 99	 → **Q103** → **Q103** → **Q103**
Q102	What kinds of sexual and reproductive health services are provided for adolescents? *Circle All Mentioned* *1 = mentioned 2 = not mentioned*	Education and counseling regarding SRH 1 2 VCT for HIV 1 2 Miscarriage/Post-abortion care services 1 2 Family planning services 1 2 STI treatment and counseling 1 2 Pregnancy care and delivery 1 2 Mental health and psychosocial support 1 2 No response 88 Don't know 99	
Q103	Have you ever visited a health facility or other place to get sexual and reproductive health services in the last year?	Yes 1 No 2 Wanted to, but services/ facility not available/accessible 3 No response 88 Don't know 99	 → **Q110** → **Q110** → **Q110** → **Q110**
Q104	Have you ever visited a health facility or other place to get sexual or reproductive health services in the last three months?	Yes 1 No 2 Wanted to, but services/facility not available/accessible 3 No response 88 Don't know 99	 → **Q110** → **Q110** → **Q110** → **Q110**

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No	Questions	Coding Categories	Skip to:
Q105	What was the reason for your most recent visit to a health facility for sexual or reproductive health services? *Circle All Mentioned* *1 = mentioned 2 = not mentioned*	Education and counseling regarding SRH 1 2 VCT for HIV 1 2 Miscarriage/Post-abortion care services 1 2 Family planning services 1 2 STI treatment and counseling 1 2 Pregnancy care and delivery 1 2 Vaccination 1 2 To get condoms 1 2 To get mental health and psychosocial support 1 2 Other (specify) _____ 1 2 No response 88 Don't know 99	
Q106	Would you return to the health facility again?	Yes 1 No 2 No response 88 Don't know 99	→ **Q108** → **Q108** → **Q108**
Q107	What is the reason that you won't return to the health facility? *Circle All Mentioned* *1 = mentioned 2 = not mentioned*	Takes too much time 1 2 Too difficult to get there 1 2 Costs too much 1 2 Too embarrassing 1 2 Not enough privacy 1 2 Mistreated by staff 1 2 No staff of the same sex available 1 2 Other (specify)_____ 1 2 No answer 88 Don't know 99	
Q108	Whom did you talk to or see at the health facility the last time you went? *Circle All Mentioned* *1 = mentioned 2 = not mentioned*	Doctor 1 2 Nurse 1 2 Health Aid 1 2 Peer educator/counselor 1 2 Other (specify)_____ 1 2 No answer 88 Don't know 99	

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No	Questions	Coding Categories	Skip to:
Q109	Was the service provider: *[Read all responses, multiple answers are possible. Circle all that apply]*	Knowledgeable and well-qualified 1 Friendly and polite 2 Interested in you and your problems 3 A good communicator 4 Respectful 5 Concerned about your privacy 6 Honest and direct 7 A good listener 8 Able to help you 9 No response 88 Don't know 99	**Skip to next section**
Q110	Would you feel comfortable going to a health facility found in your area for sexual and reproductive health services?	Yes 1 No 2	**Skip to next section**
Q111	Why wouldn't you feel comfortable going to a health facility in your area for sexual and reproductive health services? *Circle All Mentioned* *1 = mentioned 2 = not mentioned*	Not confidential 1 2 Too embarrassed 1 2 Staff unfriendly 1 2 Costs too much 1 2 Other (specify)_____ 1 2 No response 88 Don't know 99	

Part II Adolescent Sexual Behaviors

These questions can be used with Section 5: Sexual History in the CDC Toolkit

No	Questions	Coding Categories	Skip to:
Q201	Have you ever had sexual intercourse?	Yes 1 No 2 No response 88 Don't know 99	→ **Q203**
Q202	At what age would you like to have sexual intercourse for the first time?	Age in years_____ After marriage 77 No response 88 Don't know 99	**Skip to next section**
Q203	At what age did you first have sexual intercourse?	Age in years_____ No response 88 Don't know 99	

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No	Questions	Coding Categories	Skip to:
Q204	How old was the person with whom you had sexual intercourse for the first time?	Age in years_____ No response 88 Don't know 99	
Q205	Thinking about the first time you had sexual intercourse, could you tell me which statement best describes your experience? [Interviewer should read each statement and code Yes (1) or No (2). Multiple responses are permitted]	I was willing 1 2 I was persuaded 1 2 I was tricked 1 2 I was forced 1 2 I was raped 1 2 I was coerced (received money, food, clothing, gifts) 1 2 I was expected to do it as part of my job 1 2 No response 88 Don't know 99	
Q206	Have you ever received anything (such as money, food, gifts, etc.) from someone in exchange for having sex with him/her?	Yes 1 No 2 No response 88 Don't know 99	
Q207	Have you ever had sexual intercourse when somebody was physically forcing you, hurting you, or threatening you?	Yes 1 No 2 No response 88 Don't know 99	
Q208	How many persons have you had sex with in your lifetime?	Number_____ No response 88 Don't know 99	
Q209	In the past three months, have you had sexual intercourse with anyone?	Yes 1 No 2 No response 88 Don't know 99	**→ Skip to next section** **→ Skip to next section** **→ Skip to next section**
Q210	With how many persons have you had sexual intercourse in the past three months?	Number_____ No response 88 Don't know 99	
Q211	Think of the last person you had sex with in the last three months. How long did the relationship last? [If less than one month, record the number of days; if more than one year, convert to months]	Months_____ Days_____ No response 88 Don't know 99	

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No	Questions	Coding Categories	Skip to:
Q212	Think of the last person you had sex with in the last three months. How would you describe this person?	Boyfriend/girlfriend (steady partner) 1 Spouse 2 Casual partner 3 Employer 4 Fiancé(e) 5 Sex worker 6 Other_____ No response 88 Don't know 99	
Q213	Think of the last person you had sex with in the last three months. How old is/was this person?	Age_____ No response 88 Don't know 99	
Q214	Did you or your partner use a condom the last time you had sexual intercourse with him/her?	Yes 1 No 2 No response 88 Don't know 99	
Q215	With *what* frequency did you and all of your partner(s) use a condom over the last three months?	Every time 1 Almost every time 2 Sometimes 3 Never 4 No response 88 Don't know 99	
Q216	Did you ever discuss family planning with your partner or spouse in the last three months?	Yes 1 No 2 No response 88 Don't know 99	

Facility-Based Tools

The HEADSSS Assessment

Health workers may feel overwhelmed when attending to an adolescent in the health facility because they may feel unprepared or ill-equipped to address the adolescent's social and emotional needs. Direct communication is a powerful tool. During a clinical encounter, health providers are in the unique position of having one-on-one contact with adolescents. Listening and discussing issues with them may have positive impacts on adolescents' health and SRH outcomes.

Given the increased risk faced by many adolescents during crises, it is crucial to take the time to carry out individual assessments to identify high-risk adolescents and provide them with immediate counseling or link them to support systems as soon as the situation permits. The HEADSSS (**H**ome, **E**ducation/Employment, **A**ctivities, **D**rugs, **S**exuality, **S**elf Image and **S**afety) assessment tool can be used by health providers to identify high-risk adolescents and provide immediate counseling or link them to support systems. The HEADSSS assessment tool is used during a one-on-one encounter with an adolescent and takes a *minimum* of 15 - 30 minutes to implement. For each category, the provider asks questions that will provide information about protective and risk indicators. If risk indicators are identified, then the provider takes action by offering counseling support or linking the adolescent with the appropriate support or services.

THE HEADSSS ASSESSMENT

This tool is most often used in developed countries and uses the mnemonic **H**ome & relationships, **E**ducation & Employment, **A**ctivities & hobbies, **D**rugs, alcohol & tobacco, **S**ex & relationships, **S**elf harm, depression and self image, **S**afety & abuse.

For the purposes of this ASRH toolkit, the category headings and the questions have been adapted for an emergency setting, but the theory behind the use of the HEADSSS assessment remains the same.

When implementing this tool, the health provider should use simple language that is tailored to the developmental level of the adolescent. Do not use technical terms that might be confusing or threatening, but at the same time, don't "talk down to" the client. Start with questions about things that are likely to be less threatening (home, school, activities) and wait to address the more sensitive subjects (drugs, sexuality, self-image, etc.) until the adolescent has become comfortable sharing his/her feelings. Demonstrate good communications skills with the adolescent client: be respectful, show empathy and never appear judgmental. Listen to the adolescent and allow him or her to talk; don't cut him or her off, look at the clock repeatedly, or give other signals that might make the client feel rushed, uncomfortable, or inhibited. The adolescent must feel that s/he can trust the health provider and know that his/her responses will be kept confidential. Be prepared to provide some simple counseling "on the spot," but also be able to provide referrals to mental health and psychosocial support, protection, livelihoods or other services, as required.

The questions and actions in the guide below are examples of how the HEADSSS assessment might look in an emergency context. Because it is time-consuming, the HEADSSS assessment is not appropriate for use in the acute emergency setting and should be considered during individual encounters with adolescents once the situation has stabilized.

HEADSSS Adolescent Assessment

HOME

Suggested Questions:

- Tell me about where you live.
- With whom do you live?
- Who are the adults who are important to you?
- Do you feel safe in your home? Why or why not?

Protective Indicators	• Has positive relationships with adults • Identifies people who care for her/his safety
Risk Indicators	• No adolescent-adult connections • Head of household • Cares for younger siblings • Reports physical abuse • Feels unsafe

Possible Actions:

- Discuss strategies to approach trusted adults in the community.
- If head of household, ask how s/he is meeting daily needs. Explore alternatives to sex work. Ensure that the household is receiving nutritional support.
- If physical abuse is reported, ensure that the adolescent and other members of the household have a safe place to stay.
- Ask about physical injury (including sexual injury) and assist the adolescent to seek medical care.
- Explore reasons for feeling unsafe. Discuss ways to improve safety.
- Link with protection services, if appropriate.

EDUCATION/EMPLOYMENT

Suggested Questions:

- What do you do during the day on most days? During the evenings?
- What do you do in your spare time?
- How do you get money for the things that you need?
- What do you see yourself doing 10 years from now?

Protective Indicators	• In school • Acquiring new skills • Fills free time constructively • Has hope for the future

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EDUCATION/EMPLOYMENT	
Risk Indicators	• No time for leisure activities • No time for school or vocational opportunities • No vision or negative vision of the future • Too much free time and reports being bored • Engages in sex work • Engages in potentially exploitative labor, such being hired as a domestic worker • Reports fear of exploitation
Possible Actions: • Discuss how time is spent and discuss ways that time might be set aside for educational opportunities (formal or informal). • For those reporting "boredom," discuss links to adolescent- oriented activities or how they can get involved in helping the community. • Explore alternatives to transactional sex; discuss family planning options and the importance of protecting against HIV transmission; provide examples of how to negotiate condom use. • Provide the adolescent with links to livelihoods sector (vocational or skills training programs)	
ACTIVITIES	
Suggested Questions: • What activities, groups, clubs or sports do you participate in? • Where do you eat your meals? • What did you have to eat all day yesterday?	
Protective Indicators	• Involved in supervised activities • Involved in community or social activities • Eats within the household
Risk Indicators	• Spends free time in risky ways • Not involved in any activities and feels isolated • Not eating enough
Possible Actions: • Discuss alternative ways to spend free time; explore his/her interests and provide links to livelihoods sector (skills or vocational training) and to adolescent groups in the community that might be of interest; discuss ways they can "volunteer" to improve life in the community. • Explore whether the household is receiving nutritional support and link with community services sector, if needed	

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DRUGS

Suggested Questions:

- How do you feel about smoking? About drinking? About using drugs? (ask about illegal drugs as well as those that might be socially acceptable - khat, for example)
- Do you know people who use these substances? Does anyone in your family use them?
- Have you ever used these substances? When? How? (took pills, smoked, inhaled, injected, etc.) With whom?
- Where would you get cigarettes, alcohol or drugs if you wanted to use them?
- How do you pay for these substances?

Protective Indicators	• Does not know adolescents who have tried smoking, drinking or drugs • Has not tried smoking, drinking or drugs • Has a negative attitude toward these substances
Risk Indicators	• Uses alcohol or drugs • Has easy access to alcohol or drugs • Reports substances being used in the home • Substances available in the community • Resorts to high-risk behavior (e.g. selling sex, selling drugs, stealing) in order to acquire money to pay for substances

Possible Actions:

- Do not be judgmental! Ask about the reasons that s/he uses the substances and how s/he feels about it. Explore whether s/he would be willing to give up the behavior. Link with a mentor or friend who can support the adolescent.
- Evaluate the adolescent's mental health, since mental health problems and substance abuse are inter-related.
- If substances are available in the home, ask about violence in the home. If violence is reported, ensure that the adolescent has a safe place to stay and that other family members are safe. Refer to protection services, if appropriate.
- Inquire about unsafe sexual practices and offer counseling and testing for HIV, if appropriate.

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SEXUALITY

Suggested Questions:

- For very young adolescents — 10 to 14 years:
- Have you noticed any changes in your body recently? How do you feel about those changes?

For all adolescent girls:

- Have you begun to have your menstrual periods yet? If yes, how has that changed your life? Are you still able to go to school every day? What do you use to keep yourself clean during your menstrual period? If you use something, how do you clean it?

For all adolescents:

- Are you attracted to boys? To girls?
- Do you have a boyfriend or girlfriend?
- Have you ever had sexual intercourse? If yes, how old were you the first time you had sex? If no, how old would you like to be when you have sex for the first time?
- Have you ever had sex without using a condom?
- Have you ever had sex with someone in exchange for money, food, clothing or a place to stay?
- Have you ever been forced to have sex with anyone against your will? (ask boys as well as girls)
- Have you ever been pregnant?
- Have you ever gotten an infection as a result of having sex?
- Having vaginal intercourse is just one way that adolescents have sex. Other kinds of sex that adolescents have include oral or anal sex. Have you ever had oral sex? Did (or do) you or your partner use a condom when you have oral sex? Have you ever had anal sex? Did (or do) you or your partner use a condom when you have anal sex?

Protective Indicators	• Indicates intentions to abstain from sex • Is not currently sexually active • Indicates a sexual debut at greater than 16 years of age
Risk Indicators	• Indicates sexual debut at less than 16 years of age • Reports unprotected sex • Reports selling sex or exchanging sex for money, food, etc. • Reports being uncomfortable with homosexual or bisexual feelings or relationships • Reports history of sexual violence • Has had a pregnancy or STI in the past

Possible Actions:

- Discuss menstrual hygiene. Ask menstruating adolescents what they use during their menstrual periods to keep themselves clean. If they use menstrual hygiene supplies, how do they access them? Do they have difficulty accessing them? If applicable, how do they clean these supplies?
- For those who express non-heterosexual sexual feelings or gender identities, do not be judgmental! Promise confidentiality. Assure the adolescent that these feelings are natural. Emphasize the confidential nature of the conversation. If the adolescent feels uncomfortable or frightened by his/her feelings or sexuality, refer for mental health and psychosocial support. Discuss issues of safety and depression.
- For those who are thinking of becoming sexually active, do not be judgmental! Explore the reasons why they want to become sexually active and ask if they have a partner in mind. Discuss prevention of pregnancy, HIV and STIs.
- For those who are already sexually active, do not be judgmental! Discuss prevention of HIV and STIs. Discuss family planning options. Offer counseling and testing for HIV, if available. Demonstrate correct use of condoms.
- For those who report having forced sex, ask if they reported it to anyone or sought medical attention. Ask menstruating girls whether they have missed a period since it happened most recently. Ask about symptoms of STI. Ask whether s/he has felt more sad or tired than usual recently. Refer for medical evaluation and mental health and psychosocial support, if necessary.

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SELF IMAGE

Suggested Questions:

- How do you feel about yourself?
- On most days would you say that you feel generally happy, or generally sad?
- What do you do when you feel sad or upset?
- Can you sleep and eat as well as you did before?
- Do you have friends in the community?
- What adult can you go to when you need help?
- Are you important to anyone?

Protective Indicators	• Feels valued • Indicates positive outlook • Has healthy coping mechanisms • Has a caring adult who can help her/him
Risk Indicators	• Feels marginalized in the community • Reports a consistent feeling of depression and sadness • Reports symptoms of depression, such as poor sleeping, poor eating

Possible Actions:

- Explore feelings of sadness, anxiety or depression. Are there any things in particular that make him/her feel that way? Ask if s/he has ever had thoughts about hurting himself or herself. Ask if s/he has ever attempted to hurt himself or herself. If the answer to either of these is yes, make a plan for this person to come back to the health center if they ever feel this way, provide a link with an adult mentor and a referral for mental health and psychosocial support services, if available.
- Discuss positive coping mechanisms such as participation in community groups, adolescent clubs or religious activities. Explore other ways that s/he can cope with sadness and integrate with community members.
- Ask about physical abuse (including sexual abuse) and drug use. Refer for medical evaluation and mental health and psychosocial support, if necessary.

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SAFETY	
Suggested Questions: • How do you settle disagreements with other people? • Do you ever feel as if you are in danger? What do you do when you feel this way? • How do you protect yourself? • Are there places in the community where you can go to be safe? • Do you feel safe when you leave the community?	
Protective Indicators	• Engages in non-violent conflict resolution • Shows good problem solving skills related to dangerous situations • Is aware of safe spaces available in the community
Risk Indicators	• Carries a weapon for protection • Leaves community boundaries with a feeling of risk • Worries about violence and personal safety
Possible Actions: • Explore feelings of danger. Why does s/he feel threatened? Discuss non-violent ways to resolve conflicts. • Refer to protection or security services, if indicated. • Discuss the dangers of carrying weapons and the consequences of killing someone - either purposefully or inadvertently. • Identify safe spaces within the community. Ensure that s/he has a safe place to stay. • Ask about physical (including sexual) injury. Refer for appropriate medical treatment and counseling, if necessary. • Discuss community structures that are available to voice concerns of unsafe places.	

SUGGESTED READING:

1. Minnesota Health Improvement Partnership, Minnesota Department of Health. "Sample HEADSSS Questions (Long Form)," 2006. http://www.health.state.mn.us/youth/providers/headssslong.html.

Adolescent-Friendly Sexual and Reproductive Health Service Checklist

Rationale: Once a crisis situation has stabilized and comprehensive RH services are being established, it is important for health care providers to consider how to tailor services so that they are "adolescent-friendly," or acceptable, accessible and appropriate for adolescents, both male and female. Providing adolescent-friendly, gender-sensitive services directly addresses some of the external and structural barriers that are faced by adolescent females and males and this, in turn, helps to indirectly address some of the internal barriers that prevent them from accessing RH services.

The gold standard for adolescent-friendly SRH services is that they are "safe, effective and affordable; they meet the individual needs of young people [adolescent males and females] who return when they need to and recommend these services to friends." (WHO, 2002)

Quality adolescent-friendly SRH services are:

- *equitable* because they are adolescent-inclusive and they reach out to those who are most at risk;
- *effective* because they are provided by technically-competent, trained health workers who know how to communicate with adolescents;
- *efficient* because they do not waste resources;
- *equally* accessible to adolescent females and males;
- and *affordable* or free of charge to adolescents.

Adolescent involvement in the planning and monitoring of services also promotes quality because it ensures that services are acceptable to adolescents and increases the likelihood that adolescents will refer the services to their peers. (WHO, 2002).

The following checklist is a template that can be adapted to assess the adolescent-friendliness of RH services that are currently being provided in a facility or to help plan adolescent-friendly services that will be provided, once comprehensive RH services are established. This checklist does not assess quality of care; for guidance on this, please refer to the WHO Job Aid (pp. 2 -5).

After completing the checklist, count the number of "yes" responses to get the overall score.

Scoring of "Adolescent-Friendliness" is as follows:

0 - 13 Services not adolescent-friendly

14 - 20 Services somewhat adolescent-friendly

21 - 25 Services very adolescent-friendly

Adolescent - Friendly Health Services Checklist

(Adapted from African Youth Alliance/Pathfinder International)

	Characteristics	Yes	No	Feasible suggestions for improvement
Health Facility Characteristics				
1	Is the facility located near a place where adolescents — both female and male - congregate? (youth center, school, market, etc.)			
2	Is the facility open during hours that are convenient for adolescents — both female and male (particularly in the evenings or at the weekend)?			
3	Are there specific clinic times or spaces set aside for adolescents?			

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Characteristics		Yes	No	Feasible suggestions for improvement
4	Are RH services offered for free, or at rates affordable to adolescents?			
5	Are waiting times short?			
6	If both adults and adolescents are treated in the facility, is there a separate, discreet, entrance for adolescents to ensure their privacy?			
7	Do counseling and treatment rooms allow for privacy (both visual and auditory)?			
8	Is there a Code of Conduct in place for staff at the health facility?			
9	Is there a transparent, confidential mechanism for adolescents to submit complaints or feedback about SRH services at the facility?			
Provider Characteristics				
1	Have providers been trained to provide adolescent-friendly services?			
2	Have all staff been oriented to providing confidential adolescent-friendly services? (receptionist, security guards, cleaners, etc.)			
3	Do the staff demonstrate respect when interacting with adolescents?			
4	Do the providers ensure the clients' privacy and confidentiality?			
5	Do the providers set aside sufficient time for client-provider interaction?			
6	Are peer educators or peer counselors available?			
7	Are health providers assessed using quality standard checklists?			
Program Characteristics				
1	Do adolescents (female and male) play a role in the operation of the health facility?			
2	Are adolescents involved in monitoring the quality of SRH service provision?			
3	Can adolescents be seen in the facility without the consent of their parents or spouses?			

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Characteristics		Yes	No	Feasible suggestions for improvement
4	Is a wide range of RH services available? (FP, STI treatment and prevention, HIV counseling and testing, ante- and post-natal care, delivery care)			
5	Are there written guidelines for providing adolescent services?			
6	Are condoms available to both young men and young women?			
7	Are there RH educational materials, posters or job aids on site, which are designed to reach adolescents?			
8	Are referral mechanisms in place? (for medical emergencies, for mental health and psychosocial support, etc.)			
9	Are adolescent-specific indicators monitored on a regular basis? (e.g. number of adolescent clients, disaggregated by age and sex)			

SUGGESTED READING:

1. Senderowitz, J. et al. *Clinic Assessment of Youth Friendly Services: a Tool for Assessing and Improving Reproductive Health Services for Youth*. Pathfinder International: 2002. http://www.pathfind.org/site/DocServer/mergedYFStool.pdf?docID=521.

2. WHO. *Adolescent Friendly Health Services: an Agenda for Change*. WHO, 2002. http://www.who.int/reproductive-health/publications/cah_docs/cah_02_14.html.

Community-Based Distribution and Peer Education Tools

Peer Education Resource List

Peer education can be employed as part of a comprehensive RH strategy once the acute emergency stabilizes. For many adolescents living in protracted emergencies and camp settings, there are often too few opportunities to be engaged in rebuilding their communities. Providing the space and opportunity for learning can mitigate the psychosocial impact of conflict and disasters by giving a sense of normalcy, stability, structure and hope for the future.

Reducing idle time and increasing structured activities can help reduce risk-taking behavior. Peer education also offers opportunities for adolescents to demonstrate leadership, gain new skills through volunteerism, and build youth-adult partnerships with supervisors.

Peer education is an ideal way to provide RH information. Peers usually are perceived to be safe and trustworthy sources of information; using peer networks can increase adolescents' comfort in engaging in dialogue and personal risk assessments. More than a decade of program experience has shown that well-designed, curriculum-based peer education programs with consistent adult supervision can be successful in improving adolescents' knowledge, attitudes and skills about RH and HIV prevention.

The most challenging aspect of peer education programs is ensuring quality. To do so, programmers must:

- Provide high quality, intensive training to peer educators, including regular assessments and reinforcement of their capacities to provide accurate information to their peers.
- Ensure that trainings include topics relevant to adolescents in emergencies, such as sexual and reproductive health, sexual abuse and exploitation, HIV/AIDS prevention, landmine safety, sexual and gender-based violence, conflict resolution, personal health and safety.
- Use standardized checklists in the development and implementation of peer education programs to improve quality.

The following is the most widely used source to help improve the quality of peer education programs.

Youth Peer Education Toolkit

The kit contains five resources (shown below). Designed to help program managers and master trainers of youth peer educators, the tools are based on research and evidence from the field as well as local examples and experiences. The toolkit was a collaboration between the United Nations Population Fund (UNFPA) and Family Health International/ YouthNet, working with the Youth Peer Education Network (Y-PEER), a project coordinated by UNFPA. (2005-2006)

- Training of Trainers manual
- Standards for peer education
- Assessment tool for peer education programs
- Performance improvement tool for managers
- Theater-based techniques training manual

http://www.infoforhealth.org/youthwg/peeredtoolkit.shtml

SUGGESTED READING:

1. UNFPA, FHI/YouthNet. Standards for Peer Education Programmes. UNFPA, 2005. http://www.fhi.org/en/Youth/YouthNet/Publications/peeredtoolkit/Standards.htm.

Community-Based Distribution (CBD) Introduction

Rationale: Adolescents, especially those who are married, marginalized or have disabilities, face barriers that prevent them from accessing facility-based SRH and FP services. Community-based peer-to-peer methods are very useful in helping to overcome these barriers. Because they belong to the same "youth culture," adolescents may be better able to relate to their peers than to adults. Training adolescents in community-based distribution (CBD) is an appealing way to provide adolescents with access to condoms, FP methods and information related to SRH while modeling adolescent leadership and participation.

CBD programs are not appropriate for the acute emergency setting, but should be considered as soon as the situation stabilizes. Establishing a CBD program requires careful planning and preparation. In contexts where sex education and FP are not discussed among unmarried people, introducing a CBD program for adolescents can be particularly challenging. In such settings, take time to discuss with the community members - including parents, religious leaders, women's groups, and adolescents - to reach an agreement on an acceptable strategy for providing adolescents in the community with access to RH services.

Because distributors are providing RH services in the community, the quality-of-service provision is very important to program managers. International experience has shown that adolescents respond best to immediate, on-site feedback and adolescents trained in CBD appreciate the connection to adult supervisors who can help them gain and improve upon newly learned skills.

This section contains three tools to be used during the introduction and implementation of an adolescent-oriented CBD FP and condom distribution program:

- Preparing to Implement CBD Checklist
- Adolescent CBD Supervision Checklist
- Client Referral Form for adolescents trained in CBD

Each tool is a template and should be adapted to suit the context of the particular emergency setting. Additional resources and information about CBD programs and FP methods and algorithms can be found in the "Suggested reading" section below.

SUGGESTED READING:

1. FHI. *Provision of Injectable Contraception Services through Community-Based Distribution*, 2008. http://www.fhi.org/NR/rdonlyres/ewyj6yas7sltqnexxv7dvnc2assdoimhycn37pgdwwgywjshh-gcvkileqwws35jjkhs3asrca72llj/Part1NineSteps.pdf.
2. WHO. *Family Planning: A Global Handbook for Providers*. WHO, 2007. http://www.infoforhealth.org/globalhandbook/

Preparing to Implement Community-Based Distribution — Checklist

This checklist outlines the major steps that program managers should take as they plan and prepare to train adolescents in CBD and introduce a CBD program during planning for comprehensive SRH services.

✓	Action	Description
	Review national policies	Ensure that CBD is acceptable within the national policies. Advocate with national health authorities for permission to implement the CBD program, if necessary.
	Obtain local support	Inform local stakeholders (adolescents, parents, community leaders, health authorities, health workers) and encourage them to support the CBD program.*
	Identify beneficiaries and their needs	Through focus group discussions, surveys, key informant interviews, identify the adolescents who can benefit from CBD and who can be reached with the program. (For example, young married girls have a high unmet need for FP but less access to health centers because of decreased mobility). Also explore barriers to accessing SRH information and services. Ensure that members of the most at-risk groups are included in the needs assessment process.
	Establish commodity supply chain	Develop a system to ensure a consistent supply of FP commodities to avoid stock-outs. Procure supplies for program start-up.
	Select adolescents to be trained in CBD	Involve the community (leaders, adolescents, parents) in the selection process. Define selection criteria, which may include level of education, trustworthiness, attitudes toward FP and previous experience working in the community. Both girls and boys should be selected to be trained in CBD. Confirm that they are geographically distributed throughout the community, to ensure coverage without overlaps.
	Train adolescents in CBD	Train adolescents according to standard protocols according to standard protocols (national protocols, if available) to: • provide accurate and appropriate SRH information; • provide FP counseling on all methods; • distribute condoms and other FP methods (usually OCPs and possibly injectables); and • make referrals when necessary. Train how to adhere to standard precautions and to manage stocks and avoid stock-outs; Educate trainees about high-risk adolescents and the importance of reaching them with services. Educate trainees about the importance of maintaining client confidentiality. Train in data collection and reporting.
	Develop a workplan	Review the objectives of the program and identify key program activities. Establish a timeline for implementing activities.
	Develop an M&E plan	With adolescents trained in CBD, establish timeline for collection and reporting of baseline, monthly and end-of-project data. Use standardized data collection and reporting tools (national tools, if available). Ensure that reporting responsibilities are clearly established. Develop supervision schedule.
	Sensitize adolescents in the community	Sensitize adolescents about FP methods that will be made available through the CBD program. Information can be disseminated through mass media, printed materials, adolescent groups and clubs, etc. Adolescents trained in CBD should be involved in the sensitization process.

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✓	Action	Description
	Establish mechanisms for client recruitment and referral	Work with health facilities to develop a mechanism for referring adolescent clients from the health facility to the CBD program and vice versa. Work with adolescents trained in CBD, adolescents and other community members to develop a system for recruiting new clients from the community.
	Establish linkages with other sectors for recruitment and referral of clients	Establish linkages with other sectors (protection, livelihoods, education, mental health and psychosocial support, DDR, etc.) and mechanisms for referral of adolescents either to or from the CBD program.
	Establish feedback mechanisms	With adolescents trained in CBD and stakeholders, develop a user-friendly way for beneficiaries, adolescents trained in CBD and other community members to provide feedback on the program and suggest ways that it can be improved.

* *Community-based programming by adolescents could be a challenge in contexts where sex education and FP are not discussed among unmarried people. In such settings, take time to discuss with the community members - including religious leaders, women's groups, parents and adolescents - to reach an agreement on an acceptable strategy for providing adolescents in the community with access to SRH services.*

Adolescent Community-Based Distribution Supervision Tool

Instructions: Observe the adolescent trained in CBD with five clients. Assess the sessions and give marks as follows:

Activity not done	**1 point**
Activity done, but there is need for improvement	**2 points**
Activity well-done	**3 points**

Add the score for each discussion topic after the five visits have been completed. Together with the adolescent trained in CBD, create an action plan to improve upon the desired skill, based on these scoring levels:

5 - 7	Needs to re-learn skill
7 - 12	Good, but needs improvement
13 - 15	Excellent, continue as is

If the skill needs to be re-learned, or if improvement is needed, describe the steps that the adolescent should take before the next supervisory visit in the Action Step column.

Adolescent Name_____ **Supervisor Name**_____

Skill	Clients					Total Score	Action Step
	1	2	3	4	5		
Date of visit(s) -->							
Introduction							
Provided privacy by finding a place away from disturbances							
Greeted client politely and introduced self							
Assured client's confidentiality							
Asked client's name							
Assess Client's Obstetric and Family Planning History							
Asked client's age							
Asked about number of pregnancies							
Asked about the number of living children							
Asked about the number of children desired							
Asked if the client is currently using or has ever used a contraceptive method							
Asked if the client or partner uses condoms every time he/she has sexual intercourse							

Continued ▸

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Skill Date of visit(s) -->	Clients					Total Score	Action Step
	1	2	3	4	5		
Help Client to Choose a Family Planning Method							
Used teaching aids appropriately							
Explained all FP methods available (both from adolescent and health facility).							
Counseled client about STI/HIV/AIDS							
Promoted dual protection (for STI & pregnancy)							
Allowed client to ask questions and responded appropriately							
Asked client about his/her method of choice							
Ensured that client's choice is voluntary, not coerced							
Provided a referral for methods only available from the health center							
Review the Chosen Method Together with the Client							
Supplied the client with the method according to protocol							
Explained/demonstrated clearly how to use the method(s) and explained side effects							
Asked the client to repeat the information about the method(s) and repeated or corrected any missing or incorrect information							
Gave the client a leaflet about the method (if available and desired)							
Gave the client a follow-up date for a revisit or refill							
If condoms were provided, advised client of other adolescent-friendly locations in the community where condoms can be obtained							
Advised the client to visit the adolescent trained in CBD if needed before the next appointment should problems arise							

Continued ▶

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Skill Date of visit(s) -->	Clients					Total Score	Action Step
	1	2	3	4	5		
Skills Used							
Ensured sufficient supplies of condoms and FP methods before client encounter							
Asked probing open-ended questions							
Gave the client the chance to ask questions							
Addressed the client's questions appropriately							
Made appropriate referrals to other sectors or health facility for additional support or treatment, as appropriate							
Adhered to standard precautions							
Wrap-up							
Reminded the client of the importance of subsequent visits by the adolescent trained in CBD							
Thanked the client for his/her time							
Completed the client's record card							
Competed the appropriate data collection forms							
Adolescent's Remarks _____ _____ _____							
Supervisor's Remarks _____ _____ _____							

Client Referral Form for Community-Based Distribution

Instructions: *Part A* of this form is to be completed by the adolescent trained in CBD when s/he refers a client to a health facility or to another sector for evaluation, care or services. The adolescent should provide a description of the reason for referral so that the person receiving the client understands the services requested. *Part B* of the form is completed by the referral service or health facility staff member after the client has been evaluated and has received treatment, evaluation or services. Part B is returned to the adolescent trained in CBD, so that s/he has feedback on the status of the client.

Part A *(to be retained by the clinic staff or staff)*

Date:_____

Dear Colleague:

I am referring Mr./Ms. _____ *(name)* of _____ *(village)*,

_____ *(parish)*, _____

(sub-county) to you for:

- **Contraceptive method *(specify)*:** _____
- **Side effect management *(specify)*:** _____
- **Maternal health services *(specify)*:** _____
- **STI management *(specify)*:** _____
- **Other *(specify)*:** _____

_____

_____ _____ _____

Name Signature Parish

Part B *(to be completed by the clinic health worker or staff member and returned to the Adolescent trained in CBD)*

Date:_____

Mr./Ms. _____ *(name)* has received services at this health facility as per the referral.

Brief description of services provided:

_____ _____ _____

Signature of service provider Name of service facility Signature of service provider

Adapted from FHI, *Provision of Injectable Contraception Services through Community-Based Distribution*, p. 109

Sharing Lessons Learned

Rationale: While there is always some degree of trial and error, the emergency setting is not the place to be "re-inventing the wheel;" it is important that programs be implemented in the most effective and efficient way possible. There is little documentation about programs or lessons learned related to ASRH in emergency or post-emergency settings. Documenting the lessons learned during the course of implementation will allow us not only to analyze our programs, but also to share our successes and to develop a set of best practices that can be built upon over time.

The Sharing Lessons Learned tool allows you to document your experiences during the course of implementing ASRH programs in crisis settings and to share that information with other agencies. The tool should be completed after the acute emergency phase or once comprehensive RH services have been established. Once completed, the tool should be sent to the IAWG adolescent health sub-working group at arh@my.ibpinitiative.org so that your experiences can be documented and shared with other agencies. Please note that in order to upload or send documents, you must be a member of IAWG. Membership can be obtained at: http://my.ibpinitiative.org/iawg/

Another option is to send your completed tool to the RHRC Consortium at: info@rhrc.org

Sharing Lessons Learned Form

- In what type of emergency setting did you address the RH needs of adolescents?

- What key adolescents were targeted?

- Were there particularly high-risk sub-groups of adolescents in this setting?

- Did adolescent girls or women encounter any gendered barriers to accessing the RH program? If so, what were these?

- What strategies did you use to address RH needs in this emergency situation?

- Were there specific aspects of the ASRH program that you implemented that were particularly successful? To what do you attribute the success?

- Were there specific aspects of the ASRH program that did not work well at all? To what do you attribute the difficulties?

- What challenges did you face as you addressed the RH needs of adolescents in this emergency situation? Were you able to successfully address these challenges? If so, how? If not, why not?

- Were you able to monitor the impact of your program (including number of beneficiaries, disaggregated by age and sex)? If yes, please provide key results. If no, please explain why not.

- What recommendations would you offer to other agencies who want to provide ASRH services in a similar setting?

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