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## She knows best: Engaging girls in adolescent programming

More than 80 years after Albert Einstein helped create the International Rescue Committee, the number and intensity of humanitarian crises across the globe warrant a dose of Einstein-inspired innovation.



The adolescent sexual and reproductive health team poses for a photo after a result-dissemination workshop. Goma, DRC. Photo by Rita Nehmé /The IRC

Adolescents have unique sexual and reproductive health (SRH) needs and, in humanitarian settings, these needs intensify. Deprived of traditional social structures, adolescents are forced to navigate new and dangerous environments and, with few protection services available, are vulnerable to sexual abuse and exploitation. Young people, particularly girls, encounter significant barriers to accessing quality health care, including provider bias, age restrictions or stigmatization when seeking services, and concerns about confidentiality. Unprotected and early sex, early pregnancies, and STIs increase and childbearing risks are compounded.

In the Democratic Republic of the Congo (DRC), where the International Rescue Committee has worked to increase access to sexual and reproductive health since 2006, only 5% of adolescent girls are using a modern contraceptive method. As a result, unintended pregnancy is common and nearly one in three girls under the age of 20 is a mother or pregnant for the first time. The consequences of these unintended and early pregnancies are immense – physically, mentally and emotionally.

With the support of the David & Lucile Packard Foundation, the International Rescue Committee (IRC) developed and piloted a new approach to increase adolescent girls' access to contraception in three health facilities in Goma, the capital city of North Kivu in eastern DRC.

### Our approach

The IRC's multi-pronged approach aims to address foundational facility and community-level barriers that prevent adolescents from accessing, using and receiving quality SRH care. It also introduces a participatory framework to meaningfully integrate their participation in all aspects of the program cycle.

### Increasing health provider capacity

Initial facility assessments and self-administered health provider knowledge, attitude and practice questionnaires revealed poor provider attitudes towards adolescent use of contraception and other SRH services. To improve understanding, clarify values and transform negative attitudes, the IRC conducted a series of activities, including a one-day value clarification and attitudes transformation (VCAT) workshop for six project staff in April 2017. A five-day adolescent SRH training was also organized for more than 25 health providers, including those working in the pilot facilities. This training helped familiarize health providers with new adolescent SRH supervision and data collection tools. Four briefing sessions were held with service providers on data management, the use of data to enhance adolescent SRH services, and the adoption of more stringent confidentiality procedures, particularly for adolescent clients.

### Engaging and empowering adolescent girls

Adolescent participation in the design, implementation and evaluation of programs is critical to ensure sexual and reproductive health services are accessible, acceptable and of good quality. However, many implementers struggle to operationalize participation frameworks in their programs.

To address this gap and develop a project that best responds to the needs of adolescents in Goma, the IRC wanted to first understand their perspectives and explore the following key questions:

1. What are the sexual and reproductive health needs of adolescent girls in Goma, DRC?
2. What services and actors address the sexual and reproductive health needs of adolescents in the area, do they address the needs adolescents themselves prioritize, and what are the gaps that still remain?
3. What are the main barriers to sexual and reproductive health for adolescents that the project should address?

To get a better idea of these perspectives, the IRC led a participatory assessment in two phases to inform this pilot. To mitigate any potential power and gender imbalance, the IRC trained six adolescent girls and health providers to co-facilitate sessions. During the first phase, participatory workshops were led with three separate groups of key participants that aimed to address the questions listed above. A total of 40 in and out of school adolescent girls and health providers across all three pilot sites participated in the activities.

A strong theme that was prevalent throughout the activities was the emphasis on attitudes and stigma surrounding adolescent sexual and reproductive health, which was consistent with the findings from the baseline facility assessment and health provider questionnaires. All of the groups mentioned aspects of poor attitudes, whether specifically by citing "staff attitudes" as a barrier, commenting on the poor reception that adolescents receive when trying to access services at the health center, or stating that parents may not encourage their daughters to access services.

Another significant finding was the emphasis on lack of information that teenage girls have surrounding their sexual and reproductive health and the services available to them. While they could name much of the anatomy of the reproductive system, they were not always clear on what purpose each part served. This was also evident during the discussion on prevention of pregnancy, methods of modern contraception and the positive and negative side effects. All groups continually brought up the theme of lack of information or knowledge for adolescents and emphasized this as a priority in trying to increase adolescent access to sexual and reproductive health care.

### The IRC team

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Members of the adolescent coordination committee pose with students after conducting an information session. Goma, DRC. Photo by Rita Nehmé /The IRC

Contraception, in general for the adolescents seemed to be discussed as a method that was used after sexual intercourse had taken place. Both in school and out of school girls thought of contraception as an afterthought to sex instead of a preventive measure that is decided on before sex begins.

During the second stage of meetings, representatives from the three groups were brought together to present and compare the findings from all stage one meetings. They prioritized areas of action to improve uptake of adolescent family planning services, identified assets within the community, and developed an action plan for each catchment area. Twelve adolescent girls and six health providers formed coordinating committees to implement the actions. They met on a monthly basis to monitor progress and participated in IRC supervision visits to the facility.

### Implementing community and adolescent-led actions

Based on assessment results, the adolescent and health provider coordination committees prioritized three main areas of action:

- 1) **Awareness raising activities:** Participants identified the need for activities that addressed the lack of information on adolescent SRH, explained the benefits of contraception for adolescents, and challenged the stigma around adolescent contraceptive use.

During the pilot, coordination committees organized and delivered sensitization activities for mothers of adolescent girls in hair salons, fish markets, charcoal stands, and partnered with female-run local business associations to deliver messages during their meetings. They also conducted sessions in local schools and orphanages targeting adolescents. Many of the adolescent girls participating in the coordination committee functioned as informal "peer educators" and referred/escorted other adolescents to the facility for services.

### The IRC's adolescent SRH strategy

#### INCREASE PROVIDER CAPACITY

Adolescent SRH training for health providers

Values Clarification and Attitude Transformation Activities

Targeted supportive supervision

#### IMPROVE FACILITY READINESS

Baseline & endline facility assessments

Reorganization to ensure confidentiality, privacy & acceptability of services

Monthly adolescent SRH data & project review meetings

#### MEANINGFULLY ENGAGE ADOLESCENTS

Participatory workshops & monthly coordination committee meetings

Joint supportive supervision & data review visits to facility

Innovative outreach and mobilization activities led by adolescents

2) *Capacity to deliver services:* Participants also highlighted the need for improved provider capacity to deliver quality adolescent SRH care through formal trainings and targeted supportive supervision, which included addressing negative attitudes toward adolescent SRH services.

3) *The need for confidentiality:* Participants indicated a need for health care worker trainings that emphasize respect for adolescent confidentiality and activities that inform adolescents that services are confidential. The IRC and coordination committee members worked to ensure each project facility had clear confidentiality policies that were visibly posted. Outreach messages, delivered by adolescents and community health workers, also emphasized the availability of confidential services for adolescents.

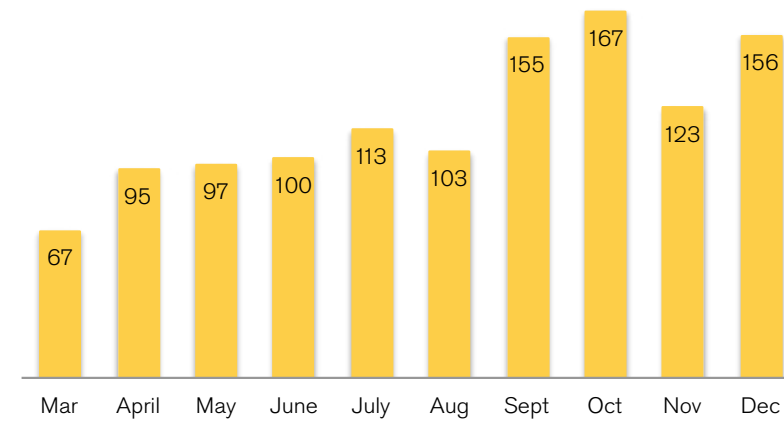
## Results

As a result of this pilot program, the number of adolescents who adopted new methods for family planning/contraception increased from 67 in March 2017 to 156 in December 2017, totaling 1,176 adolescents in a 10 month period. This increase was unique to the adolescent age group, indicating a strong likelihood that it was a result of project activities. By the second month of the project, over one-third of contraception clients were adolescent girls and 89% of adolescent clients accepted long-acting methods during this 10 month period.

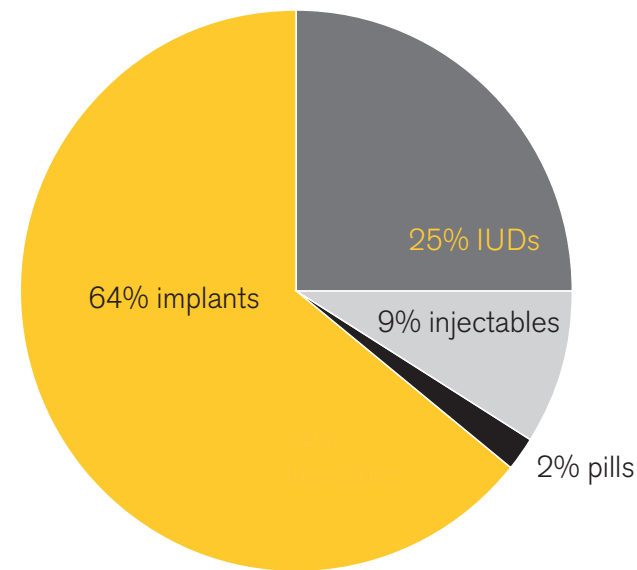
**In Goma, these efforts have allowed us to reach 1,176 adolescent girls since activities in ten months. In September, almost half of all new acceptors – 155 out of 360 – were under the age of 20.**

Further, adolescents who participated in this pilot and were active in the coordination committees reported to have an increased understanding of and ability to discuss their sexuality. Through trainings, improved communication between health providers and adolescents helped change attitudes, decrease stigma and address power imbalances between the two groups.

## New adolescent family planning acceptors



## Method mix for new adolescent acceptors



## Dissemination workshop with health and policymakers

To ensure adolescent voices are heard by key changemakers, the IRC organized a workshop to present the pilot's results to key stakeholders and partners, including local health and policy officials. The adolescent and health provider coordination committee described the activities they carried out during the pilot and their experience as change agents within the process. Health officials and policymakers discussed ways in which this approach fits into the larger national adolescent sexual and reproductive health policy and potential synergies and areas of collaboration moving forward. The workshop helped shed light on the unseen needs of adolescents, particularly when they shared their personal stories and experiences, and answer questions for partners and stakeholders looking to replicate and expand on these results. Equally powerful were the VCAT exercises in which attendees, including health and policymakers, examined their own attitudes and beliefs about the health and needs of adolescent girls.



## Looking ahead

In December, a technical program review was conducted to identify lessons-learned from this pilot and opportunities to strengthen and expand the approach throughout other areas of Eastern Congo. Some key insights include:

### • STI care can serve as a key entry point for adolescents in Goma.

Adolescents report that discussing STI care with their peers is at times easier and more acceptable than discussing the need for other SRH services. During the pilot, adolescent use of STI treatment services steadily increased which indicates increased knowledge and care-seeking behavior. The program is now working to improve the quality of STI care, with a particular focus on improving counseling and strengthening same day referrals for other SRH services including contraception and post-abortion care.

### • Engaging adolescent boys, parents of adolescents and other influential adults may strengthen the approach.

Data from the participatory assessments indicate that these key stakeholders strongly influence adolescent access and use of services. IRC is exploring ways to integrate their participation in the both the current participatory framework and future project designs.

## Applications in upcoming projects

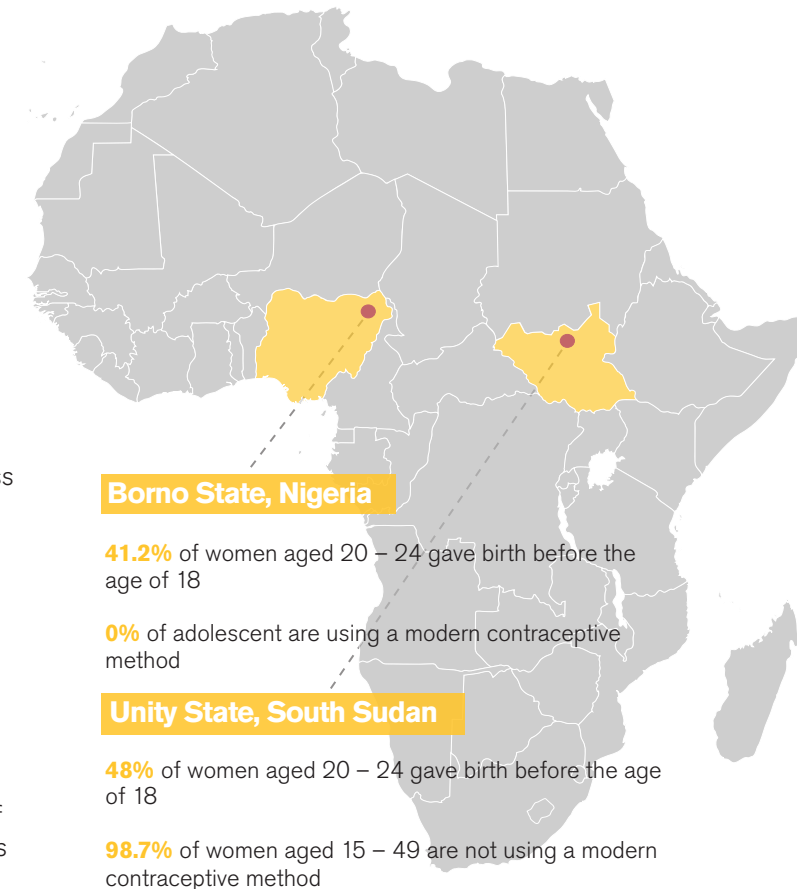
There are few field-tested intervention models that improve adolescent SRH in emergencies and strengthen adolescent-inclusiveness within the implementation of the Minimum Initial Service Package (MISP) for SRH in crises. Building on its recent success reaching adolescents in Goma with sexual and reproductive health services, the IRC will expand its program to Kalemie and South Kivu in DRC. It will also soon conduct operational research to evaluate and compare the feasibility and effectiveness of implementing two different packages of interventions aimed at increasing access to, quality of and demand for adolescent SRH services in Unity State, South Sudan and Borno State, Nigeria. Through this research, IRC aims to substantially improve the humanitarian field's understanding of the most effective combination of interventions to improve adolescent SRH, client responsiveness and adolescent-inclusiveness in acute emergencies.

As part of its core ASRH package, the IRC will first aim to address fundamental facility and community-level barriers to adolescent SRH service use and quality. It will also integrate Participatory Action Research with adolescents and key influencing groups into the core ASRH intervention package to increase adolescent engagement and ownership of health programs and improve community support for adolescent health services. The IRC will evaluate the effectiveness of each intervention package by measuring the use and quality of ASRH services at baseline and endline using a mixed-methods approach. Following the intervention and evaluation, the IRC will develop and disseminate two case studies to describe the results and lessons-learned in each country context.



### • There is a latent demand for comprehensive abortion care services.

Adolescents reported that girls in their community sought abortions through existing, informal networks, including medication to self-induce an abortion from local pharmacists, a practice that can be prohibitively expensive. Providers also mentioned that after the availability of adolescent-friendly services was made known, several adolescents presented to the health center seeking abortions. As an immediate next step, the IRC is currently working to strengthen the quality and use of PAC services among adolescents. In addition, the IRC is identifying opportunities to integrate SAC into existing health programming in DRC to better meet the comprehensive sexual and reproductive health needs of girls and women.





Members of the adolescent committee outside of an adolescent-friendly room at one of the pilot's health facilities. Goma, DRC. Photo by Rita Nehmé /The IRC .

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Front photo: members of the adolescent coordination committee pose in front of one of the pilot's facilities. Goma, DRC.

Page 4 photo: member of the adolescent coordination committee describes a body mapping exercise to local health officials and policymakers. Goma, DRC.

Page 5 photo: a sign outside of one of the IRC-supported health facility advertising adolescent-friendly services. Goma, DRC.

All photo credit: Rita Nehmé/the IRC

**The International Rescue Committee (IRC)** responds to the world's worst humanitarian crises and helps people to survive and rebuild their lives. Founded in 1933 at the request of Albert Einstein, the IRC offers lifesaving care and life-changing assistance to refugees forced to flee from war, persecution or natural disaster. At work today in over 40 countries and 22 U.S. cities, we restore safety, dignity and hope to millions who are uprooted and struggling to endure. The IRC leads the way from harm to home.

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