CHAPTER 6
ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

6.1 INTRODUCTION

Adolescence is a period of biological, physical, and cognitive changes and is accompanied by unique sexual and reproductive health (SRH) needs. Adolescents are resilient, resourceful, and energetic. They can play an integral role throughout the disaster risk management and humanitarian program cycles. Cognizant of the competing demands on adolescents, efforts should be made to offer opportunities to build on their capacities to promote their empowerment in this process. For example, they can serve as first responders in emergencies through activities such as assisting health providers as volunteers and community-based based distributors. They can expand

access to quality SRH services for the wider community as well as for their peers at the community level. In addition, they can play a critical role in coordination mechanisms to ensure that adolescent needs are considered from the outset of emergencies.

Humanitarian emergencies are accompanied by inherent risks that increase adolescents' vulnerability to violence, poverty, separation from families, sexual abuse, and exploitation. These factors can disrupt protective family and social structures, peer networks, schools, and religious institutions and can greatly affect the ability of adolescents to protect themselves and practice safe SRH behaviors. Their new environment can be violent, stressful, and/or unhealthy. Adolescents (especially adolescent girls) who live in crisis settings are highly vulnerable to sexual coercion, exploitation, and violence, and may engage in high-risk or transactional sex for survival. Adolescents are a heterogeneous group; their risks and needs may vary depending on factors such as the environment and local context as well as their marital status, education level, disability status, gender and gender identity, bodily identity, sexual orientation, and social and economic status.

BOX 6.1: KEY FACTS AND FIGURES

- Among the countries with the 30 highest rates of child marriage, over 50% are in conflict
- Every hour, 26 adolescents (15-19) are newly infected with HIV. Adolescent girls and young women are disproportionately affected by HIV in sub-Saharan Africa where 7 in 10 new infections in adolescents are among girls
- From 2009-2012, proposals for adolescent sexual and reproductive health through humanitarian funding streams constituted less than 3.5% of all health proposals; the majority were unfunded

On the other hand, in some cases, crisis-affected communities may also be exposed to new opportunities, including access to better health care, schooling, and new languages and skills, which may place adolescents in privileged positions they would not have had in a non-crisis environment. Adolescents often adapt easily to new situations and can learn quickly how to navigate through the new environment.

SRH Coordinators, health program managers, health care providers, social workers, and teachers working in humanitarian settings must consider and address the unique needs of adolescents. They must also consider especially vulnerable adolescents, including former child soldiers, adolescents heading households, adolescents with disabilities, adolescent mothers, and young girls who are at increased risk of sexual exploitation.

BOX 6.2: ADOLESCENTS PLACED AT INCREASED RISK

- Very young adolescents (under 14)
- Orphans and vulnerable children
- Adolescents engaged in transactional sex
- Adolescents living with HIV
- Adolescents engaging in same-sex intercourse
- Girl mothers
- Child heads of households
- Married adolescents
- Widowed girl adolescents
- Adolescents with disabilities
- Adolescents caring for persons with disabilities
- Child soldiers (including girls) and other children associated with fighting forces (in non-combatant roles)
- Adolescent survivors of sexual violence, trafficking, and other forms of gender-based violence
- Adolescents in urban settings

6.2 OBJECTIVES

The objectives of this chapter are to:

- Provide guidance to SRH Coordinators, health program managers, health service providers, social workers,

and teachers on effective, innovative, and culturally sensitive approaches in humanitarian settings that take into consideration the heterogeneity of adolescents, to increase availability of and accessibility to quality adolescent sexual and reproductive health (ASRH) services

- List the principles and resources that inform SRH Coordinators, health program managers, service providers, and community members on how to involve adolescents in ASRH programs
- Ensure the provision of adolescent-friendly SRH services and information and create a safe and supportive environment where adolescents can develop and thrive, despite the many challenges they face throughout a crisis

BOX 6.3: DEFINITION AND SCOPE

While this chapter refers to adolescents (typically defined as age 10-19), the services described here can be extended to a broader cadre of young women and men who may also benefit from youth-friendly services.

6.3 ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMING

6.3.1 Minimum Initial Service Package implementation

The Minimum Initial Service Package (MISP) is a coordinated set of priority activities aimed to prevent and respond to sexual violence, reduce HIV transmission, prevent excess maternal and newborn morbidity and mortality, prevent unintended pregnancy, and transition to more comprehensive SRH services as the situation permits. The MISP may not address all of adolescents' needs and it may not be possible to incorporate all ASRH principles when implementing the MISP. Given this situation, it is essential to refer to the Adolescent SRH Toolkit in humanitarian settings developed by Save the Children and the United Nations Population Fund (UNFPA) for additional guidance on the establishment and provision of adolescent-friendly MISP services along the disaster risk management cycle (see Section 6.6).

BOX 6.4: ADOLESCENTS CAN BE GOOD CANDIDATES FOR LONG-ACTING REVERSIBLE CONTRACEPTION (LARC)

Methods of LARC, including contraceptive implants and intra-uterine devices (IUDs), are safe and effective for adolescents. They can be used in women and girls who have not yet begun childbearing. They offer several advantages over other contraceptive methods: they are extremely effective; they do not require the user to take any action once they are set in place; they are relatively discreet; and they prevent pregnancy for years—during a time when most girls want to avoid childbearing. Health providers should include LARC among the full range of contraceptive methods offered to adolescents.

6.3.2 Emergency and disaster risk management for health

Include the following as part of emergency and disaster risk management efforts:

- Support systematic engagement and partnerships with adolescents in all phases of humanitarian action, especially decision-making and budget allocations
- Strengthen adolescents' capacities to be effective humanitarian actors and support local adolescent-led initiatives and organizations in humanitarian response. This includes crisis-affected adolescents such as refugees and internally displaced persons living in informal urban settlements and slums

6.3.3 Needs assessment

As the situation stabilizes, conduct a needs assessment including a mapping of existing services in coordination with other ASRH and child health actors to inform the program design process and develop an action plan to improve the adolescent-friendliness of existing health services. Involve adolescents, who can be guided to identify their own vulnerabilities as well as capacities, in this process. Ensure inclusion of adolescents placed at increased risk (see Box 12.2). For example, make sure that 10-15% of adolescents consulted in needs assessments

are adolescents with disabilities. Use adolescent-friendly service assessment tools to determine whether health services meet the needs of adolescents. Also assess protective community resources. We should examine data gathered from multiple perspectives including those of adolescents on:

- ***Health problems and behaviors:*** Prevalence of SRH issues and practices among adolescents, including planned and unplanned pregnancy, contraceptive use, safe and unsafe abortion, maternal and neonatal mortality, safer sex practices, sexually transmitted infections (STIs), and HIV
- ***Harmful practices and risk factors:*** Adolescent vulnerabilities and harmful practices, including exposure to sexual violence and exploitation, child, early and forced marriage, trafficking, transactional sex, and traditional practices such as female genital cutting
- ***Protective factors:*** Protective community resources, such as supportive parents and teachers, peer support networks, and adolescent programs with connections to caring adults
- ***Available resources:*** Adolescent and community perceptions of existing ASRH needs and providing SRH services and information to adolescents, including professional and traditional services. Specific emphasis on how needs and services vary for different groups including girls, boys, lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) youth, and those with disabilities. Reasons for gaps in the provision of and access to services
- ***Challenges:*** Barriers to accessing existing services for different groups of adolescents, including lack of knowledge about ASRH issues, lack of information about ASRH services and where they are located, insecurity, limited freedom of movement, physical barriers, cultural norms, lack of confidentiality/privacy, and lack of same-sex healthcare professionals
- ***Opportunities:*** In some situations, crises present adolescents with new opportunities for building upon their capacities and for improved access to health and education not only for themselves but also for their communities

In addition, SRH Coordinators, health program managers, and service providers must be familiar with national legislation and policies pertaining to adolescent SRH in the countries in which they work. While national governments have the authority and the responsibility to provide SRH education and services for adolescents and young people, restrictive policies may prevail.

Considerations should include:

- What are the laws or policies that restrict or prevent adolescent access to SRH information and services?
- What is the age of majority? What is the age of consent for sex? What is the age of consent for marriage? Is it different for boys/men and girls/women?
- Are there requirements for marital, parental, or guardian approval for providing health information and services to children? To non-child adolescents?
- Is the evolving capacity and best interest of children taken into consideration in laws/policies/protocols regulating adolescent access to SRH services, information, and education?
- What are the laws surrounding adolescent access to abortion-related services and to what degree are these laws implemented or enforced?
- Are there national or local laws or policies regarding sexual violence and other forms of abuse against children both within and outside of the family?

PROGRAMMATIC EXAMPLE 6.1: AN ADOLESCENT-INCLUSIVE SRH NEEDS ASSESSMENT

ORGANIZATION: CARE-International

LOCATION: Goma, Democratic Republic of Congo (DRC)

INTRODUCTION: DRC's reproductive health outcomes are among the poorest in the world. As of 2014, 27% of older adolescents (age 15-19) had begun childbearing: 21% were already mothers and 6% were pregnant. In the crisis-affected region of North Kivu, women and girls face even greater challenges. CARE's baseline survey of 709 adolescents and youth found that 32% of all surveyed girls aged 15-24 years were ever pregnant; of those who were pregnant, 29% got an abortion. As adolescents and young people in Goma City and its neighboring areas have grown up surrounded by crisis, this project aimed not only to address their SRH needs but also to provide them with the opportunity and agency to create change for themselves and their community.

PROJECT DESCRIPTION: The DFID-funded Aid Match project Vijana Juu (Swahili for "Up with Youth") was implemented by CARE from February 2016 to October 2017. This pilot project built upon CARE's existing Supporting Access to Family Planning and Post-Abortion Care (SAFPAC) intervention to assess feasibility of including a strong ASRH component within the SAFPAC model to meet the SRH needs of adolescents. The project was implemented in partnership with faith-based groups that manage health facilities and schools in close proximity to each other. CARE project staff, along with a representative from the Ministry of Health's National Program for Adolescent Health, facilitated workshops with youth from surrounding communities to review baseline assessment results and input into project design. CARE used its Community Score Card (CSC) approach to bring together youth, service providers, and government officials to agree upon 4 indicators that represent quality and accessibility of "youth-friendly services" and to put in place a process for monitoring progress on these indicators and trouble shoot problems related to access and service provision. The project also included adolescent-responsive services training and supervision for providers and a peer model approach. Moreover, the meaningful participation of program participants in designing, adapting, and providing ongoing feedback and an iterative program approach allowed for introducing additional program components such as an adolescent-specific referral card to reduce the waiting time young people face at health facilities. Given the positive feedback on this intervention, CARE introduced core Aid Match interventions (such as orientation of providers to ASRH needs, implementation of fun referral cards, and procurement on supplies that meet adolescents' needs) in SAFPAC's other health facilities in Goma, further extending the availability of adolescent-responsive SRH services across 15 health facilities.

RESULTS: CARE provided contraceptive services to 22,633 new users of family planning across the 15 SAFPAC sites, including 4,681 new users in the initial 4 Aid Match sites. When excluding condoms as a method of choice, 44.7% of young people across the 15 health facilities and 48.9% of young people across the 4 initial Aid Match facilities chose a long-acting reversible contraceptive (implant or intrauterine device). One hundred percent of adolescents that accessed the CARE supported services through the project were satisfied with the services they received. Sixty young people were trained as peer-leaders/youth mentors and 10 peer-leaders/youth mentors were trained as community counselors, an intervention that was introduced to meet the needs of young people living in IDP camps and nearby host communities that did not have access to SRH services. Nine community-based organizations (CBOs) were supported to provide community engagement events focusing on ASRH, including community dialogues. Overall, 1,742 community dialogues were carried-out to raise awareness not only among young people on SRH but also to support an environment and community dynamics that facilitate their access to SRH services.

LESSONS LEARNED: Engaging young people through a participatory approach in project research, design, and implementation resulted in adolescent-relevant services and likely higher utilization of SRH services. Qualitative feedback indicates establishing an accountability mechanism through CSC provides adolescents the opportunity to share feedback on services that is relevant not only to them but for the community-at-large. Furthermore, the CSC approach improved relationships and encouraged dialogue among youth, community leaders and health providers. Based on supportive supervision activities undertaken by CARE staff, we noted that adolescents require additional compassion and support before, during, and after receiving contraceptive methods, especially during the process of identifying relevant long-acting reversible contraceptive methods. It is noteworthy that peer leaders across the 4 sites launched an adolescent network themselves, Vijianna Vision, so as to continue community-level activities beyond the life of the project.

BOX 6.5: PROVIDING POST-ABORTION CARE TO ADOLESCENTS

Adolescents and young people in crisis settings are at increased risk for unintended pregnancy and unsafe abortion, due to factors such as their psychosocial development, existing gender and social power dynamics, socio-economic status, sexual violence and coercion, and traditional/cultural values that prevent access to SRH information and services. Adolescents often lack awareness of and access to contraceptive methods to prevent pregnancy. Then, when faced with an unintended pregnancy, adolescents are more likely than adults to seek unsafe abortions and/or to wait longer to seek abortion care, for reasons ranging from fear of stigma to policy constraints and structural barriers such as transportation costs, to delays in realizing they are pregnant or a state of psychological denial of their pregnancy. This increases their risk of complications, including severe bleeding, infection, tearing of the uterus, infertility, and premature mortality.

It is critical that adolescents have access to high-quality post-abortion care. The barriers that adolescents face in accessing SRH services generally can be compounded when they need post-abortion care (PAC) due to misconceptions that PAC is an abortion service or that PAC encourages abortions, and pronounced provider biases toward adolescents in need of PAC. Adolescent participation along the program cycle for PAC services, provider training on adolescent-responsive PAC services, and integrated PAC-family planning programming complemented by community sensitization are critical to improving access to life-saving PAC services for adolescents in emergencies.

6.3.4 Principles for working with adolescents

Large-scale implementation of ASRH programs needs clear policies and guidelines, support from institutional leaders, continued training of health personnel and other staff, and inclusion of adolescent users in the design and monitoring of these services. When working with adolescents, it is important to consider:

- Management principles
- Service provision principles

MANAGEMENT PRINCIPLES

Recognize that adolescents are not a homogeneous group

Needs vary by age, sex, education, marital status, local and cultural context, gender, gender identity, bodily identity, sexual orientation, and disability status. Sub-groups have unique needs and risks. Design and implementation of all programming, including provision of health services and behavior change communication strategies, should be tailored to their specific needs and be age and sex appropriate. Given that some groups of adolescents are placed at higher risk, it is critical to ensure that protection mechanisms are in place to prevent and respond to violence and abuse of adolescents.

Engage in meaningful adolescent participation

The primary principle of working effectively with adolescents is to promote their participation, partnership, and leadership. Due to the barriers adolescents face when accessing SRH services, they should be involved in all aspects of programming, including design, implementation, and monitoring and evaluation. The emphasis should be on the need to engage adolescents in all stages of the program cycle, not just for tokenistic participation. Programs should develop creative strategies to foster inclusion and participation from the heterogeneous population of adolescents. Often it is the more privileged, "visible" adolescents that are consulted rather than those who are at particularly increased risk of being excluded. Given this situation, it is especially important to adopt strategies that build upon strengths and capacities and provide reasonable accommodations for those who would otherwise not be able to participate to their fullest ability, such as adolescents with disabilities, among others. It is helpful to identify adolescents who have served or can serve as leaders or peer educators in their communities. These adolescents can help address the needs of their peers during program design and can assist with implementing activities, such as condom distribution, peer education, monitoring of adolescent-responsive health services, and referrals to gender-based violence counselors. Services will be more accepted if they are tailored to needs identified by adolescents themselves. Adolescents may be helpful in ensuring that the MISP response also addresses their needs, for example, by identifying culturally sensitive locations to make condoms available.

Foster community involvement

Understanding the cultural context and creating a supportive environment is critical to advancing SRH services for adolescents, as they may be affected by community values regarding ASRH. Communities may frequently become especially protective of cultural norms and the process of socializing adolescents when an emergency occurs. As outlined in the MISP (see Chapter 3) it is important to make priority SRH information and services available, including for adolescents, at the onset of the humanitarian response. As soon as possible, focus on involving communities in issues that affect adolescent health, as this can lead to more sustained, positive health impacts. Community members, including parents, guardians, teachers, health care providers, and religious leaders, must be consulted and involved in developing programs with and for adolescents.

SERVICE PROVISION PRINCIPLES

Privacy, confidentiality, equity, and non-discrimination

Adolescents presenting to health providers often feel ashamed, embarrassed, or confused in seeking SRH services. It is important for providers to create the most private space possible in which to talk and provide services. Providers should be trained on adolescent-responsive service provision without bias, judgment, or discrimination. This should include strategies to establish trust, manage power dynamics, and safely engage adolescents with different types of disabilities in decision-making on their own health needs. Information is disseminated rapidly among adolescents and if their confidentiality is breached even once, adolescents will be extremely reluctant to access available services.

BOX 6.6: ADOLESCENTS IN EVERY REGION OF THE WORLD ENGAGE IN SEXUAL ACTIVITY – WHETHER BY CHOICE OR NOT

Across developing countries globally, 17% of girls have had sex by age 16 and 50% have had sex by age 19. Adolescent boys on average become sexually active at an earlier age than girls.

Girls aged 15-19	Africa	Asia	Latin America & Caribbean	All
% ever had sex, age 16	27	11	28	17
% ever had sex, age 19	66	41	67	50

Linking HIV prevention, treatment and care, and reproductive health

When adolescents access health services to seek HIV information, testing, and care, there is an opportunity to promote comprehensive SRH services such as:

- Safer sex education and information
- Contraception, including dual method use
- STI counseling and treatment

Conversely, offer all adolescents accessing contraception or other SRH services the opportunity to learn about their HIV status as well as available care and treatment options (see Chapters 7, 11, and 12). It is also important to consider the specific needs and additional risks faced by adolescents who were born with and are living with HIV.

Sex of the service provider

Whenever possible, an adolescent should be referred to a provider of the sex of their choice. Ensure that survivors of gender-based violence who are seeking support and care at a health facility have the option of a female support person present in the examination room when a male provider is the only person available. This is essential when the survivor is an adolescent girl, but it is also important to give this option to adolescent boys who are survivors of gender-based violence.

6.3.5 Adolescent programming considerations and implications

It is important for SRH Coordinators and health program managers to remember the following factors that may increase the vulnerability of adolescents during an emergency:

ADOLESCENT GIRLS HAVE GREATER VULNERABILITIES COMPARED TO THEIR MALE COUNTERPARTS

Adolescent girls are an overlooked group within crisis-affected populations. One consequence is a dearth of distinct HIV protection and prevention responses. Where girls are married young, or forced to be married, they are often treated as adults in SRH programming, missing their unique needs around the importance of delaying first and subsequent births.

Existing power differences in relations between men and women can be heightened during an emergency. Adolescent girls are frequently expected to sustain social or cultural norms, such as being submissive to men, caring for their family, staying at home, or marrying young. Moreover, changing power dynamics created as a result of the co-mingling of displaced and host populations can place adolescent girls at increased risk. Economic hardships lead to increased exploitation, such as trafficking and the exchange of sex for money and other necessities, with their related SRH risks (including HIV, STIs, early pregnancy, unintended pregnancy, and unsafe abortion). Adolescent girls are vulnerable to gender-based violence, including sexual violence, domestic violence, female genital cutting, and early and forced marriage. The risks of a pregnancy for an adolescent girl can be exacerbated by pre-existing health conditions such as anemia. Young married girls often lack voice and decision-making power within the household due to the power imbalances with their husbands. The importance of addressing stigma against pregnant or young married adolescents and the need to build the self-efficacy and psychosocial well-being of adolescents cannot be underestimated.

BOX 6.7: HEALTH RISKS ASSOCIATED WITH EARLY MARRIAGE

Child marriage, defined as a formal marriage or informal union before age 18, affects one in three girls in developing countries. Rates of child marriage are particularly high in fragile states. During conflict, families may turn to child marriage to cope with economic hardship and to protect girls from increased violence. Health providers and community outreach workers should be aware that child marriage is likely to exist in crisis-affected communities. Married adolescents face significant health risks that require deliberate attention:

- Married adolescents are at high risk for maternal mortality and morbidity. Ninety percent of early first births occur within the context of marriage, and the risks for pregnancy complications are highest in adolescence. Complications during pregnancy and childbirth are a leading cause of death globally for girls aged 15-19. Married adolescents are also more vulnerable to pregnancy-related injuries such as obstetric fistula
- Married adolescents are at increased risk for intimate partner violence and sexually transmitted infections, including HIV, as well as for cervical cancer and malaria
- Child marriage is linked with early initiation of sexual activity. However, negotiation skills and knowledge of contraception and safe sex practices are limited among this population
- Not only is the health of the girl at risk, but that of her baby, too. Children born to married adolescents are at greater risk of infant mortality and morbidity

Adolescent-responsive SRH services (both static and mobile) are essential to ensuring that married adolescents have access to life-saving health services. Program design and implementation should include tailored outreach strategies to ensure that married adolescents can access SRH services.

SOCIAL NORMS AND SOCIAL SUPPORTS ARE DISRUPTED IN A CRISIS SITUATION

Poverty exacerbates threats to well-being while weakening family support systems for adolescents. Adolescents in crisis-affected settings must often find ways to survive and meet their basic needs for food, shelter, health, and education. The breakdown of social structures can be protective if harmful practices are discontinued, but it can also be a risk to adolescent health. Adolescents' use of free time in crisis settings may not be subjected to the same kind of scrutiny that would occur under other circumstances. When adolescents are separated from family, friends, teachers, community members,

and traditional culture, there may be less social control of risky behavior. Some adolescents, such as those with disabilities, may face increased isolation and be at increased risk of gender-based violence with this loss of familial and community support. Without access to adequate information and services, adolescents are more likely to be exposed to unsafe sexual practices that could result in unintended pregnancy, unsafe abortion, STIs, and HIV. Gender inequality contributes to sexual, health, and social problems. Adolescent girls and boys, their families, and communities should be challenged and supported to change inequitable gender norms and capitalize on any opportunities afforded by new and/or changing circumstances.

HUMANITARIAN CRISES CAN DISRUPT ADOLESCENT-ADULT PARTNERSHIPS AT A TIME WHEN ROLE MODELS ARE ESSENTIAL

In stable settings, adolescents usually have role models in the family and community; such role models may not be obvious in crisis settings. Service providers, community leaders, outreach volunteers, and adolescent club leaders may become important role models and must be aware of their potential influence. Service providers are also well positioned to address the psychosocial needs of adolescents, including mental health, traumatic war-related experiences, post-traumatic stress disorder, sexual abuse, exploitation, and victimization.

HUMANITARIAN CRISES USUALLY DISRUPT NOT ONLY DAILY LIFE, BUT ADOLESCENTS' FUTURE PERSPECTIVES

At a critical and vulnerable time of life, crisis may dramatically shift the individual's view on life. It may lead to increased risk-taking, such as violence, substance use, and/or unsafe sexual activity. Adolescents who attend activities or programs assisting them to plan for the future should be provided with immediate reasons to consider the consequences of unsafe sexual activity and the need to take responsibility for their actions. Training on improved

PROGRAMMATIC EXAMPLE 6.2: ADOLESCENTS AS FIRST RESPONDERS IN NEPAL AND SRI LANKA

ORGANIZATION: International Planned Parenthood Federation (IPPF)

LOCATION: Nepal and Sri Lanka

INTRODUCTION: South Asia is prone to natural disasters that have been growing in frequency and intensity in recent years. This includes the devastating earthquake in Nepal in 2015 and a huge landslide in Sri Lanka in 2016; these events affected a large number of people especially women and children.

PROJECT DESCRIPTION: Among the various crises in the region to which IPPF has responded, its notable work in provision of timely life-saving SRH services outlined under the MISP in Nepal and Sri Lanka received special attention from various partners due to proactive involvement of trained adolescent youth volunteers. With support from the Department of Foreign Affairs and Trade under Australian Government, IPPF provided more than USD137,000 to its Member Associations for response work in Nepal and Sri Lanka. In both the responses, IPPF mobilized and engaged its trained adolescent and youth volunteers who actively participated in strategizing the response and providing services in the field to undertaking risk reduction activities in the affected communities. Undergirding the effort is a belief that talking with young people about contraceptive use, safer sex behaviors, and gender-based violence helps in reducing their vulnerabilities and understanding better issues that are part of their day-to-day lives.

RESULTS: Trained youth volunteers in both responses supported provision of SRH services to over 22,849 people. More than 2,000 RH Kits were distributed in the two countries. Adolescent volunteers actively participated in camp management and the rapid assessment for the WHO health cluster and also attended the reproductive health cluster meetings. This helped in designing adolescent- and youth-friendly responses and in further liaising with other youth groups and partners.

LESSONS LEARNED: Adolescents and youth can act as catalysts for response work. Involvement of youth in planning and designing the intervention can improve the quality and effectiveness of the emergency response. Furthermore, capacitating youth in disaster risk reduction and SRH service provision including counseling, peer education, and referrals can play a pivotal role in saving lives.

decision-making, negotiation, and other life skills can be effective in encouraging adolescents to think through how to improve their current situation.

ADOLESCENTS MAY BE COMPELLED TO TAKE ON ADULT ROLES IN EMERGENCIES

Adolescents may be forced to take on adult roles and need coping skills that far exceed their years. Humanitarian crises may cause adolescents to wield more power than their adult counterparts, which exacerbates social confusion. Ensuring additional support for adolescents placed at increased risk who are made to take on adult roles, such as girl mothers, is particularly important.

ASRH PROGRAMMING SHOULD BE BASED ON THE CURRENT EVIDENCE-BASE AND EMERGING GOOD PRACTICES FOR INITIATING PROGRAMS AND SCALE-UP

Programming should be coordinated and complementary to meet the holistic needs of adolescents. Some popular interventions have been shown to be ineffective, especially when delivered piecemeal with inadequate or limited human and financial resources. Respecting the autonomy and decision-making capacity of adolescents and supporting informed choice is critical.

CONSIDER THE UNIQUE NEEDS, VULNERABILITIES, AND OPPORTUNITIES FOR WORKING WITH HETEROGENEOUS GROUPS OF ADOLESCENTS

Evidence indicates that adolescent concerns include healthy growth and development, protection from risks, knowledge of emerging sexuality, and gender roles and norms. For these reasons, programming aimed to address the SRH needs of very young adolescents should consider the continued education of children and adults that inform and influence their decisions and behaviors, including service providers. It is important for providers to identify and adequately address the age-, gender-, marital status-, disability-, and context-specific vulnerabilities of adolescents (see Box 6.2).

6.3.6 Implementing sexual and reproductive health services for adolescents

As illustrated on Table 6.1, the World Health Organization

TABLE 6.1: GLOBAL STANDARDS TO IMPROVE QUALITY OF HEALTH CARE SERVICES FOR ADOLESCENTS

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

(WHO) has developed global standards for providing quality health care services to adolescents. These overarching standards should guide the implementation of ASRH services.

PROVISION OF ASRH SERVICES AT HEALTH FACILITIES

Health service providers can play an important role in promoting and protecting the health of adolescents, yet there is abundant evidence that adolescents see available health services as not responding to their needs. Adolescents often mistrust and avoid SRH services or seek help only when they are in desperate need of care. Provider bias is a significant barrier that contributes to this situation and must be addressed, as it often prevents adolescents from seeking facility-based SRH care, as well as receiving adequate information and services around contraception in particular. Married adolescents, including very young adolescents, are also often treated as adults, without consideration for their unique physical, emotional, and psychosocial needs. Furthermore, adolescents with disabilities, particularly intellectual disabilities, may not be offered the same age-appropriate SRH information as others, because parents, community members, and service providers alike make assumptions about their relationships and capacities.

Adolescents need to be made aware of the availability of "adolescent-responsive" services. Adolescent-responsive SRH services have characteristics that make them more responsive to the particular SRH needs of adolescents, including the provision of a full range of contraceptive methods, safe abortion care, STI diagnosis and treatment, HIV counseling, testing, and care, antenatal and postnatal care, and delivery services, including emergency obstetric and newborn care. It is particularly critical to ensure adolescents have on-site access to supplies for SRH services as they may not have the resources to obtain them elsewhere. Follow-up with adolescents on these services is critical (see Table 6.2).

It is essential to strengthen the linkages between the individual, family, health facility, and community to ensure holistic programming for adolescents. Thus, it is important to ensure that context-specific information, educational, and communications materials are developed and distributed to inform adolescents about the availability of and benefits to seeking SRH services.

TABLE 6.2: ADOLESCENT-RESPONSIVE HEALTH SERVICE CHARACTERISTICS

HEALTH FACILITY CHARACTERISTICS	PROVIDER CHARACTERISTICS	ADMINISTRATIVE CHARACTERISTICS
Convenient hours for adolescents	Respect for adolescents and their choices	Adolescent involvement and leadership
Convenient location	Non-judgmental attitude, empathy and active listening	Boys and young men welcomed
Adequate and space and sufficient privacy	Privacy and confidentiality honored	Necessary referrals available
Comfortable surroundings	Peer counseling available	Affordable fees
Accessible for those with disabilities	Same-sex providers when possible	Drop-in clients welcomed
	Strict confidentiality maintained	Publicity and recruitment that informs and reassures adolescents
	Staff trained in adolescent-responsive health service characteristics	Develop community-based partnerships to strengthen ASRH
	Approach every adolescent as an individual, with differing needs and concerns	

PROVIDER QUESTIONNAIRE FOR ADOLESCENTS

It is good practice to screen and conduct an individual assessment of all adolescents who enter the health system for SRH issues, substance use, and mental health concerns. In doing this, the health care provider will send a message to adolescents that she/he/they cares about their needs and that the health center is a safe place to discuss SRH-related issues. In addition, the information can be used by health providers to provide appropriate

counseling and referrals. Trained, qualified, and dedicated ASRH staff, including clinical staff, are crucial to high-quality service provision.

Before collecting information from adolescents, consider the services available for referrals. Only ask sensitive questions if appropriate responses to potentially harmful situations and related referrals for additional services can be provided, otherwise more damage than good may be done. A possible adolescent psychosocial assessment that will help guide health providers to ask age-appropriate questions and adequately assess adolescent needs follow the pneumonic HEADSSS: Home, Education/Employment, Activities, Drugs, Sexuality, Suicide and Depression, Safety (see section 6.6).

PROVISION OF SRH SERVICES IN THE COMMUNITY

Community-based provision of services and information offers opportunities not only for adults but also for adolescents to demonstrate leadership and gain new skills through volunteerism while strengthening adolescent-adult partnerships. The community is also an ideal setting to receive SRH information and training and should be supported to establish an assets development approach for adolescents. This type of approach creates space for open dialogue, where adolescents are able to effectively navigate community sensitivities.

HARNESSING THE POWER OF ADOLESCENTS

Adolescents can be positioned to play leadership roles in the community by engaging them in emergency preparedness, capacity building, and other community-based initiatives. This includes participation in coordination meetings starting at the onset of the crisis as well as in camp management meetings. Including adolescents' voices in decision-making processes ensures that the issues of greatest concern to them, which may not be apparent to adults, can be addressed.

Adolescents can also serve as first responders for provision of community-based SRH services. Adolescents trained as community-based distributors (CBDs) are young people who have been trained to provide contraceptive counseling to their peers in the community. They typically focus on the provision of SRH information, oral contraceptives, condoms and information on HIV, and refer clients to the health center for other contraceptive methods and services. Adolescent CBDs can effectively integrate SRH and HIV information.

Since many barriers preclude adolescents from accessing SRH services at clinics, training adolescent CBDs is a promising strategy to increase adolescent access to SRH services and information while giving the adolescent CBDs themselves leadership roles in the community. Adolescent CBDs often become allies of facility-based health services, through working with service providers on improving the quality of adolescent-friendly services. Set targets for the age, gender, and diversity when recruiting adolescent CBDs to ensure they are able to better reach less "visible" and more vulnerable adolescents.

BOX 6.8: ADOLESCENTS CAN PLAY A CRITICAL ROLE IN HUMANITARIAN RESPONSE

Adolescents can and should have a voice in programming that targets them. Effective ASRH programming builds on adolescents' capacities to promote their own empowerment. For example, adolescents can serve as first responders in emergencies by assisting health providers as volunteers and community-based distributors. They can also participate in coordination mechanisms to ensure that adolescent needs are considered from the outset of an emergency, through the recovery process. Engaging young people in project design, implementation, monitoring, and accountability mechanisms results in improved services.

Peer educators

There is little evidence to indicate that peer education programs are effective on their own. However, peer education may offer benefits since peers are usually perceived as safe and trustworthy sources of information. Well-designed, curriculum-based peer education programs and supervised peer educators can be successful in improving adolescents' knowledge, attitudes, and skills about SRH and HIV prevention. While peer models have traditionally been viewed as very effective for achieving behavior change at the community level, emerging evidence has shown varying degrees of effectiveness due to implementation challenges and lack of fidelity to program design. Adolescents are strongly influenced by

their peers and thus peer education should be employed in the context of a multifaceted approach. To ensure quality in peer education programs:

- Provide high-quality, intensive training to peer educators, including regular assessments and reinforcement of their capacities through refresher trainings, structured supervision, recognition, and ongoing mentorship to peer educators to address motivation and retention challenges, so they can provide accurate information to their peers
- Use standardized checklists in the development and implementation of peer education programs to improve quality

Youth centers

Emerging evidence indicates that "youth centers" are problematic for several reasons. They are usually accessed by more advantaged groups and are not cost-effective in increasing uptake of SRH services. However, adolescent-centered programming may offer other benefits for positive adolescent development and adolescents tend to engage in less risky behaviors when productively engaged. Therefore, while there is limited evidence of their effectiveness in increasing uptake of SRH services, youth centers could still be useful for meeting other objectives such as bringing marginalized adolescents together.

Adolescent outreach components

It is important to develop and implement specific outreach strategies to reach adolescents who may otherwise not have access to SRH information and services. Outreach strategies should be flexible and should include transportation budgets in insecure environments and otherwise hard-to-reach areas. Innovative strategies for effective outreach to adolescents placed at increased risk include use of new media such as blogs, social media and network sites, and photo share platforms, although the required technologies may not be available in all settings. Adolescent outreach activities can also be facilitated at a neighborhood level, strengthening the protective peer networks of those who may be isolated in their homes.

Community outreach

In addressing the principle of community involvement, use community outreach to gain support from and build the skills of community members. Adults need information, skills, and encouragement, not only to support ASRH programming but also to feel more comfortable in providing information to adolescents. Community outreach may also help adolescents navigate gatekeepers and the social norms that pose barriers to accessing ASRH services.

Link ASRH services with educational settings

It is critical to strengthen linkages between SRH and educational settings in order to protect, build the resilience of, and aid recovery for adolescents. Adolescent use of SRH services during crises can be increased in an educational environment. Make ASRH services and information available in formal and non-formal schools as well as at vocational training centers. Link with educators to advocate for the creation of an enabling environment to ensure the provision of SRH services for adolescents.

Sex-specific hygiene facilities

Adolescents are likely to be uncomfortable and embarrassed about sharing hygiene facilities such as toilets with the opposite sex, and even with younger children. This is especially likely for girls during menstruation. Also, mixed-sex bathroom facilities are often cited as the location of school-related gender-based violence. A lack of sex-specific hygiene facilities, as well as a lack of feminine hygiene products, will discourage adolescent girls from attending school. In order to minimize school absenteeism and school-related sexual harassment and assault, and to promote a safer learning environment:

- Ensure safe, sex-specific hygiene facilities in schools
- Ensure appropriate washing facilities are available and accessible, including to adolescents with disabilities
- Provide girls with cloth or other culturally appropriate sanitary materials for use during menstruation

Curricula-based life skills education

Life-skills education should consider the importance of building adolescents' developmental assets (human, social, financial, and physical) to leverage adolescents' social roles, including their intellectual, emotional, and physical capital, as influential actors in their communities. Sexuality and HIV education programs based on a written curriculum and implemented among groups of adolescents

are a promising intervention to reduce adolescent sexual risk behaviors. Program managers should tailor curricula to ensure it is age, developmentally, and culturally appropriate. Characteristics of life skills curricula that have an impact on adolescent behaviors are outlined in Table 6.3 and include puberty and fertility education, menstruation, gender norms, healthy relationships, gender, gender identity, bodily identity, and sexual orientation.

As there are many challenges in providing sexuality education to adolescents, it becomes even more important for SRH Coordinators and health program managers to provide technical assistance to teachers and community educators to ensure they are comfortable in addressing the topics and choosing appropriate lessons for life skills curricula (see Box 6.6).

TABLE 6.3: CHARACTERISTICS OF EFFECTIVE LIFE SKILLS PROGRAMS

CURRICULUM DEVELOPMENT	CURRICULUM CONTENT	CURRICULUM IMPLEMENTATION
Involve people with different backgrounds Assess needs and assets of the target group Design activities consistent with community values and available resources (e.g., staff time and skills, facility space, supplies) Pilot-test the program	Focus on clear goals (e.g., prevention of STIs and/or pregnancy) Give clear messages on behaviors that lead to these goals (e.g., abstain from sex, use condoms, and/or other contraceptives) Address risk and protective factors affecting sexual behaviors. This information should include puberty, menstruation, gender norms, gender identity, bodily identity, sexual orientation, HIV and other STIs, healthy relationships and pregnancy prevention. Use sound teaching methods and include multiple activities (appropriate to culture, age and sexual experience) that actively involve participants and help them personalize the information Cover topics in a logical sequence	Train educators who can relate to adolescents Secure support from authorities, such as ministries of health, school districts or community organization Create a safe environment for adolescents to participate Recruit adolescents and overcome barriers to their involvement (e.g., publicize the program, offer food, obtain parental consent) Teach the full curriculum

BOX 6.9: LIFE PLANNING SKILLS

- Physical and emotional changes to expect during puberty
- Family planning
- Mental health
- Age-appropriate life skills for younger adolescents such as identifying values, understanding consequences of behaviors
- SRH life skills, such as condom self-efficacy, negotiating safe sex and contraceptive use, refusing unwanted sex
- Sexuality and gender, including discussion of socially constructed gender norms
- Health literacy and fertility awareness
- HIV/AIDS prevention
- Prevention of gender-based violence
- Linkages to health facilities, encouraging adolescents to seek out these services
- Other life skills, such as decision-making, critical thinking, self-efficacy, creativity, establishing values, communication, coping with emotions and stress

6.3.7 Coordinating and making linkages

Making links and coordinating between adolescent programs will enable the provision of more comprehensive ASRH services.

LINK SRH SERVICES WITH COMMUNITY SPACES AND SERVICES

Adolescents often seek out adults they trust in safe spaces where they feel information can be shared in confidence. Often, these people are working at the community level. Put in place referral systems to ensure that adolescents receive the appropriate treatment for problems that might be revealed outside the clinical setting, including sexual violence, unintended pregnancy, and unsafe abortion.

ENSURE MULTI-SECTORAL PROGRAMMING

SRH practitioners may be unable, or may lack the skills, to include livelihood components in their program. In coordination with the health cluster/sector, liaise with camp management (if applicable) and other cluster coordination groups to establish links between adolescent programs, health and protection, psychosocial services, education, and livelihood opportunities.

Supporting vocational training and skills development for adolescents will enhance their feeling of control and optimism for the future, and is essential to reconstruct and rehabilitate their social networks and communities, both during and after a humanitarian crisis. Collaborate with adolescent skills-building programs as a source for referral and to integrate SRH information into livelihood programs.

ENGAGE MEN AND BOYS AS AGENTS OF SOCIAL CHANGE

Rigid male social norms have been linked to increased sexual risk-taking, which can lead to higher risks of STI and HIV transmission, as well as increased substance use and gender-based violence. Conditions in humanitarian settings may challenge men who might feel under pressure to play out their traditional roles as providers and protectors, where they are dependent on external assistance. Resulting frustration and humiliation can lead to increased risk-taking behavior and intimate partner and intra-familial violence. Adolescent boys need safe environments where alternative male norms can be modelled while harmful social norms can be deconstructed. This gives them the opportunity to address their own needs and actively engage them in discussions about reproductive health, thereby benefitting both adolescent girls and boys and promoting gender-equitable norms. However, it is important to ensure that such programming is gender transformative and does not inadvertently reinforce unequal gender norms.

GIRLS' EMPOWERMENT AND SOCIALIZATION

Working with girl-only groups is an ideal way to also challenge female social norms of passivity, subservience, and inferiority to men. Encourage girls to find their voice and solidify their beliefs and values, thereby enhancing their potential to be equal contributors to society. Humanitarian settings can often emphasize unequal gender and power relations. Given this situation, design programs to empower girls through emerging evidence-based models such as girl-centric approaches and asset-building programming for adolescent girls that contribute to their empowerment. Parallel efforts with boys and young men should also be undertaken.

6.3.8 Advocacy

Decision-makers at all levels, from national to local leaders and from donors to humanitarian health staff, often have the power to affect broad-based change because they design and implement policies and programs that affect adolescents' access to SRH information and services. Therefore, advocacy with these stakeholders can have a big pay-off.

Advocacy efforts can occur with and among different stakeholders; SRH Coordinators and health program managers, and service providers must be change agents. Engaging adolescents directly in advocacy efforts can be an effective strategy to identify opportunities for change at the policy or program level and communicate needs to key decision-makers.

Global efforts such as the Global Strategy on Women, Children, and Adolescents, the Compact for Young People in Humanitarian Action, and the Sustainable Development Goals support ASRH in humanitarian settings and can be used as advocacy tools. Sensitize and orient influential people who are part of the relief/development community as well as the community being served to the SRH

vulnerabilities, specific needs, and rights of adolescents.

DONORS AND POLICY MAKERS

- Donors should support multi-year (as appropriate, given the emergency context), multi-sectoral programming to facilitate iterative and reflective processes of program development that engage adolescents along the disaster risk management cycle
- Advocates should encourage donors and research organizations to agree upon and implement consistent age range and age cut offs, ensuring that data is collected on 10-19 year olds

HEALTH CLUSTERS

- The health sector/cluster should prioritize and approve ASRH-inclusive projects in humanitarian funding appeals from the very onset of crises and for effective transition to long-term programming that meets the unique needs of adolescents

EMERGENCY RESPONDERS, HUMANITARIAN ACTORS, AND SRH PROGRAM STAFF

- Both humanitarian and development organizations should address ASRH during emergency preparedness to build upon adolescents' capacities and address needs
- The program cycle should include participation, inclusion, and leadership of the heterogeneous adolescent population at all phases
- Advocates should work to ensure that available information and services are adolescent-responsive thereby ensuring an enabling environment and should highlight the needs of adolescents with officials, policy-makers, and donors
- SRH program staff should be involved in awareness-raising activities in the community, such as "open days" and community dialogues

COMMUNITY LEADERS AND OTHER INFLUENCERS ALONG THE ECOLOGICAL FRAMEWORK

- Influential individuals and groups should sensitize parents, teachers, community, and religious leaders to the unique SRH needs of adolescents.
- Community leaders should ensure that there is a safe and supportive environment to facilitate adolescent health, protection, and development.

6.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

6.4.1 Human rights standards

The category of adolescent (10-19 years old) includes children, who are defined by the Convention on the Rights of the Child (CRC) as "every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier." The CRC lists the special protections to which children are entitled because of their status as children. It also recognizes the "evolving capacity of the child." This means that "as children acquire enhanced competencies, accordingly, there is a reduced need for direction and a greater capacity to take responsibility for decisions affecting their lives." Children have a right to express their views in all matters affecting them and these views must be given due weight in accordance with the age and maturity of the child. Human rights expert bodies have recognized the right of adolescents to meaningfully participate in making decisions about their reproductive health care in line with their evolving capacities and adolescents' right to access reproductive health information and services.

In considering the issues of adolescent health and development, the Committee on the Rights of the Child has interpreted the CRC as obligating States to provide adolescents with access to SRH information and services. These services include, among others, birth preparedness, maternal care, safe abortion services and post-abortion care, and contraceptive services, including emergency contraception. This obligation is based on a range of rights included in the CRC, including the right to non-discrimination, the right to health, the right to information, the right to privacy, the right to expression of views and the right to protection from all forms of abuse, neglect, violence, and exploitation, including harmful traditional practices. These rights are also included in other international human rights instruments. They apply to non-child adolescents as well, and may be violated when:

- Adolescents do not have access to SRH services and information because of their age
- SRH information and services are denied to unmarried girls because of their unmarried status
- Adolescents living with HIV are disadvantaged in formal and non-formal educational and social settings
- Girls are subjected to harmful traditional practices, such as female genital cutting, child, early, or forced marriage, and virginity testing
- Third party authorization (from a parent, guardian, or spouse) is required either by law or in practice for adolescents to access SRH services
- Adolescents are denied the right to meaningfully participate in making decisions about their SRH care, in line with their evolving capacities, including girls' right to have their opinion heard and respected in making decisions about abortion
- Girls who bear children are denied their right to continue their education, such as when they are expelled from school or not provided the proper social or economic support to finish school
- Health workers disclose to a third party an adolescent's HIV status without obtaining legal consent to reveal such information
- Health workers disclose to a third party that an adolescent girl sought SRH services, including abortion or post-abortion care, without obtaining legal consent to reveal such information

6.4.2 Challenges and opportunities

In some cases, SRH program managers and service providers may face difficult decisions or dilemmas. They may find that their ability to ensure the human rights of adolescents is restricted by national legislation, harmful social or cultural norms, or medical misconceptions. Such practices and laws can be in conflict with internationally accepted human rights principles. For example:

- Service providers may be asked by an adolescent's family to conduct a virginity (hymen) examination to determine whether she has engaged in sexual activity or has been raped. Such examinations have no medical validity and are a breach of the rights of the adolescent if done without her informed consent
- Some service providers may be asked by caregivers, or offer to conduct, procedures on adolescents with disabilities that may restrict their SRH rights. For example, forced or coerced sterilization is sometimes performed on women and girls with disabilities for menstrual management and personal care, and even for pregnancy prevention in situations where they are perceived at high risk of sexual abuse. Such practices are now recognized as a human rights violation
- Managers and service providers may be discouraged from initiating a program that provides SRH information or services to adolescents due to a common misperception that having access to sexuality education and SRH information may encourage adolescents to engage in sexual activity. In fact, accurate and accessible information supports adolescents' ability to make healthy decisions and to refuse to provide this information to adolescents is a denial of their rights
- Requiring that adolescents obtain parental consent for some services may hinder their ability to seek services confidentially and autonomously

SRH Coordinators, health program managers, or service providers may find themselves facing difficult issues around provision of SRH information and services to children and adolescents. Be aware of the agency's/organization's position on these issues and include it as part of the situation analysis and possible next steps. If facing a situation such as those described above, the first priority must be the best interest of the client, focusing on her/his/their safety and health. The safety of the SRH Coordinator, health program manager, or service provider as well as the safety of colleagues is also critical to consider.

Based on the assessment of the situation, it may make sense to:

- Talk to a supervisor
- Discuss possible options with the client including, as appropriate, information about local child rights and women's human rights organizations that might be able to help her/him/them

- Explore ways of mobilizing community support for adolescent-responsive SRH services
- Consider ways to support advocacy efforts, if the agency is engaged in advocacy on the issue, while respecting the confidentiality of the client. Identify with colleagues how to avoid/handle such situations in the future, including through strategies, such as values clarification exercises
- Raise these concerns in health coordination meetings
- Seek guidance on best culturally-sensitive approaches

6.5 MONITORING AND EVALUATION

To be sure that adolescents are making use of available SRH services and receiving SRH information, SRH indicators should be disaggregated by age and sex. Key adolescent sexual and reproductive health indicators include:

- Number of adolescent clients seeking services at health facility (disaggregated by very young adolescents, older adolescents, and other sub-groups)
- The degree to which adolescents report they felt they were meaningfully engaged in the program cycle (could be a qualitative indicator for program improvement purposes)
- Proportion of adolescents with an increase in knowledge on puberty and fertility awareness

6.6 FURTHER READING AND ADDITIONAL RESOURCES

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