Photo : Susan Warner

CHAPTER 6: ASRH SERVICES & INTERVENTIONS

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

Chapter 6: Learning Objectives

After reading this chapter, readers should be able to:

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

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

What makes a successful ASRH intervention?

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

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

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

Where's the evidence?

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

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

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

Let's first discuss adolescent-friendly health services

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

Figure J: Principles of Adolescent-Friendly Services

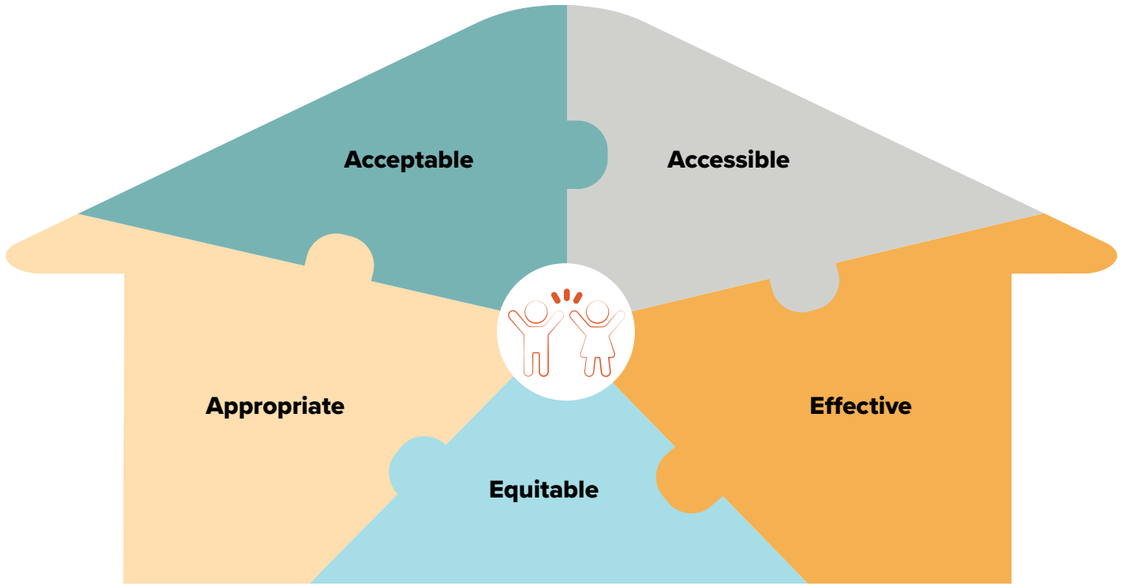


Table 5: Adolescent-Friendly Principles

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

PRINCIPLE	
ACCEPTABLE	
DESCRIPTION	**APPLICATION**
Policies & procedures are in place that guarantee patient confidentiality.	Confidentiality is defined by WHO as "the duty of those who receive private information not to disclose it without the patient's consent." This means that any information the adolescent shares with the service provider is not shared with anyone else and all collected information from the adolescent is kept in a safe and secure place. Providers will refrain from discussing what patients have shared, including what service(s) adolescent patients were seeking or if they received any services. In humanitarian settings, adolescents are often displaced from their homes and the provider may be the only person they trust to confide in, so it is paramount to foster and maintain that trust.
Point of service delivery ensures privacy.	WHO defines privacy as "the right and power to control the information (about oneself) that others possess." This means that adolescents have a right to discuss information without fear of someone seeing them (physical privacy) or hearing them (auditory privacy). In a health facility, it is important to ensure that consultation rooms have sheets or barriers to separate patients and those in the waiting room, and prevent them from seeing each other. In addition, the facility should be organized so that people in the waiting room cannot hear what adolescent patients are saying during consultations.
Healthcare providers are non-judgmental, considerate, and easy to relate to.	As provider bias and attitudes can significantly affect adolescents' decisions to seek or receive services, it is important to hire, train, mentor, and supervise staff that are welcoming, respectful, and non-judgmental toward adolescents. Providers should be trained on how to create a trustful atmosphere for adolescents seeking SRH services, which includes respecting their autonomy, maintaining confidentiality and privacy, as well as other competencies discussed in Chapter 6 under Training and Capacity Building of Staff.
Point of service delivery ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral.	Adolescents have reported facing stigma in the waiting room as an impediment to seeking SRH services. In some emergencies, adolescents may have to travel longer distances and/or face additional security risks to obtain SRH services. They may have restricted freedom of movement to travel where they want to go. This is why it is important that once adolescents arrive for SRH information or services (despite barriers they may have faced to get there), humanitarians must ensure they receive prompt attention to encourage adolescents to seek these services without the deterrence of long waiting lines.
Point of service delivery has an appealing and clean environment.	Maintaining a clean and proper facility is important for all patients. For adolescents, health staff should think about ways to make the facility more welcoming and attractive. This includes ensuring all staff (including receptionist) understand where adolescents can seek services. The facility may have a discreet entrance for adolescents or a special card/bracelet for adolescents to show providers what services they are requesting to expedite seeing a provider and to avoid having to tell others why they are there.
Point of service delivery provides information and education through a variety of channels.	Adolescents have differing learning needs, with some who are not literate and others who process information better through pictures. Adolescents may be embarrassed to ask questions; providing SRH information through a variety of channels will allow them to obtain information on topics that their parents or community members may be unwilling to discuss.
Adolescents are actively involved in designing, assessing, and providing health services.	Involving adolescents in assessment activities and service provision ensures that programming is more sensitive and responsive to their needs. This topic is discussed more fully in Chapter 3 under Adolescent Participation.

PRINCIPLE

APPROPRIATE

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

PRINCIPLE

EQUITABLE

DESCRIPTION	APPLICATION
Policies & procedures are in place that do not restrict the provision of health services.	In accordance with humanitarian principles, organizations should establish procedures and written policies that ensure no factor (sex, age, social status, etc) hinders the provision of services to all or some groups of adolescents or hinders the ability of all or some adolescents to obtain those services. These policies should include adolescent considerations that specify the services adolescents are entitled to and how they should be treated within the facility. **Principle of Capability** Adolescents who request SRH services can be considered capable of receiving SRH counseling and services without parental oversight. When applied to SRH care for adolescents, the Principle of Capability means that a young adolescent—who identifies that they want SRH services and voluntarily requests SRH care, such as maternal care, contraception, Human Immunodeficiency Virus (HIV)/ sexually-transmitted infection (STI) care, or to terminate a pregnancy—is capable of consenting to services. This principle removes the expectation or assumption that service providers should determine if adolescents can receive the services they are requesting and appropriately puts the decision-making power in the hands of the adolescent patients.
Healthcare providers and support staff treat all adolescents with equal care and respect, regardless of status (age, sex, marital or social status, cultural background, ethnic origin, disability, or any other reason).	Cultural or social norms may affect how providers or support staff interact with and/or deliver SRH services to adolescents. In a humanitarian setting, providers may be asked to deliver services to a population from another country, belief system, or culture from their own. It is important to assess the attitudes and beliefs of all staff that interact with adolescents and educate staff on the SRH rights of adolescents and their facility's policies in providing equitable care to all adolescents. This is discussed further in Chapter 6 under Training and Capacity Building of Staff.

PRINCIPLE	
EFFECTIVE	
DESCRIPTION	**APPLICATION**
Healthcare providers have the required competencies to work with adolescents and to provide them with the required health services.	Adolescents are not a homogenous group. They have unique SRH needs, and providers should be trained on the clinical and counseling competencies, as well as the interpersonal skills required to deliver quality SRH services to adolescents. There are specific considerations providers will need training on, such as using more simple terminology and language with adolescents. This is discussed further in Chapter 6 under Training and Capacity Building of Staff.
Healthcare providers use evidence-based protocols and guidance to provide health services.	Providers should be following quality standard protocols of the country they are in and the organization they belong to. In contexts where the standards of the country are not in alignment with global standards, humanitarians should work toward updating and improving those guidelines.
Healthcare providers are able to dedicate sufficient time to deal effectively with their adolescent patients.	Adolescent patients may be hesitant to discuss why they are at the facility or find it hard to describe what their SRH needs are. They may also be unaware of why, what, or how their bodies are changing. Perhaps their sexuality education was disrupted or they never received any education at all. The provider needs to build trust, make the adolescent feel comfortable, and answer their questions before providing any SRH services they request. All of these tasks require adequate time to effectively meet adolescents' needs.
The point of service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.	Without the needed materials and supplies, healthcare providers cannot deliver quality SRH services. Adolescents may be hesitant to visit the clinic, may have faced tremendous barriers in reaching the facility, or overcame stigma and discrimination to meet with a provider. Lack of supplies or materials should not be an impediment for adolescents to obtain the services they need.

Photo : Siam Diab

Training and Capacity Building of Staff

Why is it important to train staff on ASRH?

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

IMPLEMENTATION CONSIDERATION

National Training Curricula

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

Who should be trained?

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

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

How should humanitarians be trained?

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

IMPLEMENTATION CONSIDERATION

When To Train

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

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

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

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

Tools for Clarifying Values

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

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

Photo : Susan Warner

Figure K: Fundamental Attitudes for Delivering Adolescent Healthcare

- Treat each adolescent with full respect for their human rights.
- Show respect for adolescent clients' choices, as well as their right to consent or refuse physical examination, testing, and interventions.
- Approach all adolescents, including those from marginalized and vulnerable populations, in a non-judgmental and non-discriminatory manner, respecting individual dignity.
- Demonstrate understanding of adolescents as agents of change and as a source of innovation.
- Demonstrate understanding of the value of engaging in partnerships with adolescents, gatekeepers, and community organizations to ensure quality health-care services for adolescents.
- Approach adolescent health care as a process, not a one-off event, and appreciate that adolescents need time to take decisions and that ongoing support and advice might be needed.
- Approach every adolescent as an individual, with differing needs and concerns, and differing levels of maturity, health literacy, and understanding of their rights, as well as differing social circumstances (schooling, work, marriage, migration).
- Show respect for the knowledge and learning styles of individual adolescents.
- Demonstrate empathy, reassurance, non-authoritarian communication, and active listening.
- Offer services that are confidential and provided in privacy.
- Demonstrate awareness of one's own attitudes, values, and prejudices that may interfere with the ability to provide confidential, non-discriminatory, non-judgmental, and respectful care to adolescents.

KEY MESSAGE

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

How do I integrate VCAT into my trainings?

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

GENDER CONSIDERATIONS FOR VCAT

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

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

ADOLESCENT ENGAGEMENT IS KEY!

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

Training Tools

SRH Coordinators & Managers

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

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

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

Photo : Médicos Sin Fronteras

Figure L: Training Strategies for Response Staff

Acute Phase

- 1–2 day VCAT workshop for coordinators, all staff, and ASRH stakeholders
- Whole-site orientation on ASRH (half-day for providers, support staff at each intervention site, and adolescent/youth representatives, where possible)
- IAWG ASRH training packages (two days for health managers, field coordinators, and adolescent/youth representatives, where possible)
    - *Access the IAWG training packages* here
- Rapid response ASRH clinical training (two days for healthcare providers; utilize adolescent/youth participants, where possible)
- Provider support visits on site within one month after training and as needed

Protracted and Comprehensive Phases

- 1–2 day VCAT workshop and then a four-day VCAT TOT (applicable for all staff, but also including other ASRH stakeholders, such as adolescent/youth representatives and MOH staff)
- Whole-site orientation (half-day for providers and support staff for new and existing intervention sites; include adolescent/youth representatives, where possible)
- IAWG ASRH training package and then a four-day TOT (applicable for SRH officers and health facility managers, and consider inviting adolescent/youth representatives and/or MOH to participate or co-facilitate)
    - *Access the IAWG training packages* here
- Clinical trainings continued + clinical four-day TOTs (as applicable)
- Provider support visits on site within one month after training and as needed
- Provide 1–2 day refresher trainings, as needed

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

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

CASE STUDY

Pathfinder's Mentorship Program In MZ & TZ

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

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

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

KEY MESSAGE

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

REMOTE TRAINING OPPORTUNITIES

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

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

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

- TOT Package on ASRH in Emergencies for SRH Managers
- Training Package on ASRH in Emergencies for Frontline Health Workers
- Training Package on ASRH in Emergencies for Non-Health Staff

Photo: Plan International

Service Providers

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

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

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

What ASRH training components should be included for service providers?

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

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

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

At Risk Adolescents: VYAs

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

Domain 2: Laws, Policies, and Quality Standards

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

At-Risk Adolescents: GBV Survivors

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

Domain 3: Clinical Care of Adolescents with Specific Considerations

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

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

Figure M: Clinical Care of Adolescents with Specific Considerations

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

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

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

Community Health Workers

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

Why do we need to train CHWs on ASRH?

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

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

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

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

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

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

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

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

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

Photo : Plan International

Facility-Based Services

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

Are adolescents capable of making decisions about their SRH?

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

What makes a facility appealing to adolescents?

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

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

IMPLEMENTATION CONSIDERATION

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

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

What SRH services are offered at a health facility?

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

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

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

REFERRALS TO HEALTH SERVICES

What is a health service referral?

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

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

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

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

IMPLEMENTATION AND MONITORING OF ACCESSIBLE AND EQUITABLE SERVICES

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

How can we involve adolescents in facility operations?

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

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

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

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

Photo : Kathleen Prior

CASE STUDY

Strengthening ASRH Coordination and Referral Systems with Young People

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

What other health service delivery options are there?

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

Mobile Health Clinics and Teams

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

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

AT-RISK ADOLESCENTS: ADOLESCENTS WITH DISABILITIES

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

Photo : Victoria Zegler

Telemedicine and Other Outreach Methods

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

Additional evidence needed

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

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

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

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

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

Telehealth can also help bridge skills gaps among health staff.

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

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

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

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

Self-Care Approaches

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

Photo : Relief International

CASE STUDY

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

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

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

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

Facility Quality Improvement Tools

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

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

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

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

Photo : Mats Lignell

Counseling Tools & Resources

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

How is counseling adolescents different from other patients?

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

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

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

Five Principles for Creating a Trustful Atmosphere for Adolescent Counseling

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

1 Be respectful and non-judgmental with the adolescent patient

a. Respectfully introducing yourself is vital, as this is the initial moment to provide a safe environment and terminate possible walls of shame and stigma. Use plain language and utilize accurate terminology. For example, say, 'Hello, I am Shirin, and the last five years I have been providing a broad range of health services, such as pregnancy care, contraception, abortion, STI, and sexual violence services, and I have worked with lesbian, gay, bisexual, and transsexual young people, and children who have been sexually assaulted." Putting what is considered destigmatizing language on the table provides adolescents with reassurance, invites confidence in you as the provider, and assures them that they are in the right place to access SRH services.

b. Providers should also use general questions to make the adolescent feel more comfortable. For example: "How are you? What do you do for fun?" instead of, "Why are you here?"

c. Providers should respect adolescents' autonomy, including their choice of contraceptive method and/or their choice of provider, where possible. Providers should not make assumptions about their level of sexual activity (such as assuming adolescents with cognitive impairments or physical disabilities are not sexually active), nor about their sexuality preferences (see Using Gender-Neutral and Non-Stigmatizing Language).

d. It is important to recognize and acknowledge biases and perceptions of staff before thinking about how to address those attitudes when counseling others. VCAT exercises provide an excellent resource for identifying staff's attitudes and biases.

Using Gender-Neutral and Non-Stigmatizing Language

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

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

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

2 Listen actively and show interest in the adolescent

a. Active listening includes:
   i. **Silence** that allows one to hear the concerns and questions of the patient;
   ii. **Paraphrasing** language to show attention and understanding and to encourage the patient to continue; and
   iii. **Using Clarifying Questions** to better understand what the patient has said.

b. Sit in a position so that the adolescent can choose to establish eye contact or not. As the provider, it is essential to maintain eye contact when you are speaking to the adolescent and when the adolescent is speaking to you. If the adolescent does not establish eye contact, do not be discouraged, as it could be cultural or due to feeling self-conscious.

c. Adolescents are going through many changes that they may not understand. They may have questions about these changes but be too afraid to ask. Thus, it is very important that the adolescent feel like you are interested in their concerns, fears, and questions. Using the active listening technique and establishing eye contact throughout the counseling session are good ways to show your interest to the adolescent. By providing a calm, open, and welcoming atmosphere, the adolescent will be more willing to share.

3 Ensure privacy and confidentiality of the adolescent patient

a. Privacy relates to the physical surroundings (both auditory and visual privacy) of the patient. We want to ensure that anything they share will not be heard by other people.
   i. When counseling adolescent patients, providers should be talking to them in a setting where visual and auditory privacy can be ensured and where adolescents feel comfortable. With the exception of life-saving situations, humanitarians should take extra care to ensure confidentiality and privacy for GBV survivors, adolescents seeking abortion services, and SOGIE populations.
   ii. Per the Principle of Capability, adults are not required to be in the room during a counseling session. Healthcare workers can confidently trust adolescents and follow the adolescents' lead in whether or not they prefer a parent or caregiver present at the time of counseling and service delivery. If the adolescent wants someone present, allow it, but use discretion and ensure there is no coercion.
      1. Healthcare workers can utilize other options to reassure the parent or caregiver. For example, without breaking confidentiality, the provider can reassure the parent/caregiver by providing a brief status update on the adolescent's condition—stating if they are safe and well.

b. Confidentiality is related to privacy because we want to ensure that anything that is shared in these private settings is kept private—meaning that we will protect that information from being shared with anyone else. For confidentiality, all service providers must sign/agree to confidentiality policies. This means that they are not permitted to discuss any aspect of the appointment with anyone else. Should the provider need to consult another staff member for advice on how to provide services, the patient's identity must be protected.

i. Equally important, providers must clearly communicate what confidentiality entails to ensure the adolescent understands the concept. Similarly, any information collected from the patient must be guarded and kept in a safe location at all times (under lock and key) and should be destroyed responsibly when the time comes for discarding patient information.

ii. When discussing confidentiality with the adolescent it is also important for providers to be up-front regarding local medico-legal restrictions.

4 Use terms and counseling resources that are adolescent-friendly

a. SRH terms can be confusing to explain to adults. Think about how these concepts might be difficult for adolescents to understand, particularly if they have never heard these words before your session.

i. For example, if you tell an adolescent that your conversation is confidential, they may not understand what that means. Instead, you should try to use terms they are familiar with. The provider could instead say, "Whatever you want to share with me during our discussion will stay between only you and me. This is a safe space."

b. Remember to adapt your words or phrasing depending on the needs and capacities of the adolescent patient.

i. The way you explain menstruation to a VYA should be different to the way you explain the term to an older adolescent. Be prepared to adjust your explanations to ensure comprehension.

ii. Adolescents might be hesitant to ask questions about their body or the services they are requesting. Some adolescents may have difficulty understanding verbal or written explanations due to cognitive impairments, language difficulties, or other factors. Using pictorial job aids and SRH-related commodities that are user friendly are ways of helping to overcome some of these challenges.

5 Allocate more time for counseling adolescent patients

a. As demonstrated through the previous four principles, many of these considerations for adolescents require more time than other patients.

b. Providers should allow additional time for adolescent appointments to ensure adequate time to greet them and make them feel comfortable, answer questions in terms they understand, and provide all the information and optics they need for them to make an informed choice.

c. The principle of "do no harm" is extremely important when working with adolescents. Ensure that you follow through on your efforts. For example, if you have established trust and the adolescent begins to disclose information on difficult subject matters, ensure that you stay with the adolescent and finish the task of providing the necessary support and referrals they may need. As a provider, if you end the visit earlier than the adolescent needs, you can do a lot of harm by creating additional disappointment, confusion, and a deeper sense of loneliness and helplessness than was there previously.

d. When ending the appointment, it can be useful to ask an open question regarding if the adolescent has any additional concerns or questions. For example, "Is there anything else you would like to talk about and/or do you have any additional questions?" Seeking counseling can be intimidating for adolescents, and asking them an open question at the end allows the adolescent to ask or disclose information that they perhaps were not comfortable doing at the beginning of the appointment, as well as providing an opportunity to refer them to additional services they may need or request.

i. Accept that not all adolescents may want to access additional services. For example, some survivors of sexual violence may not want MHPSS counseling.

ii. Lastly, when a follow-up session is scheduled, make sure that you look through your notes from the previous session before starting the follow-up session. It gives a sense of identity to the adolescent patient (as opposed to being a number or simply the next in line) and re-establishes the trustful atmosphere.

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

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

GATHER Counseling Checklist

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

Skills Assessment Checklist for ASRH Counseling

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

SRH Counseling Cue Cards and Flip Charts

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

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

Counseling Considerations for Adolescent Survivors of Gender-Based Violence

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

Photo : Reginald Louissant Jr

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

What are the best practices for counseling GBV survivors?

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

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

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

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

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

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

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

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

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

Additional GBV Resources

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

Community-Based Services and Outreach Platforms

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

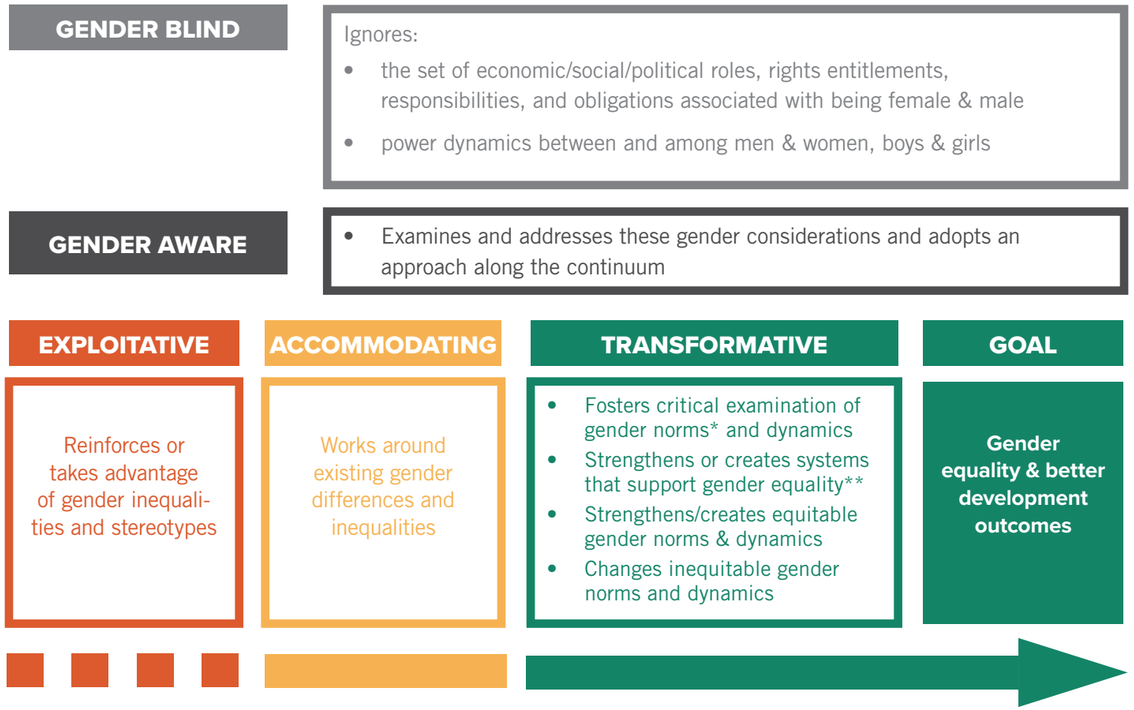
KEY MESSAGE

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

Photo : Plan International

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

Figure N: Gender Equality Continuum Tool



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

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

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

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

1. Engaging Adolescents/Youth as First Responders

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

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

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

The More You Know: Youth/Peer Models

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


Photo : Tito Justin

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

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

BEST PRACTICES FOR WHEN ENGAGING ADOLESCENTS

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

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

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

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

Who are considered supervisors of young people?

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

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

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

CASE STUDY

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

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

2. Local organizations serving youth and youth-led organizations

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

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

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

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

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

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

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

CASE STUDY

Capacitating Youth-Led Organizations during COVID-19

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

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

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

Additional evidence needed

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

3. Community health

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

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

What are some existing community health outreach roles?

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

CASE STUDY

Social Accountability and Action in DRC and North East Nigeria

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

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

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

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

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

Adolescents Supporting Community GBV Initiatives

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

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

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

Considerations for Mobility-Restricted Environments

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

4. Communications, Media, and Technology

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

Interpersonal communication, mass media, and technology—including mobile health, social media, IEC materials, and video edutainment—can be used to provide and reinforce information on SRH and rights and also motivate and build skills for adolescents. Internet-based new media has significantly changed the ways of working and social interaction with those close and far from each other, making the world ever more connected. These innovative approaches have changed access to information for personal and social development, particularly for young people. For example, telemedicine interventions have increased access for populations unable to access facilities (see Facility-Based Services for more information).

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

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

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

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

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

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

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

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

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

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

CASE STUDY

Using an Integrated Approach with Virtual Safe Spaces

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

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

Transitioning from Acute to Comprehensive

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

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

Comprehensive Sexuality Education


Photo: UNFPA

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

Life-Skills Curricula

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

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

For details of the evaluation protocol and results refer to the IRC's Impact Evaluation.

Photo : Antonia Roupell

Multi-Sectoral Linkages and Referral Pathways

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

Why is integration between sectors important?

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

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

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

Ensuring Coordination for GBV Cases

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

Building Multi-Sectoral Linkages

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

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

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

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

Plan International Research: Voices of Adolescent Girls in Crisis

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

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

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

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

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

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

Tools for Building Multi-Sectoral Linkages

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

Additional evidence needed

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

Establishing Multi-Sectoral Referral Pathways

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

IMPLEMENTATION CONSIDERATION

Building on Existing Structures

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

Photo : Isabell Modigell

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

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

Steps to Make a Successful Referral

1 Identify the problem: What does the adolescent client need? Identify and/or assess the adolescent's problems, needs, and capacities with them (eg if the adolescent has cognitive impairments or physical disabilities that require additional assistance). Refer back to the Five Principles for Creating a Trustful Atmosphere for Adolescent Counseling and the Principle of Capability.

2 Identify which organization or agency can meet the identified need. This information can be identified in the mapping and referral pathway tools developed in coordination within the cluster system and agencies. Identify and map other services that may be able to assist the adolescent with their needs. As mentioned earlier, information about other services in your geographical areas can be obtained from service guides, 3/4/5 Ws (Who does What, Where, When, and for Whom) mapping reports, or coordination meetings. Check if the adolescent is already included within the child protection management system.

3 Contact organizations that can provide the requested service(s) in advance to find out more about their services and eligibility criteria, unless the specific type of referral is commonly done with a specific agency. Confirm eligibility with the agency who will provide the requested service. Requested information should include what their referral protocol entails and whether or not they will be able to assist the adolescent.

4 Explain referral to the adolescent. Provide information about available services and explain the referral to the adolescent. What services are provided and where? How can the adolescent get there and receive services? How can the adolescent get information on direct and indirect costs associated with referrals? Why do you recommend the referral? Keep in mind that the adolescent can choose not to be referred. In addition, if the adolescent is in need of life-saving interventions and is not conscious, move forward with the referral.

5 Document consent. If the adolescent agrees to the referral, obtain consent from them before the adolescent's information is shared with others. Also explain how information will be shared between referring and receiving agencies and obtain consent from the adolescent regarding which information can be shared. If the adolescent is not conscious and life-saving interventions are required, consent is not needed; however, this should be documented. Providers and referring agencies should document consent to the full extent of local laws. If no local policy exists regarding consent, international standards for documenting consent should be adhered to. Refer to the Principle of Capability about consent, and note that International Standards do not require consent from an adult to receive services. Refer to Facility-Based Services and Data for Action sections on consent and assent to find more detailed guidance.

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

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

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

Coordinating Referrals with Other Agencies

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

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

Establishing Multi-Sectoral Referral Pathways as Part of the MISP

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

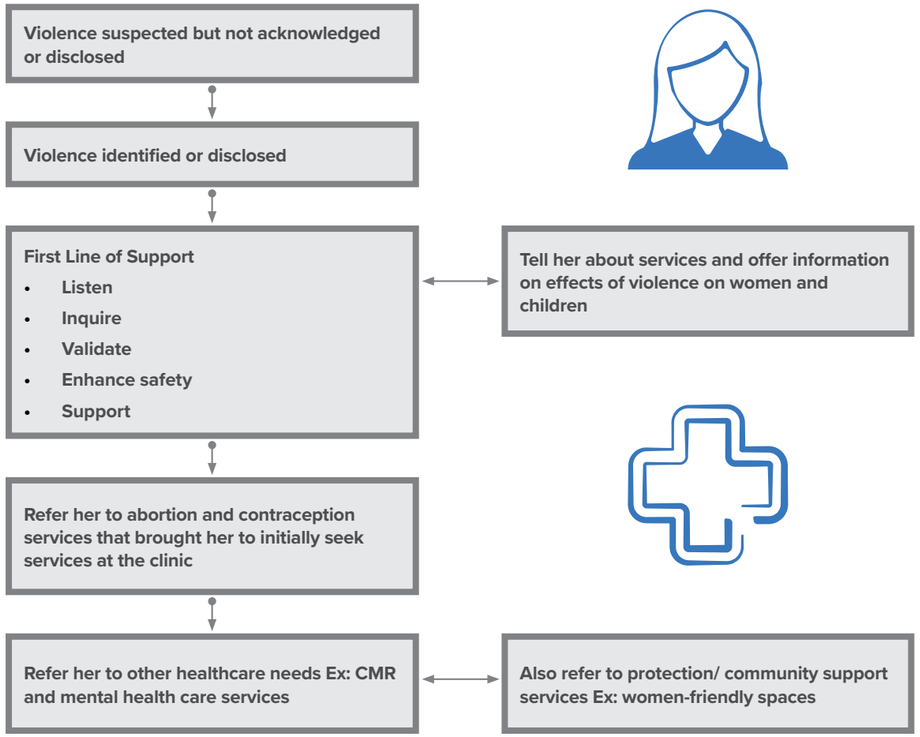
What are examples of referral pathways between sectors for adolescent clients?

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

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

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

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



Tools for Establishing Referral Pathways

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

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


Photo : Suasan Warner