

Photo : Save the Children

CHAPTER 7: DATA FOR ACTION

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

Chapter 7 Learning Objectives

After reading this chapter, readers should be able to:

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

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

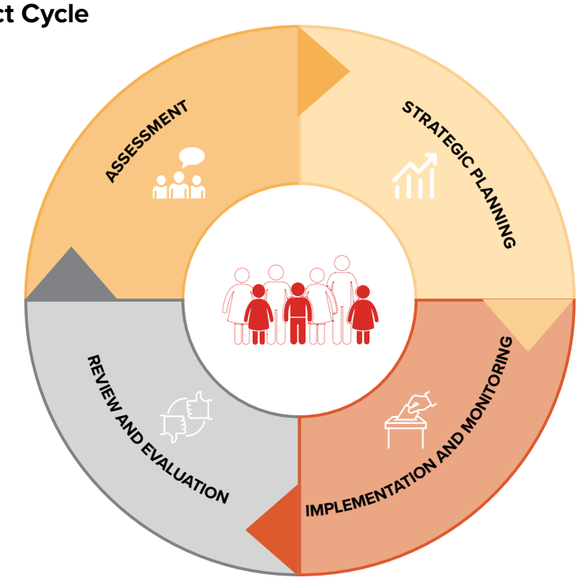
How can we implement Data for Action activities during different parts of the program and humanitarian cycle?

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

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

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

Figure P: Project Cycle



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

What is an assessment?

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

Why are needs assessments important?

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

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



Photo : Jonathan Hyams

What should we know before conducting assessments with adolescents?

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

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

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



Photo : Plan International

Checklist for Conducting Assessments with Adolescents

- ☐ **Approvals:** Approval to conduct assessments should be obtained from the coordinating agency, as well as the local government and health authorities, local community leaders, and partner organizations. Ethical review or ethical approval may also be required in some countries or by some agencies and institutions depending on the type of assessment.

- ☐ **Privacy:** Data should be collected in a setting where visual and auditory privacy can be ensured and where adolescents feel comfortable. Adults should not be present during the assessments to allow for open discussion among adolescents; however, if the adolescent requests the presence of a caregiver during an assessment, the caregiver should be allowed but properly coached beforehand to understand their role. Trusted adults are permitted to see adolescents but are not to be within earshot of the discussion among adolescents.

- ☐ **Security:** The security of the beneficiary population should always be the top priority. If conducting an assessment could put the participants or the study team at risk, then it should not be conducted. Staff should receive a security briefing prior to conducting any assessment to understand the specific risks and security protocols for that area, particularly if you are bringing in third-party individuals for the assessment (translators, vendors, etc).

- ☐ **Child safeguarding:** All staff involved (whether a part of your organization or a third-party individual) should receive child safeguarding orientation to understand what your organization does to keep children (and the information obtained from children) safe. It is also recommended to conduct a background check for all staff involved prior to working with adolescents or their data. Staff should also have experience working with adolescents or receive training on adolescent considerations.

- ☐ **Inclusive:** To the extent possible, at least one member of the assessment team should be of the same gender and speak the same language as participants. All assessment staff should be of an age that is contextually appropriate to discuss SRH-related issues with adolescents. When possible, assessments should be pre-tested to ensure the language is understood and appropriate for the participants. If you need to hire a translator, you must make sure they receive appropriate training, including security and child safeguarding protocols. Assessment team members should consult community members on what terminology is contextually appropriate to avoid stigma.

- ☐ **Referrals:** Appropriate resources or referral services must be available before any assessment is conducted. All assessment staff need training on how to respond to adolescent needs, should an assessment result in services requested by an adolescent. For example, assessment staff must know the correct referral mechanism (and bring appropriate forms) to ensure linkages to medical and psychological treatment or support are available for any participant who reports that he, she, or they is/are a survivor of sexual violence.

- ☐ **Assent/Consent:** Each individual involved in the assessment must be fully informed of the purpose of the assessment (in language/terminology they can understand). This includes the purpose of the assessment, methods that will be used, the nature of the questions that will be asked, the risks and benefits of participating prior to giving assent/consent to participate, how participants were selected, and what steps will be taken to safeguard their privacy and confidentiality. SRH managers should also explain that the adolescent can disallow the use of their data before results are published. SRH managers should comply with local laws regarding consent. Where possible, verbal assent and consent should be collected so as not to record the persons' identifiable information (eg their signature).

- ☐ *Consent:* refers to giving permission for something to occur. In research, informed consent is the formal process for getting permission before a person can participate in research. Refer back to the Principle of Capability, which states that an adolescent—who identifies that they want SRH services and voluntarily requests SRH care, such as maternal care, contraception, sexually transmitted infection (STI) care, or to terminate the pregnancy—is capable of consenting to services. Humanitarian staff must always comply with local laws regarding consent. When the laws/policies/governmental statutes do not include guidance on managing ethical and legal conflicts, practitioners should act in the best interests of the child. If parental consent is required, humanitarian staff should ensure they receive consent from the adolescent's caregiver, as well as the adolescent's assent.
- ☐ *Assent:* refers to "the willingness to participate in research, evaluations, or data collection by persons who are by legal definition too young to give informed consent…but who are old enough to understand the proposed research in general, its expected risks and possible benefits, and the activities expected of them as subjects." Assent gives adolescents who are not of legal age (according to local laws where the adolescent resides) the ability to take ownership of their participation and make their own decision as to whether or not they want to participate. Assent is crucial to conducting research activities with adolescents, as they are empowered to make their own decision on whether or not they want to participate in the activity. Even if an adolescent's caregiver provides consent, an adolescent is free to not provide their assent and should not be forced to participate in the assessment.

☐ **Voluntary Participation:** Participation is completely voluntary and any participant may decline to answer any question or may decide to withdraw from the assessment at any time. The individuals or the agency conducting the study must respect the wishes of the adolescent and must not pressure them to respond to any question. Ideally, assessment staff should not use incentives to pressure participation. If incentives are used, they should be aligned with local living standards. Adolescents should also be informed that they can withdraw without losing any benefits or services.

☐ **Confidentiality & Anonymity:** Confidentiality and anonymity must be maintained at all times. Maintaining confidentiality means that only certain people involved in data collection can link responses to a specific participant. Any data collection that includes personal information, such as a registration form, should be kept separate and have no clear links to other data. Protecting anonymity means that there will not be any identifying information of individual participants recorded (name, place of residence, etc). Members of the assessment team must sign confidentiality agreements and not discuss any aspect of the study with anyone except the study supervisor. Adolescent participants' identities should not be shared with anyone outside the study team and should not be linked to their response. Where possible, data should be de-identified from the participant. Ideally, their name or other personally identifiable information is not linked to the participants at all. If it is linked to the participants during the survey collection, the personally identifiable information must be destroyed following the end of the survey.

- ☐ *Data storage:* should be done to ensure that no one else may access the data. For data stored on computers, folders and files should be password protected. For paper-based data, files should be kept in a drawer or cabinet with a lock. All personally identifiable data should be destroyed once data analysis is complete if there is any risk that the questionnaires could pose a risk to participants or staff. Program managers should also take into consideration the cyber-security data privacy related to confidentiality and safety of providers, health facilities, and adolescents.

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

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

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

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

How do we discuss SRH values with adolescents?

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

Who Should Conduct Assessments?

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

SRH managers can help mitigate risks when conducting assessments by:

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

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

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

The MISP Does Not Wait for Assessments!

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

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

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

Table 6: ASRH Assessments, Timing & Tools

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

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

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

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

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

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

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

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

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

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

What are other sources of ASRH information we should consult?

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

KEY MESSAGE

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

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

The following are some sources of ASRH data:

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

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

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

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

CASE STUDY

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

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

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

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



Photo : Neil Thomas

Program Design

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

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

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

Steps for Program Design:

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

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

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

What information should we consult to design an ASRH program?

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

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

Identify, Coordinate, and Establish Partnerships

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

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

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

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

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

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

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

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



Figure Q: Logical Framework for ASRH

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

METHODOLOGICAL FRAMEWORK

- Action research
- Intervention mapping
- Community-based participatory research (score card)

Guiding Theory of Change: Community-Embedded SRH Care

LOGICAL FRAMEWORK

INPUTS (Resources)

- Organization staff (human resources)
- Materials & supplies
- Equipment, technology, and office space
- Budgeted level of effort funding for staff, equipment, and office operations

OUTPUTS

Actors	Activities	Direct Products
• Adolescents in affected area • Targeted group of male sex partners • Community members in affected area • Education stakeholders • Service providers • Organization staff • Ministry of Health, local authorities, and relevant governmental stakeholders • Humanitarian partners, donors, and other ASRH stakeholdes	Provide adolescent-friendly health services (condom promotion activities; adapted IEC materials and media campaigns; screening, testing, counseling, treatment, and referral services, including pre-exposure prophylaxis; post-violence care; and contraceptive mix expansion)	Trained staff members competent to provide adolescent-friendly services Adolescent-tailored HIV messaging Murals and artwork created as part of media campaigns with adolescents
	Implementing social protections for adolescents and their families (education subsidies, socio-economic support, linking adolescents and families to violence reduction programs)	Strengthened relationships with social protection agencies and programs
	Targeting male sex partners with HIV prevention activities [reviewing demographic information & assessments to target males who fit sexual network partner profiles with condom distribution and anti-retroviral treatment (ART) services]	Target list of high-risk males for implementing future SRH interventions

IMPACT	OUTCOMES
Short Term	**Medium-to-Long Term**
Improved adolescent-friendly service provision among adolescents Indicator: # receiving condoms # receiving HIV screening, testing, treatment, and referral services	Reduced pregnancies with HIV status among adolescent girls aged 10-19 Indicator: # of pregnancies among adolescents with HIV status
	Increased proportion of adolescents using condoms during sexual intercourse Indicator: # of adolescents reporting that they used condoms during their last sexual encounter (comparing baseline to end-line assessment results)
Improved assets for adolescents and their families Indicator: # of adolescents and/or adolescent households receiving education subsidies	Increased access to money in an emergency for adolescents & their families Indicator: # of adolescents reported ability to pay for immediate needs (comparing baseline to end-line assessment results)
	Increased educational attainment for girls Indicator: % of adolescent girls completing secondary school
Improved male sex partner participation in HIV services Indicator: # of males (from target list) on ART # of males (from target list) provided condoms	Increased positive attitudes toward gender equity Indicator: # of males from sexual network profile who reported high gender equity attitudes and beliefs (comparing baseline to end-line assessment results)

GOAL:
Reduce new HIV infections among adolescents in Imagineria

Needs assessments, analyses, and mapping to guide SRH needs, barriers, assets, and determinants of adolescents in program area and other interventions implemented

Guiding Questions for Developing a Theory of Change

1 **Identifying long-term goals.**

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

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

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

3 **Identifying your basic assumptions about the context.**

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

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

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

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

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

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

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

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

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

Implementing organizations should create indicators in line with their program's objectives and capacity for measuring progress and results. Additional resources with ASRH indicators can be found in the following resources: MEASURE Evaluation Database, Sexual and Reproductive Health and Rights Indicators for the SDGs, UNFPA's Community Pathways to Improved ASRH: a conceptual framework and suggested outcome indicators, and EMpower's Designing Programs for Adolescent Girls. WHO is also developing guidance for standardized SRH indicators, as well as how to collect this data, which will be released in late 2020.

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

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

Now that you have designed your project and received community buy-in, project activities can begin! Before implementation starts, though, make sure you have set up a simple information system to collect SRH data required for monitoring the implementation of the MISP, as well as any other additional donor-required indicators. See Table 6 for the tool IAWG uses for monitoring implementation of the MISP. As the humanitarian emergency changes and organizations begin implementing comprehensive SRH services, your monitoring requirements and indicators should be adjusted accordingly.

Implementation & Monitoring

What is monitoring?

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

Don't Recreate Systems or Processes

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

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

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

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

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

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

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

What should I be tracking with ASRH programming?

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

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

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

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

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

How can you tailor monitoring activities for ASRH programming?

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

Adapting Monitoring Tools

The first consideration relates to the type of monitoring data we collect. Monitoring is conducted to ensure that program implementation is on track and to make real-time adjustments to services and activities. Table 7 describes how monitoring data is collected and used and considerations for adapting monitoring tools for use with adolescents, including some ideas for how to meaningfully engage adolescents directly in monitoring activities.

Table 7: Tailoring SRH Monitoring Activities for Adolescents

Source of monitoring data	Use	Adaptations for use with adolescent populations
Patient records and charts	Used to monitor utilization of SRH services	• Ensure data is disaggregated by age and gender when providing regular reports • Collect additional information on method discontinuation or method mix
Participant or patient registers	Used to record socio-demographic characteristics of patients or participants, enabling you to ensure that the service or program is reaching adolescents	Registers can collect information that is relevant to the intervention • Ensure data is disaggregated by age and gender when providing regular reports • Beyond age and gender, you may wish to include educational status, household composition, and/or disability status in registration forms
Attendance lists	Used to monitor attendance to ensure that registered participants are in fact participating in the program	• Attendance lists should be linked to registers to identify any patterns or trends in drop-out and retention
Activity records and reports	Used to keep track of service provision or content being shared with program participants and frequency of activities	• Activity records and reports should be informed by adolescents and should include satisfaction with programming
Observation tools and checklists	Used to monitor the capacity of program staff to deliver high quality services or programming	• Observation tools and checklists should be in line with guidance on adolescent-friendly services • Criteria should reflect input from adolescents regarding their definition of quality

Ensuring/Establishing Accountability Mechanisms

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

How do we translate this data into action?

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

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

Case Scenario to Demonstrate Data for Action

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

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

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

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

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

Imagineria SRH Achievements (after one year of programming)

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

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

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

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

Evaluation & Documentation

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

What is evaluation?

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

Why do we need to document ASRH evidence?

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

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

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

- **Evaluation design:** The application of user-centered design processes in developing an evaluation protocol allows adolescents to provide input on what outputs and outcomes are measured by the evaluation, what groups of adolescents are being reached—or not reached—and what SRH-related needs are being met or not met. Adolescents providing feedback on M&E results strengthen the implications for future similar projects and create an environment of inclusion and buy-in.

Planning for Comprehensive SRH Care in Evaluation Phase

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

- **Planning and timing:** Evaluations, which should be planned at the beginning of the project, require a sufficient amount of time to measure program outcomes and impacts. Therefore, evaluations are not appropriate in acute situations. In contrast, ongoing assessments and monitoring can provide feedback on emergency actions in acute, protracted settings, and comprehensive SRH programming.
- **Documentation and dissemination:** Developing a documentation and dissemination strategy is essential when implementing ASRH programs in humanitarian emergencies. Involving adolescents in this work ensures that the information is accessible to everyone. Additionally, adolescents are creative and particularly adept with social media and other technologies. Their unique capacity to develop and create approaches will help translate data into key messages and into various technological formats that are relevant and most understandable to adolescents and key stakeholders.

What is required to conduct a successful ASRH program evaluation?

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

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

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

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

What is typically included in an evaluation protocol?

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

EVALUATION PROTOCOL CONTENT COMPONENTS

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

What evaluation criteria is recommended?

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

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

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

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

CASE STUDY

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

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

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

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

What other resources are there for conducting evaluations on SRH?

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

Closing the Gap between Implementation and Research for Practitioners

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

Research Opportunities—Closing the Gap

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

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

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

Developing and Piloting ASRH Programmatic Tools—Closing the Gap

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

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


Photo: Médicos Sin Fronteras