Adolescent Girls in Disaster & Conflict:

Interventions for Improving Access to Sexual and Reproductive Health Services

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Cover photo:
Adolescent girls in Dalori IDP camp, Borno State, Nigeria, displaying their hand woven caps. These hats are made in the IDP camp and sold to the neighbouring communities or visitors. UNFPA has established safe spaces in Borno and Adamawa States, to provide a platform for women and girls such as these to learn vocational skills and as an entry point to comprehensive sexual and reproductive health education and psychosocial counselling for survivors. © UNFPA/Simi Vijay

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Adolescent Girls in Disaster & Conflict

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Interventions for Improving Access to Sexual and Reproductive Health Services

United Nations Population Fund

Srijana, 16, gave birth to her daughter in a camp that was established in 2015 for earthquake survivors in remote Goljung, Nepal. A UNFPA-supported mobile team was providing services for safe delivery in the camp.

Adolescent Girls in Disaster & Conflict
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Interventions for Improving Access to Sexual and Reproductive Health Services

Introduction

Safe spaces, mobile medical teams and youth engagement are effective ways to reach displaced, uprooted, crisis-affected girls at a critical time in their young lives. Adolescent Girls in Disaster & Conflict: Interventions for Improving Access to Sexual and Reproductive Health Services is a collection of UNFPA-supported humanitarian interventions for reaching adolescents when crisis heightens vulnerability to gender-based violence, unwanted pregnancy, HIV infection, early and forced marriage and other risks.

Adolescent girls are overlooked in turbulent times of disaster and conflict. Traumatized, constrained by tradition, torn from school and family structures and familiar social networks they can be lost in the crowd in a refugee camp or disrupted community. We must look harder to see the realities of girls aged 10 to 19, include them in humanitarian programming, and plan interventions that restore health and hope at a critical time between childhood and adulthood.

Adolescent girls are overlooked in turbulent times of disaster and conflict.

Millions of adolescent girls are in need of humanitarian assistance – displaced by conflict or uprooted by disaster. A crisis heightens their vulnerability to gender-based violence, unwanted pregnancy, HIV infection, maternal death and disability, early and forced marriage, rape, trafficking, and sexual exploitation and abuse. To meet their needs and respect their rights, UNFPA, the United Nations Population Fund, provides operational, programmatic and technical support for adolescent sexual and reproductive health (ASRH) as part of its humanitarian programming.

Three areas of intervention in particular are making an impact on adolescent girls in crisis-affected settings:

- Safe spaces provide adolescent girls with livelihood skills, psychosocial counselling for gender-based violence, access to sexual and reproductive health information and referral to services;
- Mobile clinics and mobile outreach teams bring life-saving services and supplies, including contraceptives, to adolescent girls in hard-to-reach locations when health systems are damaged or destroyed and not functional;
- Engagement and participation of adolescents and youth, especially female, is a strategy that empowers and respects girls as part of humanitarian response – as first responders, agents of change and volunteers – consulted and engaged in planning, distributing dignity kits, collecting data and communicating with peers within their communities.

Millions of adolescent girls are in need of humanitarian assistance –displaced by conflict or uprooted by disaster.

Effective interventions for adolescent girls tend to share certain characteristics, starting with planning and programming before or early in a crisis. Such interventions are flexible, culturally sensitive, innovative, multisectoral and integrated. An integrated approach addresses not only HIV, for example, but also maternal health, family planning and gender-based violence as well as certain sexuality issues, and these comprehensive services should ideally be provided in an adolescent-friendly manner by qualified health professionals at a single site. They offer protection, life skills, literacy, numeracy, vocational training and livelihood skills – elements valued by girls and that serve as entry points for adolescent sexual and reproductive health (ASRH).[1] They also provide the essential supplies to support ASRH services.

In this initial collection of effective interventions, we feature seven countries, with more examples in development.

[1] Women's Refugee Commission, Save the Children, UNHCR, UNFPA (2012). Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services.

About Humanitarian Emergencies

UNFPA supports initiatives taking a variety of approaches in response to disaster and conflict, whether natural or caused by humans, acute or protracted. UNFPA works closely with governments, United Nations agencies, community-based organizations and other partners to ensure that sexual and reproductive health is integrated into emergency programming. Local NGOs that know and work with the crisis-affected populations are often involved as implementing partners. Organized youth groups are sought out for partnership to reach adolescents and youth in their own communities.

UNFPA provides hygiene supplies, obstetric and family planning supplies, trained personnel, and other support to vulnerable populations, and works to ensure the needs of women and adolescents and young people are served through both the emergency and the reconstruction phase. Ensuring that adolescent girls, who eventually engage in sexual activity, have the information and means to decide the number, timing and spacing of their children is essential to protecting their basic human rights to health, life, dignity and equal opportunity.

Adolescents and youth

UNFPA commits to working with adolescents and young people towards a future in which they can enter freely into a productive adulthood because they are educated, healthy, free from STIs and HIV, and are not exposed to violence, unintended pregnancy or unsafe abortion; a future where girls are treated with dignity and respect in equal measure with boys and where, regardless of their identity, young people's human rights are promoted and respected. Evidence shows that disaster and conflict can derail this future and exacerbate potential vulnerability.

In partnership with young people, national and international organizations, and United Nations partners, UNFPA assists countries to identify and implement policies and programmes to secure the health, development and human rights of adolescents and youth.

The UNFPA contribution to the advancement of adolescents and youth has five strategic priorities:

1. Enable evidence-based advocacy for comprehensive policy and programme development, investment and implementation;
2. Promote comprehensive sexuality education;
3. Build capacity for sexual and reproductive health service delivery (including HIV prevention, treatment and care);
4. Take bold initiatives to reach marginalized and disadvantaged adolescents and youth, especially girls; and
5. Promote youth leadership and participation.[2]

By inference, these priorities apply likewise to humanitarian settings. In addition, UNFPA Supplies, a flagship programme that helps countries build stronger health systems and widen access to a reliable supply of contraceptives and life-saving equipment and medicines for sexual and reproductive health has a specific deliverable to reach women and adolescent girls in humanitarian settings with emergency reproductive health kits and services.

Why focus on adolescent girls?

The need is staggering: 26 million women and adolescent girls in their childbearing years are in need of humanitarian assistance around the world today. Of the 830 women and adolescent girls who die every day from causes related to pregnancy and childbirth, 507 die in countries that are considered fragile because of conflict or disaster – about three fifths of all maternal deaths worldwide.[3]

[2] UNFPA (2013). UNFPA Strategy on Adolescents and Youth: Towards realizing the full potential of adolescents and youth. UNFPA: New York, p. vi.

[3] UNFPA (2015). State of World Population 2015: Shelter from the storm. UNFPA: New York, p.2.

For all adolescent girls, but especially for the very young adolescents aged 10 to 14, gaps in services and family networks reduce their ability to access age-appropriate and developmentally appropriate information and services for their health and well-being, including for their sexual and reproductive development.

Access to ASRH is extremely challenging in humanitarian settings: Access to affected populations is a challenge in all disaster and conflict situations and UNFPA is committed to programming for ASRH beyond camps or catchment areas where people are known to congregate, to reach those who are hard to reach. It is even more difficult when girls are not located in a specific camp or geographic area but are dispersed across urban areas: over 60 per cent of the world's 19.5 million refugees and 80 per cent of 34 million IDPs live in urban environments.[4] Barriers to access can be diverse, e.g. a river crossing washed out in a flood, an unfamiliar language or culture, a perceived lack of acceptance by a host community, or a lack of identity papers to register in host country. Limits on girls' mobility that traditionally come with adolescence are intensified, and an adult may be required to accompany them to any safe space or health clinic.

For all adolescent girls, but especially for the very young adolescents aged 10 to 14, gaps in services and family networks reduce their ability to access age-appropriate and developmentally-appropriate information and services for their health and well-being, including for their sexual and reproductive development. Girls with physical, psychological or developmental disabilities have even greater difficulty accessing services.

Girls face heightened risk at an already vulnerable age: In disaster and conflict, adolescent girls experience increased exposure to coerced sex, early and forced marriage and childbearing, increased risk-taking associated with gender roles in family circles, and reduced availability of adolescent sexual and reproductive health services. The risk of pregnancy-related death is twice as high for girls aged 15 to 19 and five times higher for girls aged 10 to 14 compared to women in their twenties. Pregnant adolescents are more likely than adults to pursue unsafe abortions. At the same time, adolescents in humanitarian settings have similar needs for sexual and reproductive health information and services as their peers in non-crisis settings. In developing countries, 15 million adolescent girls aged 15 to 19 gave birth in 2015; 13 million lacked access to contraceptives.[5]

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[4] www.unhcr.org/en-us/urban-refugees.html

[5] UNFPA (2015). Facing the Facts: Adolescent Girls and Contraception. Accessible at www.unfpa.org/sites/default/files/resource-pdf/UNFPA_Adolescent_brochure.pdf

Girls' rights are not respected: Crisis situations exacerbate gender inequality and gender-based discrimination, which is already deeply entrenched in many societies and manifests itself in less access to education, economic and political resources and social networks. Adolescent girls and boys, women and men experience disaster and conflict differently. Girls have the least power and status of all, which places girls in situations of heightened risk and vulnerability. Experience has shown that addressing gender inequality and empowerment of women and girls requires strategic interventions at all levels of programming and policymaking, including humanitarian settings.

Protecting and promoting the reproductive rights of adolescent girls – including the right to control fertility – is essential to ensuring girls' freedom to participate more fully and equally in society. Failure to provide information, services and conditions to help adolescent girls protect their reproductive health constitutes gender-based discrimination and is a violation of women's rights to health and life. By offering opportunities for girls to acquire livelihood skills and learning for literacy and numeracy, safe spaces can help meet girls' needs and respect girls' rights.

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Programming does not prioritize adolescent girls: A lack of programming for adolescents is a striking gap in reproductive health in times of peace as well as crisis. When a crisis strikes and risks escalate, humanitarian programming should prioritize girls. Instead, adolescents are underserved in humanitarian programming, both acute and protracted.6 Among the very few existing programmes that address adolescent health needs in humanitarian settings, there is a tendency to target older youth, and programmes are rarely accessed by or designed appropriately for younger populations.[7] Girls are not consulted and programming rarely incorporates girls' opinions, ideas and experiences. Information is especially limited about very young adolescents.

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Crisis exposes girls to heightened risk and those responding must make girls a priority or they will be overlooked. Adolescent girls have specific

6 Casey, Sarah E. (2015). 'Evaluations of reproductive health programs in humanitarian settings: a systematic review'. Conflict and Health, 9 (Suppl 1): S1. Available at www.conflictandhealth.com/content/9/S1/S1

7 World Refugee Commission et al., (2012).

vulnerabilities, and humanitarian actors must recognize from the start the risks compounding these vulnerabilities and prioritize actions that address their needs, ensure their safety and preserve their dignity. When humanitarian actors do not collectively account for adolescent girls, humanitarian sectors can constrict girls' abilities to safely access life-saving information, services and resources. Too often adolescent girls are left idle, isolated and invisible.

Strategic investment in adolescent girls' education, health, safety, and economic opportunities can help end inter-generational poverty; positively affect the most marginalized and underserved communities; and boost the economies of entire countries.

A lack of adequate advocacy for adolescent girls is reflected in lack of funding: In 2014, the United Nations required a record $19.5 billion to respond to humanitarian situations around the world, but faced a record $7.5 billion shortfall.[8] Of these limited resources, few were programmed with adolescent girls in mind. Evidence-based advocacy is required to raise awareness, understanding and commitment to this neglected population. To carry out this advocacy, we need more data focused on adolescent girls in crisis-affected settings – a topic rarely addressed by research.

Girls multiply benefits for their communities: Strategic investment in adolescent girls' education, health, safety, and economic opportunities can help end intergenerational poverty; positively affect the most marginalized and underserved communities; and boost the economies of entire countries.[9] Girls' voices, experiences, and insights are key to the development of sustainable and effective programmes, projects and institutions. ASRH is an investment with value: it can delay first pregnancy, reduce maternal death and disability, improve health outcomes, contribute to broad development goals and reduce poverty.

Before, during and after a crisis, programming for girls supports their successful transition into productive and rewarding adulthood, and upholds their human rights. Investing in adolescent girls saves lives and protects their potential as educated, empowered and productive members of their families, communities and countries.

[8] UNFPA (2015). State of World Population: Shelter from the storm. UNFPA: New York, p.95.

[9] Coalition on Adolescent Girls. Partners and Allies: Toolkit for Meaningful Adolescent Girl Engagement.

Methodology

This collection showcases a number of UNFPA-supported initiatives reaching adolescent girls in crisis-affected settings. Documentation of progress to date in humanitarian settings has been insufficient, including a lack of reporting on programmes that effectively integrate sexual and reproductive health services for adolescent girls. UNFPA recognizes the importance of documenting its experiences with efforts to improve the access of girls (and all youth) to ASRH in humanitarian settings, in order to support others to duplicate them in other contexts.

This collection is based on a process of selection and development to which many UNFPA colleagues contributed, from offices at country, regional and HQ level. Each country example examines the following categories: Objectives; Background; Strategy and Implementation; Progress and Results; Lessons Learned and Conclusion and Recommendations.

The documentation process included a desk review of UNFPA humanitarian interventions aimed at adolescent girls' access to reproductive health services and essential supplies. Successful interventions were identified based on review and assessment of works plans and other documentation provided by UNFPA Country Offices. To be selected, a country had to meet at least one of two criteria. It had to be considered a high-risk humanitarian country and/or be a UNFPA Supplies programme country.

A call for submissions was sent to UNFPA Country Offices from the Chief of the Humanitarian and Fragile Contexts Branch requesting them to complete a shared template10 describing their work on providing adolescent girls with adolescent sexual and reproductive health information and services. A team of experts from across the Fund was formed to review the submitted cases and evaluate them against a standardized matrix that included categories such as relevance,

[10] Sections of the template included: title, output area of UNFPA Supplies, objectives, description of the problem, description of the context that warrants an innovative approach including key challenges, strategy implementation: the solution, progress and results: the impact, lessons learned (is it scalable? is it replicable? is it sustainable?), conclusions and recommendations, partners, pictures, sources, and an optional human interest story.

innovation, results-oriented, replicability and sustainability. Team members then recommended the strongest examples for publication and the continued development of many other compelling examples.

The results reported by the Country Offices are age disaggregated when available. When the results were not reported by age, an estimation was made based on experience and the estimation formula contained in the Minimum Initial Services Package (MISP) for reproductive health in emergencies: women and adolescent girls comprise 25 per cent[11] or more of the population served in a given humanitarian situation, on average; in some communities, a higher percentage of the clients are adolescent girls. Data disaggregated by age group can be difficult to collect in humanitarian situations though such efforts are strongly encouraged.

In Somalia, a health promotor reaches out to an adolescent girl during a reproductive health promotion event.

[11] MISP Estimates, http://misp.iawg.net/

RESOURCES ON ASRH IN HUMANITARIAN SITUATIONS

Though ASRH programming falls far short of need, guidance is available. A key normative tool is the field manual produced by the Inter-agency Working Group on Reproductive Health in Crises. Additional resources are available on the UNFPA website and at www.unfpa.org/emergencies.

- Inter-agency Field Manual on Reproductive Health in Humanitarian Settings[12]
- Adolescents Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter Agency Field Manual on Reproductive Health in Humanitarian Settings[13]
- Women and Girls Safe Spaces: A guidance note based on lessons learned from the Syria crisis;[14]
- Girlhood, Not Motherhood: Preventing Adolescent Pregnancy[15]
- Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services[16]
- Taking Stock of Reproductive Health in Humanitarian Settings: 2012 2014 Inter agency Working Group on Reproductive Health in Crises' Global Review[17]
- Marrying Too Young: End Child Marriage[18]
- UNFPA Humanitarian Response Strategy[19]
- UNFPA Strategy on Adolescents and Youth[20]
- The State of World Population 2015: Shelter from the Storm[21]

More tools and guidance will be required in the future to facilitate scaling up of initiatives demonstrating results, and to greatly increase the inclusion and prioritization of girls in ASRH programming in humanitarian contexts. View related videos on the UNFPA YouTube channel at www.youtube.com/user/unfpa

12 http://iawg.net/resource/field-manual/

13 http://www.unfpa.org/publications/adolescent-sexual-and-reproductive-health-toolkit-humanitarian-settings

14 www.unfpa.org/resources/women-girls-safe-spaces-guidance-note-based-lessons-learned-syrian-crisis

15 www.unfpa.org/publications/girlhood-not-motherhood

16 www.unfpa.org/resources/adolescent-sexual-and-reproductive-health-programs-humanitarian-settings-0

17 http://conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-9-S1-S1

18 www.unfpa.org/end-child-marriage

19 www.unfpa.org/resources/humanitarian-response-strategy

20 www.unfpa.org/resources/unfpa-strategy-adolescents-and-youth

21 www.unfpa.org/swop

Areas of intervention

"For the adolescent girl who survives sexual violence, who is at risk of HIV or unwanted pregnancy, life-saving reproductive health services are as vital as water, food and shelter in an emergency. We need to do a much better job of helping the most vulnerable, especially adolescent girls."

Dr. Babatunde Osotimehin, UNFPA Executive Director

Safe spaces

In the chaos following a disaster, security can be difficult to establish, and opportunities for abuse and exploitation increase. During such times, adolescents may also be stressed, bored or idle and find themselves in risky situations (or exposed to risky behaviours by others) that they are not prepared to deal with. They may be isolated when mobility is limited by their family or even by poor lighting on the way to the toilet. Gender inequality can go from bad to worse. At one level, safe spaces provide opportunities to change the narrative from one of despair to one of hope.

The establishment of safe spaces for women and girls affected by crisis is increasingly recognized as a good practice of emergency response and recovery, and a key strategy for the protection, leadership and empowerment of women and girls.

Safe spaces are formal or informal places where adolescent girls feel physically and emotionally safe. For adolescent girls, safe spaces can be a haven in which to learn livelihood skills, socialize with friends to rebuild social networks, enjoy creative outlets such as art and dance, receive psychosocial counselling, obtain gender-based violence-response services and, over time, learn about their sexual and reproductive health and rights and where to find services. Such issues

may include how to deal with gender-based violence, HIV, pregnancy, early and forced marriage and other topics.

Safe spaces can help girls cope with new realities, including issues ranging from their sudden new role as head of household to their changing bodies and where to find sanitary supplies. As their body changes, it is important for girls to be able to identify with peers and mentors. UNFPA ensures that safe spaces for women and girls are closely linked to reproductive health services.

Distinct from shelters, these spaces may take different names such as women's community centres or listening and counselling centres. Structurally, a safe space can take many forms, such as a tent, a special room in a facility, a stand-alone facility, or a designated time scheduled for several hours in a shared location. Safe space can be established in camps as well as in existing structures within communities. At the end of 2015, UNFPA had established and was operating 430 women and youth safe spaces in 33 countries.[22]

UNFPA-supported examples

- Aiming to serve more than 1,500 internally displaced women and girls, UNFPA established a safe space in the Debaga camp in Northern **Iraq**, providing a wide range of services including dignity kits distribution and gender-based violence prevention and response.

- In the Zaatari refugee camp in **Jordan**, created for Syrian refugees, safe spaces set special hours for adolescent girls; 5,000 women and girls per month access gender-based violence services through 21 safe spaces.

- Three safe spaces in Kakuma refugee camp in **Kenya** revamped their approach to target out-of-school girls and provide life skills, livelihood skills and integrated ASRH.

- In **Madagascar**, reducing teen pregnancy was a priority in six towns affected by chronic food shortages, where integrated

[22] UNFPA Humanitarian Action, 2016 Overview

and culturally sensitive approaches reach vulnerable rural girls, including through youth-friendly safe spaces.

- Safe spaces offered crucial services to women and girls displaced by floods in **Malawi**.
- Tents transformed into 'adolescent-friendly corners' welcomed young earthquake survivors in **Nepal**.
- Illimin, a programme to delay early marriage and pregnancy among adolescent girls, offers lessons on life skills and reproductive health in safe spaces set up in Sayam Forage and Kablewa refugee camps in **Niger**.
- Fleeing Boko Haram, girls and women in camps in north-eastern **Nigeria** are building resilience in safe spaces.
- In **Syria**, 22 safe spaces and 20 health facilities provide services for sexual and reproductive health and clinical management of rape.
- Adolescent girls from Eastern **Ukraine** affected by ongoing armed conflict attended a summer camp combining psychosocial rehabilitation learning on healthy lifestyles and safe behaviours.

"I came to the centre during my pregnancy because health care was free at the clinic. Then I learned about the recreational and skill-based training workshops. I made several friends and together we attend workshops to learn new skills. I often bring my children along as they can play in a safe environment and interact with other children of their age."

Abeer, a Syrian refugee woman in Jordan

"I heard gunshots and started running. The shooting will not stop and went on for hours. There were dead bodies everywhere but I escaped to a nearby village."

Amina, woman receiving psychosocial support at IDP camp after Boko Haram attack in Nigeria

"We are trying to rebuild trust among these women by reminding them that they are human beings who deserve to be protected and who have the right to live a life of dignity."

Suha Nimir, UNFPA gender-based violence focal point, speaking of a safe space at a mosque in Karbala, Iraq

Mobile teams and mobile clinics

Mobile medical teams bring much-needed reproductive health services directly to crisis-affected populations, including referral for complicated deliveries. Mobile outreach teams do not wait passively for people to come to a fixed facility but equip a clinic on wheels – a minivan, bus or container truck – and drive out to meet the people where they are. Staff typically include a doctor, a midwife, a lab technician and a driver who also handles logistics. Among the essential supplies and equipment are contraceptives, life-saving medicines for maternal health, ultrasound devices and laboratory supplies. Over time, mobile outreach teams also set up services in tents, imported structures or refurbished rooms to reach refugees and internally displaced persons living in camps as well as outside of camps. They support host communities and help governments fill critical gaps in health services. They deliver life-saving services to remote and hard-to-reach populations in locations cut off from health services. Mobile medical teams reach as many people as possible with health services.

Mobile medical teams reach as many people as possible with health services.

Mobile medical teams and mobile clinics are a key part of the UNFPA commitment to strengthen reproductive and sexual health

services where local health systems have been damaged, destroyed or overwhelmed and are not functional. For adolescent girls already vulnerable from the consequences of disaster or conflict, they provide much-needed health services, gather information about their needs and, often, provide one of the first youth-friendly points of contact in an emergency situation. Mobile teams are often engaged in outreach to alert crisis-affected communities that they are coming into an area, for example a scheduled monthly reproductive health camp, which provides an opportunity to engage adolescents and youth in communicating ASRH information to their peers in a camp or catchment area. They also provide reproductive health and general public health information and referrals for additional services.

UNFPA-supported examples

- In a transit centre for refugees fleeing Afghanistan, Syria and Iraq, a new mobile clinic reaches refugee women in the **Balkans**.
- In **Mauritania**, mobile teams provided comprehensive and integrated services to Malian refugees in the Mbera refugee camp, raising the profile of ASRH responses among all humanitarian actors.
- Mobile reproductive health clinics are reaching girls displaced and stateless in **Myanmar**.
- In Mahama refugee camp in **Rwanda**, more than 15,000 adolescents and youth aged 10 to 24 fleeing conflict in Burundi attended information sessions by 110 Community Health Workers selected from within the refugee population to receive reproductive health training.
- In remote conflict-affected areas of **Yemen**, where health services have broken down, UNFPA-supported mobile teams are providing reproductive health services that include antenatal and postnatal care, family planning services and referral for complicated deliveries.

"We were afraid to take the trip because she is pregnant, but we had to go."

Shagah, a refugee from Kabul, visited a mobile clinic in the former Yugoslav Republic of Macedonia with his wife, Morsay, pregnant with her first child at age 16

"Despite all difficulties and tough weather conditions, we carried on our weekly visit to Damascus shelters to ensure that affected people will receive the essential medical services."

Dr. Qutieba Shehab, who works at a UNFPA-SFPA supported mobile clinic

Adolescents and youth are eager to channel their energy in ways that contribute to their communities and to be regarded as part of the solution, not part of the problem.

Engagement and participation of adolescents and youth

Opportunities to participate in humanitarian activities empower adolescents and youth to see themselves not as victims but as agents of change. In humanitarian settings, the contributions of adolescents and youth are undeniable. They can be effective brokers of information to their peers. After being consulted about their own needs and ideas, they may choose to lead information and education sessions promoting ASRH, distribute dignity kits or supplies such as condoms and contraceptives, collect data or carry out other activities to help their friends and families. Adolescents and youth are eager to channel their energy in ways that contribute to their communities and to be regarded as part of the solution, not part of the problem.

Once basic needs in an emergency are met, many adolescent girls (and boys) in camp settings are frustrated with little to do: no school, no work, no need to prepare food, no place to go in a confined area. Some fill the hours with risky behaviours such as sex, substance abuse and fighting. By engaging girls in dialogue, we learn that they want their voices to be heard, and that they want health, education and livelihood

By engaging girls in dialogue, we learn that they want their voices to be heard, and that they want health, education and livelihood skills so they can care for themselves and others.

skills so they can care for themselves and others. Without engagement and dialogue, adolescents traumatized by their experiences may be lost to the cycle of violence.

Adolescent girls who become leaders for ASRH can 'break the ice' with other girls and thereby increase their access to information and promote the use of sexual and reproductive health services. For example, many girls are reluctant to visit health clinics in camp settings, yet this barrier can be addressed with messages that let girls know they are welcome. When young volunteers from the same affected-community reach out with ASRH information, or a safe space expands access, more girls obtain the services they need. The model in which health service providers wait for a girl to walk into a clinic seeking services does not work. Non-traditional methods of health service provision may be more effective at reaching and being utilized by girls. Engaging girls in outreach during humanitarian response is an effective step in this direction.

Advocacy conducted during humanitarian response is another channel for girls' participation. In crisis-affected settings, events convey ASRH messages through theatre, song, dance and sports. Such interactive models for reaching girls with information promise impact beyond a printed brochure or poster. Youth often form their own groups in camps, and may be invited to speak as the 'voice of youth' when camps are visited by high-level actors in the humanitarian response. They not only speak to the immediate short-term needs of their peers, but voice concerns and dreams for the future on a range of youth-related issues including health, education, employment, youth rights and well-being, and civic participation.

More monitoring and evaluation of youth participation in humanitarian settings is required. Measuring the effectiveness and reach of messages delivered by adolescents and youth is a challenge, as is evaluating whether adolescent and youth-led/designed/monitored programmes are more effective than those without. In contrast to the perception of youth as instigators of trouble, countless positive contributions demonstrate that adolescents and youth are part of the solution as partners and first responders and can actively participate in emergency preparedness and humanitarian response programming.

UNFPA-supported examples

- Training of trainers prepared hundreds of young peer educators in **Djibouti** to provide ASRH information to hard-to-reach adolescents and youth in refugee and host communities in Obock.

- Galvanized by a call for help after a tropical storm in the **Philippines**, trained youth volunteers conducted RH awareness-raising sessions, distributed hygiene kits, collected data and set up safe spaces – leading to lasting changes in UNFPA emergency preparedness strategy in support of youth participation.

- Peer educators and parents protected girls from sexual exploitation when floods in Freetown, **Sierra Leone**, displaced thousands; nearly 4,000 adolescent girls attended peer education sessions linked to provision of ASRH services and supplies including condoms and contraceptives.

- In **South Sudan**, youth peer educators trained to work in camps for the internally displaced have reached more than 12,000 adolescents and youth with information on ASRH issues and where to find services, and distributed many thousands of condoms.

"I was unaware of the fact that young people have the right to decide freely on matters related to their sexuality and that sexual and reproductive rights are basic human rights."

Barun Kuinkel, age 17, after attending an outreach session led by a peer educator in post-earthquake Nepal

"I had to immediately appeal to friends to help me. It was very challenging because some of the volunteers were themselves affected by the disaster… Helping those who have suffered the most is a way to deal with the stress they are going through."

Mona Basir, youth volunteer, tropical storm Washi, Philippines

"We are kids but we have a lot to offer, we have a lot of power to bring about change… As a peer educator, I spread knowledge. We talk to teenagers about all types of things from 'how to connect better with your parents' to more technical things like 'how to avoid STIs' and 'how to protect yourself',' what your sexual reproductive rights are' and about adolescent sexual and reproductive health in emergency settings."

Chloe Reynaldo, 15, peer educator, Philippines

"Sometimes we are so overwhelmed… but we are glad to be of help. Our own homes were inundated by floods, but we do this to give hope to the flood victims."

Ma Tin Tin Myint, a youth volunteer with the UNFPA-supported Youth Information Corner programme, leads a discussion about reproductive health issues with flood survivors in Myanmar

A trained youth volunteer provides health information to pregnant women affected by Super Typhoon Haiyan. The youth volunteerism and first responders model developed from the response to tropical storm Washi in the Philippines has demonstrated the importance of youth participation in the design and implementation of programmes targeting young people.

1 SAFE SPACES MALAWI

‘youth club’ tents give adolescent girls and boys displaced by fl oods their own safe spaces

Summary

After severe floods in Malawi, special tents were set aside in displacement camps to serve as ‘youth clubs’ for adolescents, both girls and boys, in an innovative adaptation of existing safe spaces for women and girls. The youth clubs offered recreational opportunities as well as youth-friendly access to sexual and reproductive health information and services, resulting in a high uptake of information and supplies among displaced adolescents in flood-ravaged Malawi. From January to June 2015, the 32 youth clubs provided services to more than 18,000 internally displaced adolescents, and reduced the incidence of sexually transmitted infections.

Safe spaces in displacement camps welcomed adolescents like these two girls in Malawi, where floods affected millions of people in 2015.

Humanitarian situation

Malawi suffered its worst flooding in decades in January 2015, when the southern region received 400 per cent higher rainfall than average and floodwaters submerged more than 63,000 hectares. More than 1.1 million people were affected by the disaster. Nearly a quarter of a million people were forced to seek temporary shelter in schools, churches and temporary sites. The devastation caused hundreds of millions of dollars in damage to properties and livelihoods.

Roads and other infrastructure washed away, making health facilities and public services inaccessible. Health and sanitation in camps for people affected by the floods became humanitarian priorities, especially for women and girls of reproductive age. Hundreds of visibly pregnant women were identified in the worst-affected areas of Malawi, and between 10 and 24 January 2015, 88 births were recorded.

Medical supplies that had been prepositioned by UNFPA in disaster-prone areas were provided to health workers and hospitals in six of the flood-affected districts, helping to support safe childbirth, including Caesarean section deliveries and treatment of labour complications. Supplies also included condoms and contraceptives for dual protection from HIV infection and unwanted pregnancy. Dignity kits were distributed to women and girls, whose hygiene needs are too often overlooked in emergencies.

Adolescent girls faced their own risks. While adults were busy receiving food and non-food items, adolescents –girls and boys – were largely left idle and unattended. Further, the disruption of schooling and other services, including sexual and reproductive health and HIV prevention services, rendered adolescents vulnerable to unwanted pregnancies, sexually transmitted infections and gender-based violence. Girls and women said they feared walking to the toilets located at far reaches of the camps due to threat of rape.

Expanding on the existing safe spaces model for women and girls, special tents were set aside in displacement camps to serve as 'youth clubs' for adolescents, both girls and boys. Youth clubs had been used before successfully in Malawi to reach young people with such services

in a recreational setting, and the model was adapted as an innovative approach in the camps' use of the safe spaces model. While women had their safe spaces where they could receive counselling and support to recover from gender-based violence, tents were specifically dedicated to the adolescents for youth clubs to provide recreational and skill-building activities and materials, psychosocial support and access to youth-friendly sexual and reproductive health information and services.

Objectives

The overall aim was to prevent unwanted pregnancies, HIV and other sexually transmitted infections. The innovation targeted adolescent girls and boys displaced by floods in Chikwawa, Machinga, Nsanje and Phalombe from January to June 2015, with the following objectives:

- Provide youth-friendly information and services including sexuality education, HIV/STI prevention and contraception to adolescents affected by floods;
- Ensure continued access for adolescent girls during time of displacement to adolescent sexual and reproductive health information and services;
- Enhance access to quality sexual and reproductive health and HIV services for young people affected by floods in rural southern Malawi using youth clubs.

Activities were initiated to keep adolescents and youth positively engaged during the displacement period and to provide psychosocial support.

Strategy and implementation

From registration data in the camps, young people were identified and the adolescent population determined. With the support of the reproductive health coordinator, UNFPA worked with NGO implementing partners Youth Net and Counseling (YONECO) and Centre for Victimized Women and Children (CAVWOC) to set up 32 youth clubs in displacement camps. The NGOs were oriented on

Collaboration between the youth clubs and women's safe spaces addressed gender-based violence issues for the young people and referrals.

the Minimum Initial Service Package (MISP) in humanitarian settings, and the importance of adolescent sexual and reproductive health in times of emergency. The creation of youth clubs and related support for adolescents was implemented in four districts in southern Malawi. UNFPA interventions integrated STIs and HIV, gender-based violence and young people's welfare within the interventions of the MISP.

The youth clubs provided a variety of activities for entertainment and education, such as games, sporting activities such as football and netball games, traditional dance, drama competitions, song, poetry and art. Activities were initiated to keep adolescents and youth positively engaged during the displacement period and to provide psychosocial support.

At the same time, the youth clubs served as an 'entry point' for provision of adolescent sexual and reproductive health information and services with counselling and peer education addressing contraceptives, HIV prevention and gender-based violence. Condoms were distributed free of change, dispensed in strategic areas easily accessed by adolescents and youth. Condom uptake was high within the clubs compared to general condom uptake in the camps. The youth-friendly approach contributed to uptake in use of modern contraceptives, with the oral pill the contraceptive method of choice among most of the adolescent girls referred by their youth clubs for family planning services. Collaboration between the youth clubs and women's safe spaces addressed gender-based violence issues for the young people and referrals.

Progress and results

The interventions targeted young internally displaced persons in camps. Reported cases of sexually transmitted infections decreased as access to condoms and family planning services increased. Overall, prevention of unwanted pregnancies and HIV/STI infections were among the key results of UNFPA-supported efforts in response to devastating floods in Malawi.

UNFPA-supported interventions:

- Reached more than 2,000 adolescents and young people with a variety of sexual and reproductive health interventions;
- Provided 8,830 adolescents with services including family planning information and supplies, antenatal care, STI treatment and, HIV testing and counselling;
- Established 32 active youth clubs in Chikwawa, Machinga, Nsanje and Phalombe districts.

Youth clubs enabled girls to obtain youth-friendly information and services to prevent unwanted pregnancy and HIV when natural disaster disrupted the health system.

Lessons learned

The concept of youth clubs is well-known in Malawi, which made it easier to adapt and scale up the practice to address adolescent sexual and reproductive health in this time of crisis. The participation of adolescents and young people in the planning and implementation of the youth clubs and their activities ensured buy-in and sustainability.

The participation of adolescents and young people in the planning and implementation of the youth clubs and their activities ensured buy-in and sustainability.

The establishment of youth clubs in the displacement camps, as part of the safe spaces already established for women and girls, provided adolescents with their own safe spaces to access vital sexual and reproductive health information and services. Recreational materials and drama proved attractive to adolescents, and contributed to providing a non-threatening and receptive environment in which to provide sexual and reproductive health information and referral for services. Youth-friendly environments within the camps enhanced uptake of condoms and contraceptives.

NGOs are continuing to implement the interventions in their programmes. They have taken the concept of youth clubs based on safe spaces to other districts beyond the ones supported by UNFPA during the humanitarian situation triggered by flooding, demonstrating that the innovation is scalable and replicable.

Conclusion and recommendations

Youth clubs, like safe spaces for women, are promising strategies for improving access to adolescent sexual and reproductive health information and services in Malawi. While ASRH may not be appreciated by all humanitarian actors as an urgent need when first initiated, the consequences of not intervening may include high numbers of new HIV infections and unwanted pregnancies in a vulnerable age group. ASRH should be mainstreamed in planning for humanitarian emergencies. Service providers should be oriented before disasters strike and have coordination mechanisms in place for timely interventions.

Partners

Youth Net and Counseling
Centre for Victimized Women and Children
District Youth Offices
District Health Offices
Participating adolescents

More Information

UNFPA Malawi website
http://unfpamalawi.org/

Acknowledgements

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2 SAFE SPACES NEPAL

Mobile RH camps create 'corners' for adolescent sexual and reproductive health in post-earthquake Nepal

Summary

Mobile medical teams deployed in earthquake-affected regions of Nepal in 2015 made a special effort to reach adolescents girls when they established mobile reproductive health (RH) camps. Each mobile RH camp included a separate tent for adolescents only, known as 'adolescent-friendly corners', with youth volunteers, educators and coordinators that offered youth-friendly access to information and commodities and a valuable opportunity for peer-to-peer knowledge sharing. As part of its overall earthquake response UNFPA supported a total of 132 mobile reproductive health camps, reaching more than 100,000 earthquake-affected people, including nearly 17,000 adolescents.

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A young mother, not yet 16, holds her baby, delivered by a UNFPA-supported mobile reproductive health team at a camp for the displaced in Betrawati, Rasuwa, Nepal.

Humanitarian situation

In April 2015, Nepal was rocked by a devastating earthquake and aftershocks that left more than 9,000 dead and 600,000 displaced. Over a thousand health facilities were destroyed or damaged by the disaster, including one third of the facilities providing specialized maternal and neonatal care. Based on data from Nepal's Health Management Information System, the estimated number of affected girls and women of reproductive age in the 14 most-affected districts was 1.5 million. The earthquake destroyed or damaged most health facilities. Hospitals in district capitals, including Kathmandu, were overwhelmed, medical supplies severely depleted and capacities overstretched.

In Nepal, adolescents aged 10 to 19 account for a quarter (24.2 per cent) of the population. Among adolescent girls aged 15 to 19, some 29 per cent are or have been married, 12.3 per cent have experienced physical or sexual violence, 16.7 per cent are either pregnant or already had children. Unmet needs for family planning for married girls stands at 41.5 per cent.[23]

For adolescent girls, the most significant part of mobile RH camps were the separate adolescent-friendly corners with messages, information and services specific to their age group

UNFPA, in coordination with the Ministry of Health and Population and other relevant stakeholders, initiated the Minimum Initial Service Package (MISP) implementation in the 14 most-affected districts. Soon the partners established mobile reproductive health camps equipped with male and female doctors, skilled birth attendants, health assistants, Auxiliary Health Workers, psychosocial counsellors, youth health educators, youth coordinators and youth volunteers. The mobile RH camps provided antenatal, delivery and post-partum services including basic emergency obstetric and newborn care and family planning; laboratory services (including for STI/HIV testing); general health check-ups and response to gender-based violence.

For adolescent girls, the most significant part of mobile RH camps were the **separate adolescent-friendly corners** with messages, information and services specific to their age group. The project addressed gaps identified by a barrier study conducted by the Government's Family Health Division, UNFPA and UNICEF.

[23] National Demographic and Health Survey, 2011

UNFPA designed the adolescent-friendly corners specifically to address the lack of knowledge among adolescents on sexual and reproductive health and sexual and gender-based violence issues, and to improve adolescent girls' utilization of services. UNFPA empowered adolescent peer volunteers to increase effective access to sexual and reproductive health information for adolescent girls. Local adolescents and young people were mobilized and engaged as active participants and responders in the process, and received training to deliver awareness-raising sessions and carry out outreach activities in earthquake-affected communities.

Objectives

- Adolescent-friendly corners in the mobile RH camps contributed to delivery of the Minimum Initial Service Package (MISP) – the series of crucial actions necessary to respond to reproductive health needs at the outset of any humanitarian crisis. With a focus on the needs of adolescent girls, humanitarian programming had the following objectives:

- Mobilize adolescent volunteers to raise awareness among earthquake-affected populations, especially adolescent girls and young people, for the prevention of sexual and gender-based violence (GBV), prevention of HIV and other sexually transmitted infections, and sharing of essential messages on sexual and reproductive health and family planning information;

- Provide life-saving comprehensive sexual and reproductive health services, including clinical care for survivors of sexual and gender-based violence, by trained health workers and youth health educators (professional nurses) appointed in the mobile RH camps. Integrate adolescent sexual and reproductive health in emergencies (ASRHiE) in the mobile RH camps;

- Provide essential supplies, including contraceptives, to the earthquake-affected population, especially adolescent girls, to

improve access to appropriate sexual and reproductive health services and to meet demand;

- Build capacity of local adolescents and young people as volunteers to engage directly with adolescent girls and boys in increasing their access to sexual and reproductive health information and services.

Strategy and implementation

Mobile medical teams ensured that the structure of each camp included a separate tent set up specifically for adolescents. Young volunteers from the local community who served among the first responders received training by youth health educators on a wide range of issues including menstrual and personal hygiene management; HIV and STI prevention; consequences of child marriage and adolescent pregnancy; danger signs during pregnancy, delivery and after childbirth; contraception, birth spacing and protection; and safety issues linked with gender-based violence.

In each camp, six to 12 trained volunteers were mobilized to engage directly with adolescent girls and boys; 60 per cent of the volunteers were female. Each camp had a youth coordinator to oversee the management of each adolescent-friendly corner and the performance of the youth health educator (a professional nurse appointed in each corner). Every staff member in the mobile RH camp participated in an orientation on the clinical management of rape (CMR), which included specifics on handling cases of adolescent rape survivors.

Services provided through the adolescent-friendly corners included: youth-friendly adolescent sexual and reproductive health services and referral; prevention of sexual and gender-based violence and clinical management of rape and referral; emergency obstetric services, treatment and referral; IEC materials on security and precaution (safety and protection); distribution of condoms and condom demonstrations; condom boxes in toilets to ensure privacy; emergency contraception; post-exposure prophylaxis (PEP) for HIV; and psychosocial counselling

for gender-based violence and referral. Services were provided by health workers including the youth health educators.

Progress and results

As part of its overall earthquake response, UNFPA-supported mobile RH camps provided life-saving reproductive health services in remote areas of earthquake-ravaged Nepal, and helped avert maternal and newborn deaths and morbidities. The programme for mobile RH camps achieved the following results:

- Established 132 mobile reproductive health camps that delivered sexual and reproductive health and gender-based violence services to 104,461 earthquake-affected people in 14 districts, including 16,977 adolescents;
- Delivered services to 13,117 female and 3,860 male adolescents through mobile RH camps;
- Provided general medical and diagnostic services to some 8,325 adolescents, ASRH to nearly 4,000 adolescents and referrals for services related to gender-based violence to 1,461 adolescents;
- Provided family planning services and supplies through mobile RH camps to 1,155 women and girls of reproductive age (including 510 adolescent girls) and 265 men and boys (including 158 adolescent boys);
- Trained 433 youth-friendly facilitators and volunteers who conducted awareness-raising activities on ASRH and sexual and gender-based violence in earthquake-affected districts, reaching more than 3,000 adolescents and youth, with more than 70 per cent girls.

Lessons learned

The participation of young people during the emergency response was an effective way to reach adolescents who might otherwise have received less attention. Mobilization and training of volunteers who were themselves adolescents and youth helped improve **knowledge** of adolescent sexual and reproductive health issues and **utilization** of sexual and reproductive health services among their peers. Involvement of female community health workers was also important as it allowed for more effective dissemination of information about the mobile RH camps and the services available to the community – especially among other women.

Integration of ASRH in emergency response through comprehensive mobile reproductive health camps helped address the needs of vulnerable young girls in the earthquake-affected communities and should be mainstreamed in any future SRH and GBV intervention in an emergency situation.

Mobilization and training of volunteers who were themselves adolescents and youth helped improve knowledge of adolescent sexual and reproductive health issues and utilization of sexual and reproductive health services among their peers.

Emergency interventions are most effective when services provided in the mobile RH camps are both comprehensive and integrated – that is, providing a complete package for sexual and reproductive health and response to gender-based violence.

The experience in Nepal highlights the need to improve overall preparedness and planning ahead of a disaster. Emergency preparedness capacity and supplies should be maintained (prepositioned) in a planned manner. Also, it is important to involve governmental District Health Offices and relevant members of the community from the initial planning stage for better ownership and support for effective programme implementation.

Conclusion and recommendations

Building the capacity of local adolescents and young people as volunteers and first responders was highly effective in terms of engaging directly (peer-to-peer) with adolescent girls and boys to

deliver sexual and reproductive health information and education. The benefits of this training for youth volunteers is expected to benefit girls and boys not only in the emergency phase, but also in the long term after the emergency, and build resilience within the community and among young adolescents.

Insufficient knowledge of sexual and reproductive health was identified in the barrier study report of 2014 as one of the key barriers to accessing adolescent-friendly services. In this regard, programming in Nepal that integrated specific adolescent sexual and reproductive health information and services in the humanitarian response and mobilized youth volunteers was seen as a successful intervention.

Partners

Manmohan Memorial Community Hospital (MMMCH)
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More Information

UNFPA Nepal website
http://countryoffice.unfpa.org/nepal/

Acknowledgements

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SAFE SPACES
NIGERIA

Safe spaces for girls and women displaced by Boko Haram: reproductive health and resilience for recovery

Summary

For girls and women fleeing from violence in the Boko Haram insurgency, safe spaces in camps are an entry point for reproductive health information and services including family planning and psychosocial counselling for gender-based violence (GBV). These gathering places also build resilience by offering women and girls opportunities to acquire livelihood skills and engage with others to rebuild community networks. With support from UNFPA, nine safe spaces were established in camps for the displaced in north-eastern Nigeria in August 2015. A total of 29,415 women and girls were reached by March 2016.

Adolescent girls in Dalori IDP camp, Borno State, where UNFPA has established safe spaces to provide a platform for women and girls to learn vocational skills and as an entry point to comprehensive sexual and reproductive health education and to provide psychosocial counselling to survivors.

Humanitarian situation

In the six years since the conflict with Boko Haram began in the region, more than 2.2 million people have been internally displaced, 20,000 civilians killed, and as many as 7,000 women and girls abducted. An estimated 92 per cent of internally displaced persons (IDPs) in north-eastern Nigeria live within host communities and 8 per cent in camp settings. Some 53 per cent of IPDs are female and among them are 510,555 women of reproductive age, with more than 81,000 pregnancies expected during 2016.

The humanitarian response launched by UNFPA in 2013 in the affected states is ongoing and continues to seek innovative approaches to reach women and girls whose access to reproductive health information and services is limited by cultural, religious and societal inhibitions. Risks to adolescent girls, who are often overlooked in the race to provide water, food and shelter in times of any emergency, are of heightened concern in the Boko Haram crisis. UNFPA supports initiatives that are acceptable, accessible and appropriate for adolescents, taking cultural sensitivity and diversity into consideration. One such innovative approach is the use of safe spaces for women and girls in Nigeria.

Objectives

- Increase access to information, services and supplies for sexual and reproductive health, including family planning;
- Build the capacity of the women to be 'survivor advocates' and 'role model mothers' in their community on reproductive health issues;
- Use safe spaces to provide an area where women and adolescent girls can:
  - » rebuild social networks and get social support;
  - » acquire contextually relevant skills, including livelihood skills, and use them as an entry point for increased access to services;

- receive information on issues related to women's rights, health and services; and
- access safe and non-stigmatizing multisectoral gender-based violence-response services such as psychosocial support and counseling.

Strategy and implementation

In August 2015, with support from the Government of Japan and USAID, UNFPA established nine safe spaces for women and girls in some of the most populated IDP camps in north-eastern Nigeria. Seven safe spaces were established in Maiduguri, Borno State. Two safe spaces were established in the Malkohi and Damere IDPs camp in Yola, Adamawa State.

These gathering points help to meet reproductive health needs and build resilience by protecting dignity and well-being and empowering women with life skills and livelihood skills. They provide girls and women with a safe and non-stigmatizing entry point for information and services for sexual and reproductive health as well as gender-based violence prevention, response and management. Girls and women of reproductive age can access family planning counseling and supplies including long-acting reversible contraceptive implants, injectable methods and oral contraceptives. Safe spaces ensure confidentiality and in many cases reduce the cultural barriers faced by girls and women as they have an opportunity to obtain accurate information directly from health service providers.

Safe spaces ensure confidentiality and in many cases reduce the cultural barriers faced by girls and women as they have an opportunity to obtain accurate information directly from health service providers.

In addition, safe spaces provide opportunities to learn life skills such as literacy, numeracy and livelihood skills to earn income during and after the crisis. They also offer women and girls an opportunity to engage with and support each other, exchange information, obtain psychosocial support, and begin rebuilding social and community networks. Safe spaces not only address immediate needs during displacement but aim to empower women when they reintegrate into their home communities and begin the process of recovery.

Progress and results

- Beneficiaries of the nine safe spaces include a total of 29,415 women and girls between their inception in August 2015 and March 2016 Ð one third of them are adolescents.
    - » 10,230 adolescent girls enrolled in the safe spaces and received a variety of services:
    - » 4,379 girls received psychosocial support (individual and group);
    - » 4,322 girls participated in information and awareness-raising;
    - » 1,105 girls benefited from outreach on GBV prevention;
    - » 314 girls gained livelihood skills;
    - » 110 girls received referral support as GBV survivors.
- 158 girls and women benefited from the skills acquisition training programme in the safe spaces, which includes tailoring and how to knit caps, make soap, and make bags and mats of polythene (a recyclable plastic). After completing the programme, some will form cooperatives and receive start-up grants and equipment.

As of April 2016 a total of 6.2 million people impacted by the crisis in north-eastern Nigeria have received UNFPA-supported services, including over a million women who have received sexual and reproductive health care and the safe delivery of some 63,000 newborns.

The safe spaces are part of a larger UNFPA-supported humanitarian response launched in 2013 that is ongoing in the affected states. As of April 2016 a total of 6.2 million people impacted by the crisis in north-eastern Nigeria have received UNFPA-supported services, including over a million women who have received sexual and reproductive health care and the safe delivery of some 63,000 newborns. With the recent rescue of more women and girls from captivity by the military, and the increased access to more affected populations trapped in territories controlled by Boko Haram, more safe spaces are needed in more places in order to respond to the growing humanitarian need.

The opportunity to learn livelihood skills attracted girls and women to safe spaces in IDP camps, where services aimed to restore health and hope.

Lessons learned

One of the key lessons is that skill acquisition training is an effective way to attract the attention of girls in the IDP camps, providing an entry point for awareness-raising around information and services to protect their sexual and reproductive health.

The skill acquisition training conducted in the safe space removes the stigmatization of the centre, which otherwise is often perceived as a place to go for family planning services. It also equips and empowers girls with livelihood skills which enhances their economic power; in turn, this enables them to make appropriate reproductive health decisions. Training on livelihood skills also enhance the sustainability of the intervention. Its impact on girls' income is being monitored around groups of young girls who formed small cooperatives in anticipation of the time when they return to their home communities.

Conclusion and recommendations

To reach adolescent girls during emergency situations, programmes must take innovative approaches like safe spaces to make services acceptable, accessible and appropriate for this vulnerable and disempowered population, taking cultural sensitivity and diversity into consideration.

To reach adolescent girls during emergency situations, programmes must take innovative approaches like safe spaces to make services acceptable, accessible and appropriate for this vulnerable and disempowered population, taking cultural sensitivity and diversity into consideration.

Partners

Adamawa State Primary Health Development Agency
Adamawa State Ministry of Women Affairs and Social Development

More Information

UNFPA Nigeria website
http://nigeria.unfpa.org/

Acknowledgements

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4 SAFE SPACES PAKISTAN

Displaced girls benefit from Women-Friendly Health Spaces and culturally sensitive strategies in Bannu District

Summary

In a region of Pakistan disrupted by military security operations, culturally sensitive strategies including establishment of Women-Friendly Spaces benefited not only adult women but the adolescent girls who accompany them to these safe spaces. The safe spaces enabled delivery of sexual and reproductive health, including family planning and maternal health, and provided services to survivors of gender-based violence among displaced adolescent girls and women. Locating sexual and reproductive health services within government health facilities, engaging local health practitioners, and utilizing both male and female social organizers proved effective in creating culturally-acceptable portals for access. The programme's success established the groundwork to continue services in local communities and areas of return for displaced persons.

The safe spaces enabled delivery of sexual and reproductive health, including family planning and maternal health, and provided services to survivors of gender-based violence among displaced adolescent girls and women.

Supplies for hygiene and safe delivery were distributed with UNFPA support as part of a culturally sensitive humanitarian response in Pakistan's Bannu District.

Humanitarian situation

By mid-2014, nearly 1 million people had become internally displaced and in need of humanitarian assistance in the North Waziristan, Federally Administered Tribal Areas (FATA), due to military security operations. In July 2014, UNFPA estimated that 74 per cent of these internally displaced people are women and children, and at least 36,000 were pregnant. Most of the displaced sought shelter in the Bannu District of Khyber Pakhtunkhwa Province, living in cramped surroundings, either with host families or in public (rented) buildings.

In Bannu District, women's access to basic reproductive health and gender-based violence services was limited or completely lacking. Mobility of women was limited and often restricted by practices related to local culture and religion. Nearly all women in this part of the country follow the practice of wearing a veil, locally known as 'chaddar', and the practice of 'purdah' (secluding women) is prevalent.

The cultural and religious context called for sensitive, innovative and integrated approaches to reach women and girls with much-needed information and services. UNFPA adopted a comprehensive **multisectoral approach** and employed a variety of strategies in order to make sexual and reproductive health and gender-based violence services more acceptable and accessible to the local population, working with NGO partners Muslim Aid (MISP) and Sarhad Rural Support Programme (GBV). For example, for the implementation of MISP, UNFPA supported and strengthened key health facilities with the provision of health care providers, life-saving drugs (ERH kits), medical and non-medical equipment and community awareness-raising at large. However, for prevention and response to GBV, the Fund supported interventions were conducted under the more neutral umbrella of 'reproductive health' and sought strategic entry points within the community, such as engagement with men and application of Women-Friendly Health Space model. Safe spaces created for women also facilitated access by adolescent girls, who were accompanied by adult women of their families.

Objectives

- Support the Government's National Health Emergency Preparedness and Response Network (NHEPRN) under the Ministry of National Health Services, helping to ensure that pregnant women are able to safely deliver by providing clean delivery kits and newborn baby kits and providing women of reproductive age with essential hygiene supplies;

- Provide emergency reproductive health kits at the request of NHEPRN;

- Implement the Minimum Initial Service Package (MISP) for reproductive health and provide prevention and response services to address gender-based violence.

Strategy and implementation

Women-Friendly Health Spaces (WFHS): These safe spaces were critical to the successful implementation of the programme. Core sexual and reproductive health services and GBV services were integrated and provided in the same health spaces, and combined with other activities. Women-Friendly Health Spaces facilitated access to assistance and services for both adult women and adolescent girls – meeting their psychosocial and reproductive health needs and facilitating referrals. The spaces also facilitated linkages between reproductive health and GBV teams seeking to reach local communities for enhanced awareness efforts.

Several factors improved the effectiveness of the WFHS and other interventions, facilitating acceptance of the programme activities and utilization of services within the community at large – eventually helping to reach adolescent girls.

- A key factor was the **location** of the spaces. UNFPA and its implementing partner decided to locate Women-Friendly Health Spaces inside government health facilities such as the

Rural Health Centre in Gouriwala, Bannu District. Locating WFHS in government structures allowed the programme to gain credibility among the local population and eased their transition and interaction with counsellors and health service providers.

- The programme hired staff members locally who were well versed in the Pashto **language** spoken in the North Waziristan Agency, a strategy that opened corridors for understanding their problems and providing responsive services.

- Identifying **female** staff and medical personnel was also crucial in outreach to women.

Awareness-raising sessions: Conducted as part of outreach activities that targeted both the host community and the displaced population, awareness-raising sessions provided RH information and also served as an occasion to distribute dignity kits and other essential supplies among adolescent girls in attendance. Social organizers and health promoters helped organize the sessions. Outreach team members consisted of both female and male social organizers. The use of the male social organizers also allowed the programme to reach out to adolescent girls in a unique manner. On numerous occasions, fathers and other adult men who attended awareness-raising sessions on psychosocial support self-identified cases in their family of women who were suffering from depression and other mental traumas, and brought them to UNFPA-supported health facilities.

The WFHS targeted both adult women and adolescent girls, in an effort to stimulate access. Though some sessions on sexual and reproductive health or GBV were held separately for different population groups, it was strategic to ensure access by all. Family members were more willing to accept and support the engagement of young women and adolescent girls, provided they were in the company of elder women as guardians.

Referrals for services: Referrals were provided to adolescent girls who were identified as needing further medical services, referred to other medical facilities in nearby areas. Keeping the cultural and societal

norms in mind, transportation was provided and it was ensured that a male guardian accompanied them in travel. If a male guardian was not available, girls and young women were accompanied by their mother or their mother-in-law. This referral strategy ensured that women could obtain access to high-quality medical services without disrupting or intervening with the societal norms.

Registration of displaced girls and women became an important service: One of the major findings of the project's assessment of the displaced population was that the most adversely affected people were those who had never been registered in the **national identity database**. This meant that they were deprived of most of the relief efforts provided by other relief organizations. An active effort was made to register them in order to ensure that they were included in the standard response, able to benefit from humanitarian response, and able to benefit more from early recovery efforts. Eventually 400 women were registered. Most of these women were household heads, which means that some 400 families were entered into the system.

Progress and results

Through the creative use of multiple strategies that were sensitive to the cultural norms of the community, the programme achieved significant results during the humanitarian response starting in June and July 2014:

- 4,014 adolescent girls visited Women-Friendly Health Spaces;
- 26,440 women received basic reproductive health services, of whom 4,895 were adolescent girls;
- 6,902 women received basic emergency obstetric care (EMOC) services, of which 371 were adolescent girls, with complicated cases referred to higher levels of care;
- 21,644 dignity kits and 20,000 clean delivery kits were distributed among the target populations;

- 104 safe deliveries for adolescent mothers were facilitated by the programme; and
- 27 adolescents were screened for HIV and other sexually transmitted infections.

Lessons learned

UNFPA has contextualized its sexual and reproductive health and GBV interventions within the prevailing cultural norms in the displaced population. This approach may also facilitate continuation of activities through adoption and ownership by local communities and local government. In response to demand generated from communities for continued access to services, UNFPA implementing partners succeeded in mobilizing additional resources for the continuation of some activities. Government partners such as the district health departments and the military were essential due to their support of the interventions by allocating use of other health facilities.

Conclusion and recommendations

Given successful outreach, UNFPA plans to scale up the operations in the existing health facilities while at the same time moving from emergency response interventions to provision of comprehensive reproductive health and multisectoral GBV services. The Fund also plans to work in the areas of return (NWA), once the Government of Pakistan gives access to the humanitarian community.

UNFPA will explore further strengthening capacities and resources to ensure interventions are improved with a differentiated approach for adolescent girls. This implies generating knowledge products and materials that are more tailored to adolescent girls. It also entails developing the capacity of implementing partners to improve the quality of awareness-raising sessions conducted and services provided. Documenting in detail the approach applied to date will also facilitate further knowledge-sharing.

Partners

Muslim Aid
Sarhad Rural Support Programme (SRSP)

More Information

UNFPA Pakistan Facebook page
www.facebook.com/UNFPAPakistan/

Acknowledgements

Sarah Masale, UNFPA Deputy Representative (Programmes)

5 MOBILE CLINICS AND OUTREACH TEAMS MYANMAR

Stateless and displaced by conflict in Rakhine State: mobile teams reach girls with life-saving services and supplies

Summary

Mobile reproductive health teams established six mobile clinics and one fixed-location clinic to serve the sexual and reproductive health needs of adolescent girls and women among the displaced and stateless population of Rakhine State, a conflict-torn region of Myanmar. Four of the mobile teams were staffed by the Myanmar Nurse and Midwife Association. In the first three quarters of 2015, 13 per cent of the women seeking antenatal care were adolescents. The absence of identification documents for the large stateless population creates hurdles to monitoring and evaluation of the project as UNFPA and its partners seek to expand sexual and reproductive health services to other affected areas of Myanmar.

Ma Nu Yee received a dignity kit with hygiene supplies after meeting with a midwife in the mobile team at a camp for the displaced in Myanmar's Rakhine State.

Humanitarian situation

Adolescent girls and women of childbearing age in Myanmar face deep poverty and gender discrimination, compounded by armed conflict and inter-communal violence. For girls and women affected by conflict and forced displacement, gender-based violence is an added challenge. Myanmar has a long history of internal conflict, and it has the highest number of internally displaced people (IDPs) in Southeast Asia. Around 76 per cent of the region's IDPs are concentrated in Myanmar. The majority live in protracted displacement, unable to return, integrate locally or settle elsewhere. While the peace process in Myanmar has the potential to bring hope, 645,000 displaced people live in conditions where maternal mortality is prevalent.

Stateless people lack citizenship and face severe restrictions on freedom of movement and access to basic services, including health and reproductive health services, protection and livelihoods. Restrictions on marriage and childbearing for this stateless population have influenced the reproductive rights of women and girls as well as the rights of their children. Lack of citizenship leads to a range of human rights violations that affect access to food security, health, education, and the right to choose how many children to bear and birth spacing.

Adolescent girls are vulnerable to numerous challenges during this ongoing emergency. These include: early sexual initiation, early and unwanted pregnancies leading to unsafe abortion or teen parenthood, higher risk of contracting sexually transmitted infections and HIV, forced and early marriage, risky migration practices (trafficking for marriage or sexual exploitation), accrued risks of sexual violence (rape, sex slavery, survival sex), gender-based violence including family/domestic violence, and lack of basic information on sexual and reproductive health.

UNFPA-supported efforts to promote reproductive health have encountered several key challenges in Myanmar:

- Adolescents lack awareness of and access to reproductive health information. Most participants of health education sessions are pregnant women who seek access to antenatal

care or treatment for specific reproductive health issues. Adolescents, like most people, do not come to the clinics unless they have a specific problem. Adolescents in particular shy away from traditional health care providers, as youth-friendly health services are rare in Rakhine and prevention messages are not reaching women and girls;

- Stateless adolescents and youth face further challenges accessing more specialized levels of health facilities. Some are rejected, while others have difficulty obtaining travel authorization to access referral to hospitals;

- For health service providers, and overall programming, the lack of identity cards among internally displaced persons makes it difficult to ascertain the correct age of the clients. This contributes to the lack of disaggregated data, which frustrates monitoring and evaluation and hinders efforts by UNFPA and its partners to improve data-collection tools in order to obtain and analyse more accurate disaggregated data.

Objectives

The project targeted an estimated affected population of 4,550 beneficiaries over 12 months from January to December 2015. Although the project was not adolescent-specific, it was designed to provide basic reproductive health services to the displaced population, including adolescent girls, seeking to achieve two main objectives:

- Improve access to and utilization of reproductive health **services** among affected populations, including women, girls and adolescents, through ensuring supplies of reproductive health **commodities**;

- Provide sexual and reproductive health **knowledge** to women, girls and adolescents in the conflict-affected areas.

Strategy and implementation

Project coverage included 10 camps for internally displaced and stateless persons, 30 villages within Sittwe Township and 24 villages within Minbya Township of Rakhine State.

Mobile teams and a temporary clinic: The project established one temporary clinic and six mobile teams. The fixed clinic location in Sittwe was managed by Myanmar Medical Association, which also provided two mobile teams. The Myanmar Nurse and Midwife Association managed four mobile teams. Mobile clinics helped to serve the needs of girls and women who did not have the freedom to safely move to stationary or government-run hospitals or clinics.

Family planning supplies: The temporary clinic and the mobile teams offered male condoms and oral and injectable contraceptive methods, provided free of charge to the target population. UNFPA, working with its implementing partners Myanmar Medical Association and Myanmar Nurse and Midwife Association, recruited teams of medical doctors and midwives to provide oral and injectable contraceptive methods to clients upon informed consent after counselling; in addition, condoms were distributed for dual protection.

Health education sessions: Through maternity health promoters and health volunteers, health education sessions communicated basic reproductive health messages to beneficiaries. The main objective of these health education sessions was to follow-up on recommendations provided by health staff; for example to make sure pregnant women visit the clinic for antenatal care, and women using oral contraceptives take them regularly. Health volunteers provided translation to clients at temporary clinics, as a number of languages are spoken in the region. Health volunteers also referred clients to UNFPA-supported Women and Girl Centres that served as safe spaces where women and girls could access psychosocial support and counselling for gender-based violence as well as sexual and reproductive health information and services.

Progress and results

Implementing partners reported the following results from January through September 2015:

- 1,078 clients received family planning services via the Sittwe clinic and mobile clinics;
- Adolescents accounted for 13 per cent of all clients accessing antenatal care services;
- More women (including younger women) have been taking up post-partum family planning services in the UNFPA-supported mobile clinics and static clinic over time;
- Supplies of contraceptives included a choice of methods: long-acting reversible contraceptives (injectable methods), oral contraceptive pills and male condoms.

The main indicators of the project included: 1) number of pregnant women who received antenatal care services during pregnancy; 2) number of clients who received health education on SRH; 3) number of essential reproductive health commodities provided to clients; 4) percentage of increased knowledge on maternal and newborn health among reproductive aged women after health education sessions. It should be noted that data was not disaggregated by age, so it was difficult to determine with precision the number of adolescent clients. As part of its ongoing monitoring, evaluation and improvement of the project, UNFPA and its partners are revising the existing tools to collect age-disaggregated data.

Lessons learned

Throughout 2015, increasing numbers of young women sought family planning services after birth. Two areas of action can build on this early finding: 1) empower local health professionals with training on youth-friendly services, and 2) expand young people's access to adolescent

sexual and reproductive health **information** through peer education and provision of youth-friendly health services. This will allow young people to become promoters of services and make informed choices about their lives and sexual and reproductive health issues. It will also reduce early childbearing, unwanted pregnancies and unsafe abortions. In 2015, health volunteers informally referred some reproductive health clients to the Women and Girls Centres; in future, gender-based violence and reproductive health services will be integrated in order to provide prevention and response mechanisms among the affected population.

The project could be readily replicated in other areas affected by prolonged conflict, with appropriate documentation and project evaluation.

The programme of mobile clinics in IDP camps could be linked with reproductive health programming in development contexts and with governmental authorities to ensure sustainability of reproductive health care, especially for adolescents, as part of the health care system one day. Coordination between partners at the humanitarian response stage and beyond and modifications such as the introduction of Youth-Friendly Spaces in post-conflict settings would be key.

Adolescent-specific interventions can help to prevent early and unwanted pregnancy, delay sexual initiation, and address a lack of information related to sexual and reproductive health and gender-based violence.

The project was implemented in Rakhine State in 2015, with plans to expand to Kachin State, which is another conflict-prone state in Myanmar. In late 2015 UNFPA, Finland and Sweden agreed to launch a three-year $11.8 million joint initiative to protect the rights of women and girls in Myanmar, title 'Women and Girls First'. Working with local and international partners, the focus of 'Women and Girls First' is on the most vulnerable women and girls in the remote and conflict-affected areas of Rakhine, Kachin and northern Shan states. The initiative is a commitment to prevent and respond to violence perpetrated against women and girls in Myanmar, and to realize their sexual and reproductive health and rights.

Conclusion and recommendations

This project reached adolescent girls, though they were not the primary target population. Targeted interventions for girls are recommended during humanitarian interventions as crucial to protecting this

vulnerable population. Adolescent-specific interventions can help to prevent early and unwanted pregnancy, delay sexual initiation, and address a lack of information related to sexual and reproductive health and gender-based violence. Another recommendation is that reproductive health projects should raise awareness among communities to avoid the risk of stigmatizing adolescents and youth as they seek access to life-saving reproductive health services including family planning.

To ensure comprehensive services, sexual and reproductive health commodities – condoms as well as oral and injectable contraceptive methods – should be prepositioned with advance planning and inclusion into reproductive health projects to address shortfalls likely to occur during emergency situations.

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Partners

Reproductive health implementing partners:
Myanmar Nurse and Midwife Association
Myanmar Medical Association
State Health Department
GBV implementing partners:
International Rescue Committee
Department of Social Welfare

More Information

UNFPA Myanmar website
http://countryoffice.unfpa.org/myanmar/

Acknowledgements

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6 MOBILE CLINICS AND OUTREACH TEAMS SOMALIA

Outreach campaigns announce monthly 'community RH camps' serving displaced adolescent girls in nine districts

Summary

Monthly 'community reproductive health camps' are at the core of a programme for thousands of displaced and marginalized Somali women and girls. Outreach campaigns alert pastoral populations to the date and place of the next mobile clinic. The programme has reached more than 24,000 reproductive-age women within two years, including 4,800 adolescent girls aged 15 to 19. In addition to strengthening capacity at the Ministry of Health, training programmes prepare a team of health service providers and community health workers to empower girls and women with culturally sensitive sexual and reproductive health information and services, including family planning. The integrated campaigns and services benefit vulnerable adolescents devastated by drought, floods and conflict in one of the world's largest humanitarian crises.

The programme has reached more than 24,000 reproductive-age women within two years, including 4,800 adolescent girls aged 15 to 19.

A pregnant woman is examined by a health worker in Somalia, where mobile teams reached adolescent girls with life-saving reproductive health services.

Humanitarian situation

Somalia remains one of the largest humanitarian crises in the world, with some 2.9 million people in need of humanitarian assistance, including an estimated 1.1 million people internally displaced by recurrent droughts, floods and conflict. Women bear the unequal brunt of hardship: Somalia has extremely high rates of maternal mortality, rape, female genital mutilation, violence against women and child marriage. Reproductive health services among this displaced population include few operational facilities, and of those most are poorly equipped, with inexperienced and demoralized health personnel. Reproductive health among adolescent girls and youth remains highly neglected due to intense religious and cultural beliefs that prevent access to information and services.

The maternal mortality ratio in Somalia stands at 732 deaths per 100, 0000 live births. Fewer than 30 per cent of births are assisted by skilled personnel. Basic and comprehensive emergency obstetric care is poor, with a Caesarian section rate of less than 2 per cent. The fertility rate is high, with six to seven children per woman, and the contraceptive prevalence rate is low, with less than 3 per cent of couples using a modern method of contraception. Some 26 per cent of women of reproductive age have an unmet need for family planning.

More than 75 per cent of Somalis are under age 30. Adolescents and youth between 15 and 24 years of age represent one fifth of the Somali population (18.7 per cent) and most have known only conflict and hardship during their lifetimes. Barriers to reproductive health services access by women and girls include low awareness, myths and misconceptions surrounding the use of most reproductive health services and products, poor basic education and lack of sexual education. The level of information on risks related to pregnancy and childbirth is low and frequently derived from traditional beliefs.

Adolescents and youth between 15 and 24 years of age represent one fifth of the Somali population (18.7 per cent) and most have known only conflict and hardship during their lifetimes.

UNFPA supports a range of programmes to protect and engage marginalized and vulnerable adolescents and youth in Somalia. Efforts focus on groups of youth at risk, unemployed young entrepreneurs, and existing youth networks such as the Y-PEER Network, which prepares young health educators to act as champions in their

communities for adolescent sexual and reproductive health. Despite these good efforts, use of and access to reproductive health services by adolescents and youth remains very low – especially among pastoral, rural and marginalized populations. Today a more integrated approach is delivering results. In this example of UNFPA programming in a humanitarian situation, integrated community-based interventions for women and young girls target marginalized populations.

Objectives

- Equip and sustain a team of competent reproductive health service providers with the knowledge, attitude and skills to provide integrated reproductive health services at the community level (Integrated services refer to a comprehensive range of sexual and reproductive health services to meet peoples' needs over time, e.g. maternal health, family planning and HIV, in ways that make effective use of a country's health resources);
- Ensure that men and women, including girls and youth, in nine focus districts acquire full, accurate information regarding reproductive health, empowering them to make informed decisions;
- Increase demand and utilization of reproductive health services including family planning among women, girls and youth in marginalized communities;
- Demystify misconceptions surrounding the use of reproductive health services and products;
- Address harmful traditional beliefs and practices that affect reproductive health such as female genital mutilation, child marriage and gender-based violence.

Strategy and implementation

1. Map the districts with a participatory process.
One of the first steps was to identify the women and girls most in need and select locations where they could gain access to information and services. Mapping was carried out by the UNFPA implementing partners in collaboration with Ministry of Health (MOH) personnel from each of Somalia's three zones, supported by a process with UNFPA of discussion with resource persons from local communities. This participatory process led to agreement on the project's implementation and helped to identify key actors. The MOH, UNFPA and community leaders jointly selected the community health workers and health facilities for the implementation phase. The Population Estimation Survey for Somalia conducted by UNFPA in 2014 was used as reference to identify hard-to-reach populations, such as nomads and other population groups living far from established health facilities.

From a pilot phase in three districts, the project was scaled up to nine districts, spread equally across three zones.

2. Build capacity in the MOH and implementing partners.
The programme trains, equips and motivates MOH and NGO personnel from the nine focus districts, building capacity for the provision of integrated reproductive health services. This is followed by practicum experience offered during community outreach events (described below) to ensure proficiency and quality in the delivery of these services, and especially provision of youth-friendly services.

3. Provide training for service providers, e.g. community health workers and community health extension workers.
With support from UNFPA, implementing partners conduct training for service providers in nine districts to improve the delivery of community reproductive health packages. This work includes a number of related actions:

- Carry out reproductive health awareness-raising to help households including women and young girls to take control of their own reproductive health;
- Empower community members to take responsibility for their lives, and to promote demand, accountability and utilization

of maternal health, family planning and other sexual and reproductive health services;

- Using evidence-based advocacy, promote dialogue leading to action to improve sexual and reproductive health interventions, and identify the priorities of households and communities to be responsive and to gain their support;

- Help communities (especially their women and young girls) to seek prompt care for reproductive health problems and to avoid common delays in seeking life-saving emergency obstetric care;

- Provide communities with rights-based education to raise awareness and understanding of women's rights, i.e. empower communities to participate in decision-making and invest community resources in maternal health and protection against gender-based violence, female genital mutilation (FGM), early marriage, early pregnancy, etc.;

- Facilitate improvement of the declining reproductive health indicators in Somalia, especially by promoting birth spacing, access to family planning and skilled birth attendance with backup emergency obstetric care, girl child education and women's empowerment.

4. Accelerate demand creation for reproductive health services and products.

The trained community health workers carry out a variety of activities for the month prior to the next visit by the mobile team or 'community reproductive health camp'. Health education sessions are offered to women's groups, religious leaders and youth groups; through mass media campaigns on radio and television; and via public address systems. Community health workers also conduct house-to-house visits for discussions with family members, and provide opportunities for one-on-one interaction. In these health education sessions, key community resource persons learn about the benefits of the community reproductive health packages, including birth spacing in the legacy of Islam, as well as the harm caused by traditional practices such as FGM and early marriage.

5. Implement monthly outreach events or 'community reproductive health camps' in each district.
Community reproductive health camps take place once a month in each of the nine focus districts. They are carried out by selected implementing partners in collaboration with the MOH. Health posts and/or basic obstetric and neonatal care facilities are used for the camps depending on availability. During each event, five main community reproductive health packages are implemented:

- Family planning: Family planning promotion is integrated with delivery of counselling on a choice of methods, services and supplies;
- Antenatal care. This includes complete physical examination of the mother and her foetus, systematic screening for syphilis, urine analysis and haemoglobin, as well as establishment of delivery plan including referrals when appropriate;
- Obstetric fistula: Identification and referral of obstetric fistula cases for surgical management and social re-integration into the community;
- Screening: Screening looks for gynaecological cancers (breast and cervical cancer), HIV and other sexually transmitted infections, and is accompanied by laboratory testing and counselling;
- Health education messages: Outreach and education to the community continues during the community RH camp, with health workers going tent to tent, or addressing girls and women while they wait for services, or holding public discussions. Topics may include nutrition, breastfeeding, family planning, birth spacing, FGM, early marriage, early pregnancy, gender-based violence, girl child education, etc.

6. Monitor and evaluate the project.
Internationally-recognized and approved guidelines and protocols for reproductive health service delivery are used to ensure quality. Appropriate data-collection tools for health information management system have been put in place. A project quality assurance team is charged with enhancing monitoring and evaluation as well as capturing the lessons learned. This work is supported by UNFPA.

Progress and results

The project was launched in December 2014 in three districts, one in each of Somalia's three zones. During this pilot phase, it delivered reproductive health services including family planning to 8,000 women of reproductive age (15 to 49 years), including 1,600 adolescent girls aged 15 to 19. Most of the girls were already mothers. It was soon scaled up. By the third quarter of 2015, this project had reached 24,000 women of reproductive age, among them 4,800 adolescent girls aged 15 to 19.

The project now serves nine districts, three in each of Somalia's three zones. It reaches underserved and marginalized populations including internally displaced populations, nomadic populations and hard-to-reach populations. Women and men from the targeted districts continue to change their reproductive health-seeking behaviours due to information acquired on reproductive health issues, with a high number of women and young people attending the outreach events and subsequently seeking reproductive health services at the community reproductive health camps.

This project has equipped and sustained a team of competent service providers as well as community health workers with the requisite knowledge, attitude and practice. It has also fostered resource persons from local communities. The project is having a measurable, positive impact:

- 24,000 women of reproductive age, among them 4,800 girls aged 15 to 19, have received information and/or services to improve their sexual and reproductive health;
- 140,560 male and female adolescents and youth have attended health education sessions, not only gaining knowledge but increasing the involvement of men in reproductive health;
- 2,482 women and young married couples have started using modern family planning methods of their own choice.
- 1,669 young people have voluntarily decided to undergo HIV/AIDS confidential counselling and testing;

- 699 young people who participated in the monthly outreach events have agreed to take advantage of services to prevent and address sexually transmitted infections;

- 2,562 mothers aged 15 to 19 as well as 4,550 mothers over 20 have received antenatal and postnatal care services, a notable increase in the uptake of services.

Based on such results, this project is expected to translate into increased demand and utilization of improved quality reproductive health services, leading to reduction of maternal and neonatal mortality and morbidity rates in Somalia.

Lessons learned

Collaboration through a participatory process involving key stakeholders from the start contributes to ownership of the project and to its sustainability. Culturally sensitive approaches are necessary to reach and engage the hard to reach and the most conservative actors. The hard-to-reach actors here are the most vulnerable groups isolated by traditional and cultural barriers. Developing resource persons from the local community is an effective way to reach these groups, as are channels for reaching large numbers of people, from meetings with key groups to presentations over public address systems.

Working through national partners and prominent allies (i.e. governors, mayors, health directors, youth and women's groups) at the community level helped establish effective, proactive engagement with religious and traditional clan leaders. Advocacy based on evidence was essential. Common ground with religious and clan leaders was forged by relying on the concept of family planning in the legacy of Islam, while concepts of gender, gender-based violence and sexual and reproductive health were harmonized with culturally sensitive messages.

Culturally sensitive approaches are necessary to reach and engage the hard to reach and the most conservative actors.

Conclusion and recommendations

- This project is scalable, replicable and sustainable in every aspect, and should be scaled up to more districts in Somalia to ensure equity in the distribution of reproductive health services to women and young girls;
- Additional reproductive health packages such as cervical cancer screening and mammography should be included in this project;
- Reproductive health service providers should be trained on cervical cancer screening and cryotherapy;
- More reproductive health equipment should be purchased to offer expanded reproductive health services;
- Mobile services should be added to bring reproductive health services within reach of more nomadic populations, which requires training of mobile service delivery teams as well as the procurement of vehicles.

Partners

Ministries of Health from the three zones: Somaliland MOH, Puntland MOH and Federal Government of Somalia MOH
Health Poverty Action
Human Development Concern (HDC)
Somaliland Family Health Association (SOFHA)

More Information

UNFPA Somalia Country Office
Website: http://somalia.unfpa.org

Acknowledgements

Nikolai Botev, UNFPA Representative

7 ENGAGEMENT AND PARTICIPATION OF ADOLESCENTS AND YOUTH PHILIPPINES

Tropical storm Washi sets the stage engagement and participation of adolescents and youth in humanitarian response

Summary

Young people proved to be valuable partners as first responders and outreach volunteers in the humanitarian response to one of the Philippine's many natural disasters – tropical storm Washi. In this and future emergencies, including Super Typhoon Haiyan, UNFPA developed and implemented the Adolescent Sexual and Reproductive Health in Emergencies (ASRHiE) strategy. The Washi response in 2011 introduced the concept of engagement and participation of young people as active partners in, not passive recipients of, UNFPA humanitarian response. Trained youth volunteers conducted communication sessions to raise awareness of peers in evacuation camps and disaster-affected communities, and to communicate and provide health information to pregnant women. They also distributed hygiene kits, gathered data and set up Women-Friendly Spaces – later introducing Youth-Friendly Spaces – all of which informed the response strategy used in the Philippines today.

The Washi response in 2011 introduced the concept of engagement and participation of young people as active partners in, not passive recipients of, UNFPA humanitarian response.

Youth volunteers interviewed displaced young people in an evacuation centre in Cagayan de Oro City to assess the impact of tropical storm Washi in 2011.

Humanitarian situation

An archipelago of 7,107 islands, the Philippines is situated in the Pacific Ring of Fire, making it highly vulnerable to various natural hazards such as typhoons, floods, landslides, earthquakes and volcanic eruptions. In some areas such as Mindanao, the situation is aggravated by man-made conflicts. In 2013 alone, 16 disasters hit the country including the Super Typhoon Haiyan, which displaced 14.1 million people, killed more than 6,000 and injured some 28,000 people.

Such natural disasters result in extensive damage to properties and livelihood, exacerbating poverty. Loss of employment opportunities contributes to an increase in the number of people, particularly young women, engaged in sex work as a coping mechanism. The functioning of social services breaks down as government infrastructures, including health facilities, are destroyed. Access to information and services for sexual and reproductive health, including the provision of condoms for HIV prevention and anti-retroviral drugs for people living with HIV and AIDS, becomes a huge challenge. Gender-based violence also becomes a major area of concern. Increased alcohol consumption and other forms of substance abuse in the aftermath of emergencies has a direct influence on young people's attitudes, which exacerbates the risks and vulnerabilities they face.

In the early hours of 17 December 2011, tropical storm Washi triggered flash floods that caused some 1,200 fatalities, and displaced more than half a million people across six regions in the southern Philippines. The UNFPA-supported humanitarian response to Washi demonstrated strong support to young people affected by disaster. At the UNFPA Country Office in the Philippines, the Adolescent Sexual and Reproductive Health in Emergencies (ASRHiE) strategy set the standards by which such interventions would be measured in subsequent emergencies: the response improved preparedness planning.

Increased alcohol consumption and other forms of substance abuse in the aftermath of emergencies has a direct influence on young people's attitudes, which exacerbates the risks and vulnerabilities they face.

Considering the massive scale of the disaster caused by severe tropical storm Washi, there was an immediate need to mobilize human resources to support the UNFPA response, which focused on protecting adolescents and youth and protecting maternal health. As in any crisis,

the protective mechanisms and structures normally provided by family and community were severely disrupted. UNFPA sought to ensure that young people would not be marginalized nor their needs neglected – as too often occurs in humanitarian situations, despite their evident vulnerability.

Objectives

Common objectives of UNFPA humanitarian response for adolescents and youth, building on the Washi experience, include the following:

- Ensure delivery of high-quality sexual and reproductive health information and services for adolescents and youth in the emergency situation;
- Strengthen capacity of health service personnel to provide reproductive health information and services to young people, particularly in geographically isolated and disadvantaged areas;
- Ensure inclusion of programming for adolescent sexual and reproductive health (ASRH) before, during and after emergencies;
- Build the capacity of young people to demand and access to ASRH information and services;
- Establish Youth-Friendly Spaces (YFS) in emergencies in consultation with young people;
- Encourage youth participation in the design and implementation of humanitarian response plans focusing on young people;
- Advocate for the incorporation of ASRH in the local implementation of the Minimum Initial Service Package (MISP) for reproductive health.

The youth engagement model adopted in the response to tropical storm Washi provided substantial inputs for the eventual development of the ASRHiE module, a process supported by UNFPA HQ and Save the Children. This model became the template in succeeding humanitarian responses supported by UNFPA in the Philippines. It has also evolved. The concept of Youth-Friendly Spaces, for example, was introduced by youth volunteers who also served as first responders during the Super Typhoon Haiyan response in 2013-2014. Through a series of consultations with young people who have supported emergency responses, the Youth-Friendly Spaces concept has been further developed as part of emergency preparedness and prepositioning.

Strategy and implementation

The Washi response in 2011 positioned young people as active partners in – not just passive recipients of – humanitarian response. Their contributions inspired the introduction of youth engagement and participation in UNFPA humanitarian programming.

When tropical storm Washi struck, the Y-PEER youth network initiated a call for volunteers over social media, specifically the personal Facebook and Twitter accounts of peer educators. Many volunteers were themselves survivors of the disaster. During the acute phase of the disaster, the youth volunteers gathered data on pregnant and lactating women and adolescent girls in evacuation centres. The information served as the basis for reproductive health medical missions.

Youth volunteers participated in training to build their capacity to conduct awareness-raising sessions on ASRH with disaster-affected young people living in evacuation camps and communities, and to conduct health information sessions on reproductive health topics (e.g. safe motherhood, family planning, sexually transmitted infections and gender-based violence). Training included peer education, community organizing, MISP orientation, data gathering, how to conduct information sessions with pregnant and lactating women and other women and girls of reproductive age on SRH subjects, and an orientation on ASRH in emergencies (ASRHiE).

The humanitarian response depended heavily on the support of the youth volunteers to carry out a number of activities:

Conduct awareness-raising and health information sessions: These sessions were conducted to enhance the knowledge of disaster-affected populations on reproductive health issues and encourage them to access available RH services during and beyond the crisis. The trained youth volunteers facilitated these sessions specifically targeting key affected populations: 1) pregnant and lactating women, to encourage them to utilize pre- and postnatal services during RH medical missions; 2) women and girls of reproductive age for GBV concerns; and 3) young people for the peer education sessions.

Distribute dignity kits and teen kits: Youth volunteers from different cities and municipalities were mobilized to distribute several kinds of ready-made kits:

- Youth distributed dignity kits and conducted health information sessions to accelerate delivery of assistance to affected populations. The dignity kits, in practice, became an effective entry point to engage women and girls on the discussion of reproductive health and gender-based violence issues;

- In consultation with the youth volunteers/first responders, UNFPA packaged a hygiene kit specifically addressing the hygiene needs of girls and boys affected by the disaster. The kits were distributed after peer education/ASRH awareness-raising sessions with the young people.

Set up Women-Friendly Spaces: These safe spaces became the venue for more effective and comprehensive health information sessions after the initial phase of the emergency.

Engage celebrity advocates: UNFPA facilitated visits by celebrities championing ASRH to the affected areas to generate greater interest and discussion on the issues faced by young people in emergencies.

Design peer education sessions with young people and develop IEC materials: These materials were developed to equip the youth

volunteers when carrying out peer education and health information sessions. The products ranged from posters to functional information materials such as fans, shirts and bags.

Support updating of the humanitarian response database: UNFPA was the only humanitarian agency during the disaster that deployed youth volunteers/first responders for rapid data gathering. In the absence of data specifically on pregnant and lactating women and young people, other humanitarian agencies relied on information gathered by the youth volunteers/first responders for their response planning.

Also, UNFPA provided **emergency reproductive health kits**. ERH kits were provided to health facilities to enable them to respond to increased demand for services and supplies resulting from demand generation activities conducted by the youth volunteers and other partners.

Progress and results

For the response to tropical storm Washi, UNFPA delivered results through the following activities:

- Carried out 115 reproductive health medical missions;
- Distributed dignity and hygiene kits to 18,434 women and adolescent girls;
- Distributed teen hygiene kits to 2,494 adolescents and youth;
- Served a total of 20,944 (19,874 of which are female) internally displaced persons, including adolescent girls;
- Provided health services to 3,000 pregnant women, 2,362 lactating women and 3,396 family planning users, including adolescent girls;
- Trained 30 youth volunteers on ASRH and peer education methodologies, in a joint effort of UNFPA and the National

Through the work of the youth volunteers, awareness on the importance of RH and GBV interventions in the emergency improved among women and girls reached by the services.

Youth Commission. The youth volunteers reached 1,967 pregnant and lactating adolescent girls and young women up to age 24 and provided an additional 2,000 young people with teen kits, for a total of 3,967 young people served.

Local health offices in the affected areas soon started to recognize the capacity of the youth volunteers/first responders and tapped into the capacity of the young people to conduct peer education sessions and training for displaced youth. The volunteers/first responders were also engaged in providing Community Health Trainings on ASRH.

Through the work of the youth volunteers, awareness on the importance of RH and GBV interventions in the emergency improved among women and girls reached by the services.

Young people, who were otherwise idle as a result of school disruption, also actively participated in peer education and ASRH sessions. Some of them, after attending the sessions, expressed interest in further training to become peer educators themselves.

Over the years, the investment that UNFPA has provided for ASRHiE has not only enabled focused-response to the ASRH needs of young people in emergencies but has reaped the added benefit of moulding some of the current and future reproductive health and GBV champions in the Philippines.

Lessons learned

Addressing the special needs and vulnerabilities of young people during emergencies must be factored in to any crises response to ensure that their sexual and reproductive health and protection needs are addressed. Support for continuous capacity development for youth volunteers in emergencies maximizes their full capacities in responding to humanitarian crisis. This includes developing new generations of potential volunteers and first responders for future emergencies to ensure that we have a stable of trained volunteers ready to be deployed

any time. Recognizing and developing the potential of young people to be first responders and support humanitarian response is an effective strategy that can reap great results. It is important to sustain advocacy with humanitarian partners the value of youth involvement both in emergency preparedness and response. Also, more specifically, dignity kits for pregnant and lactating women and teen hygiene kits for young people are effective entry points and creates an incentive to increase attendance and participation in health information sessions.

One **implementation issue** may affect cost. While the volunteers/first responders were not paid for the work they rendered, UNFPA reimbursed out-of-pocket expenses including transportation, communication and meals during missions. This, therefore, has some implication on the budget for the response, depending on how many volunteers/first responders are engaged. Another issue is that in some RH medical missions, the number of pregnant and lactating women being served can sometimes overwhelm the volunteers. The venue and environment for the health information sessions can also have an impact on how effectively they can handle the sessions. Chaotic and noisy evacuation centres with many distractions are not conducive to an effective session.

Regarding **replicability**, the youth volunteerism and first responder model developed in the Washi response has become a standard component in UNFPA Philippines' humanitarian action. The same approach was adopted in the response for Typhoon Pablo in 2012, and the triple whammy that hit the Philippines in 2013 – the Zamboanga armed conflict, the magnitude 7.2 earthquake in Bohol Province, and Super Typhoon Haiyan.

Support for continuous capacity development for youth volunteers in emergencies maximizes their full capacities in responding to humanitarian crisis.

In the Haiyan response in 2014, the ASRH intervention introduced Youth-Friendly Spaces (YFS), which provided a venue for peer education, as well as for other activities for young people displaced by the disaster. The age-appropriate information sessions covered the following modules: Understanding Adolescence; Teen's Sexuality and RH Concerns; Orientation on Youth Peer Education; Sex, Gender and Sexuality; Peer Helping; and Organizing and Designing Youth Peer Education Sessions. This was a step in the right direction as youth sessions conducted in previous emergencies were done in evacuation

centres or in any available space in the community. Having a youth-friendly space ensures regularity of activities for young people.

An innovation was introduced in the peer education session for young people through the addition of the U4U teen trail, an interactive learning session on ASRH implemented by the Commission on Population that can be further developed to better fit humanitarian contexts. Youth volunteers tapped for the Washi humanitarian response and the other disasters that followed came from the same communities affected by the crises. This is a key factor in the **sustainability of the model** – they are familiar with the local context and language, they can easily reach out to their peers, and they have the passion to help the community in which they belong. In the Haiyan response, the Protection Cluster requested joint activities with peer educators in their camp visits and an ASRH Working Group was included in the Humanitarian Consortium. This, in effect, supported efforts to mainstream ASRH response in the emergency.

A review of the comprehensive ASRHiE package is being conducted in consultation with young people to identify prepositioning requirements and possible updating of the ASRHiE module to ensure that ASRH will continue to be strategic and effective in future emergencies. The module will soon be included in the localized MISP package of the Department of Health in the Philippines.

Conclusion and recommendations

Young people show a high level of interest in being engaged in humanitarian response to emergencies, as shown by the experience with youth volunteers in the Washi response. Involvement of young people in humanitarian responses solidifies their appreciation of and commitment to ASRH, and experience shows that many youth volunteers later become more active ASRH advocates after the response and become involved in the mainstream RH and GBV programming initiatives of their communities.

The youth engagement strategy has proven that young people affected by disasters are more than passive recipients of assistance in times of emergencies: they can do more. The youth volunteerism and first responders model developed from the Washi response has demonstrated the importance of youth participation in the design and implementation of programmes targeting young people, which is a global UNFPA priority.

Partners

UNFPA has leveraged existing and new partnerships in emergency preparedness and humanitarian programming. Over the years, these partner have included the Family Planning Organization of the Philippines (FPOP is a national NGO affiliated with the International Planned Parenthood Federation), Y-PEER Pilipinas, Philippine Obstetrical and Gynecological Society, Integrated Midwives Association of the Philippines, the Department of Health (national, regional, provincial, and local levels), among many others. Youth volunteers have been mobilized through FPOP and the Y-PEER network.

More Information

UNFPA Philippines website
http://www.unfpa.org.ph/

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Distribution of supplies, like these dignity kits for pregnant and lactating women, was one of many tasks carried out by young volunteers in the humanitarian response to tropical storm Washi.

Delivering a world where every pregnancy is wanted every childbirth is safe and every young person's potential is fulfilled

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