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Technical Brief on Comprehensive Sexuality Education for Adolescents in Protracted Humanitarian Settings

Introduction

Adolescence is a unique stage in life characterized by the transition between childhood and adulthood. Young people between the ages of 10 and 19[a] face rapid and complex physical, cognitive, and psychological changes.[1] Living through adolescence is not a homogenous experience; it is greatly influenced by cultural, socio-economic, and religious norms, also heavily influenced by digital media.

During puberty, adolescents experience hormonal shifts that affect their physical growth, and they go through psychological changes. Adolescents also start to discover their sexual identity, sexual orientation, and gender roles. They begin to move from exploring their own sexuality to experimenting with sexual relationships. This evolution is heavily influenced by their intersectional identities around gender, age, race, wealth, ability, status and sexual orientation.[2] This requires transformative approaches that enable adolescents to overcome barriers and feel safe with their identities.

Talking about sexuality and sexual relationships in many societies is a common cultural taboo, and engaging adolescents on this topic is considered unacceptable. However, adolescence is a pivotal time to address issues pertaining to sexual and reproductive health (SRH).[b] Comprehensive sexuality education (CSE) helps them understand their bodies, empowers them with knowledge to make well-informed decisions and ultimately experience positive health outcomes.

Purpose of the Technical Brief

IPPF envisions a world where "all people are free to make choices about their sexuality and well-being in a world without discrimination." One of the priority objectives in IPPF's current Strategic Framework[C] is to "enable young people to access comprehensive sexuality education and realize their sexual rights." Member Associations (MAs) are committed to reaching all adolescents with rights-based and contextually-relevant CSE to realize their sexual rights. In line with the IPPF Humanitarian Strategy 2018–2022,[d] we present promising practices to guide IPPF Member Associations and partners in the provision of CSE, specifically when operating in protracted humanitarian crisis environments and call the humanitarian community to action to recognize and adolescent sexual and reproductive health (ASRH) needs and rights in emergency response programming.

Intended Audience

The brief is intended for agencies implementing programmes for adolescents, including youth organizations, local and international NGOs, and community-based organizations. The goal is to inform their strategy, programme design, programme implementation, and advocacy of ASRH and CSE in protracted humanitarian emergencies. It is also intended to serve as

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[a] The World Health Organization (WHO) defines adolescents to be between 10–19 years; youth as 15–24 years; and young people's age ranges from 10–24. World Health Organization (WHO) Adolescent Health. Available from: https://www.who.int/southeastasia/health-topics/adolescent-health

[b] An integrated definition of Sexual and Reproductive Health and Rights (SRHR) is the "state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right." Guttmacher Institute. Accelerate Progress: Sexual and Reproductive Health and Rights for All. Available from: https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary

[c] I International Planned Parenthood Federation (IPPF) (2016) Strategic Framework 2016-2022. Available from: https://www.ippf.org/sites/default/files/ippf_strategicframework.pdf

[d] International Planned Parenthood Federation (IPPF) (2018) Humanitarian Strategy 2018-2022: Strengthening IPPF's SRH service delivery in humanitarian settings and championing rights. Available from: IPPF - Humanitarian Strategy 2018_FINAL.pdf

an advocacy tool for the wider humanitarian community to advocate, coordinate, and mobilize resources for ASRH in emergencies.

SECTION 1 YOUNG PEOPLE IN HUMANITARIAN EMERGENCIES AND THEIR CSE NEEDS

Despite the numerous challenges and risks that young people[e] face in humanitarian settings, they are often resilient and resourceful. It is essential when designing and implementing humanitarian and ASRH programming to engage them as agents of change.

Engaging young people promotes their participation and encourages them to build effective communication, teamwork, and leadership skills. Most importantly, programmes designed by young people are best suited to meet their needs.

Young people should participate in assessments, community consultations and distribution of kits. They can provide valuable input on where services are accessible and where they are not, and where and how young people are exposed to violence. They should receive training on how to provide health information; conduct health education sessions; assist in camp registration processes of displaced persons; become facilitators in child-friendly and adolescent-friendly spaces; and serve as teaching assistants and nurse aides.

What is Adolescent Sexual and Reproductive Health?

Adolescent Sexual and Reproductive Health (ASRH) encompasses a rights-based and life-saving approach in the equitable provision of information and services. It promotes sexual diversity and well-being; gender equity and gender diversity; and maintaining a balance between autonomy and protecting[3] adolescents.

ASRH information refers to education and counselling on female and male puberty; menstrual hygiene; reproduction, pregnancy, contraception, and safe abortion; sexually transmitted infections (STIs) and HIV/AIDS; maternal health; gender equity and equality; mitigating gender-based discrimination, abuse, and violence; sexual diversity; and sexual and gender-based violence (SGBV). In line with the integrated definition of SRH, ASRH also promotes a positive approach to sexuality and reproduction.

The provision of ASRH services includes access to maternal and newborn care; a full range of contraceptive methods; prevention and treatment of STIs including HIV; comprehensive abortion care including post-abortion care; and prevention and management of sexual abuse and violence, including an integrated response to the needs of survivors. ASRH service provision should be guided by bodily autonomy, client-centredness, sexual rights and wellbeing as well as choice and agency.[4]

Globally, the SRH needs of young people remain unmet because of barriers largely imposed by cultural, social, religious, and pre-conceived notions of parents, teachers, health workers, communities, and adolescents themselves. This restricts young people from receiving essential information and services to protect their bodies and empower their minds. Several countries also limit adolescent rights through restrictive policies. For example, they govern if and how CSE is taught in schools or they require adolescents to be accompanied by adults and/or to seek parental or spousal consent to access ASRH services.

Why is ASRH important?

There is an evident need for ASRH information and services and a recognition that they should be catered to the adolescent population, ages

[e] Adolescents are the primary focus of this statement. However, commitments are made towards young people as a whole and research and best practices demonstrate their abilities and needs across the life-cycle continuum of a young person. Therefore, the term 'young people' may be used interchangeably with adolescents in this statement.

10-19 in all its diversity. This diversity could be framed as based on gender (girls, boys, lesbian, gay, bisexual, transgender, intersex, queer, and other (LGBTIQ+) individuals) and based on the age group (very young adolescents ages 10-14 vs. older adolescents ages 15-19). These factors usually intersect with other identities and tend to expose adolescent to further vulnerability and a state of need as well as barriers to access services even when they are available.

For example, one of the main ASRH unmet needs of adolescent girls is related to access to contraception, SRH information and services including for HIV and STIs. According to the Guttmacher Institute (2019), approximately 27% of women in middle and low-income countries gave birth before the age of 18. This means an estimated 12 million girls gave birth to children while still adolescents themselves; approximately 780,000 became mothers before age 15. Yet 14 million adolescent girls ages 15–19 are not using modern contraceptive methods out of the 32 million adolescent girls who wanted to avoid pregnancy.[5]

Pregnant adolescent girls face high risks of obstetric complications such as eclampsia, puerperal endometritis, and systemic infections contributing to a higher risk of maternal and neonatal mortality and morbidity.[6] Yet, adolescent girls, particularly those who are not married, have limited access to contraception due to a variety of barriers related to marital status, age and parental consent to access SRH services, in addition to service provider stigma and bias. In sub-Saharan Africa – where HIV infection rates are the highest in the world – 80% of infections occur among girls between the ages of 15 and 19. And, adolescent girls are twice as likely to be living with HIV than adolescent boys of the same age.[7]

Sexual and gender-based violence (SGBV) is one of the main risks that adolescents in all their diversity are more prone to experience during their lifetime.

Adolescent girls often face higher levels of sexual and gender-based violence (SGBV), including child, early, and forced marriage (CEFM); harmful traditional practices such as female genital mutilation (FGM); sexual harassment; and sexual abuse. They are also more likely to be targeted for transactional sex.

Adolescent boys are also vulnerable to SGBV, and can experience sexual exploitation and abuse. In addition, due to attitudes around gender and masculinity, their abuse tends to be silenced, which means they are less likely to seek services or legal protection. Increasingly evidence suggests that LGBTIQ+ individuals with diverse sexual orientation, gender identity or expression, and sex characteristics are usually targeted with sexual violence and abuse especially in situations of conflict, flight, and displacement.[9] Circumstances and needs may vary considerably by gender, sexuality, and other factors.[f]

Social taboos notably prevent Very Young Adolescents (VYAs), ages 10–14, from accessing information as they start experiencing puberty, exploring their sexuality, and developing their gender identity. Additionally, they are often targeted for sexual exploitation, including transactional sex.

Who are the High-Risk Adolescents?

Homophobia and transphobia are rampant in many cultures, and adolescents with diverse sexual orientations, gender identities, expressions, and sex characteristics face multiple taboos and risks.

[f] Guidance on addressing the needs of Male Survivors of Sexual Violence in humanitarian settings can be found at: https://gbvaor.net/sites/default/files/2021-09/Guidance%20Note%20Male%20Survivors_FINAL29.9.21.pdf

Other vulnerable groups include adolescents with disabilities; out-of-school adolescents or those engaged in forced labour; adolescent girls at risk of early and forced marriage and unions (CEFMU); adolescents from ethnic or other minority groups; heads of households facing humanitarian situations; and migrant refugees. These groups risk compromised health outcomes, combined with restricted access to life-saving information and services and restrictive social norms.

What is Comprehensive Sexuality Education (CSE)

At IPPF, CSE is understood as a "holistic, developmental and age appropriate, culturally and contextually relevant and scientifically accurate learning process grounded in a vision of human rights, gender equality, sex positivity and citizenship."[10]

CSE emphasizes participatory teaching approaches to personalize information, strengthen communication and decision-making skills, and empower young people to be agents of change. An evaluation on current CSE trends and practices[11] concluded that CSE programmes emphasizing gender, power, and rights through "an empowerment approach to CSE," especially for girls and marginalized young people, improved their recognition of themselves as equal partners in relationships and protection of their bodies. Such approaches were found to be more likely to reduce STIs and unintended pregnancy.

CSE is typically implemented by integrating into formal education and school curriculums. However, adolescents who are out of school also have a **right** to ASRH information and services and are more vulnerable to misinformation and exploitation. CSE sessions for out-of-school adolescents can be held in a variety of settings, ideally identified by the adolescents themselves and scheduled at convenient times and places. UNFPA recently published the *International Technical and Programmatic Guidance on Out-of-School Comprehensive Sexuality Education*[12] to specifically address this need.

> "A comprehensive sexuality education curriculum is very important for all aspects of life, and therefore the program must be developed in line with Palestinian culture." 19-year-old Palestinian adolescent girl interviewed for this brief

CSE and health information sessions differ in that the sessions focus on providing facts on SRHR topics and promoting access to services in the community. They often reflect 'one-way' communication where the facilitator provides information to adolescents.

CSE, on the other hand, is a process with clear learning objectives, delivered over time, using a specific methodology informed by evidence and adapted to the local context. It is designed to measure and address beliefs, values, attitudes, and skills, which can increase adolescents' ability to care for themselves and others in the realm of intimacy and sexuality. It supports lasting and generational changes in knowledge, attitudes, and values.[13, 14]

CSE must be culturally relevant and appropriate to the context and it may include the following characteristics:

- scientifically accurate
- incremental
- age and developmentally appropriate
- curriculum based
- based on a human rights approach
- conscious about the intersecting barriers that face young people
- inclusive of all diverse individuals
- based on gender equality
- develops life skills needed to support healthy choices

Understanding Humanitarian Emergencies

> "A humanitarian crisis is a situation in which human suffering is at a high level. The basics of human well-being are in danger." 15-year-old Indonesian adolescent girl interviewed for this brief

A humanitarian emergency occurs when the human, physical, economic, or environmental damage from an event, or series of events, overwhelms a community's capacity.[15] The event can occur naturally or be man-made, and it can also result from the combination of man-made and environmental disasters. The onset of an emergency can be sudden or gradual.

Protracted crises are environments in which a significant proportion of the population is acutely vulnerable to death, disease, and disruption of livelihoods over a prolonged period. In protracted crises, individuals might: 1) remain in their community; 2) flee their homes to other places within the same country; or 3) cross international borders and become refugees. A protracted setting may reflect some level of constancy or predictability. There may also be sudden spikes of conflict, displacement, and destabilization that significantly affect people's lives.

This brief focuses on protracted crisis settings that range from countries experiencing decades of conflict and displacement such as Palestine, Afghanistan, and the Democratic Republic of Congo (DRC) to long-term refugee hosting countries such as Lebanon, Jordan, Turkey, Colombia, Uganda and Kenya. Refugees may reside in camps or non-camp settings within host communities.

ASRH in Humanitarian Emergencies

ASRH is a critical health issue in humanitarian crises, and adolescents are often over-looked as a vulnerable group. However, there are critical life-saving services for adolescents living in humanitarian emergencies. These include preventing adolescent pregnancy, unsafe abortion, and adolescent maternal mortality; providing services for adolescent survivors of GBV; and providing information and protection in preventing HIV and other STIs.

The risks adolescents face are compounded in a time of crisis. There is a breakdown in their protective and nurturing structures: their families, communities, schools, recreational outlets, and places of worship. They may face family separation and be exposed to violence, forced recruitment, sexual abuse, and exploitation. They may also be compelled to take on adult roles that they are ill-prepared for and are coerced into engaging in risky behaviours to survive, cope, or care for their families. As a result, the emotional and psycho-social impacts of adolescents living in a humanitarian crisis are immense.

> "I think I am affected by a humanitarian crisis, it also affects us by climate changes, climate change is a new word for me and of the crisis or disasters is COVID-19 which made me scared and worry for my future." 13-year-old Kiribati adolescent boy interviewed for this brief

It is important to strengthen ASRH services and responses during all stages of humanitarian actions. CSE should be better promoted in protracted emergencies. During these crises, children become adolescents, and adolescents become adults as the humanitarian situation continues for decades. Some may not know another way of life. Uncertainty looms over their lives and impacts their physical and mental health, education, economic, and social-behavioural

outcomes. As a result, it is important to use a well-tested methodology and pedagogy – such as the one included in CSE – to approach their information and learning needs regarding sexuality, health, well-being, and relationships.

SECTION 2 PROMISING PRACTICES OF CSE AND ASRH EDUCATION IN PROTRACTED HUMANITARIAN SETTINGS

Depending on the context, programming for protracted crisis settings may mirror long-term development programming in a low-income country. That is, where individuals may have lived for decades in displacement faced with poor infrastructure and limited access to basic services such as housing, food, education, and health for their communities.

The IPPF Member Association in Palestine – the Palestinian Family Planning and Protection Association (PFPPA) – introduced CSE by contextualizing the *It's All One*[16] curriculum in 2012. Peer educators conducted community outreach sessions in Hebron and in refugee camps in the West Bank and the Gaza Strip as well as within schools, youth centres, and women's centres. In Lebanon, the Lebanese Association for Family Health (SALAMA) trained Syrian refugee peer educators, mainly reaching Syrian refugee adolescents and youth but also young people form the host community. At the height of the COVID-19 pandemic[17] when movement was severely restricted, PFPPA engaged 70 peer educators to conduct over 280 digital sexuality education sessions in the West Bank and Gaza via Zoom and WhatsApp. SALAMA made videos with and for young people that were posted on Facebook to be viewed when they had time and privacy; these were well received by Syrian refugees.

PFPPA and SALAMA both stated that implementing the outreach model was effective among young people, especially among those with no consistent access to school and those who were marginalized due to gender, disability, and poverty. They found that young people also know where to find other young people outside of formal education structures. As a result, peer communication is easier and there is a deeper level of trust and relatability.

Both Member Associations reported that it is hard to capture conversations and lessons that happen outside a structured CSE or ASRH session. Once young people identify their peers as trusted messengers of information, the formal sessions organically evolve into personal conversations, interactions through social media, and assistance to seek ASRH services. This approach was specifically successful among young people between the ages of 15 and 24.

> "Those topics (referring to CSE topics) were useful but limited, because the teachers might feel that these topics were not suitable for us considering of our age, we can feel the awkwardness." 13-year-old Filipino adolescent girl interviewed for this brief

In Colombia, armed conflict has lasted for more than 50 years and caused widespread displacement. For more than 20 years, Profamilia has been implementing CSE programmes for displaced young people. The organization combined the *It's All One* curriculum together with UNFPA's *Operational Guidance for CSE: a focus on human rights and gender.*[18] Recently, Profamilia also incorporated UNESCO's *International Technical Guidance on Sexuality Education.*[19] The CSE modules are between 20–80 hours in length, depending on the context and the location (schools, temporary shelters, sports centres, cultural centres, etc.). The development and updates to this contextually-designed curriculum demonstrates the ability to implement actions in a protracted setting; the crisis sometimes involves periods of relative

'stability' that facilitate the such programme implementation. At the same time, consultations with young people and outreach to marginalized groups were also possible because the affected population became aware of informal community structures and coordination mechanisms within their existing environment.

In 2013, Save the Children and the Women's Refugee Commission in Goma, DRC[20] trained peer educators on the *My Changing Body: Fertility Awareness for Young People*[21] curriculum, specifically targeting VYAs ages 12–14 through in-school peer education. They also designed a separate curriculum for pregnant adolescents and adolescent mothers run at a health facility.

While it was a short, pilot project, the findings shared valuable lessons on implementing CSE in protracted, insecure humanitarian settings. Due to a fluctuating security situation, schools were damaged and closed and when schools re-opened, students had a rigorous schedule to make-up for lost time. Both teachers and students also had to physically restore their own schools, restricting the time adolescents had for any other activities which affected the number of in-school CSE sessions that could be conducted. In many contexts, parents and teachers are unaware of participatory methods that involve young people in community solutions and education outcomes. Building knowledge and acceptance among gatekeepers is a gradual process, which the programme design must keep in mind.

Finally, increased knowledge and improved attitudes must be supported by essential supplies and services. Several female peer educators, for example, revealed that while they raised awareness on menstrual hygiene, they still faced a lack of menstrual hygiene products, inadequate toilet facilities, and inadequate waste disposal methods that forced them and their female peers to miss school during their menstruation. To address this, Save the Children facilitated setting up Menstrual Hygiene Committees at schools, consisting of a female teacher and female peer educators to ensure supplies were available at latrines and directly to the girls when they needed supplies. Save the Children provided these committees with sanitary napkins, soap, laundry detergent, bins, and gloves for waste management. While this is not a sustainable solution, it points to a wider issue: implementing CSE without access to services ultimately compromises ASRH outcomes.

Given the risks faced by adolescent girls, there tends to be a greater effort to target female adolescents in CSE than their male counterparts. For example, the Adolescent Mothers Against ALL Odds (AMAL) Initiative[22] was designed by CARE to meet the needs of pregnant adolescents and first-time mothers affected by crisis while also addressing issues of gender, power, and social norms. The project was implemented in Syria and the evaluation found a reported 34% increase in self-esteem, confidence, ability to communicate on SRH matters, and health-seeking capacity. Qualitative findings reflected an increased acceptance of using contraception post-marriage.

In Cox's Bazar, Partners in Health and Development (PHD) – with support from the Women's Refugee Commission – implemented the Skilled Girl Force Project. They used the *I'm Here Approach,*[23] which is a set of steps and tools designed to help humanitarian actors identify, engage, and to be accountable to the most marginalized adolescents. Adolescent girls facing limited mobility and restrictions in leaving their house were identified and 300 girls were trained to implement the I'm Here Approach and provide CSE to the most-hard-to-reach girls. A key recommendation from this project was to include questions on mobility that identify related barriers and changes in access to programming from childhood to early adulthood, including specific screening questions to identify marginalized groups such as married adolescents.

The *Boys on the Move*[24] model developed by UNFPA and UNICEF is a life-skills programme for unaccompanied adolescent male migrants and

refugees. The objective is to create a safe space for boys and men to reflect on their experiences and develop coping and interpersonal skills in order to make informed decisions on their bodily autonomy, sex, sexuality and relationship.

All programmes were designed with common and essential criteria to promote change in ASRH behaviour as well as improve access and utilization of ASRH services. The common features that made interventions effective and successful are:

Meaningful and active participation of young people at every stage of the project cycle to ensure that programmes truly respond to their needs and context.
Involvement of caregivers, teachers, health workers, and the community to understand the risks faced by young people and the importance of ASRH; to remove barriers to access information and services; to build their confidence and skills in communicating with young people about ASRH issues; and to advocate on their behalf.
Linkages to services to ensure youth-responsive and gender-responsive health services are available for young people to receive ASRH services in a safe and non-judgemental environment.
Advocacy to shift norms and policies to enable young people to have unrestricted access to ASRH information and services

SECTION 3 ANALYSIS OF THE CURRENT LANDSCAPE OF CSE PROGRAMMING

Health and ASRH agencies increasingly recognize the importance of promoting ASRH programming in humanitarian settings. However, an urgent need remains: scaling up CSE programming in development settings which can be replicated in humanitarian emergencies, especially in a protracted response.

ASRH and Multi-Year Funding in Humanitarian Response

The project examples cited above engaged a holistic model to ASRH programming. Yet, most are short-term, donor-influenced projects rather than systematic programming modalities that can be brought to scale. ASRH continues to be 'project' driven and implemented through pilot projects. In 2013, the Women's Refugee Commission and Save the Children conducted a mapping exercise to determine the number of ASRH programmes implemented through humanitarian funding appeals. They found that proposals for ASRH programmes comprised less than 3.5% of all health proposals per year and the majority went unfunded.[25] The exercise also revealed that only 37 programmes between 2009–2013 focused on ASRH for 10–19-year-old adolescents.

Humanitarian funding cycles also tend to be short-term and ear-marked, which makes it difficult to measure long-term social improvements and lasting change in ASRH knowledge, attitudes, and behaviour of adolescents.[26] This results in high staff-turnover of teachers and health workers, and the constant need to re-prioritize ASRH to ensure health workers' commitment and skills in providing the full range of SRH services to adolescents.

Peer Education in Humanitarian Settings

The peer educator model remains a popular method of running CSE and health education sessions in most development and humanitarian programming. Peers trust each other and often rely on each other for information and counselling. Also, this is particularly suited for community-based and cost-effective programmes and provides strong benefits to peer educators themselves by improving their communication and leadership skills.[27]

The peer educator approach does however come with some limitations. A review on commonly accepted best practices for ASRH programming[28] revealed that while programmes succeed in information sharing, they have limited impact on promoting healthy behaviours and improving

health outcomes. Five meta-analyses showed that peer education programmes mainly benefit peer educators rather than the intended beneficiaries.

Programmes continue to favour older adolescents and youth to become peer educators. Yet, they still ignore the needs of Very Young Adolescents (VYA) and the need for ASRH awareness and prevention among this age group to create long-lasting change. Youth interviewed for this statement also indicated that they wished CSE was more systematically taught in schools and taught at younger ages.

Still, peer educators do contribute towards information sharing and young people interviewed for this statement were keen to learn from them and to become peer educators themselves. Integrating a well-managed peer education as part of a larger holistic ASRH programme package can therefore increase its effectiveness.

In 2013, UNFPA developed the Peer Education on Youth Sexual and Reproductive health in Humanitarian Settings: Training of Trainers Manual adapting the peer education approach to address the challenges faced in humanitarian settings. This manual offers sessions to be delivered over eight days and was pilot-tested in Hargeisa, Somalia, and the Choucha Camp in southern Tunisia. This resource can be adapted in protracted emergencies.

In protracted emergencies, peer educators can deliver key ASRH information in a variety of locations and mediums (i.e., physical and virtual). They can be trained to conduct outreach sessions to marginalized adolescents, such as those with limited mobility due to gender or disability or to adolescents unable to access formal spaces due to security restrictions and/or the breakdown of transportation infrastructure.

Linking CSE to ASRH Services

Awareness and knowledge can be affected by whether young people receive quick ASRH sessions or an intensive CSE curriculum. Ensuring the link to youth-centred services (accessing contraception and safe abortion care, STI testing, attending antenatal care visits, benefiting from facility-based deliveries, receiving GBV services, etc.) is however harder to implement in a consistent and comprehensive way, especially in a crisis setting. This remains a critical gap to reaching impactful change in ASRH outcomes. CSE interventions should be linked to provision of ASRH services, at the facility and community level. Furthermore, ASRH services must be embedded within the routine delivery of reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH+N) services. It is also important for trained youth-friendly health providers to consider ASRH part of an essential package of primary health services. Additionally, in a humanitarian context, funding for reproductive and maternal health services are less likely to be phased out compared to stand-alone ASRH programmes. This means that integrating ASRH into RMNCAH+N ensures the stability of service provision for adolescents.

Programming for Vulnerable Adolescents

Guidance and evidence are scarce on how to reach the many vulnerable adolescents, especially in crisis settings. Adolescent girls experience disproportionately high risks, compounded threats, and adverse health outcomes compared to other vulnerable adolescents. However, focusing ASRH programmes solely on adolescent girls might distract resources from accomplishing an all-inclusive model of ASRH programming. Adolescent girls are readily identified when determining vulnerable groups while other harder-to-reach, marginalized groups who require more

complex programming are not as easily identified. These groups include adolescents with disabilities, male adolescents experiencing SGBV, and LGBTQI adolescents among others. A programme's value therefore lies in seeking ways to enhance programming – including for adolescent boys and vulnerable groups – rather than detracting resources from programming for adolescent girls.

Coordination and Collaboration to Maximize Impact

A common and unified approach for agencies working in the same humanitarian response and targeting ASRH is important to maximize resources, avoid duplication of efforts, and expand reach. Setting up ASRH Working Groups[9] is a strong first step for coordination. Another approach includes collaboration, consisting of jointly developing and utilizing materials; combined trainings; and a common use of ASRH friendly service points.

Contextualization of resources with meaningful participation of adolescents is the ultimate goal. Successful projects show that adolescent participation was one of the fundamental principles in implementing a CSE programme. Maximizing the existing contextualized resources rather than agency-specific curriculums so that a common resource can be used in the same setting should be considered. For instance, a contextualized manual developed by one agency in Cox's Bazar or for Syrian adolescent refugees living in the Bekaa Valley can be utilized by all agencies working in the same location, rather than duplicating the process.

SECTION 4 RECOMMENDATIONS ON EXPANDING CSE IN PROTRACTED HUMANITARIAN SETTINGS

This section outlines recommendations for IPPF Member Associations, followed by recommendations for the wider humanitarian community recommendations are based on the following:

- Guidelines from the Adolescent Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian settings.[29]
- Consultations with young people ages 10–14, 15–19, and 20–24, facilitated by IPPF Member Associations.
- Documentation and examples of promising practices by IPPF and peer agencies implementing CSE in humanitarian contexts.

Recommendations on CSE programming in protracted settings

IPPF Member Associations are well-positioned to advance CSE programming in protracted humanitarian environments by implementing the following recommendations:

1. **Train staff and youth volunteers on the Minimum Initial Services Package (MISP)[30] for Reproductive Health and the ASRH Toolkit in Humanitarian Settings.** Both Profamilia and the Family Planning Organization of the Philippines (FPOP) recommended that these trainings be conducted as part of emergency preparedness efforts as well as conducted routinely for new staff given high levels of turnover in emergencies. This will complement the knowledge of Member Associations on CSE curricula, such as the *It's All One* curriculum. It will also help them integrate CSE curricula and ASRH programming within a humanitarian framework.

2. **Aim to 'be flexible'** and **'think outside the box'.** This is a recurring recommendation from Member Associations who have implemented ASRH programmes in humanitarian settings. For example, referring to CSE by another term – **content and approach are more relevant than the**

[9] The ASRH Working Group is recommended to be set up as a sub-working group to the SRH Working Group which is part of the Health Cluster.

label – or seeking alternative solutions to in-person sessions. Trusted modalities of integrating ASRH sessions into IPPF's mobile medical teams or referring young people to youth drop-in centres can remain as standard programming benchmarks while expanding options based on the context, especially when it comes to reaching marginalized young people.

3. **Conduct comprehensive community mapping exercises to inform your understanding of the intersecting vulnerabilities that young people especially adolescents are facing.** These vulnerabilities include chronic poverty, protracted violence, conflict and displacement, coupled with weak health, education and protection systems which provide a backdrop to adolescents' lives. Also, ensure that your ASRH and CSE interventions are inclusive to the needs of adolescents in all their diversity based on gender, age, race, wealth, ability, status and sexual orientation.

After the 2018 earthquake in Lombok, Indonesia, the Indonesia Planned Parenthood Association (IPPA) and UNFPA Indonesia established a Youth Forum to discuss SRH issues faced by young people and offer strategies and recommendations that were subsequently raised in the SRH sub-cluster.

4. **Know the needs of the young people you seek to serve.** Young people in protracted humanitarian settings are a diverse population with varying needs and aspirations. Before designing an ASRH intervention you need to learn about the population. Assess their needs, understand their specific profiles, and their awareness, attitudes, and behaviours, especially on SRHR issues. Include the target population from the beginning at the needs assessment stage. Consider implementing participatory research approaches with young researchers from the community. Always aim to adapt and contextualize the activities and services to the specific context to meet the needs of the population through continuous feedback mechanisms. Finally, remember that the sexuality education curriculum can be adapted to the specific context and based on feedback from adolescents without having to alter the objectives and intended outcomes.

5. **Explore options to complement the peer education and youth volunteer model.** In-person sessions may not always be conducive and are not always the most cost-effective option. The COVID-19 experience has demonstrated that a **digitalized humanitarian response** is possible, and **a hybrid model of in-person and digital mediums can be brought to scale.** The young people who were consulted in the development of this statement also noted that they appreciated the autonomy and privacy that digital mediums offered in accessing sensitive information.

When asked about how best to teach CSE, adolescents mentioned they prefer face to face modalities yet with COVID-19 that wasn't possible. "Honestly, I prefer meeting in person, but now it's a pandemic, so we go through digital media and that is easy to use to share knowledge or information." 15-year-old Indonesian adolescent girl interviewed for this brief

6. **Scale-up innovative CSE interventions that are implemented in development programmes to include adolescent refugees** who are hosted in the same countries. For example, IPPF's Get Up Speak Out for Youth Rights (GUSO)[31] project introduced an innovative approach of conducting CSE through WhatsApp groups for young people. The seven countries that implemented the GUSO project were in a development context – Ethiopia, Ghana, Indonesia, Kenya, Malawi, Pakistan, and Uganda – and four out of the seven countries host refugees living in protracted emergencies. This project model can be scaled-up to include refugee adolescents living in these countries.

7. **Design and implement Very Young Adolescent (VYA) programmes to provide critical information and skills to adolescents before they enter their highest risk years.** These programmes should be intentionally designed in close cooperation with parents and teachers and, at a minimum, address menstrual hygiene management, life skills, sexual and reproductive health and care for survivors of sexual abuse and violence. Limited research and programming exist on VYAs in humanitarian emergencies. However, a VYA study[32] conducted with refugees (adolescents, parents, and community leaders) affected by protracted crises from Syria, Somalia, and Myanmar emphasized that puberty and sexual and reproductive health education is widely accepted and appropriate for VYAs. It also underscored the larger protection concerns for this age group and that health and protection programming are essential to address the often-overlooked risks to this group. Most importantly, safeguarding adolescents and other vulnerable groups is a duty of care for all IPPF and Member Associations staff, volunteers and partners and it is their responsibility to raise any safeguarding concerns they have and reported them using the available tools such as the safe report platform: https://secure.ethicspoint.eu/domain/media/en/gui/107397/index.html.[h]

> When asked about suggestions for topics to be included in CSE sessions, a 17-year-old Filipino adolescent male interviewed for this brief mentioned "Teenage pregnancy, since during pandemic the increased numbers of teen pregnancy is alarming. I think, this is timely and relevant. SGBV topic also, since many were violated and not able to asked help. HIV and AIDS topics are also important, it effects and how could it be managed."

8. Remember that the **needs of adolescents in all their diversity are similar in different humanitarian contexts** and often overlap with the needs of other population groups. Therefore, the recommendation is to **adapt existing ASRH and CSE tools and guidelines** to the needs of the context rather than invest resources into creating new tools.

9. Ensure the availability of **rights-based accountability mechanisms** to help identify barriers to SRH information and services and improve access, especially for adolescents. In addition, promote **social accountability processes that prioritize the community, including young people participating** in decision-making.

[h] More information about IPPF's Safeguarding Policy for Children and Vulnerable Adults is available at: https://www.ippf.org/sites/default/files/Policy%201-17%20SAFEGUARDING%20CHILDREN%20AND%20VULNERABLE%20ADULTS.pdf

Recommendations to the Humanitarian Community

1. **Prioritize ASRH information and services in the acute phases of an emergency.** This will likely result in ASRH programming being recognized, funded, expanded, and integrated into programming in protracted emergency settings. For example, the recently revised ASRH Toolkit specifically provides guidance on how to implement an adolescent-inclusive MISP.[i]

2. **Strengthen coordination of ASRH actors within the humanitarian structure and integrate CSE sessions with other humanitarian interventions.** An important element of the MISP is coordination. Coordinating for ASRH at an acute stage provides the opportunity to communicate with various clusters and actors across different sectors. While the cluster system may move into different phases and take on different modalities in a prolonged crisis setting, it is critical for ASRH actors to be embedded in the humanitarian response mechanisms. There is opportunity for every sector – protection, education, health, water and sanitation, shelter, camp management – to contribute to adolescent health and well-being.

3. **Promote integrated, multi-sectoral programming,** a protracted setting can benefit from a forum such as an Adolescents and Youth Working Group.[j] This group would include representatives from different sectors, adolescent and youth representatives who work together to fulfil programming for young people. A goal should be to integrate adolescent specific considerations across every sector where possible and to keep them separate only when it is not feasible or fails to adequately address adolescents' needs.

4. **Establish partnerships and coalitions among agencies providing ASRH programming.** These partnerships can maximize resources and expand reach by conducting joint assessments; consultations and community sensitization; establishing a unified CSE curriculum; conducting trainings of peer educators and health facilitators; and jointly identifying and sharing spaces to conduct ASRH sessions. This also helps to expand reach through economies of scale.

5. **Advocate and pursue opportunities for multi-year funding in line with the humanitarian-development nexus model.** Protracted emergencies specifically reflect the humanitarian-development nexus environment and have the capacity to implement the New Way of Working (NWOW) approach.[k] One of the key concepts of NWOW includes a multi-year timeframe for strategizing, planning, and financing operations in complex and protracted emergencies. A main barrier to ASRH programmes not moving beyond pilot projects is that they are short-term and

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[i] Refer to Chapter 4 of the Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings. Available from: https://cdn.iawg.rygn.io/documents/ASRH%20Toolkit%202020%20Edition/English/ASRH%20Toolkit/Ch4%20uploads/IAWG-Toolkit_Chapter-4.pdf?mtime=20210719203053&focal=none

[j] This group would ensure that young people are engaged in identifying their needs, risks, opportunities and threats, and offering adolescent and youth-led solutions. An example is the Youth Task Force in the Za'atari Refugee Camp that is an action-oriented field-level forum focused on youth advocacy and coordination while addressing the cross-cutting needs of all population groups, and works toward advancing the youth agenda in humanitarian settings in line with the Global Compact for Young People in Humanitarian Action. Available from: https://www.youthcompact.org/blog/2020/6/1/youth-task-force-in-zaatari-refugee-camp-young-people-and-covid-19

[k] The New Way of Working (NWOW) approach recognizes that greater collaboration, coordination, and coherence between humanitarian and development actors can be accomplished through collective outcomes, comparative advantage, and multi-year timeframes. https://www.unocha.org/es/themes/humanitarian-development-nexus

have limited funding. However, protracted settings can reflect multi-year programming portfolios implemented by humanitarian agencies who have a long-standing footprint in those locations. Donor negotiations can include developing consortium models with other SRH or youth organizations to maximize funding and expand reach. Another approach is to merge programmes and have every RMNCAH+N, protection, or education project integrate adolescents and ASRH interventions.

6. **Assess the availability and access to technology including mobile devices and internet through community mapping exercises.** Access is often seen as a barrier to digital humanitarian programming and digital health interventions (DHI). However, this could be mitigated with interventions such as the allocation of cash transfers and vouchers for mobile phones and internet access to promote access to digital services. Young people also prefer digital communication methods and can contribute to their design and implementation through community mapping exercises that assess young peoples' behaviour and barriers to access technology. Mapping exercises should also determine groups with restricted access so that the programmes can be designed to ensure that the most vulnerable are not left behind.

7. **Reinforce a strong measurement mechanism to document impact and design data-driven programmes.** A protracted setting allows the time and capacity to measure changes in attitudes and health-seeking behaviours. It also includes collecting nuanced indicators, such as how many young people who attended CSE sessions directly accessed services and the type of services they received, as well as the impact of CSE on their attitudes and behaviours, disaggregated by age and gender. The data generated must be consistently used to design and reshape programmes for evidence-driven programming and results.

8. **Integrate protection with the provision of ASRH services** to ensure a continuum of CSE programmes and services. A significant gap in humanitarian settings remains regarding how to reach and inform adolescent girls (and to a large extent, women as well) on protection issues such as physical safety, mobility, and SGBV. UNFPA's Women and Girls' Safe Spaces (WGSS)[33] address this need through case management, referral, information, and response services. Safe spaces can be replicated in protracted humanitarian settings to also cater to hard-to-reach areas and to complement the outreach and mobile teams and clinics that usually provide protection-related information and services. ASRH services – that include ensuring access to contraception, comprehensive safe abortion and post-abortion care, care for survivors of sexual violence, STI/HIV testing and treatment, assisted deliveries for adolescent mothers and other sexual reproductive health services, and maternal newborn child and adolescent health and nutrition services – can be easily complemented by protection information, case management, and services. This allows adolescents to act on the information they receive through CSE programming and ensure a continuum of services and care.

Conclusion

Protracted crisis settings provide some prospects for humanitarian programming that benefits from the lessons learned from long-term development programming. People affected by protracted crises may have lived in an uncertain environment for decades. As a result, communities and coping mechanisms have been formed, and have witnessed the threats and vulnerabilities of young people over time. These mechanisms seek to create more stable spaces where CSE sessions and a continuum ASRH services and protection can be conducted or combined with other outreach or youth programming initiatives. Partnerships and coalitions with governing bodies and other agencies have also been created, offering increasingly coordinated and established ways

of working. This setting offers opportunities for ASRH and CSE programming to be introduced and systematically integrated into existing structures as well as opportunities to measure behavioural change and lasting SRH outcomes for young people.

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Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

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