

# Adolescent Mothers Against All Odds Learning Report

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## Acknowledgements

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The authors wish to extend their gratitude to their global partners whose curriculum provided the basis for the design of the Adolescent Mothers Against All Odds (AMAL) Initiative. Most importantly, the authors recognize and thank the adolescent girls and frontline health workers of northwest Syria for their ongoing commitment to strengthening this Initiative and for working to uplift women and girls in their communities.

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## Summary of the AMAL Initiative

Syria's humanitarian crisis resulted in substantial increases in early marriage and adolescent pregnancy. Informed by CARE's gender-based violence (GBV) regional advocacy strategy and global evidence-based practices on adolescent sexual and reproductive health (SRH) in emergencies (such as the Inter-Agency Field Manual for SRH in Crisis-Settings), the Whole of Syria Adolescent Strategy highlighted the critical gap in pregnant adolescents' access to life-saving SRH information and services. It also acknowledged the need for context-specific, practical programmatic tools and resources to meet the needs of vulnerable sub-groups of adolescents. In line with this strategy, CARE, UNFPA, SRD and other local partners developed the Young Mothers' Club (YMC) to meet the unique needs of pregnant adolescents in northern Syria. Following the implementation of YMC, the AMAL Initiative was born out of a larger need for adolescent-responsive interventions grounded in transformative gender and social norms approaches at both the community and health service levels.

Adolescent Mothers against All Odds (AMAL) Initiative was designed to meet the immediate needs of pregnant adolescents and first-time mothers in crisis-affected settings, while simultaneously addressing community consciousness and engagement around gender, power, and social norms. Using Syria's context as a frame, this program was developed through an iterative process of adapting global approaches for humanitarian crisis-affected settings.

The AMAL Initiative has three main components: A Young Mothers' Club with girls, participatory dialogues with marital family and community members, and reflective dialogues with healthcare providers. Each of these are described below:

- The Young Mothers' Club (YMC) is a peer-based discussion group made up of pregnant adolescents and first-time mothers centered around improving sexual and reproductive health knowledge and strengthening life skills.
- Community dialogue groups comprise influential individuals such as religious leaders, teachers, and community health workers as well as mothers, mothers-in-law, and husbands of adolescent girls. Members garner support for project activities to create enabling environments for adolescent girls, and work to influence programmatic elements to make them more adolescent-responsive.
- To improve attitudes and reduce biases towards adolescent SRH service provision, the AMAL Initiative engages health services providers in participatory exercises focused on rights-based approaches to family planning counseling, communication skills and ensuring adolescent-friendly health services.

True participatory approaches recognize not only the unique needs of adolescents, but also their capacity to influence change for themselves. To embody this spirit, the AMAL Initiative also includes Adolescent Advisory Committees (AACs). YMC graduates who demonstrate interest in supporting other adolescents participate in AACs and undergo a series of leadership sessions to further facilitate their self-efficacy. AAC members play a key role in strengthening the responsiveness of the program to the needs of adolescents by (1) liaising with relevant stakeholders to share recommendations and feedback, and (2) identifying hard-to-reach and marginalized adolescents in their communities to refer them to AMAL programming, health facilities, and other support systems.

Launched in collaboration with Northwest Syria's GBV sub-cluster in March 2020, the AMAL Initiative is being scaled up through local partners. With the face of fragile contexts becoming increasingly young, the AMAL Initiative seeks to inform the global evidence base and dialogue around nexus approaches to adolescent responsive SRH and GBV programming.

## Evaluation Methodology

In designing the evaluation tools for the AMAL Initiative, we sought to address three areas of inquiry: changes in behaviours and norms, perceptions of impact, and areas for program improvement. Ultimately our goal was to leverage program monitoring and evaluation data to extrapolate recommendations on the implementation of the AMAL Initiative within and outside Syria.

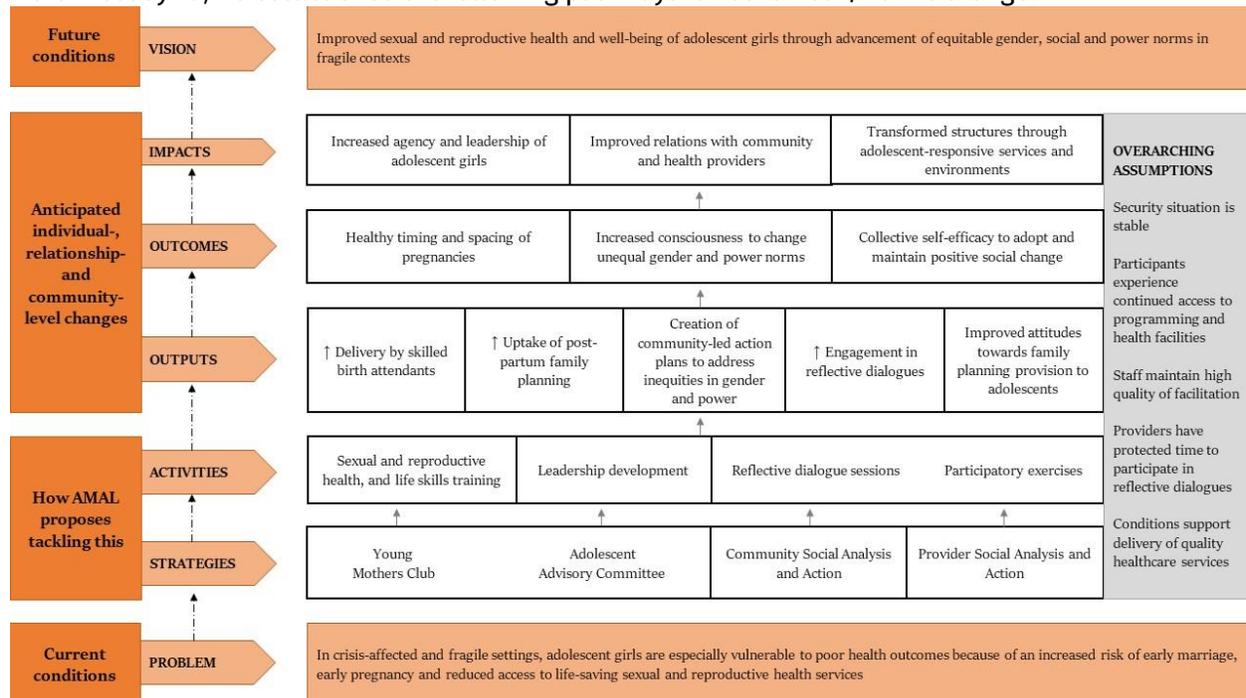
To assess the outcomes of the AMAL Initiative, we employed a multitude of monitoring and evaluation tools. Prior to the start of each YMC, CAG and health provider cycle, staff administered a baseline survey of all participants followed by an end-line once the cycle was completed. The baseline and end line surveys employed mixed-methods and were designed to serve as a pre-post measures of attitudes and behaviours related to gender and power norms. At the close of each YMC, community and health provider session, facilitators administered an end-of-session evaluation. These were designed to collect information on process and identify opportunities for continuous quality improvement. The questions for each component were connected to domains of change for each of the target populations, as determined through the AMAL theory of change.

To assess participant perceptions of the AMAL Initiative, we gathered feedback and stories of personal impact from adolescent girls via a rapid qualitative evaluation. To assess potential areas for program improvement, CARE staff conducted reflective discussions with session facilitators at the end of the year-long AMAL Initiative.

## Changes in Behaviours and Norms

### Theory of Change

When road mapping how we hoped to achieve our vision of improving the lives of adolescents in Northwest Syria, we established the following pathways for behaviour/norms change:



## Domains of Change

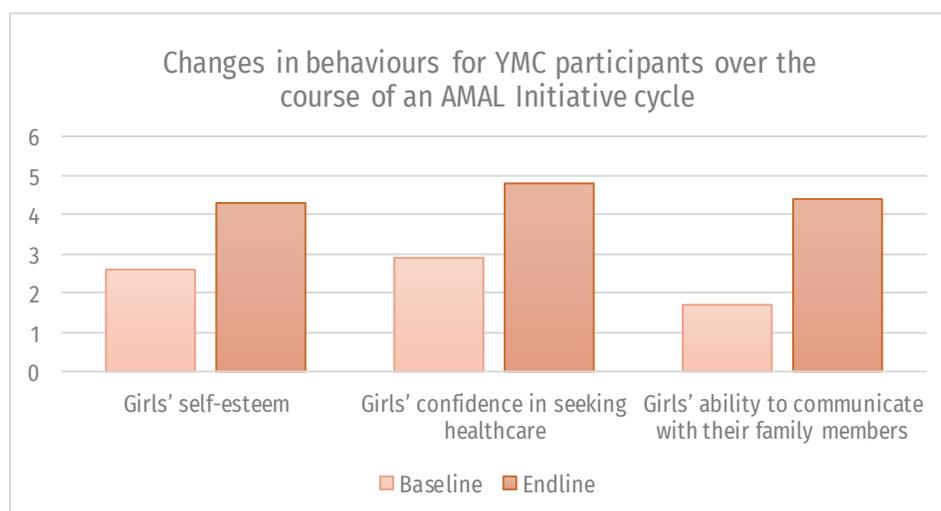
To determine whether we achieved our intended outputs, outcomes, impact, and vision per the theory of change, we identified relevant domains of change for each of the three target populations included in the components of the AMAL Initiative. These are outlined below:

AMAL Component	Young Mothers' Club	Community Dialogues	Provider Dialogues
Target Population	Pregnant adolescents and first-time mothers between the ages of 13 and 18 years	Religious leaders, teachers, community health workers, mothers, mothers-in-law, and husbands of YMC girls	Healthcare providers at community-based health facilities
Domains of Change	<ul style="list-style-type: none"> <li>Girls' self-esteem</li> <li>Girls' confidence in seeking healthcare</li> <li>Girls' ability to communicate with their family members</li> </ul>	<ul style="list-style-type: none"> <li>Ability to recognize unequal gender norms</li> <li>Interest in changing unequal gender norms</li> <li>Ability to support girls' equal access to services</li> </ul>	<ul style="list-style-type: none"> <li>Comfort providing family planning to adolescents</li> <li>Beliefs on girls' choice to use family planning</li> <li>Influence on girls' ability to exercise reproductive rights</li> </ul>

The baseline and end line surveys administered to all AMAL Initiative participants were designed so that a set of questions addressed each of the domains of change. For example, to determine changes in girls' self-esteem, the surveys required girls to reflect on ten statements such as "I am a person of worth" and "I feel happy about who I am" using a five-point Likert scale. Each ranking on the Likert scale was assigned a score between one and five. To assess changes in outcomes between baseline and end line, our analysis consolidated the scores across the set of questions relevant to each domain of change. Where available, this measurement was supplemented with qualitative data. Our findings on changes in behaviours and norms are described for each AMAL Initiative component below.

### Young Mothers' Club

104 adolescent girls participated in YMC groups across Azmarin and Abin over the course of the AMAL Initiative. Their reported changes in self-esteem, confidence and communication are illustrated below:

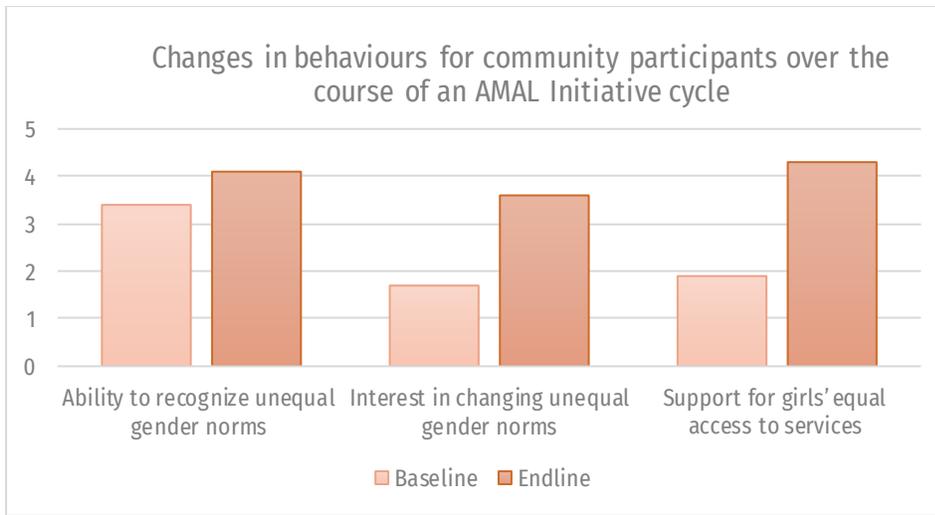


"I've told my family about what I've learned about pregnancy and made sure my relatives got healthcare. It feels like saving lives with my knowledge"  
YMC participant

Girls' confidence in seeking healthcare was the highest overall domain at end line, with all YMC participants increased knowledge of family planning, intention to access care, and ability to do so. The greatest observed change over the course of the AMAL Initiative reported by adolescent girls was in their ability to communicate their thoughts and emotions to family members.

### Community Dialogues

219 community members participated in community dialogue sessions across Azmarin and Abin over the course of the AMAL Initiative. Their reported changes in recognition of, and interest in changing unequal gender norms, and supporting equal access are illustrated below:

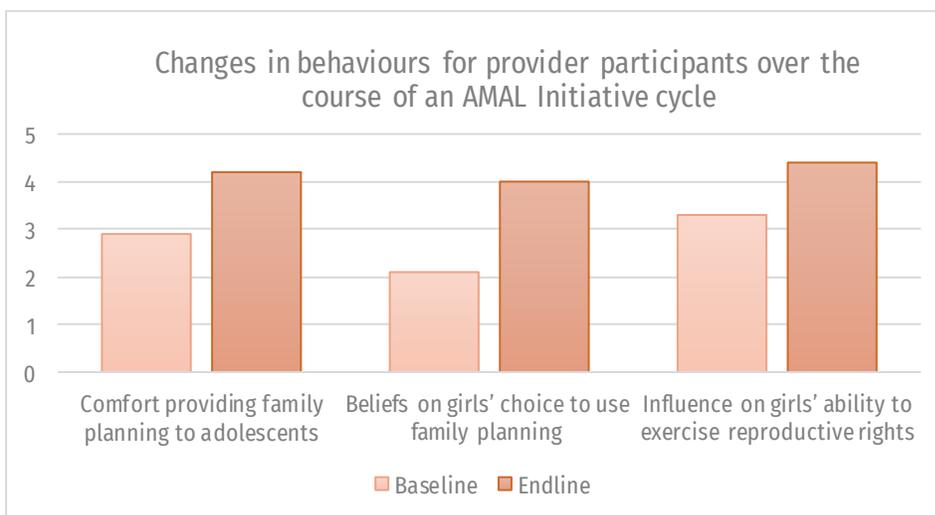


*"[AMAL] helped me get rid of some mistakes in my thinking on when girls should get married"*  
Community participant

Community support for girls' equal to services experienced the greatest change over the course of the AMAL Initiative, despite participants reporting high existing ability to recognize unequal gender norms.

### Provider Dialogues

120 healthcare providers participated in provider dialogue sessions across Azmarin and Abin over the course of the AMAL Initiative. Their reported changes in comfort serving adolescent patients, beliefs on reproductive choice, and influence on rights are illustrated below:

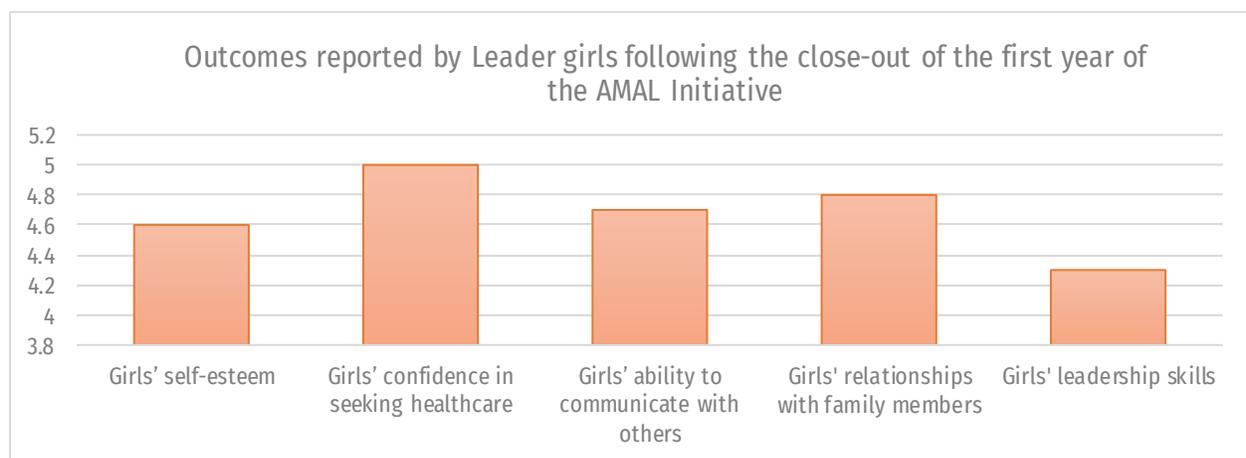


*"I realize now the importance of speaking directly with a girl and listening to her tell me what she needs"*  
Healthcare provider

Healthcare providers acknowledged the strength of their position in influencing girls' abilities to exercise their reproductive rights. While there was a significant shift in providers' beliefs towards girls having freedom of choice in their reproductive decision-making, many providers maintained at end line that they require their husbands' permission to use a family planning method.

### Adolescent Advisory Committees: AMAL Leaders

33 adolescent girls received leadership training to serve as AMAL leaders as part of AACs across Azmarin and Abin over the course of the AMAL Initiative. While not considered a separate target population with unique domains of change, we sought to evaluate the impact of the advisory training and role on Leaders' self-esteem, confidence in seeking care, communication ability, and additionally their relationships with family members, and leadership capacity. To do so, we retroactively surveyed the 33 AMAL Leaders via WhatsApp. Leaders' self-reported reflections in these five areas at end line are illustrated below, scored between 1 (none) to 5 (very strong):



### Perceptions of Impact

Per the AMAL Initiative theory of change, we had hoped to achieve impact across three areas: increased agency and leadership of adolescent girls, improved relations with community and health providers, and transformed structures through adolescent-responsive services and environments. While it is difficult to determine population-level impact after just a one-year pilot, we gathered qualitative feedback from several program stakeholders on the individual impact that AMAL has had on their lives.

Increased agency and leadership of adolescent girls

*"I will insist on getting healthcare when I need it. I understand my body more"*  
YMC participant

*"I see myself in a positive way now. It's harder for others to change that, and I can persuade my family to see that value too"*  
YMC participant

*"I've learned how to talk to my husband and family about what I want. I should be able to make some decisions"*  
AAC participant

*"I used to be afraid, but now I think I'm the strongest among my family. I'm changed and can do anything"*  
AAC participant

Improved relations with community and health providers

*"I better understand the health needs of adolescents now, and I think I can talk to girls in a better way than before"*

Health provider

*"As a midwife, my confidence to talk to adolescents has hugely increased after the sessions, especially with the healthcare providers because they really showed me respect and cooperation"*

Community participant

*"We have built [adolescents'] confidence, and our own too. We have built bridges of trust with them. It is the biggest sensation of professional fulfilment I've ever had"*

Community participant

*"[AMAL] positively affected the community. On our way back home after working people greet us and thank us for what we are doing, and this is the best thing"*

AMAL facilitator

Transformed structures through adolescent-responsive services and environments

*"[AMAL sessions] have had a great impact on my practice and how I can deal with adolescents reproductive care, especially for girls. I got a lot of new information, and can see how the power and gender dynamics between spouses affects their own health, and how I can change that"*

Health provider

*"I see a change in our community's views on a husband and wife's roles in household chores"*

Community participant

*"We are starting to reject early marriage, and there is a desire for girls to complete their education"*

Community participant

Despite overall positive shifts in participants' attitudes and behaviours from baseline to end line, there were a few existing societal norms that experienced minimal to no change in level of acceptance. Belief that a girl should complete her education after marriage remained low and expectation that a girl requires her husband's permission to use family planning remained high after the end of the program.

As outlined in the theory of change, the AMAL Initiative's vision was for improved sexual and reproductive health and well-being of adolescent girls through advancement of inequitable gender, power, and social norms. Given Syria's context and the resulting additional vulnerabilities for adolescent girls, an environment of improved well-being could cover several domains. Based on the literature on creating enabling environments for marginalized populations, we choose to focus our domains of change on the sub-groups of pregnant adolescents and first-time mothers, with the intention of contributing to the field of interventions tailored to their unique needs. While not explicitly included in our measured domains of change as our selected sub-groups were already married, our evaluation findings suggest a lower individual and community tolerance for child and early marriage. YMC and AAC participants shared intentions to negotiate later marriages for their younger female siblings, with most saying that 18 years was the earliest appropriate age for a girl to be married. Community participants indicated a general shift in attitudes towards greater recognition of the issues posed by early marriage for girls, and a trend towards decreased acceptance of the practice.

## Stories from AMAL Participants

“I had planned for my other son to marry a girl in our neighbourhood. She is 14 years old. But now, I will cancel the marriage and wait for her to be 18 before my son marries her.”

Community participant



“We sent a bus to bring one of the girls to our YMC session, and her father-in-law came to the bus and said – “What are you teaching her? She talks more now and has helped us all think in better ways.””

AMAL facilitator

“My children died so I’ve been taking care of my grandchildren on my own. Our economic situation has been difficult, and I was considering marrying off my granddaughter for the dowry, but I’ve decided to send her back to school.”

Community participant



“My mother-in-law wanted to arrange a marriage between my brother-in-law and my sister, who is 13. I said that my sister must finish school first and can be married when she is 18. My mother-in-law agreed to wait for five more years.”

YMC participant

“We noticed a huge change in the mentality of men after attending community sessions. An Imam (religious leader) said that the highest divorce rate is among adolescents, and that influential people in the community should be doing something about it by raising awareness about the wrongness of early/child/forced marriage.”

AMAL facilitator



## Program Reflections

The final piece of our program evaluation puzzle was to gather reflections on the design and delivery of the AMAL Initiative. To do so, we conducted focus group discussions with AMAL facilitators, who shared feedback they had received from AMAL participants, and SRD program staff. During these focus groups, we asked participants to reflect on what went well and identify areas for potential improvement in relation to their training, and to the content, structure, and timing of the AMAL sessions. Participants also shared stories of their own experiences related to their awareness of adolescents' needs, confidence to affect social change, integration into the community, and professional satisfaction.

### *Facilitator Preparedness*

Critical to the success of any program is the quality of its delivery. To assess our program quality and facilitator preparedness, we sought to determine whether and how the AMAL Initiative could have better equipped its facilitators to carry out program sessions on sensitive topics with vulnerable and/or challenging groups.

### Training

AMAL facilitators underwent a 3-day training spanning all the session content and evaluation tools prior to the start of the AMAL Initiative. This training adopted a train-the-trainer model, and individuals were then able to share their knowledge with other facilitators. At end line, facilitators reported feeling well-prepared to tackle the delivery of the AMAL program sessions and to manage participant interactions within and between groups.

While not directly pertaining to the AMAL Initiative, facilitators noted that it would be helpful if they were enabled to handle case management on their own in the center, to reduce the need for external referrals to services.

### Materials

Facilitators shared that the AMAL Manual was effective at providing guidance and direction on how to conduct the program sessions, connect with participants meaningfully, and mitigate challenging scenarios. They found the exercises to be an easy way to engage with participants and said participants particularly liked the end-of-session evaluation tool because it helped build their critical thinking and communication skills.

Additional materials not currently part of the AMAL Manual that facilitators said they would benefit from are visual aids. Specific examples of these that facilitators named included: samples of contraceptives, short videos to explain the reproductive health system, and medical mannequins for the sessions on male and female anatomy.

### *Session Content*

The AMAL Initiative was created through an iterative participatory process involving multiple stakeholders, including local partner organizations. Much of the program content was informed by and adapted from other evidence-based approaches implemented by CARE, USAID, and UNICEF. It is intended for humanitarian practitioners working in crisis-affected and fragile settings with the goal of supporting married adolescents to practice healthy timing and spacing of pregnancies and improve their overall sexual and reproductive health well-being. As this was its first full implementation, the AMAL Initiative sought to gather feedback on the relevance and appropriateness of the sessions to inform potential future programming.

### Young Mothers' Club

Facilitators and YMC participants shared the following feedback on potential areas for improvement for relevant AMAL sessions:

Session	Suggestions for improvements
1	Add elements of effective listening. Provide visual aids for reproductive anatomy
3	Split this content into two sessions as there are too many topics to adequately cover
4	Add sexually transmitted diseases section from Session 3 here instead
5	Delete section on danger signs during pregnancy as it is covered elsewhere
6	Add more in-depth explanation of family planning methods, and pros and cons of each. Supplement with visual aids
8	Add information on breast-related diseases and signs of danger

### Community Dialogues

Facilitators and community participants shared the following feedback on potential areas for improvement for relevant AMAL sessions:

Session	Suggestions for improvements
2	Add more in-depth explanation of signs of puberty, and role of parents in supporting girls
4	Add information on means of preventing use of force for discipline
5	Add more in-depth explanation of types and wrongness of violence, and how to address it
6	Add information and discussion/exercise that addresses norms on the provision of family planning to unmarried adolescents

### Provider Dialogues

Facilitators and participating health providers shared the following feedback on potential areas for improvement for relevant AMAL sessions:

Session	Suggestions for improvements
1	Reduce the number of scenarios: delete story #2
2	Split this content into two sessions as it is too much to adequately cover in allotted time
4	Four Corners activity is challenging to implement while following social distancing (Covid)

### Community Receptiveness

Facilitators commented on how the design of the AMAL Initiative enabled its success in the communities within which it was implemented. They believed that while previous efforts related to sexual and reproductive health programming with adolescents were received poorly, AMAL's multi-component approach and participatory nature resulted in community buy-in. The AMAL Initiative's intentional inclusion of individuals that affect the lives of married girls, such as their mothers/mothers-in-law, husbands, and health providers was crucial to its acceptance by the greater community. Facilitators shared that following the first cycle of sessions, there was a significant increase in interest and the program was not able to match the high demand for participant spots. They described repeatedly receiving requests from individuals and girls in the community to be included, especially girls aged 19 and older. Per the original design of the AMAL Initiative, those girls would have missed eligibility for enrollment in the program due to their age but were chosen to be included in this implementation due to the immense demand.

## Recommendations for Future Programming

Together, the outcome data, program evaluations, and participant feedback indicate that the AMAL Initiative's adolescent-responsive approach is effective in improving the lives and well-being of married girls. Given that the implementation discussed in this report was for a one-year pilot of the full AMAL Initiative, we sought to identify whether and how we might hone the program design to better meet the unique needs to pregnant adolescents and first-time mothers. Below are recommendations on areas for improvement/ exploration in the future, supported by the AMAL Initiative evaluation data:

### Young Mothers' Club component

- The AMAL Initiative's Young Mothers' Club was designed to accommodate first-time mothers and pregnant girls between the ages of 10 and 19 years. This target group was intentionally defined due to their unique SRH needs and risks in emergency settings. However, this implementation with Syria Relief and Development included girls between the ages of 14 and 25 years. The reason for this inclusion of a different age group than originally designed for was because individuals outside of the intended target group continually expressed substantial interest in participation, specifically young women above 20 years of age. This highlights how in contexts such as Syria, SRH-related gender and social norms continue to affect older, married girls and points to the need for integration of varying types of age-appropriate programming for girls and young women.
- For reasons described in the above recommendation, the average age of a YMC participant in this implementation was 17 years. Of all the YMC participants, 37% were above the age of 19, 60% were married with no children, 22% had one child and 18% had two or more children. Based on this, we recommend greater outreach to include adolescents who are younger and first-time parents.
- A surprising change in participant attitudes observed between baseline and end line was that more girls reported being unable to or unwilling to visit a health facility without the permission of their husbands. While it is possible that their response to this question was influenced by a feeling that their husbands should be in attendance for any visit to a health facility because family planning is a joint responsibility, we are unable to discern that with our current data and recommend this as an area for further exploration with future YMC participants and their health providers.

### Community Dialogues component

- The AMAL Initiative intended to improve community members' attitudes related to adolescent reproductive healthcare. While it appears to have achieved this overall, some areas improved more significantly than others. For example, attitudes towards unmarried women and women with less than three children having access to family planning significantly improved based between baseline and end line. Attitudes towards a woman having the right to choose family planning simply because she wants to, however, improved only slightly. For future programming, we recommend exploring this concept of choice and empowerment for inclusion in dialogue sessions.
- One community attitude towards adolescents that did not see expected changes was the ability for girls to continue school after they are married. This should be considered for future program implementation, ideally with the development of a dialogue session on this topic.
- While it is expected that a small percentage of participants would be somewhat dissatisfied (2% at end line) by a program component that is new and challenging of social norms, it is worth exploring why these individuals feel this way and how the program approach can address it.

### Provider Dialogues component

- Results suggest that health providers may benefit from additional professional training around the use and administration of long-acting reversible contraceptive (LARC) methods for adolescents.

When reflecting on sessions with providers, facilitators shared having to tackle misconceptions on the use of LARCs at the start of program cycles. For example, there was a strong belief that IUDs would cause infertility and so a woman should not use them until she had birthed at least three children. While end line data shows that health providers had improved their knowledge of all contraceptive methods, perhaps there is a need for an additional exercise on LARCs to further cement that knowledge.

### *Overall Recommendations*

With the intention of continually learning to better meet the unique needs to adolescents, we are committed to understanding not only the overall results and impact of activities but also the quality of program implementation. To that end, one area to strengthen for the future is effective accompaniment of local implementing organizations to ensure adherence to the essential components of the AMAL Initiative. As evidenced by our evaluation data and facilitator feedback, generating positive change in behaviours and norms is best facilitated by a multi-component approach that engages not just adolescents but their familial and societal communities in programming.

Adherence to the essential components of AMAL includes implementing the monitoring, evaluation and learning approaches that integrate community-level efforts for reflection and action planning. Specifically, the AMAL Toolkit describes a process of deliberation between facilitators after every second session wherein they review participant feedback from the end-of-session evaluations and identify potential changes to the program. This internal process is necessary for the continuous improvement of the AMAL Initiative, and should be prioritized.

Due to the constraints that humanitarian programs typically operate within, it can be challenging to design activities that intentionally, actively, and continually consider the needs and opinions of young people. The AMAL Initiative has demonstrated some success in this area by using participant feedback to improve subsequent YMC cycles and providing a platform for girls' voices through the AACs in liaising with community members and program staff. It is critical to continue to invest in approaches that leverage and lift up the active participation and leadership of young people in crisis-affected contexts.

Through this first pilot, we have seen encouraging results across all components of the AMAL Initiative. Over this and subsequent implementations, we hope to continue to identify lessons on what is and isn't effective towards meeting the unique needs of vulnerable sub-groups of adolescents in crisis settings. Such an ongoing investment in learning is necessary for organizations like CARE and others as well as humanitarian practitioners to ensure our work is relevant, fruitful, and empowering.



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The development of the AMAL Initiative has been truly participatory with insights from several partners along the way. Though learning from the pilot described in this report demonstrates results from CARE's implementation in collaboration with UNFPA and Syria Relief and Development, other partner organizations are implementing components of the AMAL Initiative in Syria and Nigeria.

**Photos:**

- p1, Mariam (name changed) works on a farm with her mother where she earns the equivalent of 20 US cents per day. She received assistance through CARE's program partnership with Syria Resilience Consortium. Photo © Abdullah Hammam/Syria Resilience Consortium 2019
- p9, Maya (name changed) lost her father at the age of one and has since been displaced from Homs to northwest Syria with her family four times. She started attending a psychosocial support center in Aleppo run by CARE's partner IYD. Photo © IYD/CARE
- p9, Syrian refugees participate in classes in Zaatari camp in northern Jordan. Photo © Laura Sheahen/CARE
- p9, Photo © CARE
- p9, Yamaha, Shaheed (names changed) and two friends participate in peer-to-peer support groups in a CARE community centre. Photo © CARE
- p9, Sisters Haneen, 14, (left) and Sidra, 13, (right) join friend Reem, 14, (centre) in a support group for Syrian teens at a CARE community centre in Irbid, Jordan. Photo © Mary Kate MacIsaac/CARE

March 2021