Learnings from Integrating Adolescent Sexual Reproductive Health and Rights (ASRHR) into a Multi-Country Girls' Education

Thematic Brief

Background

Addressing the sexual and reproductive health (SRH) of young people is critical to their development and to ensuring healthy and successful futures for themselves and their families. As adolescents are at a transitional stage of growth from childhood to adulthood, providing them with comprehensive sexuality information and access to adolescent-friendly services can enhance protective sexual behaviors and improve reproductive health outcomes, such as reductions in early and unwanted pregnancy and sexually transmitted infections, including HIV and AIDS. Reducing unintended pregnancies and other reproductive health issues among young women and men not only saves lives, but it also improves education outcomes and employment opportunities, reduces poverty, and increases economic growth. Studies demonstrate that adolescents are often unprepared for their body changes; substantial numbers of girls in many countries have knowledge gaps and misconceptions about menstruation that cause fear and anxiety and leave them unprepared when they begin menstruating.[1] Critical gaps in knowledge exist among adolescent girls, especially in Africa and Asia, about where to obtain and how to use a range of modern contraceptive methods.[2]

Gaps among adolescents in SRH information, knowledge and risk perception; limited teachers' experience and confidence in exploring SRH issues with young people; and lack of access to and use of services by adolescents compelled CARE to seek ways to integrate ASRH into education programs, test new models, and gather evidence for how ASRH and education can enhance the impact of adolescent empowerment

[1] Chandra-Mouli, V. & S. Vipul Patel. *Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low- and middle-income countries*. *Reproductive Health. 2017;1*(14):14–30
[2] Woog, V., Singh, S., Browne, A., & J. Philbin. *Adolescent women's need for and use of sexual and reproductive health services in developing countries*. New York: Guttmacher Institute; 2015, https://www.guttmacher.org/fact-sheet/adolescent-womens-need-anduse-sexual-and-reproductive-health

programs through the Patsy Collins Trust Fund Initiative (PCTFI).

PCTFI's Cohort 3 (2015-2021) was an innovative, multi-country multisectoral program to empower adolescents through education and life skills development, including financial literacy and comprehensive SRH for adolescents. This initiative was implemented in seven countries, Cambodia, Rwanda, Nepal, India, Kenya, Mali and Zimbabwe, with SRH integrated into six of these countries. A summary is provided in the table below.

What We Know

Adolescents need access to high quality, comprehensive, and confidential sexual and reproductive health services and education. Research shows that adolescents face barriers to receiving sexual and reproductive health care including "lack of familiarity with the health care system, limited ability to pay for services, fear of disclosure of confidential information to family and friends, and uncertainty about their ability to access services without the consent of a parent or guardian."[3]

PCTFI Cohort 3 baseline studies showed gaps in adolescents' SRH knowledge as well as challenges in accessing ASRH information and services. For example, in **Nepal**, although schools were identified as the major source of ASRH information dissemination, only 8% of program participant girls said that they have talked to their teachers about ASRH, puberty and body changes.[4] Communication on SRH between parents and adolescents is minimal; nine out of 10 parents reported that they are not comfortable speaking about family planning, especially condom use, with girls.[5]

In **Cambodia**, just over 55% of students had correct responses for SRH knowledge questions during the Cohort 3 baseline, and males were significantly more knowledgeable than females (59% vs. 51%).[6] The main barrier to receiving information in school in the

Snapshot: PCTFI Country Program Activities to Integrate ASRH

Cambodia: Know and Grow project. Life Skills for Reproductive Health (LSRH) Curriculum; build community and school leadership support for SRH through capacity building training, coaching and mentoring of teachers, boarding house parents, school support committees (SSC) and students. Use of social analysis and action (SAA)[1] with teachers and students for behavior and norm change.

Rwanda: SS4G (Safe Schools for Girls)
Girls' clubs and mentorship for building life skills andSRH awareness ; adapt comprehensive sexuality education (CSE) curriculum; girls and boys leading school score card (CSC)[2] processes.

Nepal: Haushala Project
SRH health promotion and education in schools; facilitating access to youth-friendly health services (YFS); community mobilization against gender- based violence (GBV), eve teasing and early marriage through girl collectives and VSLA (village savings and loan associations) platforms.

Kenya: Adolescent Empowerment Program (AEP)
ASRH education through school clubs and SMS during Covid-19 response; shifting community perception on ASRH using Social Analysis and Action (SAA).

Mali: Education for Change (E4C) Training teachers on ASRH and establish core group of trainer trainers; share experience and advocate for adoption of SRH education in schools; include SRH topics in community level meetings and advocacy; raising awareness through conference debates, round tables and sharing ASRH messages through SMS to school groups.

Zimbabwe: Adolescent-led ASRHR advocacy
Delivery of ASRH information through guidance and counseling classes; School ASRH service and education promotion using community score card (CSC) and facilitating referrals for services.

[1]SAA is a facilitated process to explore and challenge discriminatory gender and social norms, leading to individual and collective actions to create equitable behaviors and norms.

[2] CSC (community score card) is a two-way and ongoing participatory tool for assessment, planning, monitoring and evaluation of services; mostly used in the health sector and adapted for education/school settings under PCTFI.

[3] Ralph, L. J, & C. D. Brindis. *Access to reproductive healthcare for adolescents: establishing healthy behaviors at a critical juncture in the life course. Current Opinion in Obstetrics and Gynecology. 2010;22(5):*369-374
[4] CARE Cambodia. *Haushala, SRH and Social Norms Survey, September 2019*
[5] Nepal Evaluation and Assessment Team (NEAT). *Hausala: Empowering Adolescent Girls in Nepal, Baseline Survey Report, February 2017*, p. 5
[6] Ritter, T./CARE Cambodia. *CARE Cambodia Know & Grow Baseline Report, June 2017*, p. 78

project's target areas was embarrassment – both on the part of students and teachers. It was particularly challenging with mixed sexes in the group or where teacher facilitators are from another sex. Students don't bring up issues with teachers as they are too shy, and some teachers felt the issue was too embarrassing to bring up for the students but also for themselves.[7] Challenges around educating on issues related to SRHR and gender-based violence (GBV) in schools further include capacity of the teachers, sensitivity about and complexity of concepts related to sexuality education, ambitious curriculum to cover within the school year, and insufficient teaching and learning materials.[8]

In **Kenya**, during the baseline evaluation, students who had received information about SRH were more likely to have visited SRH services in the past 12 months and less likely to have had sexual intercourse compared to those who had not received any information about SRH. These include information about body changes, sex, HIV/AIDS, sexually transmitted infections (STI) or family planning. Those who had not received SRH information were also not confident about their ability to access information (48% agreed that they could access SRH-related information compared to 74% of those who had received information) or their access to family planning methods (35% of those not having received information compared to 49% of those who had).[9]

> *"ASRH is a culturally toned-down subject both at home and in education system."*
> Zimbabwe team

In **Mali**, 67% of students in government schools and 63% of out-of-school adolescents who participated in the baseline survey believe that health centers are the main SRH service providers. However, only 2% of students and 5% of out-of-school adolescents used those services; only 20% of married in-school adolescents and 17% of married out-of-school adolescents have ever used SRH services, while most others do not know where to find those services.[10] About 14% of adolescents reported being in a relationship, and 55% of them had already started being sexually active while half of them have already changed partners. Yet, only about a quarter (26%) of schools have integrated SRH education into their formal teaching curriculum.[11]

Theory of Change and Program Approach

CARE's approach to integrating ASRH interventions into cross-sectoral programming encompasses different components and is informed by CARE's global experiences and learning, as well as by CARE's Gender Equality Framework (GEF) which grounds CARE's adolescent empowerment approaches. CARE's GEF (Figure 1) emphasizes that change needs to take place and to be sustained across three domains, including building the agency and assets of our primary target groups + creating supportive relationships and networks and +

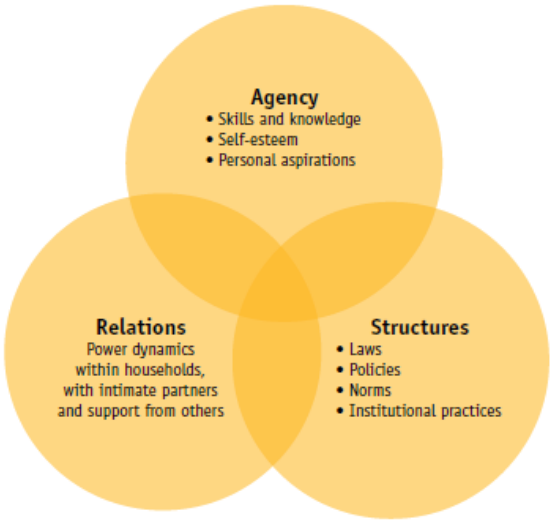

Figure 1. CARE's Empowerment Framework

[7] Ibid, pp. 78-79
[8] Khieu, D. *Promoting Gender Equality through Educating SRHR and GBV in Schools.* CARE Cambodia, August 2020
[9] CARE International Kenya, *Adolescents' Sexual Reproductive Health Baseline Survey Report. Adolescent Empowerment Program, March 2017*
[10] CARE International in Mali. *PCTFI Education for Change Project, Baseline Report, 2017,* p. 3
[11] Ibid, p. 6

transforming structures, including harmful norms and practices rooted in systems/laws into more supportive environments at the societal and policy levels, in order to achieve lasting change in the power and choices women and girls have over their own lives.

CARE believes that adolescent empowerment can happen when young people have the power to make their own informed choices, plan their futures, pursue opportunities to realize their aspirations, and lead the change/s they desire for themselves and their communities. Our approaches therefore include addressing the underlying socioeconomic, cultural and political barriers that limit adolescents, particularly girls, from realizing their ASRH rights.

Our approaches to integrating ASRH under PCTFI included establishing and fostering an enabling service delivery environment, an enabling social environment, and inclusive spaces for meaningful adolescent participation and adolescent-led change. Five focus areas were identified to integrate ASRH into PCTFI girls' education program (Figure 2).

Figure 2. Focus areas for comprehensive integration of ASRH information and access to services

This thematic brief will focus on learnings across the three key components (highlighted in Figure 2) that are directly linked to improving access to SRH information and services.

Strengthening SRH Knowledge and Rights Awareness

To improve SRH knowledge and rights awareness among adolescents, PCTFI programs, Cohort 3 included the development of, adaptations to, and (re) packaging of SRH curricula and the inclusion of relevant extracurricular activities, delivering essential age- and culturally appropriate ASRH information. The review of existing SRH curricula involved identification of missing topics such as puberty and associated changes and development during adolescence, sexual health and rights, HIV/STI, pregnancy prevention, gender norms and GBV, stigma/discrimination, as well as making the sessions and content more adolescent- and girl-user friendly with girl-positive pictures and stories. Comprehensive sexuality education (CSE) was provided where possible and supported by Ministries of Education to foster productive attitudes and behaviors as well as to increase reliable SRH information access to help adolescents make informed choices that can result in improved health and well-being. This component not only targeted adolescents but also their teachers, mentors, parents and caregivers to help them better understand, support and advocate for adolescents, particularly girls and other marginalized sub-groups.

Building Skills and Social Support for Informed SRH Decision Making

This focus area included building adolescents' capacity and skills for making informed decisions about their health and well-being; understanding norms, relationships and peer influences; enhancing skills to communicate, refuse and negotiate effectively; and finding help and support when needed.

Early on, considerations were taken into account about how best to involve adolescents in the design, implementation, and monitoring of program activities to help ensure that interventions were responsive to their needs and enabled them to develop and exercise their skills. Another key consideration was which approaches could be used to create enabling social environments where parents, teachers, and other community members understand, respect and support adolescents' rights to access accurate and appropriate SRH information and services as needed. This was done using different models and strategies to engage adolescents and their key influencers, creating safe spaces for critical reflection, dialogue and learning. Models included mentorship, with teachers serving as mentors for adolescent girls (in **Rwanda**). The adolescent development model (ADM) adapted CARE's leadership development model[12] (in **Zimbabwe**). Additionally, Social Analysis and Action (SAA)[13] approach was adapted for adolescents (in **Kenya and Cambodia**). Gender equity and diversity (GED) training and intergenerational dialogues (in **Nepal**) were also used to facilitate critical reflections, leading to individual and collective actions to support adolescents to be able to make informed decisions.

Increasing Adolescents' Access to SRH Services

Cohort 3 interventions facilitated the creation of inclusive spaces for meaningful adolescents' participation and adolescent-led change processes to improve their access to ASRH information and services. Adolescent voices were included to articulate their SRH needs and to highlight gaps in service delivery, including the absence of referral linkages for optimal uptake of ASRH services. CARE's community score card (CSC) approach[14] was adapted to be responsive to the contexts where it was implemented and to enable adolescents to articulate their ASRH needs and priorities. Through CSC, adolescents were able to inform which services should be prioritized and how they should be provided, as well as to define roles to be played by the different actors including schools and adolescents themselves. Additionally, trainings on and strengthening of adolescent friendly SRH services were conducted in some contexts to ensure quality and responsiveness of services and to improve adolescents' experiences and access to ASRH services.

Interventions and Results

Strengthening ASRH Knowledge and Rights Awareness

With the objectives of providing reliable and age appropriate SRH information and promoting the SRH rights of adolescents, Cohort 3 projects included not only included adolescents but also teachers and other caretakers (e.g., boarding house parents in Cambodia) as targets for ASRH awareness raising, information sharing, and capacity building training.

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[12] Adolwa, J., Brand, C., Kintz, G., Renault, L. and C. Toth. *Girls' Leadership Development in Action: CARE's Experience from the Field.* (Atlanta, GA, 2012). http://www.care.org/sites/default/files/documents/EDU-GE-2012-Girls-Leadership-Development-in-Action.pdf

[13] Social Analysis and Action, or SAA, is a facilitated process to explore, reflect on, and challenge discriminatory gender and social norms to eventually create equitable norms and behaviors.

[14] CARE's Community Score Card (CSC) is a citizen-driven approach that brings together local governments, health care service providers, and community members to identify barriers to accessible, equitable, and quality health services, including policy barriers. Together participants define key actions to improve services and implement and monitor progress. This model has been used to promote active participation by adolescents. See http://www.care.org/sites/default/files/documents/FP-2013-CARE_CommunityScoreCardToolkit.pdf and https://www.youtube.com/watch?v=TZJBPXaCLu4

After receiving SRH training, at the midline, biology teachers and boarding house parents in **Cambodia** self-reported higher levels of confidence in providing SRH information to students than other teachers.[15] Similarly, results of the students' self-reported knowledge, attitudes and expected future practices related to SRH showed examples of students with well-articulated knowledge, increased self-confidence, and positive attitudes toward sexuality education.[16] The midterm qualitative follow-up report also indicated that the project had made a significant impact on teachers' and students' knowledge and behaviors related to sexual and reproductive health (SRH), early marriage, and gender-based violence (GBV). Specifically, the SRH/GBV subjects were well recognized and appreciated by both teachers and students, and messages about SRH and GBV were delivered effectively through classrooms by biology teachers at most of the project's target schools.[17] Most students interviewed mentioned that they learned a lot from these sessions. Over time, learning in the SRH classes became more participatory since the start of the project, as students were increasingly encouraged to discuss issues openly and felt there was less shame and stigma attached to these subjects. Girls reported greater confidence in confronting or interacting with boys/males about SRH and GBV issues.[18] Yet, overall SRH knowledge showed no significant change at the endline, at 54% (versus 55% at baseline). It is worth noting that there was a significant difference in knowledge between male and female students, particularly on condom use; males (85%) were found to know that condoms can prevent pregnancy and reduce the risk of HIV or STI, more so than female (72%) students; and the question most participants in all categories got wrong was if a boy can get a girl pregnant the first time they have sex.[19] These results could indicate the limited depth of SRH discussions and comfort levels of both facilitators and adolescents. Additionally, the national CSE curriculum is facilitated by teachers who have no formal training in CSE, and the content in classes focuses more on the biology of the reproductive system.[20]

In **Nepal**, awareness regarding SRH increased over the period of intervention for both girls and parents. At the endline, around 63% of girls reported having heard or knowing about SRH, a significant increase from the baseline when only 6% of girls reported to be aware of SRH.[21] The majority (more than 92%) of the students reached by the project have accessed SRH information through schools, including accelerated education centers (ALCs) and formal schools. Nonetheless, the accurate knowledge level stands at only 23% during the endline evaluation.[22] Parents were also found to be less comfortable and less open to discussing or learning about ASRH (only 35% of parents attended SRH sessions organized by social mobilizers).[23] Parents were not willing to allow their girls to speak openly or to ask questions about multiple SRH issues. Topics that parents are discussing with their daughters mostly include menstruation and appropriate and inappropriate touching while they expect schools, clubs and other organizations to teach other SRH issues to their girls.[24] Similarly, girls participating in FGDs also reported challenges and reluctance to discuss SRH issues in the presence of boys or men,[25] indicating the critical role of sociocultural norms as barriers to receiving SRH information.

[15] CARE Cambodia. *Midterm Evaluation Report, Know and Grow project, July 2019,* p. 11
[16] Khieu, D. *Promoting Gender Equality through Educating SRHR and GBV in Schools.* CARE Cambodia, August 2020
[17] CARE Cambodia. *Know and Grow Midterm Qualitative Follow-up Report, November 2019,* p. 11
[18] Ibid, p. 11
[19] Hoban, L. & J. Williams. *Know and Grow Project Endline Report, October 2021 (Draft).* CARE Cambodia, p. 69
[20] Ibid, p. 88
[21] Rooster Logic. *Endline Evaluation of Hausala Initiative Final Report, March 2021*, p. 181
[22] Ibid, p. 182
[23] Ibid, p. 181
[24] Ibid, p. 181
[25] Ibid, p. 199

In **Mali**, through the development and use of mobile phone text messages and an M-Health platform on SRH and other adolescent-relevant topics, 23,010 adolescents (3,827 of whom are from girls' friendship circles) accessed reliable SRH information, and children's rights awareness has been enhanced. At midline, 45% of in-school adolescent respondents were aware of four contraception methods; there was a high level (88%) of self-reported knowledge about sexually transmitted infections (STIs) including HIV; and the percentage of those who **'**ever visited a health professional' about information or services related to sexual and reproductive health was reported to be 12%, an improvement from 2% at baseline.[26] At endline, 49% of students with access to a mobile phone reported receiving an SMS about SRH, while 31% of students said they had received SRH information through friendship circles.[27]

In **Rwanda**, one critical element of the Safe Schools for Girls (SS4G) project was to train school-based teacher mentors. Over 2,000 teachers underwent training to serve as mentors and to deliver a Comprehensive Sexuality Education (CSE) curriculum adapted from "The World Starts with Me" model.[28] Mentors provided information and counselling to adolescents through one-on-one and group-based sessions to improve access to health services to address contraceptive and reproductive health information needs. At midline, the proportion of respondents who reported feeling that they knew 'whom to reach out to' for information and services increased from 86% at baseline to 92% at midline.[29] The proportion of respondents who said they would know where to get a contraceptive if they needed one increased from 78.2% at baseline to 89.1% at endline, and female adolescents were 13 percentage points more likely than their male peers to know where to obtain contraceptives.[30] Students still cited teachers (40%) friends (35%) and parents (32%) as reliable source of SRH information at endline; however, use of radio significantly increased as a reliable source to 66% (from 32% at baseline).[31]

In **Zimbabwe**, a standardized ASRH teachers' manual provided guidance to teachers about lesson planning, content delivery, and daily and weekly learning assessments through tests, drama, paired and group activities, and role plays. Additionally, engagement with ASRH service providers from the Ministry of Health and Child Care (MoHCC) and Population Service International (PSI) as external facilitators and resource people complemented the delivery of the curriculum and improved the dissemination of accurate and age appropriate SRH information. With these efforts, promising positive changes in knowledge among adolescents were recorded: in Epworth district, girls' knowledge on the preventive use of condoms against HIV/STIs significantly increased from 73% at the baseline to 89% at the midline and 93% at the endline; adolescent boys' knowledge of using condoms to prevent pregnancy progressively changed from 79% at baseline to 91% at midline and 88% at the endline.[32] Learners became more aware of their rights and were risk-averse when faced with situations that threatened their SRH status. The majority of adolescent learners perceived that abstaining from sex prevents HIV infection, and results showed a steady increase from 85% to 89% for boys and 85% to 92% for girls from midline to endline respectively. Learners also confirmed during FGDs at the endline that the project empowered them with awareness, confidence and power to

[26] CARE USA. *Education for Change, Midterm Supplementary Analysis, October 2019,* p. 1
[27] Daouna Development Conseils. *Education for Change. Endline Evaluation, January 2021,* p. 101
[28] The World Starts With Me (WSWM) is a comprehensive sexuality education (CSE) program developed by Rutgers, a non-profit funded by the Government of the Netherlands Ministry of Health. WSWM combines sexuality education with learning ICT skills and includes topics often difficult to discuss by teachers and young people related to sexuality, relationships, and the human body.
[29] Laterite. Data| Research| Advisory. From data to Policy. *Safe Schools for Girls Project, Midline Evaluation Report, June 2019,* p. 32
[30] Grassroots Research. *Endline Evaluation for the Safe Schools for Girls' Project, Final Report. December 2021*, pp. 25-26
[31] Ibid, p. 23
[32] The CSR Group Africa. *Final Endline Evaluation Report. PCTFI, Empowering Adolescents for Lifelong Learning Project in Epworth and Zaka District, Zimbabwe. June 2020*, pp. 33-34

report any kind of abuse including sexual abuse that they might experience whether at home or at school.[33]

Building Skills and Social Support for Informed SRH Decision Making

Beyond improving ASRH knowledge and rights awareness, ASRH approaches under PCTFI Cohort 3 focused on creating an enabling environment for adolescents to be able to put their ASRHR knowledge into practice and action - through skills development for adolescents as well as creating spaces to rally support from their gatekeepers.

In **Kenya**, the Adolescent Empowerment Project (AEP) created 'safe spaces' for dialogue using the Social Analysis and Action (SAA)[34] model and adolescent-led fora that enabled students to discuss ASRH issues affecting them as well as to identify ways of addressing the barriers and associated challenges. Facilitated by community-based youth facilitators and health care workers, the dialogue sessions created opportunities to unearth underlying barriers and to dispel myths and misinformation on ASRH.[35] Using the SAA process, and complemented by leadership skills development activities, adolescents were able to plan and implement individual and collective actions, which included conducting adolescent-led SRH reflection sessions using school assemblies. Issues presented by adolescents during the school assemblies included teenage pregnancies, female genital cutting (FGC), GBV (including early marriage), and drug abuse.[36] These sessions along with other project interventions contributed to the identification of adolescent mentors who took up roles to share SRHR information with other adolescents and supported life skills development efforts.[37]

Similarly, in **Rwanda**, the mentorship model was used as a tool to help teachers listen to the challenging issues and emotions experienced by adolescent girls and boys, to provide guidance to student clubs and through one-on-one sessions on different issues ranging from attendance and relationships to adolescent girls' specific challenges, including menstrual hygiene management issues.[38] Yet, at the endline, even though knowledge about SRH and contraceptives has improved from previous evaluations, girls were more convinced than boys that "real men don't use condoms" and that women are responsible for protection instead,[39] indicating the need for programs to focus on gender attitudes and (mis)perceptions in addition to improving access to SRH information and facts.

In **Cambodia**, improvements were reported in SRH-related self-efficacy measures - students' confidence in refusing sex if they didn't want to have it; obtaining SRH services; and ability to make their own decisions to use contraception without permission from a parent or partner all significantly improved from baseline to midline.[40] The percentage of students who were 'extremely confident' to refuse sex if they don't want it increased from 33% at baseline to 60% at the endline.[41] However, ethnic minority students reported being less confident than Khmer students in their ability to report inappropriate touching and in refusing to have

[33] Ibid, p. 75
[34] SAA is a facilitated process to explore and challenge discriminatory gender and social norms, leading to individual and collective actions to create equitable norms and promote behavioral changes.
[35] CARE Kenya, *Technical Brief, Social Analysis and Acton (SAA) with Adolescents and Parents, April 2021*
[36] Ibid
[37] CARE Kenya, *Technical Brief, Social Analysis and Action (SAA) with Adolescents and Parents, April 2021*
[38] CARE Rwanda. ASRH learning session presentation, February 2020, p. 11; p. 28; p. 54
[39] Grassroots Research. *Endline Evaluation for the Safe Schools for Girls' Project, Final Report. December 2021*, p. 11; p. 28; p. 54; p. 58
[40] *Midterm Evaluation Report, Know and Grow Project, CARE Cambodia, July 2019,* p. 11
[41] Hoban, L. & J. Williams. *Know and Grow project Endline Report, October 2021,* p. 42

sex if they didn't want to,[42] indicating the need to better understand unique needs and barriers of different adolescent sub-groups, and to tailor approaches to better address specific root causes and issues.

In **Zimbabwe**, the Adolescent Development Model (ADM) was integrated into the school Guidance and Counselling (G&C) learning area and served as a platform where both girls and boys could easily converse about their ASRH issues. Additionally, the project team adapted the Community Score Card (CSC)[43] where adolescents participated in identifying and highlighting barriers to accessing lifelong learning opportunities that are responsive to the unique and ever-changing needs of young people. The CSC process was adapted for use with teachers, learners, parents and service providers (for example, community nurses) and enabled open discussions around ASRH, facilitating the "rebranding" and demystifying of what ASRH traditionally means for adolescents, their parents and teachers. Amongst the challenges identified during the process were poor adolescent health-seeking behaviors, unwanted pregnancies, drug abuse, child prostitution, poor parental support, lack of accurate ASRH information, and lack of menstrual hygiene management services both in schools and at the community level.

In **Mali**, the Education for Change (EFC) project saw the need to address misunderstandings, traditional beliefs and behaviors around the use of contraceptives, including condoms, which are perceived to be used only by adults. To this end, the project facilitated community mobilization and dialogue sessions for project endorsement and buy-in through close collaboration with local key community actors, including elected officials, school authorities, women's Village Savings and Loan Association (VSLA) groups and networks, men's groups, traditional and religious leaders, and youth groups.[44] At the midline, 34% of in-school respondents reported receiving information from a friend or family member,[45] which is significant in a context where discussing SRH topics is highly limited due to cultural and religious norms. Moreover, at the endline, almost 65% of adolescents visited SRH counseling and referral services (39% for contraceptive services and 26% for treatment services), and approximately 51% of students reported being 'very confident' or 'confident' that they could ask a partner to use a condom or some form of contraception if they wanted to.[46]

In **Nepal**, the Hausala project provided Gender Equity and Diversity (GED) and SAA trainings to NGO staff; adapted 'Rupantaran'[47] weekly sessions for adolescents; and facilitated intergenerational dialogues among parents and adolescents to address the deep-rooted taboo of discussing ASRHR issues among girls and parents. Community engagement through dialogue sessions among collectives and parents was found to be useful to build acceptance around discussing ASRHR issues and facilitated open discussions on discriminatory beliefs and biases around menstruation and menstruation-related issues among parents.[48] An assessment on SRH and social norms done by the project showed that 61.7% of respondents report having communicated about body changes and norms with someone, of which 79.7% had done it with their mother and 54% with their friends.[49] However, at endline, parents were found to be still looking towards

[42] Ibid, p. 72
[43] The Community Score Card (or CSC) is a two-way and ongoing participatory tool for assessment, planning, monitoring and evaluation of services.
[44] CARE Mali. ASRH learning session presentation, Empowering young women and girls through digital skills, February 2020.
[45] CARE Mali. *Education for Change. Midline, June 2019,* p. 15; p. 18
[46] Daouna Development Conseils. *Education for Change. Endline Evaluation, January 2021,* p. 161
[47] *Rupantaran* is a social and financial skills package that provides practical skills and knowledge on gender equality and human rights, reproductive health, gender-based violence, nutrition, communication, decision making and negotiation skills. The package was adopted by the Government of Nepal's Department of Women and Children and supported by UNFPA.
[48] Nepal and PCTFI: Linkages with adolescent friendly sexual and reproductive health services. ASRH learning session presentation, February 2020
[49] CARE Nepal, *Haushala, SRH and Social Norms Survey, September 2019*

schools to address SRH issues with girls and lacking information about SRH services. Moreover, despite efforts to empower girls, parents were considering girls to be married around the legal age of marriage, reducing their chance for higher education.[50] These highlight the importance of exploring and addressing decision making power dynamics within households and ultra-marginalized communities and the need to create and sustain a supportive social environment for adolescent girls to thrive.

Improved Access to ASRH Services

To make SRH services adolescent-responsive and user-friendly, Cohort 3 adapted CARE's flagship social accountability approach, the Community Score Card (CSC), to ensure adolescent participation to improve ASRH service delivery provided at different levels and through various platforms.

With the aims of lifting up student voices and highlighting their needs for ASRH services through CSC, the project team in **Zimbabwe** created a feedback mechanism among schools, service providers, communities, and local authorities. The CSC process complemented other PCTFI interventions, including mapping of and linking service providers to schools, creating space for dialogues on ASRHR, building trust and positive relationships with service providers, and encouraging visits to services by adolescents. This process enabled prioritisation of menstrual hygiene management (MHM) as an issue affecting access to quality and equitable education amongst adolescent girls. In Zimbabwe, drawing upon the CSC process and conducting additional research on MHM advocacy, adolescents developed a position paper on MHM for lobbying policy makers to provide sanitary wear for learners. In response, the National AIDS Council provided USD$2,000worth of sanitary kits for the Epworth district.[51]

Additionally, the Ministry of Primary and Secondary Education (MoPSE) issued a regulation circular requiring schools to allocate a mandatory budget for MHM kits and collaborated with a local partner (ECOZI) in the strategic development of the guidance and counseling (G&C) policy brief advocating for multiplication of impact (adoption and adaptation at national level), including a joint project advocacy strategy focusing on ASRH and incorporation of MHM into its sustainability plan.[52] Monitoring data suggested that about 83% of all project schools had deliberate interventions targeting girls and boys, such as provision of sanitary pads, pain-stop tablets and inviting voluntary medical male circumcision service providers. The G&C teachers from these schools further confirmed that girls had increasing confidence in seeking sanitary wear and pain stop tablets during their menses.[53] The midline evaluation showed that amongst learner respondents, 25.6% of boys and 16.7% of girls had received STI testing and counselling, 40.3% of boys and 30% of girls had received HIV testing and counselling, and 31.1% of boys and 24.6% of girls had visited a health facility or other place to get reproductive health services or counselling within the twelve months prior to the assessment.[54] Boys' confidence in getting condoms if required increased the most between midline and endline (44% vs. 72%); confidence to getting HIV test if needed also increased significantly for boys (79% vs 87% vs 90%) and for girls (73% vs 92% vs 87%) at baseline, midline and endline respectively.[55] Yet, at endline though not statistically significant, there were declines in the number of learners who visited a health facility for ASRH services in the last 12 months for boys

[50] Rooster Logic. *Endline Evaluation of Haushala Initiative of LEAD program. March 2021,* p. 14
[51] CARE Zimbabwe. Improving learner voices on ASRH through CSC, ASRH learning session presentation, Feb. 2020
[52] Ibid
[53] Ibid
[54] Empowerment for Career Development (EMCAD). *Empowering Adolescents for Lifelong Learning Project in Epworth District, Zimbabwe, Midline Evaluation Final Report, November 2019,* p. 34
[55] The CSR Group Africa. *Final Endline evaluation Report. PCTFI, Empowering Adolescents for Lifelong Learning Project in Epworth and Zaka district, Zimbabwe. June 2020,* pp. 36-37; p. 71; p. 39

(32% to 26%) and for girls (24% to 19%)[56] which could be associated with the overall socioeconomic deterioration rather than their level of awareness of or confidence in accessing services.

In **Kenya**, the CSC process under the AEP project involved health service providers discussing and explaining about the services provided at their facilities, and at the same time the service providers got an opportunity to listen to the challenges faced by adolescents accessing ASRH information and services. As a result, in one school community in Kajiado, the reproductive health coordinator established an adolescent desk at the community facility (Enkorika Health Centre) while in some school communities in Mukuru (Mennonite and Lunga Lunga SDA), the community health volunteers started discussing with adolescents about ASRH services available at the local health facilities.[57] GBV service providers in Mukuru area also started organizing sessions with adolescents about GBV services, including the reporting mechanisms and information on how adolescents can access GBV services safely and confidentially.[58]

Similarly, in **Rwanda**, the SS4G project adapted the CSC approach with adolescents in a school-based setting to give adolescents a forum to voice their concerns regarding education and ASRH, to define the issues and barriers they encounter in accessing quality education and ASRH information. Some of the actions they took related to ASRH resulted in the provision of private girls' rooms at schools equipped with sanitary towels and free provision to girls in need; separation of toilets for boys and girls; and the implementation of a code of conduct for teachers.[59] Yet, boys reported to have lost confidence when it comes to accessing health facilities for SRH services to 89% at endline from 98% at the baseline while girls' self-confidence increased to 98% from 95% at baseline.[60] Students explained in the FGD that shortage of staff at the health facility, lack of confidentiality, and lack of health insurance and transportation are challenges they face in accessing services.[61]

In **Nepal**, the Hausala project supported schoolgirls' clubs where girls identify barriers to ASRH services, presented their findings to different stakeholders including parents, teachers and local government, and demanded support to implement their action plans. Through dialogue sessions organized with different stakeholders in Rupandehi district, girl-led action plans related to service access led to improved community awareness while amplifying their voices, demanding adolescent friendly services including clean toilets, free distribution of sanitary pads at school, as well as training on homemade reusable sanitary pads for affordable and hygienic management of menstruation.[62] Health workers in both Rupandehi and Kapilvastu districts were trained on the delivery mechanism of adolescent-friendly health services while the local government started taking forward the initiative to establish adolescent-friendly health services to motivate more adolescents to seek and access services in safe and secure environments from supportive service providers.[63] The endline evaluation showed that 22% (N=619) of girls have visited health facilities for SRH services. Most of them (85%) visited the nearest public health facilities with the majority of these (88%) looking for menstruation-related issues including pain, excessive bleeding, and sanitary materials.

[56] Ibid, pp. 41-42
[57] Adolescent Empowerment Project (AEP). Integrated Community score card and social analysis to address biases and barriers to ASRH. ASRH learning session presentation, February 2020
[58] Ibid
[59] CARE Rwanda, ASRH learning session presentation, February 2020
[60] Grassroots Research. *Endline Evaluation for the Safe Schools for Girls' Project, Final Report. December 2021,* p. 29; p. 54
[61] Ibid, p. 30
[62] Nepal and PCTFI. Linkages with adolescent friendly sexual and reproductive health services. ASRH learning session presentation, February 2020
[63] Ibid

More than half (52%) who visited health facilities reported that they were comfortable with the experience.[64]

Lessons and Recommendations

Inclusion and targeted interventions: Designing integrated programming with ASRH components should include mapping relevant stakeholders in each context, with intentional inclusion of men and boys as key population groups. For Comprehensive Sexuality Education (CSE) or integrating ASRH into national curriculum, proper assessment, capacity building, and regular monitoring of capacity, comfort and confidence levels of facilitators, teachers, and mentors are essential to ensure quality and effective delivery of information as well as skills building for adolescents.

Additionally, interventions need to include awareness raising, social and behavioural change (SBC) among key stakeholders to ensure favourable and supportive conditions and shared understanding of the challenges facing adolescent girls and boys. These stakeholders include parents, caretakers, and health care providers, to ultimately create a social and service delivery environment that enables adolescents to make informed choices and exercise their SRH rights.

Diverse approaches to deliver accurate and quality ASRH information: Communication and engagement of program participants through multiple channels including print, audio-visual tools, social media and other ICT platforms create opportunities to reach multiple subgroups of adolescents with accurate information. Relying on teachers, in-school platforms, or parents may not ensure access to correct information, as was noticed in some of PCTFI's endline evaluations. Using multiple options and ensuring the accuracy and credibility of information being shared needs to be emphasized as well as guiding users on how to search for, vet, and select reliable ASRH information sources. Availing alternative ways will enable more opportunities for ASRH dialogues, provide choices to engage within the different comfort levels of the respective target audience, and enable better access to learn about SRH issues mostly considered as 'taboo' topics (e.g., condom use, contraception, early marriage, female genital cutting).

Adolescent voices and meaningful engagement: Working with and engaging adolescents from the start is key to designing more responsive programs based on adolescents' diverse needs and more feasible ways of addressing barriers. Building adolescents' agency, leadership, and life skills so that they can take charge of their ASRH needs and rights can lead to shifting the power dynamics among different stakeholders in their lives, including parents, teachers and health care providers. Providing opportunities and platforms to elevate the voices of adolescents where they get to negotiate for and be able to take adolescent-led actions, including adolescent-informed advocacy, can mobilize stakeholders' support around the value of providing ASRH information as well as improving access to adolescent-friendly services.

Partnerships/cross sectoral collaboration: Effective delivery of ASRH information and services requires collaboration across sectors. At a minimum, education and health sectors should work together to provide age-appropriate and accurate information through engaging curriculum and activities, as well as responsive SRH services tailored for adolescents. Engaging with other relevant cross-sectoral actors including policy makers for favourable mandates in support of effective integration of ASRH within the education system is also a critical enabler to be considered (e.g., CSE).

Do no harm: It is important to ensure proper understanding of context, as well as buy-in and trust from

[64] Rooster Logic. *Endline Evaluation of Haushala Initiative of LEAD Program. March 2021,* p. 150

different gatekeepers at different levels, including school and community level stakeholders. The success of interventions, particularly addressing relatively 'sensitive' issues like adolescent sexuality, reproductive health, gender-based violence, and other forms of abuse is determined by the level of adult support and the creation of enabling environments for adolescents to act upon their knowledge and needs, and to be able to exercise their rights safely. Program staff need to assess and understand both the context and the impact of interventions and ensure relevant stakeholders are included in the planning and execution of appropriate trainings, skills transfer, and capacity building activities.

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