Global

A Safe Place to Shine

Creating Opportunities and Raising Voices of Adolescent Girls in Humanitarian Settings

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INTERNATIONAL RESCUE COMMITTEE

Front cover image:
Alewya, 14, lives in Bombassi refugee camp, in Ethiopia. To pursue her dream of becoming a teacher, she attends life skills sessions run by the IRC in girl-only safe spaces. "Adolescent girls need to come to the safe space to learn and to make friends," she says. Photo credit: Meredith Hutchison

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While every effort has been made to ensure the data contained in this report is accurate at time of publication, IRC recommends that readers consult forthcoming journal articles for the latest analysis and findings. Further details of these may be found in Annex 5.

ACRONYMS

aOR	Adjusted odds ratio
ACASI	Audio Computer Assisted Self-Interviewing
CAPI	Computer assisted personal interviewing
CBO	Community based organisation
COMPASS	Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces
DFID	UK Department for International Development
DRC	Democratic Republic of Congo
GBV	Gender-based violence
IDP	Internally displaced person
INGO	International Non-Government Organisation
IRC	International Rescue Committee
ITT	Intent to Treat
PAIMAN	Pakistan Initiative for Mothers and Newborns
PP	Per Protocol
SRH	Sexual and reproductive health
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
VPRU	Violence Protection and Response Technical Unit
WASH	Water, Sanitation and Hygeine
WPE	Women's Protection and Empowerment

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FOREWORD

Adolescence is a distinctly challenging and critical time for girls. During adolescence, while boys' worlds expand, girls' worlds start to shrink.

Harmful gender norms underpin beliefs that girls have less value and are less capable than boys, which often means girls are denied education, socially isolated and exploited. Adolescent girls living in emergency settings are among the most marginalised populations in the world and humanitarian crises render adolescent girls even more vulnerable to risks of gender-based violence (GBV), such as sexual violence and exploitation, early and forced marriage and intimate partner violence.

This report represents the culmination of the International Rescue Committee's (IRC) and UK Department for International Development's (DFID) three-year investment in the Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces (COMPASS) programme, implemented with adolescent girls, their families and communities in eastern Democratic Republic of Congo (DRC), refugee camps on the Sudan/Ethiopia border, and north-west Pakistan. It fills a critical gap in documenting the nature of GBV affecting adolescent girls in humanitarian settings and understanding of how we can protect adolescent girls from violence and promote their safety, health and empowerment.

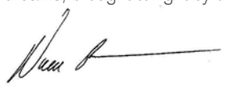
While COMPASS research revealed that a shockingly high number of girls, some as young as 10, are experiencing GBV, it also demonstrated that interventions to support, empower and protect adolescent girls in humanitarian settings are feasible and welcome by girls, their families and their communities. COMPASS delivered support for adolescent girls at a crucial time in their lives, helping them build networks of support and feel more positive about themselves and the future, while increasing girls' knowledge of life-saving GBV services.

Nonetheless, adolescent girls continue to fall behind during humanitarian responses – too young for women's services, too old for child-friendly programmes. Although current global policy frameworks and initiatives increasingly recognise the need to address protection of adolescent girls, none provide a comprehensive, gender and age sensitive plan of action for adolescent girls in humanitarian contexts.

The IRC applauds DFID for their investment in programming and research that focuses specifically on the experiences and voices of adolescent girls. Without targeted initiatives like COMPASS, it would be impossible to both understand the complex vulnerabilities of girls living in crisis and to design practical solutions to protect and empower them.

The IRC is committed to keeping adolescent girls at the centre of humanitarian responses worldwide through continued investments in the development and roll-out of the Girl Shine resource package, which builds on learning from COMPASS. We thank the tireless frontline teams whose dedication, openness to change and ingenuity allowed the IRC to reach almost half a million adolescent girls in 2016.

No matter where they are, adolescent girls deserve a safe start in life and an equal chance at realising their ambitions. We hope that this report will be a concrete step in the right direction, providing evidence and recommendations for practitioners, policymakers and donors towards a holistic response to the needs, and dreams, brought to light by the girls featured in this report.



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EXECUTIVE SUMMARY

Adolescence is a distinctly challenging and critical time for girls, during which they face immense social barriers that limit them from leading safer, healthier and more self-sufficient lives. Humanitarian crises, which rupture existing key community and state structures such as health care, education and social services, and break up or displace families and communities, render adolescent girls even more vulnerable. Adolescent girls living in crisis-affected communities, including refugees and internally displaced persons (IDPs), are at increased risk of gender-based violence (GBV), including sexual violence and exploitation, intimate partner violence and early and forced marriage.

GBV is a direct attack on girls' mental and physical health, and future aspirations and prospects. It has implications on girls' access to education, participation in society, employment prospects and family life. Although there is a growing body of information on the prevalence of GBV against girls, there is still little research available specific to adolescent girls in humanitarian settings. As a result, there is also a lack of rigorous evidence on effective strategies for protecting adolescent girls in humanitarian settings from GBV and helping them recover.

To respond to the specific needs of adolescent girls in humanitarian settings and to address the gap in evidence of what works to promote the health, safety and empowerment of adolescent girls, the International Rescue Committee (IRC) has invested in a robust adolescent girl programming and research agenda. As part of this effort, the IRC partnered with Columbia University over a three year period (2014–2017) to develop, implement and evaluate the Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces (COMPASS) programme, funded by the UK Department for International Development (DFID). COMPASS was implemented with refugees living in camps on the Sudan/Ethiopia border, conflict-affected communities in eastern Democratic Republic of Congo (DRC), and displaced populations in north-west Pakistan.

The IRC developed and implemented the interventions used in COMPASS by building on existing programming and resources on adolescent girls and GBV, as well as adapting them for the complex contexts of diverse humanitarian settings. COMPASS was implemented by IRC's Women's Protection and Empowerment (WPE) programme teams, with support from IRC researchers and technical advisors, and evaluated by Columbia University.

COMPASS included the following core interventions:

- **Adolescent girls' life skills sessions:** weekly discussions with groups of adolescent girls in allocated safe spaces, facilitated by young female mentors.
- **Parent/caregiver discussion groups:** monthly discussions with parents/caregivers of adolescent girls participating in the programme.[1]
- **Service provider support:** targeted training and ongoing support to develop knowledge, capacity and skills regarding the specific needs of adolescent girls, and particularly those who have experienced GBV.

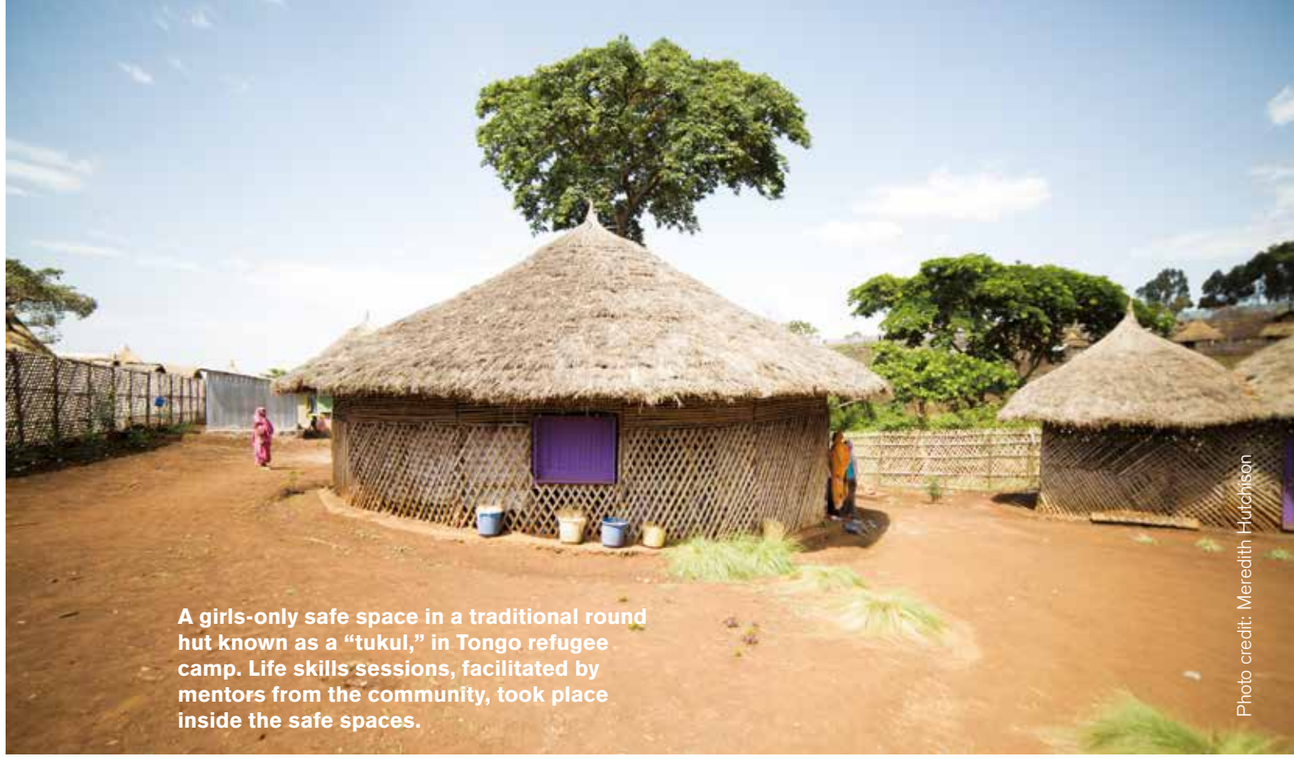
An external evaluation, led by Columbia University, was carried out across the three programme locations to assess the effectiveness, feasibility and acceptability of the above programme interventions. The evaluation in each programme location had different objectives and different designs. Methodologies included quantitative and qualitative data collection. Each country's evaluation is described below:

- In Ethiopia, an impact evaluation was carried out to study whether the adolescent girls' life skills sessions conducted as part of COMPASS had an impact on the girls' exposure to gender-based violence (GBV) and their social and health outcomes.[2]
- In DRC, the evaluation sought to assess the additional impact of the parents' group discussions on adolescent girls' exposure to GBV, their social and health outcomes, as well as on the attitudes of parents towards adolescent girls.[3]
- In Pakistan, the evaluation assessed the feasibility and the acceptability of the programme to adolescent girls and parents in their context, and measured changes in girls' social and health outcomes over the course of the programme.

Though the study design was different in each country, common outcomes were measured in all three, to enable some comparison. In addition to the external evaluations led by Columbia University, the IRC's Women's Protection and Empowerment teams in each location collected monitoring data throughout the implementation of the programme to assess what did and did not lead to desired changes, and to inform programme adaptations and feed into wider learning.

This report shares learning from the implementation and evaluation of COMPASS across locations in Ethiopia, DRC and Pakistan.[4]

1. The term parent will be used here on out in the report to indicate parent/caregiver.
2. The evaluation examined girls' exposure to sexual, physical and emotional violence. For the purposes of this report, these types of violence are referred to as gender-based violence (GBV). Exposure is the equivalent of experiencing violence. For more information on the research questions asked to assess exposure to violence, please see Annex 3: External Evaluation Methodology.
3. As compared to girls who received the life skills sessions, without their parent/caregiver participating in the group discussions.
4. For more detailed information on the implementation and evaluation of COMPASS in each location, please see the country specific reports. They are available at http://gbvresponders.org



A girls-only safe space in a traditional round hut known as a "tukul," in Tongo refugee camp. Life skills sessions, facilitated by mentors from the community, took place inside the safe spaces.

Photo credit: Meredith Hutchison

The state of adolescent girls in humanitarian settings: findings from the COMPASS baseline survey

The COMPASS baseline survey, carried out prior to the implementation of the COMPASS interventions, provides insight into the frequency of GBV experienced by adolescent girls, the norms and attitudes adolescent girls hold related to GBV and gender, their knowledge of GBV services, their existing systems of support and their hopes and expectations for their future.[5]

Adolescent girls as young as ten in humanitarian settings are at high risk of GBV.

In DRC and Ethiopia, the study conducted prior to the beginning of the programme revealed that adolescent girls are exposed to extremely high levels of GBV. 45% of adolescent girls in Ethiopia and 37% in DRC reported experiencing sexual violence in their lifetime. In the past 12 months, 52% of adolescent girls in Ethiopia and 61% in DRC reported experiencing at least one form of sexual, physical or emotional violence.

Frequencies of sexual violence experienced in the past 12 months were particularly high: 29% in Ethiopia and 26% in DRC.[6,i] In Ethiopia, forced sex (or rape), was the form of sexual violence most frequently reported to have taken place in the past year (18%). The baseline survey also suggested that many girls experience forced sex regularly; nearly 40% of those who had experienced forced sex reported that the most recent occurrence was within the past week.

Adolescent girls are also experiencing sexual violence at a young age. In DRC, girls aged 10–12 were more likely to report coerced sex and unwanted sexual touching than older girls, and in Ethiopia, adolescent girls aged 13–14 were more than twice as likely to report having experienced sexual exploitation than girls aged 15–19.

Intimate partners were most likely to be the perpetrators of nearly all types of violence against adolescent girls across both countries. Sexual violence against adolescent girls was most commonly perpetrated by an intimate partner. In Ethiopia, 43% of sexual violence was perpetrated by intimate partners, followed by parents or relatives (29%) or friends/neighbours (9%).[7] Similarly, in DRC, 49% of sexual violence was committed by intimate partners, 17% by parents and 14% by friends/neighbours. There was low reporting of other perpetrators, such as community officials (police, teachers, local leaders) or armed actors.

In addition, around 1 in 5 girls across the three countries had experienced early marriage, or were living with a man as if married. Early marriage not only makes girls more vulnerable to GBV; it limits girls' opportunities and constitutes a form of violence itself.

5. Questions explicitly about adolescent girls' exposure to GBV or sex were not included in the Pakistan survey due to safety concerns. The primary focus of the study in Pakistan was on feasibility and acceptability of the programme
6. Sexual violence will be used in this report as an aggregate term for exposure to unwanted touching, forced sex, or coerced sex. Girls were asked if they had experienced "unwilling sex." if they had been threatened or pressured to have sex by someone with influence/authority, or if someone had touched them in a sexual way without their permission.
7. Data on perpetrators was not disaggregated according to gender. This was due to the need to minimise response categories in order to use the ACASI software effectively with the research participants.

Photo credit: Meredith Hutchison

Girls play together in Tongo refugee camp. Helping girls to make friends was a key impact of COMPASS, and was often described by girls as a highlight of the programme.

There is a high acceptance of gender inequality and tolerance of violence against women and girls.

Adolescent girls broadly agreed, particularly in DRC, that men have the final word on decisions in the home, and that women were responsible for avoiding pregnancy. On violence, 71% of adolescent girls in Ethiopia and 81% in DRC agreed with at least one of a number of statements which deemed it acceptable for a man to hit his wife in certain circumstances. In DRC, an overwhelming 95% of girls agreed that women should tolerate violence to keep the family together. These findings suggest a normalisation of violence against women in the home.

Adolescent girls lack social support outside of their family, and have little knowledge of professional GBV services.

In all three countries, adolescent girls had good relationships with their parents and other relatives, and in particular women and girls in their family. However, few girls had an adult they could talk to if they had problems or experienced GBV. In addition, they also reported a fear that they would be blamed or stigmatised if they experienced GBV, or would be subjected to further violence such as early or forced marriage.

While the majority of adolescent girls had friends outside of their family who they could talk to about important things, their social networks were limited: around half the girls in DRC (55%) and Ethiopia (43%) did not have a female figure in the community they could go to with their problems on a regular basis.

Adolescent girls and their parents had limited knowledge of professional services to help GBV survivors in all three countries. In Ethiopia, only one in four girls knew a place they could go to for help if they experienced sexual violence. Even where adolescent girls did know about GBV services, they were reliant on an adult for access. Despite fears about how they would react, girls said they were more likely to seek help from a family member or community leader about an act of violence.

Adolescent girls have low hope and low expectations for their future.

In all three countries, adolescent girls had average levels of self-esteem compared to global levels.[9] However, they had limited expectations about opportunities for adolescent girls and lacked belief about their ability to achieve their own goals. This included having low expectations about the level of education a girl should complete, and the opportunities available to girls compared to boys.

8. Self-esteem was assessed though the Rosenberg self-esteem scale (Rosenberg, 1979). The 10-item Likert scale has been used in over 50 countries, and higher scores indicate greater self-esteem (Rosenberg, 1979; Schmitt & Allik, 2005).

What works to address GBV against adolescent girls: Learning from COMPASS

The evaluations of the COMPASS programme in all three countries provide important learning on how effective the interventions were in reducing adolescent girls' exposure to GBV and improving other social and health outcomes that can help protect them from GBV. The learning on how feasible and acceptable such programming is in humanitarian settings, and best practices regarding day-to-day implementation of the programme, are also important.

Effectiveness and change: The impact of COMPASS on adolescent girls

By the end of the programme, adolescent girls in Ethiopia were almost twice as likely to have friends, and more than twice as likely to have a trusted non-family female adult, compared to girls who did not attend the life skills sessions. In DRC, the number of girls who had four or more friends rose from 54% to 96% from the beginning to the end of the programme. More girls in DRC and Pakistan had a trusted female adult outside of their family that they could talk to, and had friends of their own age outside their family.

In all three countries, interviews with adolescent girls revealed they had a strong sense of companionship with other adolescent girls in the programme, and that the quality of their friendships, and in some cases family relationships, had improved. At the end of the programme, adolescent girls had a stronger understanding of quality friendships: they often mentioned that good friends give good advice, help each other stay safe and share ideas with each other.

COMPASS improved adolescent girls' hopes and expectations for the future.

In all three countries, adolescent girls who participated in the programme had higher expectations for what the future held for them and their peers. In Ethiopia, the number of adolescent girls who thought that girls should be 18 or older before having their first child or getting married doubled from the beginning to the end of the programme. In Pakistan, girls were significantly more likely to believe they should be given the same life opportunities as a boy, and more likely to agree that working outside the home after marriage is acceptable, following completion of the programme.

Girls were also more hopeful about their own futures at the end of the programme in all three countries.[9] In DRC, this was most significant with the youngest girls, aged 10-12. In Pakistan, girls' self-esteem was significantly higher at the end of the programme.

COMPASS provided girls with a safe place, but it's broader impact on girls' safety was unclear.

Adolescent girls in Ethiopia and DRC gave positive feedback about the safe spaces. In Pakistan the median average number of places outside the home that girls could visit rose from one to two. In DRC, girls were more likely to report having a safe place to spend time with other girls as a result of the programme. Importantly, at the end of the programme, adolescent girls across all three countries were able to talk about many of the key messages in the life skills curriculum which focused on strategies for keeping safe.

The impact of COMPASS on girls' safety outside the safe space was less clear. Although there was an overall reduction in girls' reported exposure to GBV in DRC from the beginning of the programme to the end of it, the evaluation could not demonstrate that this change came as a result of COMPASS. The evaluation also did not show a statistically significant improvement in girls' feelings of safety outside the safe space in Ethiopia or DRC.

In addition, at the end of the programme, adolescent girls in Ethiopia and DRC continued to hold attitudes that indicated acceptance of gender inequality and GBV. In both countries, a majority of adolescent girls agreed that women and girls are responsible for avoiding pregnancy, men should have the final word on decisions in the home, and females should tolerate violence to keep their family together. In Pakistan, girls still associated safety with restriction of movement, saying that they felt safer if they did not leave the house alone.

Due to the limited scope of the intervention and the short time between the end of the life skills sessions and the evaluation, this finding is unsurprising. Adolescent girls live in environments where attitudes towards gender equality are entrenched in deep-rooted social norms, and continually reinforced across generations. Sustained, long term interventions are required to transform these norms.

9. Measured by the Children's Hope Scale. An average score above 4.7 indicates respondents have a strong positive perception of his or her own capacity to achieve goals. A score of 3.0–4.7 indicates medium perception of self-capacity to achieve goals, and a score below 3.0 indicates low perception of self-capacity. On average, adolescent girls in DRC scored 2.3 at baseline and 2.5 at endline; in Pakistan, the average was 3.67 at baseline and 4.00 at endline.

Effectiveness and change: The impact of COMPASS on parents/ caregivers and their relationships with adolescent girls

COMPASS helped parents learn how to support and care for their adolescent girls.
In all three countries, parents[10] learned in group discussions how to support and care for their adolescent girls, and about their girls' development and puberty. In Ethiopia, adolescent girls said they felt more comfortable discussing some programme topics with their parents following the programme. In Ethiopia and Pakistan, adolescent girls talked about how relationships with family members had improved as a result of COMPASS, but many said that this had happened because girls had modified their own behaviour, doing more household chores or being more respectful or obedient.

In Pakistan, many positive changes were observed in girls' mothers following the programme, although this was not indicative of a broader transformation in attitudes towards gender inequality. Mothers still associated safety with adolescent girls' "honour" and limited movement. Mothers said they valued their daughters, though many were still unwilling to allow them to make decisions about their own lives. Mothers acknowledged the importance of education and dangers of early/forced marriage, but had limited ability to put this learning into practice in the home.

In DRC, parents who participated in group discussions said their parenting styles were warmer and more affectionate after the programme, and reported lower overall rejection of their daughters compared to parents who did not participate. Despite these positive changes, the evaluation in DRC showed that parent participation had no statistically significant impact on girls' exposure to GBV, or on the attitudes of girls and parents towards gender equality. As already mentioned, this may be due to the limited scope of the programme to transform deeply entrenched social norms. In addition, it is important to recognise that the vast majority of parents who took part in COMPASS in DRC were female (96%), who are not the main perpetrators of GBV and were likely to have limited decision-making power in their families and communities. These findings underscore the need for programming that addresses wider gender inequality and the systemic discrimination of women and girls, alongside and in support of targeted adolescent girl programming.

Effectiveness and change: The impact of COMPASS on GBV service provision for adolescent girls

COMPASS increased adolescent girls' knowledge of and access to professional GBV services.
Adolescent girls' knowledge of and access to GBV services also increased considerably. In Ethiopia, adolescent girls who participated in the programme were nearly twice as likely to know a place to go to for help if a girl experienced sexual violence compared with girls who had not taken part in the programme, and more than twice as likely in the case of physical violence. Girls' knowledge of GBV services also increased in DRC and Pakistan. In all three countries, there was a considerable increase in the number of adolescent girl survivors accessing services in programme sites. This is an encouraging trend, showing that more girls had started to receive the critical, life-saving care they needed by the end of the programme.

COMPASS-trained GBV service providers made services more adolescent girl friendly.
In all three countries, the IRC worked to improve the quality of GBV service provision for adolescent girl survivors by providing training on general and child-specific GBV case management and clinical care for sexual assault survivors, as well as some context specific topics.[ii]
Given their life-saving nature, it is critical that in any humanitarian crises adolescent girls feel safe and comfortable in accessing health and psychosocial GBV response services and that, when they do, they are provided with quality care by providers who understand their needs and are equipped to respond to them.

IRC WPE staff carried out training for first responders at several points throughout the programme, and provided regular support and supervision. Health and GBV case management service providers were assessed every quarter on their knowledge of and attitudes towards adolescent girl friendly services. Following the delivery of training and support, the majority of professionals trained achieved the standards of quality GBV service provision identified in the project.[11] Adolescent girl survivors also provided very positive feedback on their experiences with services, with 100% of adolescent girls reporting satisfaction with the services they received in Ethiopia, 94% in DRC, and 75% in Pakistan.

10. In Ethiopia and DRC, when adolescent girls were asked to identify a parent to participate in the parent group discussions, they overwhelmingly selected their mothers or another female caregiver (across both cycles this was 96% in DRC and 68% in Ethiopia). In Pakistan, only female caregivers of the adolescent girls were invited to attend the parent/caregiver discussions groups.
11. The GBV service provision standards used in COMPASS were based on global standards of good practice set out in various inter-agency guidelines and resources.

Feasibility and acceptability of COMPASS

The IRC explored the extent to which the COMPASS model of programming for adolescent girls was feasible and acceptable in humanitarian settings. Feasibility was considered in terms of girls having safe, consistent access to the programme and the ability to participate. Acceptability was considered in relation to how open girls, families and communities were to the topics included in the girls' life skills sessions and parent group discussions, and how supportive community leaders, authorities and other influential actors were regarding the girls' participation.[12]

COMPASS proved to be feasible and acceptable in humanitarian settings.
In many communities across the three country contexts, the concept of programming for adolescent girls was new. As a result, there were examples in all countries where parents voiced concerns about the appropriateness of the activities, which initially limited the programme's acceptability. However, IRC's extensive awareness-raising with communities, including group discussions, house-to-house visits and meetings with local authorities and community leaders, increased acceptance of the programme by parents and the community, and resulted in high levels of interest and enrolment by adolescent girls. Acceptance by communities in DRC and Ethiopia was also due to the positive relationships IRC WPE staff had built up in these countries over time and the positive attitudes communities already had towards IRC's previous programming for women and adolescent girls.

High enrolment and attendance demonstrated adolescent girls' enthusiasm for the programme.
Adolescent girls' attendance to life skills sessions was very high, at an average of over 75% in all three countries. Parent attendance was also high, at an average of 82% in all three countries, although it varied between sites within each country. The attendance rates of adolescent girls and parents improved over the course of the programme in all countries, demonstrating that they increasingly valued the programme. When girls and parents dropped out of the programme, this was overwhelmingly because they had moved away from the area. This was particularly true in Pakistan, as one area the programme took place in was the focus of a government initiative to return displaced people to their communities of origin.

These findings emphasise the challenges of implementing a programme over a set period of time with highly mobile populations. They also reflect the need for anticipating and managing dropouts, and more broadly, for flexible, responsive programming, capable of adapting to unique and changing contexts.

Adolescent girls and parents gave positive feedback about COMPASS.
In all three countries, adolescent girls provided very positive feedback on the delivery and content of the life skills sessions.

In Ethiopia, 100% of adolescent girls said they were happy after the fifteenth session, up from 45% after the first. Parents were also positive about the programme with regards to their own learning, and initial concerns were eventually abandoned once they became familiar with COMPASS.

In DRC, over 90% of adolescent girls were satisfied with the safe space, saying that they felt it was accessible, had good materials and mentors, and provided a good opportunity to spend time with their peers. Feedback from parents was also generally positive. Although some parents commented about feeling uncomfortable when discussing sensitive topics, others said they were grateful that these sensitive topics were being addressed, as they had no other opportunity to discuss them.

In Pakistan, adolescent girls and their mothers provided very positive feedback on the women's community centres, with all reporting they were very satisfied or satisfied. They considered learning new and useful things, as well as meeting peers, as the greatest benefits of visiting the centres.

Lessons from the implementation of COMPASS

Safe spaces gave adolescent girls a place to feel safe, learn, and make friends.
Given the levels of GBV perpetrated against adolescent girls by intimate partners and parents, it was extremely important girls had a neutral, safe space they could go to in their community.

In Ethiopia, the adolescent girls' life skills sessions were held in safe spaces specifically constructed just for adolescent girls and in response to girls wanting to have their own space. In DRC and Pakistan, existing community spaces were adapted and used for the life skills sessions.

These spaces proved effective, with adolescent girls saying that they appreciated having a physical space where they could build friendships, have fun and develop skills. In Ethiopia, some adolescent girls explained how IRC safe spaces could be useful for girls when they felt unsafe at home and in other spaces in the community. In emergency sites in DRC, where finding an appropriate space was more challenging, teams noted the importance of adolescent girls having a safe space to express themselves, even if the space was temporary and informal.

12. Please see Annex 1 for the list of topics covered in the life skills sessions and group discussions.

Curricula had to be designed and implemented in a way that acknowledged the diversity of adolescent girls, and responded to their feedback.
In all three countries, a flexible and responsive approach to the implementation of the life skills sessions for adolescent girls and the parent group discussions was required. This was due to the diversity of the ethnic backgrounds, languages and other characteristics of the girls and parents who participated in the programme.

The curricula were developed by IRC at a global level and adapted to each context by the implementing WPE team, a process which involved consultation with adolescent girls, parents and community members. In Ethiopia, for example, the curriculum was written and adapted in a fluid, responsive manner, allowing the team to closely observe what was and was not working well and to adapt accordingly. In DRC, a shortened curriculum for emergency contexts was also developed and implemented in with populations that were recently affected by conflict or displacement, as the delivery of a full 10-month long curriculum was deemed infeasible. In Pakistan, both the life skills and parent curricula were heavily contextualised to facilitate cultural acceptance, while ensuring key messages were consistently addressed. This flexibility helped to ensure that the curricula were feasible and acceptable.

Mentors helped deliver COMPASS key messages, and developed strong relationships with girls.
A mentorship approach was used to deliver the adolescent girls' life skills sessions. In DRC and Ethiopia, criteria for mentors were that they had to be close to the age of the participating girls, from the same area/neighbourhood, and hold positive attitudes towards adolescent girls. In Pakistan, IRC staff facilitated the first cycle of the programme, and then older girls (18–19 years old) who successfully completed the life skills sessions were enrolled to be mentors for the second cycle.

Although there were concerns in all three countries that because the mentors came from similar backgrounds to the adolescent girls, they may reinforce harmful gender norms, ongoing training and supervision for the mentors was provided in order to improve mentors' understanding of GBV and acceptance of gender equality. Training improved mentors' facilitation styles and increased their comfort addressing sensitive topics.

As mentors grew in confidence, they developed strong relationships with adolescent girls, with some girls commenting that they viewed their mentor as a role model. Importantly, girls started going to their mentors for help, including when they experienced GBV. Mentors also reported that they benefited personally from the programme: they enjoyed working with other mentors and the adolescent girls, and learning new things from the life skills curriculum.

Conclusions and Recommendations

Below is a summary of the key conclusions from the implementation and evaluation of the COMPASS programme and recommendations to donors, policy makers, practitioners and researchers on supporting a robust programming and research agenda for adolescent girls in humanitarian settings.

1 **Adolescent girls as young as 10 are experiencing GBV in humanitarian settings. Intimate partners were most likely to be the perpetrators of nearly all types of violence against adolescent girls.**

2 **Adolescent girls expressed a clear demand for the tailored support provided by COMPASS. As a result of participating in the programme, girls had better knowledge of professional GBV services, felt more positive about themselves and about the future, and had stronger social networks and a safe space to go to.**

3 **Consultation with adolescent girls throughout implementation was essential to ensure programming was responsive, flexible and addressed the needs of girls from diverse backgrounds.**

4 **The existence of quality GBV services and trained staff was critical to ensure the safety and wellbeing of adolescent girls targeted by COMPASS.**

5 **COMPASS has made a valuable contribution to the evidence of what works to promote the health, safety and empowerment of adolescent girls in humanitarian settings. However, further programming and research is needed to build on this learning and increase understanding of which strategies and interventions are most effective in reducing GBV against adolescent girls in humanitarian settings.**

Based on these conclusions, the IRC has developed a programme model and resource package called Girl Shine. It builds on the positive practices in COMPASS and bridges the gaps identified during the implementation of the programme and by associated research. Girl Shine is intended to be a practical and flexible resource for practitioners. It includes step-by-step guides on how to design, implement and monitor a life- skills programme for adolescent girls and parents/caregivers living in humanitarian settings. It also features a training component for mentors and staff.

IRC makes the following recommendations to donors and policy makers, (including donor governments, UN bodies and humanitarian bodies) and practitioners (including INGOs, national, local and women's organisations in emergency-affected contexts):

1 **Donors and policy makers should commit to the development of a strategy or government-wide policy dedicated to adolescent girls in humanitarian settings.**

2 **Donors and policy makers should provide long-term, dedicated funding to programmes like COMPASS that specifically address GBV against adolescent girls in humanitarian settings.**

3 **Donors and practitioners should ensure adolescent girl programming is driven by adolescent girls' needs and voices and is responsive to ongoing monitoring.**

4 **Practitioners should ensure that adolescent girl programming also targets younger adolescent girls.**

5 **Donors and practitioners should invest in safe spaces for adolescent girls.**

6 **Donors and practitioners should invest in mentorship approaches.**

7 **Practitioners should ensure staff implementing adolescent girl programming have GBV knowledge and skills, and receive training on how to work appropriately and effectively with adolescent girls.**

8 **Donors, policy makers and GBV service providers should ensure adolescent girls can access quality GBV services that are tailored to meet their needs.**

9 **Donors, policy makers and practitioners should ensure holistic programming exists that tackles wider harmful norms.**

10 **Donors, practitioners and researchers should pilot further programmes and research to better understand how female and male parents/caregivers can contribute to the safety and wellbeing of adolescent girls.**

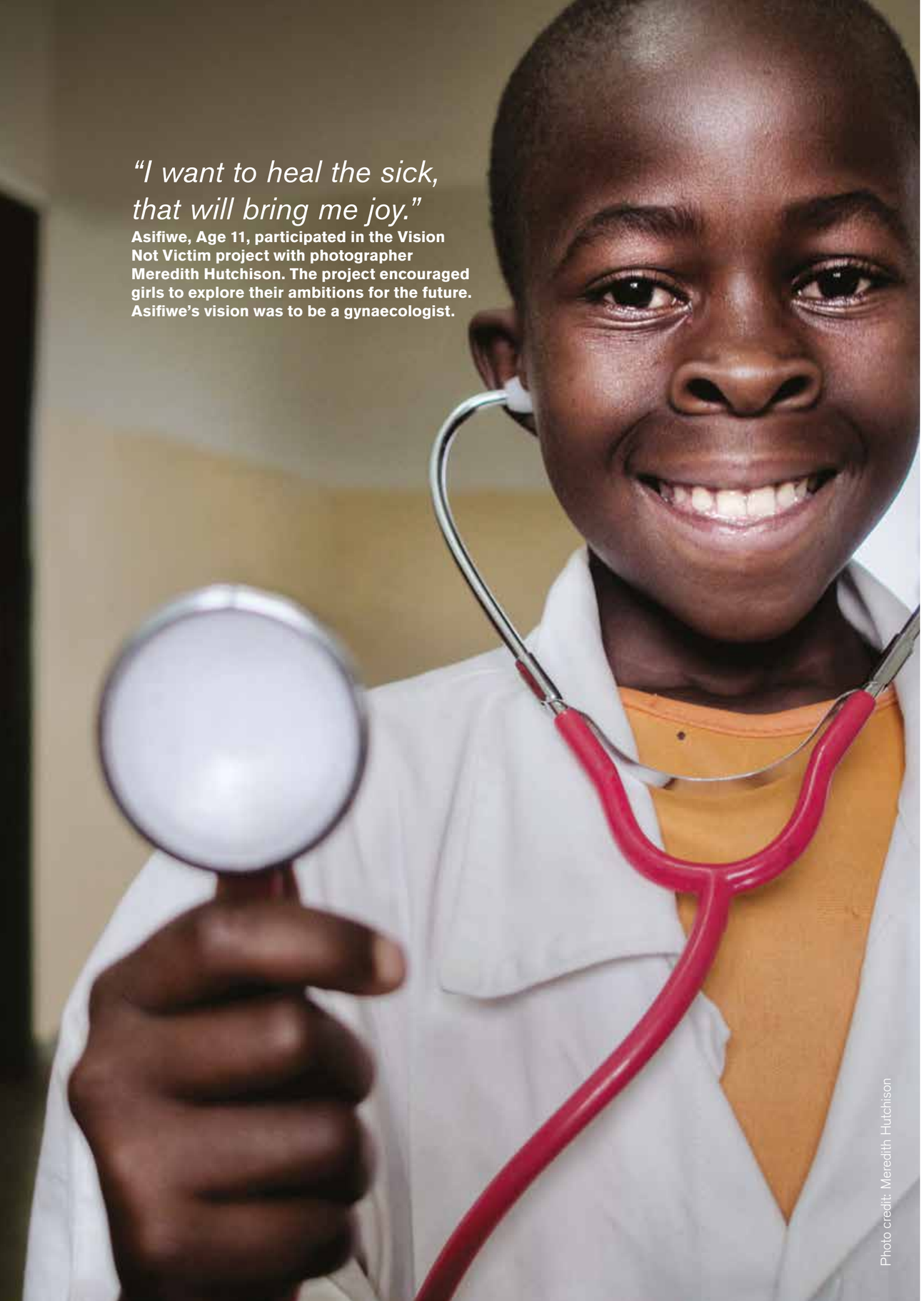
11 **Donors and researchers should continue to invest in research to improve programme models before moving to large -scale impact evaluations.**

12 **Donors, practitioners and researchers should prioritise the following areas of research on strategies and interventions that reduce GBV against adolescent girls in conflict and humanitarian settings:**

- Another cycle of COMPASS data collection to better measure the long-term effects of the intervention.
- The effectiveness and impact of mentorship models on the empowerment, community status and gendered attitudes of mentors themselves.
- The ways in which mothers, fathers and caregivers influence girls' exposure to violence and how this is mediated by gender and power dynamics in the household.
- Further develop qualitative research methods to better understand the needs of younger adolescent girls in order to inform programming.

"Previously, before we began participating in the programme, we didn't have a good relationship…but now, after we got a lesson about the importance of neighbourhood, we realise that we should support each other like relatives."

Adolescent girl, 13 years old, evaluation interview, Ethiopia



"I want to heal the sick, that will bring me joy."

Asifiwe, Age 11, participated in the Vision Not Victim project with photographer Meredith Hutchison. The project encouraged girls to explore their ambitions for the future. Asifiwe's vision was to be a gynaecologist.

Photo credit: Meredith Hutchison

Chapter 1:

INTRODUCTION

Introducing COMPASS:

- Adolescent girls in humanitarian settings require tailored programming, as the combination of their age, gender and environment leaves them extremely vulnerable to gender-based violence (page 1).
- The COMPASS programme sought to address this need by creating safe spaces for adolescent girls; delivering a life skills curriculum for girls through young adult female mentors; working with parents to develop a supportive environment; and training and supporting service providers to facilitate access to quality adolescent girl-friendly care (page 4).
- Columbia University and the International Rescue Committee (IRC) worked together to generate rigorous evidence on the effectiveness of the programme and identify ways to improve the social and health outcomes of adolescent girls in humanitarian settings (page 6).
- COMPASS was implemented in three humanitarian contexts: with refugees in camps on the Ethiopia/Sudan border, conflict-affected communities in eastern DRC and displaced populations in Pakistan (page 10).

Responding to an urgent need

Adolescent girls living in conflict-affected communities, including refugees and internally displaced persons (IDPs), are highly vulnerable to gender-based violence (GBV), including sexual violence and exploitation, intimate partner violence and early and forced marriage.

Adolescence is a distinctly challenging and critical time for girls, during which they face immense social barriers that limit them from leading safer, healthier and self-sufficient lives, especially in comparison to boys.[iii] Nearly half of all sexual assaults across the world are committed against girls younger than 16 years.[iv] Humanitarian crises, which rupture existing key community and state structures, such as health care, education and social services, and break up or displace families and communities, render adolescent girls even more vulnerable to GBV. Furthermore, adolescent girls rarely have the appropriate knowledge, support and confidence to navigate their way through adolescence and access help when they need it.

Ensuring safety from GBV is critical for adolescent girls to develop and live full, productive lives.

Although there is a growing body of information on the prevalence of GBV against girls, there is still little research available specific to adolescent girls in humanitarian settings. As a result, there is also a lack of rigorous evidence on effective strategies for protecting adolescent girls in humanitarian settings from GBV and helping them recover.

To respond to the specific needs of adolescent girls in humanitarian settings and to address the gap in evidence of what works to promote the health, safety and empowerment of adolescent girls, the International Rescue Committee (IRC) has invested in a robust adolescent girl programming and research agenda. As part of this effort, the IRC partnered with Columbia University over a three year period (2014–2017) to develop, implement and evaluate the Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces (COMPASS) programme, funded by the UK Department for International Development (DFID). COMPASS was implemented in conflict-affected communities in eastern Democratic Republic of Congo (DRC), refugees living in camps on the Sudan/Ethiopia border, and displaced populations in north-west Pakistan. It sought to test effective strategies and interventions for protecting adolescent girls from GBV in humanitarian settings and aimed to generate much needed evidence on the acceptability and impact of such interventions.

The report provides a comprehensive overview of learning from COMPASS in Ethiopia, DRC and Pakistan, to inform policy and practice for adolescent girl programming in humanitarian settings. In the introduction, there is an outline of the COMPASS programme and research partners, a summary of data sources and methods, and an overview of the context and the adolescent girls who participated in the programme.

Chapter 2 outlines findings from the baseline surveys on adolescent girls' exposure to GBV, gender norms and attitudes, informal support networks, expectations for the future and knowledge of service providers.

Chapter 3 presents the findings from the COMPASS programmes and evaluations carried out in Ethiopia, DRC and Pakistan. They focus on the effectiveness of the interventions, the feasibility and acceptability of programming in these contexts, and what was learnt from implementation.

Finally, the report concludes that there is an urgent need for tailored adolescent girl programming in humanitarian settings. It also recommends the policies and investment, good practice and future research needed to develop and implement strong, effective and relevant programmes which will improve the lives of such a critical yet overlooked population.

The COMPASS programme

The IRC developed and implemented the interventions used in COMPASS by building on existing programming and resources on adolescent girls and GBV, as well as adapting them for the complex contexts of diverse humanitarian settings. COMPASS was implemented by IRC's Women's Protection and Empowerment (WPE) programme teams, with support from IRC researchers and technical advisors, and evaluated by Columbia University.

Before launching the programme, a theory of change was developed by identifying ways in which adolescent girls are exposed to GBV and the interventions needed to reduce this exposure. This theory of change is based on the hypothesis that multi-sector interventions are required on an individual/girl, family and systemic level to improve how individuals and society prevent and respond to GBV against adolescent girls in humanitarian contexts. The theory of change diagram is included in annex 2.

COMPASS included the following core interventions:

- **Adolescent girls' life skills sessions:** weekly discussions with groups of adolescent girls in allocated safe spaces, facilitated by young female mentors.
- **Parent/caregiver group discussions:** monthly discussions with parents/caregivers of adolescent girls participating in the programme.[13]
- **Service provider support:** targeted training and ongoing support to develop knowledge, capacity and skills regarding the specific needs of adolescent girls, and particularly those who have experienced GBV.

Additional activities were carried out as part of COMPASS, such as a small cash transfer pilot project in DRC, business and vocational skills training activities in Ethiopia and vocational skills training in Pakistan. These activities aimed to improve adolescent girls' financial assets to help protect them from GBV, and they were designed to suit the specific needs of adolescent girls in the context of the country in which they lived.

This report focuses only on the core interventions of COMPASS outlined in the Programme intervention table on the next page, results from these additional activities are not included in this document but are presented elsewhere.[v]

The COMPASS theory of change

COMPASS impact goal:
Adolescent girls in humanitarian settings are safer from violence and the threat of violence.

COMPASS outcome goal:
Improved prevention of and response to violence against adolescent girls in humanitarian settings, particularly in Pakistan, Ethiopia and DRC.

COMPASS output goals:

1. **ADOLESCENT GIRLS** have increased human, social, physical and financial assets to protect themselves from violence and respond to threats or incidents of violence.
2. **PARENTS AND CAREGIVERS** of adolescent girls' lives have improved relationships with girls and improved attitudes, knowledge and skills to support girls to be safe from violence.
3. **SERVICE PROVIDERS** have increased capacity to provide safe, girl-friendly and lifesaving services.

13. The term parent will be used here on out in the report to indicate parent/caregiver.

Programme interventions:

Intervention	Purpose	Structure
Adolescent girls' life skills sessions	To **increase adolescent girls' assets, social networks and safety** by creating opportunities for girls to engage with female peers and mentors; providing information and skills that help to improve adolescent girls' sexual reproductive health, understanding of SRH and GBV, and knowledge of GBV support services; and building up the self-esteem and leadership skills of adolescent girls.	Adolescent girls were grouped with girls of a similar age, area and language. In groups facilitated by a female mentor aged 18–30, girls met weekly in a designated 'safe space' to take part in life skills sessions. The same group of girls met weekly with their mentor to discuss content ranging from decision-making and interpersonal disagreement resolution, to reproductive health, gender norms and safety planning.
Parent/caregiver group discussions	To **create spaces for parents/caregivers** to talk about the experiences of raising and caring for adolescent girls, and to **foster attitudes that are supportive of adolescent girls.**	Monthly conversations were held with one parent/caregiver of each participating adolescent girl (usually a female family member). These were conducted by IRC WPE officers, with the support of community facilitators. The curriculum focused on positive relationship building, empathetic communication, non-violent discipline methods and specific developmental and cultural issues experienced by adolescent girls.
Service provider support	To ensure the **provision of responsive and high-quality essential services** to adolescent girl survivors of gender-based violence.	IRC WPE staff provided targeted training and ongoing support to health, case management and legal service providers that may come into contact with GBV survivors. This was to make sure they had specialist knowledge, capacity and skills to respond to the specific needs of adolescent girls who experience gender-based violence.

Implementation of interventions and evaluations

The adolescent girls' life skills sessions and parent group discussions were implemented with two groups of girls and their parents in DRC and Ethiopia, and with three groups in Pakistan. With variations by country on exact timing, the first programme cycle with the first group was implemented between June 2015 to July 2016, and the second programme cycle was implemented from February 2016 to June 2017. In Pakistan, a third programme cycle was conducted within this timeframe. The external evaluation led by Columbia University was conducted on one programme cycle in each country – see table on page 5 for details.

Terms used in this report:

intervention group – group which received the full intervention during the period of the evaluation. In Ethiopia and DRC, this refers to adolescent girls and their parents who took part in the first programme cycle.

waitlist group – group which did not receive the full intervention during the period of evaluation (the 'control' group). In Ethiopia, this refers to adolescent girls and parents who participated only in the second programme cycle, but not the first. In DRC, this refers to adolescent girls who participated in the first programme cycle but their parents did not participate until the second programme cycle.

	Programme cycle 1	Programme cycle 2	Programme cycle 3
DRC	**September 2015 to July 2016** Adolescent girls aged 10–14: 1,444 Parents/caregivers: 649 (96% female)[14] Included external evaluation August – October 2016	**September 2016 to May 2017** Adolescent girls aged 10–14: 773 Parents/caregivers: 1156* (96% female)[15]	**Not applicable**
Ethiopia	**November 2015 to July 2016** Adolescent girls aged 13–19: 978 Parents/caregivers: 915 (67% female) Included external evaluation July – August 2016	**September 2016 to June 2017** Adolescent girls aged 13–19: 960* Parents/caregivers: 960 (69% female)	**Not applicable**
Pakistan	**June 2015 to November 2015** Adolescent girls aged 10–19: 555 Parents/caregivers: 161 (100% female)	**February 2016 to October 2016** Adolescent girls aged 10–19: 311 Parents/caregivers: 239 (100% female) Included external evaluation December 2016 – March 2017	**November 2016 to March 2017** Adolescent girls aged 10–19: 112 Parents/caregivers: 81 (100% female)

Programme learning:

Through the external impact evaluation and routine programme monitoring, the programme sought to generate learning in the following areas:

Effectiveness:
- extent to which these assets contribute to decreasing girls' risks of and exposure to violence
- extent to which the programme builds adolescent girls' human and social assets
- aspects of programme implementation which most contribute to this change

Feasibility and acceptability:
- extent to which such programming can be carried out in humanitarian contexts
- acceptability of this programme to adolescent girls and their families
- perceptions of adolescent girls, families and the wider community about programme content and delivery

Processes of change:
- analysis of how adolescent girls' assets were built and violence reduced
- assessment of how programme implementation contributed to changes in the adolescent girls
- experiences of implementing adolescent girl programming in this context.

14. In DRC data on gender of parents was not available for North Kivu in cycle one.
15. Due to the evaluation design, a number of parents in DRC were placed in the waitlist group and participated in the second programme cycle rather than the first. In Ethiopia, a number of adolescent girls and their parents/caregiver were placed in the waitlist group and participated in the second programme cycle.

Programme partners

International Rescue Committee (IRC)

The IRC is a humanitarian organisation dedicated to helping those whose lives and livelihoods are shattered by conflict and disaster to survive, recover and gain control of their future. Since 1996, the IRC has implemented specific programmes to empower and protect women and girls affected by violence in various contexts of acute and protracted emergencies.

The IRC has gained a wealth of experience in the field and has earned a reputation as a global leader, with unique knowledge, expertise and capacity in violence against women and girls programming.

The IRC delivers women and adolescent girls' protection and empowerment (WPE) programming in 31 countries across Africa, Asia, Europe and the Middle East, and has over 20 WPE technical advisors, specialists, advocates and researchers in its Violence Prevention and Response Technical Unit (VPRU). The VPRU works to reduce people's vulnerability to violence, supports them to recover, and carries out long-term transformative work that aims to create a future free from violence. The unit houses experts in the fields of child protection, protection and rule of law, and WPE, who work collaboratively to support women, adolescents, children and other vulnerable groups affected by crisis across the world. The IRC WPE team led the implementation of the COMPASS programme in the three countries and the overall management of the programme.

Columbia University and the Child Protection in Crisis (CPC) Learning Network

The research partner (Columbia University Mailman School of Public Health, led by Dr Lindsay Stark and Dr Marni Sommer) brings expertise in the fields of epidemiology, qualitative research, measurement of sensitive topics including GBV, and randomised trials.

The Child Protection in Crisis (CPC) Learning Network, headquartered at Columbia University, seeks to build the evidence based about children, youth and families living in adversity. In this study, Columbia University (Lindsay Stark – principal investigator), led on evaluation and tool design and testing, ethical approaches and approvals, quality and data analysis and training for the evaluation component.

Generating data: data sources and research design

The learning presented in this report is drawn from external evaluations led by Columbia University in each country, as well as monitoring data collected by IRC WPE programme staff throughout implementation.

External evaluation design

Columbia University Mailman School of Public Health led mixed-method evaluations of the COMPASS programme in all three locations, each of which had different objectives and designs.

In Ethiopia, the impact evaluation was carried out to study whether the adolescent girls' life skills sessions had an impact on social and health outcomes for adolescent girls, compared to girls who were waitlisted (participated in the second cycle of the programme only). The DRC study measured the relative impact that parent participation in group discussions had on social and health outcomes for adolescent girls, as well as the attitudes and characteristics of parents compared to girls who participated in COMPASS, but whose caregivers were waitlisted to the second cycle. In Pakistan, the evaluation assessed the feasibility and acceptability of the programme to adolescent girls and parents in their context, and measured changes in girls' social and health outcomes over the course of the programme. Though the study design was different in each country, common variables were measured in all three, to enable some comparison.[vi]

Details of the three studies are included in the table on page 8 and 9, and a detailed methodology for each country can be found in annex 3.[vii]

Programme monitoring data sources

Throughout the programme cycles, IRC collected monitoring data from adolescent girls, parents, mentors and service providers to assess progress, improve programming, generate learning about good practice and understand what works for the adolescent girls. The following sources of monitoring data inform this report:

- attendance rates for adolescent girls' life skills sessions and parent group discussions (DRC, Ethiopia and Pakistan)
- a check-in exercise with adolescent girls to test delivery methods and relevance of the topics according to adolescent girls themselves (DRC only)
- group discussions with adolescent girls and parents to ascertain their understanding of key topics of the life skills sessions and the parent group discussions (DRC, Ethiopia and Pakistan)
- observations of adolescent girls' life skills sessions and parent group discussions to confirm quality implementation of the curriculum (DRC, Ethiopia and Pakistan)
- client satisfaction surveys with adolescent girl survivors who accessed case management and psychosocial services, providing a better understanding of the experiences of girls who receive support (DRC, Ethiopia and Pakistan)
- GBV service provider knowledge and attitude assessments (DRC, Ethiopia and Pakistan)
- quarterly and annual narrative reports (DRC, Ethiopia and Pakistan)
- GBV information management system records (DRC, Ethiopia and Pakistan)[16]

16. The Gender-based Violence Information Management System was created to harmonise data collection on GBV in humanitarian settings. It provides GBV project managers with a simple system to collect, store and analyse their data and safely and ethically share it. Learn more at http://www.gbvims.com

Study location /sample	Hypothesis	Objectives	Study design	Methods
Ethiopia • Bambasi, Sherkole and Tongo refugee camps, Ethiopia/Sudan border • 919 girls, aged 13–19 • (subset of 114 girls, plus 95 parents/caregivers in qualitative)	Adolescent girl and parent/ caregiver participation in the COMPASS programme will lead to reduced risk of violence against adolescent girls compared to adolescent girls who do not participate in COMPASS.	1. To assess the impact of the adolescent girls' life skills sessions and parent/caregiver group discussions on a) girls' experiences of physical, sexual and emotional violence; b) girls' confidence and self-esteem; c) girls' support networks; and d) gender attitudes. 2. To explore qualitatively the process and pathways by which the adolescent girls' life skills sessions and parent/caregiver group discussions may influence levels of violence and support networks.	Two group waitlisted cluster randomised controlled trial. Groups randomised to receive either: 1. Adolescent girls' life skills sessions + parent/caregiver group discussions **(intervention group)** OR 2. No intervention **(waitlist group)** Adolescent girls and their parents/caregivers in the waitlist group were invited to participate after the study on cycle 1 was completed.	• Study conducted on programme cycle 1. • Baseline/endline quantitative survey with adolescent girls. Use of ACASI** only. • Qualitative discussions/participatory activities with adolescent girls and parents/ caregivers at baseline, individual in-depth interviews with adolescent girls and parents/caregivers at endline.
DRC (South Kivu only) • 14 conflict-affected communities • 869 girls, aged 10–14 • 764 parents/caregivers (subset of 117 girls and 128 parents/caregivers in qualitative)	Participating girls whose parents/caregivers also participate in the monthly parent/caregiver group discussions will be better protected from violence compared to participating girls whose parents/caregivers do not participate in the monthly parent/caregiver group discussions.	1. To assess the incremental impact of the parent/ caregiver group discussions added to the adolescent girls' life skills sessions on a) girls' experiences of physical, sexual and emotional violence; b) confidence and self-esteem; c) girls' support networks; and d) gender attitudes. 2. To explore qualitatively the process and pathways by which the addition of parent/caregiver group discussions impacted on girls' social and health outcomes.	Two arm waitlisted randomised control trial. Groups randomised to receive either: 1. Adolescent girls' life skills sessions + parent/caregiver group discussions **(intervention group)** OR 2. Adolescent girl life skills sessions **(waitlist group)** Parents/caregivers in the waitlist group were invited to participate after the study on cycle 1 was completed.	• Study conducted on programme cycle 1. • Baseline/endline quantitative survey with adolescent girls and parents/caregivers. Use of CAPI* for parents/caregivers, and CAPI and ACASI** for adolescent girls. • Qualitative discussions/participatory activities with adolescent girls and parents/ caregivers at baseline, individual in-depth interviews with adolescent girls and parents/caregivers at endline.
Pakistan • Internally displaced persons (IDPs) in camps/host communities in Kohat, Peshawar and Nowsherha, Khyber Pakhtunkwa province • 78 girls, aged 12–19 • (subset of 15 girls, plus 15 parents/caregivers in qualitative)	Adolescent girls and parent/caregiver participation in the COMPASS programme will lead to improved knowledge, attitudes and practices among adolescent girls. The overall aim of the study was to understand the acceptability of safe space programming to adolescent girls and parents/caregivers in this context, and measure changes in adolescent girls' outcomes over the course of the programme.	1. To determine the feasibility and acceptability of the adolescent girls' life skills sessions and parent/ caregiver group discussions.	Single group pre and post-test survey evaluation, all programme girls invited to participate.	• Study conducted on programme cycle 2. • Baseline/endline quantitative survey with adolescent girls. Use of enumerator-administered paper surveys. • Individual in-depth interviews with adolescent girls and parents/ caregivers at endline. (Note parent/caregiver analysis was conducted by IRC).

* CAPI: Computer assisted personal interviewing (enumerator reads questions and records responses on a tablet computer programme);
** ACASI: Audio computer assisted self-interviewing: girl hears survey questions through headphones and follows instructions to select an appropriate response on her tablet by tapping on colour or image coded response options.

Programme contexts

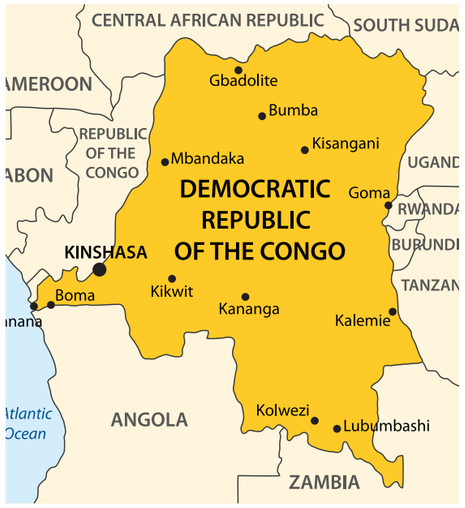
Refugee camps on the Ethiopia/Sudan border

Refugee camps in Benishangul-Gumuz, western Ethiopia, were established in response to years of war and instability in Sudan and South Sudan, resulting in mass displacement and large numbers of refugees coming into western Ethiopia. As of 30 September 2015 (prior to the start of COMPASS), the United Nations High Commissioner for Refugees (UNHCR) reported a total of 46,726 refugees hosted in Benishangul-Gumuz, mainly from Blue Nile State in Sudan, as well as Kurdofan state in Sudan, Upper Nile state in South Sudan and a small number from countries of the Great Lakes region (Congo, Rwanda and Burundi).[vii]

The IRC has documented significant levels of GBV in refugee camps, and assessments have identified adolescent girls as particularly vulnerable to sexual exploitation and abuse, sexual violence, early marriage and intimate partner violence. Like adult women, girls often experience survivor stigma, and receive a lack of community understanding and support.

COMPASS was implemented by WPE programme teams in Sherkole, Bambasi and Tongo camps, where refugees have access to health centres, schools, WASH (Water, Sanitation and Hygiene) facilities, shelter, livelihoods, protection programming, security and legal services. Services are implemented and maintained by a range of government, United Nations (UN) and non-governmental actors. The IRC has been implementing WPE programming in camps in Benishangul-Gumuz since 2012 and is the lead actor on GBV prevention and response in Sherkole, Bambasi and Tongo camps.

During the COMPASS programme, IRC's WPE teams provided GBV case management services, which included referring adolescent girls who experienced violence to appropriate services. They also trained health and GBV case management service providers to improve their attitudes towards adolescent girls and the quality of the support they provide to girls who experience GBV.



Conflict-affected communities in eastern Democratic Republic of Congo

Civilians in eastern DRC have been affected by conflict and uncertainty for almost 20 years. Despite a period of relative calm since 2009, the security situation deteriorated in the wake of the 2011 national elections, and was further undermined by increased armed group action following the creation of the M23 group in April 2012. In 2016, the increasing presence of armed groups and an upsurge in inter-ethnic tensions escalated concerns in an already volatile security environment. As of December 2016, there were 2.1 million internally displaced persons (IDP) in the country, largely concentrated in North Kivu, South Kivu and Tanganyika provinces, with North Kivu hosting up to 40% of all IDPs.

An estimated 1.8 million women in DRC have been raped in their lifetime, and in a 2007 study over 3 million women reported experiencing intimate partner sexual violence.[ix] Assessments have shown that adolescent girls are particularly vulnerable to violence, and that incidents of GBV against this group increase in times of conflict.[x] Adolescent girls' exclusion from decision-making processes and lack of control over their own lives limits their physical, intellectual and social development, and constitutes a form of violence against them. In addition, when adolescent girls experience GBV they often have limited access to essential services. This is typically due to a lack of services that are friendly towards adolescent girls, inadequate information about available services or a lack of trust in them, or because parents, relatives or boyfriends/husbands deny access.

COMPASS was implemented by WPE programme teams in conflict-affected villages and towns in 14 sites in South Kivu and five sites in North Kivu. The WPE programme began in 2002 in South Kivu province and expanded to neighbouring North Kivu in 2007, and to Katanga province in 2014. In all three provinces, the IRC helps survivors of GBV access quality care and offers women and girls greater social and economic opportunities to help empower them. The robust nature of IRC's WPE programming in DRC has allowed for extensive and rigorous research on a range of GBV interventions, which have contributed to global learning for the GBV humanitarian community.[xi]

Communities and camps in north-west Pakistan

Military operations since June 2014 in North Waziristan and federally administered tribal areas have resulted in unrest and mass displacement. In total, the Internal Displacement Monitoring Centre estimates that as of July 2015, there were more than 1.8 million displaced people living in Pakistan, with the vast majority of those living in host communities in Khyber Pakhtunkhwa.[xii]

The displacement from North Waziristan started to level off by the end of 2014, and in 2015, the Pakistani government implemented a programme of returning displaced persons from Jalozai displacement camp to their place of origin. In April 2016, the closure of Jalozai camp was announced. Many displaced persons moved to live within communities in the district.

Levels of GBV against women and girls is high in Pakistan. According to the Demographic and Health Survey 2012–13, 39% of ever-married women aged 15-49 report having experienced physical and/or emotional violence from their spouse during their lifetime, and 52% of Pakistani women who have experienced GBV didn't seek help or tell anyone about the violence they had experienced.[xiii] Women, girls and camp service providers have identified unmarried adolescent girls as the population at greatest risk of sexual violence, with unmarried teen daughters sent to live with relatives in host communities for protection. Marriage, which is often forced, is used as a form of protection for both women and girls against possible kidnapping.

COMPASS helped establish IRC's first non-emergency GBV programming in Pakistan. It was implemented in nine sites across three districts in Khyber Pakhtunkhwa province: Kohat, Nowshera and Peshawar. The programme primarily targeted displaced communities, but it also included host communities in some settings. IRC WPE teams implemented COMPASS directly in Nowshera district; IRC partners and local WPE organisations Pakistan Initiative for Mothers and Newborns (PAIMAN) and Kwendo Kor, implemented the programme in the other districts.[xiv] Four women's centres where COMPASS was implemented were based in Jalozai displacement camp for the first cycle of the programme, but they were moved to community-based sites surrounding the camp when the camp's closure was announced in April 2016. During 2015, all international non-government organisations were required to obtain a new Memorandum of Understanding with the government. In August 2016, the government requested that the IRC suspend activities in Khyber Pakhtunkhwa province until the Memorandum of Understanding had been finalised. In response, the women and adolescent girls' community centres run by the IRC in Nowshera district were temporarily closed down, though programming in the other two districts, implemented by IRC partners, was able to continue.

Adolescent girls in humanitarian settings often have little opportunity to make their voice heard. But in the safe spaces, they learn that their opinion is important. In Bombassi camp, Ethiopia, girls use a megaphone to get their message across.

Photo credit: Meredith Hutchison

Demographics of adolescent girl participants

Over the course of all programme cycles, a total of 5,133 adolescent girls and 4,161 of their parents (predominantly female) took part in COMPASS. On average, adolescent girls who took part in the baseline survey were aged 12 years old in DRC and 15 years old in Ethiopia and Pakistan. The majority were unmarried; an average of 20% of adolescent girls across all three countries were either married, widowed or living with a man as if married. In all three countries, girls had very low levels of education (about three years on average), and many in DRC and Pakistan were not currently attending school (56% and 68% respectively).

Summary of introduction

The COMPASS programme seeks to fill the gap in programming and evidence around adolescent girls in humanitarian settings, including what can prevent their exposure to GBV and what can help them heal and recover when they experience violence.

The IRC and Columbia University formed a partnership to evaluate a multi-sector intervention targeted at adolescent girls, their parents, wider members of the community and GBV response service providers. The core interventions of COMPASS included a life skills curriculum for adolescent girls, which was facilitated by female mentors in safe, girl-only spaces; a corresponding curriculum delivered to parents in group discussions; and training and support for service providers who come into contact with GBV survivors, to improve their attitudes towards adolescent girls and provide appropriate care for them.

COMPASS was implemented by the IRC's Women's Protection and Empowerment teams in conflict-affected communities in eastern Democratic Republic of Congo, refugee camps on the Ethiopia/Sudan border and communities and camps in north-west Pakistan. External evaluations were conducted by Columbia University in all three countries, each with a different study design but with some common variables so comparisons can be made.

In total, COMPASS reached 5,133 adolescent girls and 4,161 of their parents (predominantly female) over the course of the programme. This report presents findings from the baseline survey and learning from implementing and evaluating the programme. In particular, the report focuses on the feasibility of programming and the acceptability of COMPASS to adolescent girls and communities; outcomes for adolescent girls; parents' knowledge and attitudes; service provision; and lessons learned during implementation.

Figure 1: Demographics of adolescent girls, according to the baseline survey

	South Kivu, DRC	Ethiopia	Pakistan
Number of girls in the survey	869	919	78[17]
Average age (mean)	12	15	15
Unmarried	70%	71%	97%
Living with one or both biological parents	91%	92%	94%
Ever attended school	80%	69%	80%
Ever worked for money or payment	20%	41%	14%

17. Nearly 200 girls participated in the COMPASS baseline survey in Pakistan. However, due to the closure of the camp, only 78 participated in the endline survey.

In Pakistan, vocational activities like embroidery provided an accessible entry point for girls to enroll in the programme. It also made safe spaces more acceptable to the community.

Photo credit: Colleen Roberts

CHAPTER 2:

THE STATE OF ADOLESCENT GIRLS IN HUMANITARIAN SETTINGS: FINDINGS FROM COMPASS BASELINE SURVEY

Key findings from the baseline survey:

- 45% of adolescent girls in Ethiopia and 37% in DRC reported experiencing sexual violence in their lifetime. 61% of adolescent girls in DRC and 52% in Ethiopia reported having experienced some kind of GBV in the past 12 months; 26% of adolescent girls in DRC and 29% in Ethiopia reported experiencing sexual violence in the same period. In most cases, the perpetrator of GBV was an intimate partner, followed by a parent or caregiver. In Ethiopia, 43% of sexual violence was perpetrated by intimate partners, followed by parents[18] (29%). Similarly, in DRC, 49% of sexual violence was committed by intimate partners, with 17% perpetrated by parents. (page 18).
- Traditional gender norms are prevalent among adolescent girls and parents, with participants in COMPASS likely to agree that men are decision makers, women should accept violence, and domestic chores are the responsibility of women and girls (page 21).
- Adolescent girls have friends and family members they trust to talk to about some issues, but generally they have no one to talk to about sensitive topics and little knowledge of where to go if they experience GBV (page 22).

18. Data on perpetrators was not disaggregated according to gender. This was due to the need to minimise response categories in order to use the ACASI software effectively with the research participants.

In this chapter, key findings are presented from the quantitative and qualitative data collected as part of the baseline survey carried out prior to the start of the COMPASS interventions. The baseline survey provides insight into the prevalence of GBV experienced by adolescent girls, the harmful gender norms and attitudes many hold, their knowledge of GBV services, their social support systems and their hopes and expectations for their future. As the baseline survey intended to understand the overall status and experiences of adolescent girls prior to participating in the COMPASS programme, the results presented consider all adolescent girls that participated. For Ethiopia and DRC, where the programme included an intervention group and a waitlist group the data is not disaggregated according to which group girls joined.

Adolescent girls' exposure to GBV

Adolescent girls in humanitarian settings are at high risk of GBV.

In Ethiopia and DRC, the baseline survey revealed high levels of GBV are being perpetrated against adolescent girls.[19] 45% of adolescent girls in Ethiopia and 37% in DRC reported experiencing sexual violence in their lifetime.[20] 61% of adolescent girls in DRC and 52% in Ethiopia reported having experienced some form of physical, sexual or emotional violence in the past 12 months.

Sexual violence victimisation was particularly high: 26% of adolescent girls in DRC and 29% in Ethiopia.[21] In Ethiopia, forced sex sex (or rape), which was primarily perpetrated by intimate partners, was the form of sexual violence most frequently reported to have taken place in the past year (18%), and nearly 40% of those who had experienced forced sex reported that the most recent occurrence was within the last week.

In DRC, over 1 in 4 adolescent girls (26%) reported experiencing sexual violence in the past 12 months, primarily perpetrated by intimate partners (49%). Sexual violence perpetrated by intimate partners was equally high in Ethiopia (43%).

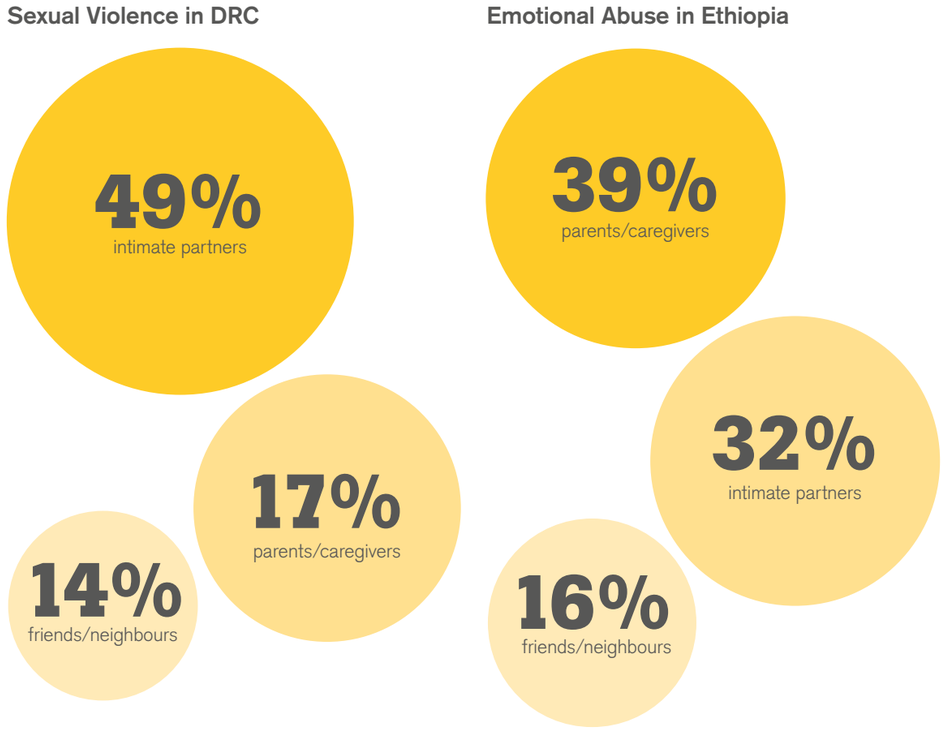
In both countries, younger girls reported higher levels of victimisation: adolescent girls aged 10–12 in DRC were more likely to report experiencing sexual violence in the past 12 months than older girls; and in Ethiopia, adolescent girls aged 13–14 were more than twice as likely to report having been sexually exploited at some point in their lives than adolescents aged 15–19.

In DRC, slightly less than half of the adolescent girls (44%) reported experiencing emotional violence (insults and/or loud or aggressive screaming), which was perpetrated in equal measure by intimate partners and parents (35%). In addition, over 49% of adolescent girls reported feeling uncared for by their parents in the past 12 months.

In Ethiopia, 36% had experienced emotional abuse, primarily perpetrated by parents (39%). Around half (49%) of the adolescent girls felt uncared for by their parents in the past 12 months.

19. Questions explicitly about adolescent girls' exposure to GBV or sex were not included in the Pakistan survey, as the primary focus of the study was on feasibility and acceptability of the programme.
20. Sexual violence will be used as an aggregate term for exposure to unwanted touching, forced sex, or coerced sex.
21. Girls were asked if they had experienced "unwilling sex", or if anyone had "touched them in a sexual way" without their permission, or if they had been "threatened or pressured to have sex by someone with influence/authority."

Figure 2: Perpetrators of violence, by violence type



Perpetrators are overwhelmingly intimate partners, followed by parents/caregivers.

Intimate partners were most likely to be the perpetrators of almost all types of violence, followed by parents or other relatives (see figure 2).[22]

The only exception was emotional abuse in Ethiopia, which was perpetrated primarily by parents. Reports of GBV being perpetrated by other people, such as officials (police, teachers, local leaders) or military personnel, were lower.

> *Rape is common outside of the home, and happens when the girl goes to the bush. Boys can follow her and ask her for sex. If she refuses, boys use force or frighten her that they are going to kill her by sword or knife.*
>
> **Male parent, baseline focus group discussion, Ethiopia**

22. Data on perpetrators was not disaggregated according to gender. This was due to the need to minimise response categories in order to use the ACASI software effectively with the research participants.

> *You can see an older man telling your daughter, 'I am going to give you a pen, uniform,' because he can see your daughter starts growing up; then that man becomes her lover. He says, 'Let's go out and enjoy something,' but then they enjoy everything.*
> **Female parent, baseline focus group discussion, DRC**

> *If she meets her boyfriend and takes so long, her parents beat her when she goes back home*
> **Adolescent girl, 15 years old, baseline participatory activity**

Adolescent girls reported feeling safe in most places, despite their exposure to GBV.

The majority of girls in all three countries said they felt safe in most places listed in the survey, and particularly in their home and school, though feelings of safety were notably lower in Ethiopia. In group discussions in Ethiopia and DRC, adolescent girls and parents were more likely to talk about threats that exist in unfamiliar places away from the home and community, such as isolated fields, farms or forests.

This is despite the fact that perpetrators of GBV were mainly people adolescent girls knew, who would often be present in familiar spaces such as the home. This could suggest that violence in the home is normalised, with the result that girls report feeling safe despite the actual risks they face. It may also suggest that when violence is discussed in families and communities, the focus is primarily on perpetrators as strangers, and violence as something that happens in unfamiliar or unknown places, which girls need to be protected from or avoid. This aligns with the finding in all three countries that adolescent girls' movement is restricted, as this is perceived to minimise the risk of GBV and stigmatisation. In Pakistan, in particular, adolescent girls were often confined to their home and a few other areas; less than 15% of girls reported going to school, a friend or neighbour's house or the market in the past month, and 15% reported not leaving their home at all.

Figure 3: Girls' agreement to statements on gender attitudes

95%
of girls in DRC believed a woman should tolerate violence to keep the family together

3 in 10
girls in Ethiopia believed males and females should share household chores

Norms and attitudes about gender and GBV

There is a high acceptance of gender inequality and tolerance of violence against women and girls.

A significant number of adolescent girls in DRC held attitudes that demonstrated acceptance of gender inequality, including almost unanimous agreement (95%) that women should tolerate violence to keep their family together and that men should make decisions in the home (see figure 3).[23]

In Ethiopia, girls were more likely to disagree with such statements. Even so, around half of adolescent girls in Ethiopia agreed that men are decision makers (58%), women are responsible for avoiding pregnancy (50%) and that women should tolerate violence to keep the family together (58%).

When asked about instances of intimate partner violence, 71% of adolescent girls in Ethiopia and 81% in DRC reported agreement with at least one statement that deemed it acceptable for a man to hit his wife in certain circumstances. These findings suggest normalisation of violence against women in the home, and demonstrate the entrenched nature of harmful gender norms.

A baseline survey was also conducted with parents in DRC because of the research questions related to the caregiving component of COMPASS. It revealed a high level of agreement with statements which support unequal treatment of women and girls. This included "a woman has to have a husband or sons or some other male kinsman to protect her because she is unable to do so for herself" (82% agreement), and "a good woman never questions her husband's opinions, even if she is not sure she agrees with them" (73% agreement).Slightly less than half (47%) of parents believed that sons should have more education than daughters, and a majority (63%) believed that daughters should be sent to school only if they are not needed to help at home. Despite these views, 90% of parents agreed with the statement that "daughters should have just the same chance to work outside the home as sons", and 97% agreed with the statement "I would like my daughter to be able to work outside the home so she can support herself and her family, if necessary".

In group discussions in both Ethiopia and DRC, parents discussed the roles that girls are expected to assume from a young age, including carrying out chores in the home while boys participate in education or leisure activities. In addition, data suggested that both adolescent girls and parents believed that adolescent girls were responsible for protecting themselves from sexual violence and sexual harassment.

23. Questions on gender norms and attitudes were not included in the Pakistan research, as this was beyond the scope of the evaluation.

> *Some parents do raise their children properly, and discipline them, and get them married to good men, and have a proud marriage ceremony, and may get a good job and live a happy life. But those girls who refuse to listen to their parent's advice are exposed to various risks.*
> **Male parent, focus group discussion, Ethiopia**

Adolescent girls' social networks and access to services

Adolescent girls lack informal sources of support outside the family.

In all three countries, adolescent girls reported having good relationships with their parents and others within their family. When asked whether they had an adult in their life who provides support and guidance, most adolescent girls identified their mother (over 50% in Ethiopia and DRC and 39% in Pakistan) or another female family member. The majority of adolescent girls reported having friends outside of their family who they could talk to about important things, though in most cases their social networks were fairly small.

Only 21% of adolescent girls in Pakistan had a female figure outside of their family who they could go to with problems. Though these figures were higher in Ethiopia and DRC (51% and 45% respectively), they suggest adolescent girls are primarily dependent on family members for support in all circumstances, an important finding given the high levels of GBV perpetrated by parents.

Adolescent girls in all three countries were likely to discuss plans for the future, school or health issues, and family problems with parents and other adults that provide them with support and guidance. However, they felt less comfortable talking to these people about conflicts with peers and intimate partners, or topics related to sexual health, such as pregnancy or sexually transmitted infections. Importantly, a minority of adolescent girls in DRC (40%) and Ethiopia (43%) and a majority in Pakistan (61%) identified someone in the community they could trust to talk to if they were forced to have sex.

Adolescent girls feared that they would be blamed or stigmatised, or would be subjected to further violence such as an early or forced marriage if they experienced GBV. Nearly half of adolescent girls in DRC (46%) and a third in Ethiopia (30%) reported that they felt that their family would blame them if they were raped, while 38% of adolescent girls in DRC and 23% in Ethiopia reported that they believed their community would force them to marry the perpetrator if they were raped. In Pakistan, 22% of adolescent girls thought that their family would blame them if they were harassed by men while walking on the street, and 30% if there were problems in their marriage.

Adolescent girls and their parents have little knowledge of professional GBV services.

Adolescent girls' and parents' knowledge of professional services to help GBV survivors was relatively low in all three countries. Both adolescent girls and parents reported that they were more likely to first seek help from family or community leaders than service providers if GBV occurred. Approximately 57% of adolescent girls in DRC, 47% in Ethiopia and 42% in Pakistan reported knowledge of a place to go to for help if she was a survivor of either physical or sexual violence.

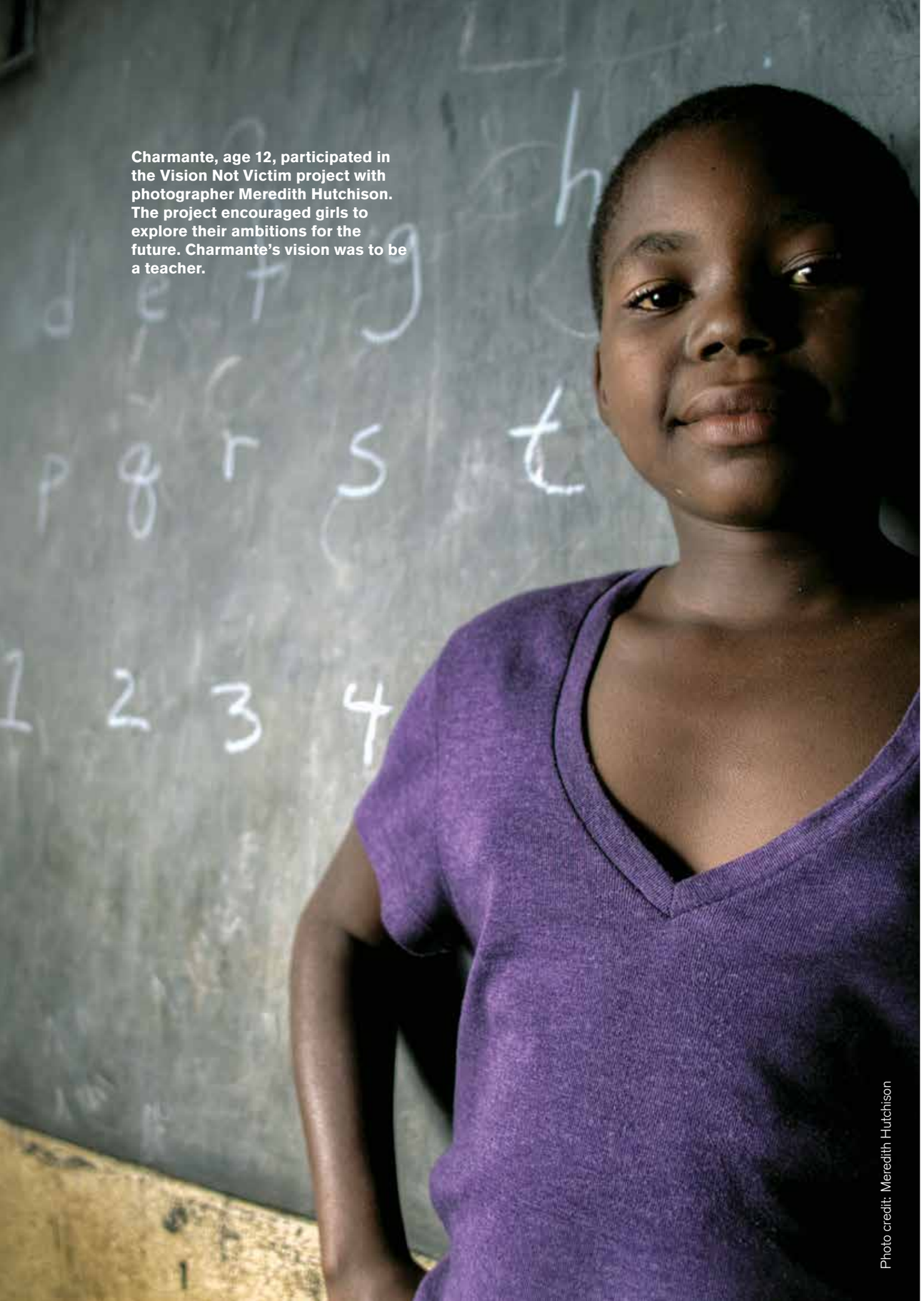
Discussions with adolescent girls and parents in DRC and Ethiopia revealed that even when adolescent girls knew about services, they were reliant on a parent to facilitate access. Both girls and their parents emphasised resolving issues related to sexual violence within the family and community. For example, adolescent girls are often forced to marry their perpetrators as a proposed 'resolution' to rape; this remedy was most often sought by the parents of the adolescent girl survivor and perpetrator, sometimes with influence from community authority figures.

Photo credit: Meredith Hutchison

Adolescent girls aged 10-19 in Bambasi refugee camp. In Ethiopia, girls from a variety of different ethnicities, languages, and social backgrounds participated in the programme.

> *It is often the case that a girl starts working from 8am to 8pm while a boy goes to school early in the morning and returns at 3pm. When he comes back he will not care that there is no firewood, water, and sometimes not even bringing goats back home. Rather, he will go and play soccer, and after playing, he will come and ask if no food is ready.*
> **Female parent, focus group discussion, DRC**

> *A girl in this village reported that she was raped by a father and people started calling her 'the wife of an old man'. She had no peace in the neighbourhood.*
> **Female caregiver, focus group discussion, DRC**



Charmante, age 12, participated in the Vision Not Victim project with photographer Meredith Hutchison. The project encouraged girls to explore their ambitions for the future. Charmante's vision was to be a teacher.

Photo credit: Meredith Hutchison

> *First we let her get medical service. Then the girl's family meets with the boy's family. They all discuss together with the local people about the problem. If a girl agrees, marriage will be arranged for her and the perpetrator.*
>
> **Male parent, focus group discussion, Ethiopia**

Adolescent girls' hope and expectations for the future

Adolescent girls did not feel positive about their futures.

In all three countries, adolescent girls had average levels of self-esteem compared to global levels.[24] While girls in Pakistan had medium levels of hope for the future, measured in terms of girls' perceived capacity to achieve their goals, adolescent girls in DRC had very low levels of hope.[25]

Adolescent girls also had low expectations about future opportunities for girls. In DRC, only about half of adolescent girls stated that girls should complete the final year of primary school before discontinuing their education, and just 30% believed that girls should complete a university education. On average, they considered 20-21 years old as an appropriate age for marriage, though girls aged 13–14 were more likely to indicate a higher age of marriage than girls aged 10–12. In contrast, more than half of the parents interviewed in DRC said they wanted girls to complete a university education and delay marriage until they were at least 23 years old.

Adolescent girls' expectations for the future in Ethiopia were even more limited. On average, they stated that girls should complete slightly more than four years of schooling. In addition, 43% stated that a girl should get married before 18 and 47% thought a girl should have her first child before 18.

In contrast, almost all the adolescent girls in Pakistan (91%) thought that every girl should be afforded the opportunity to go to school and over half (57%) thought they should be given the same life opportunities as a boy. The majority (85%) considered 18 years or older to be an appropriate age for marriage, and slightly more than half (55%) believed working for money outside of the home was acceptable, even after marriage.

Summary of the state of adolescent girls in humanitarian settings

Findings from the baseline survey in Ethiopia and DRC indicate that adolescent girls living in humanitarian settings are at high risk of GBV. More than one in every three girls, some as young as 10 years old, had experienced sexual violence in their lifetime. This demonstrates the importance of GBV programming and the involvement of younger adolescent girls.

Perpetrators of GBV were overwhelmingly people that adolescent girls knew well: intimate partners, followed by parents and other relatives. Adolescent girls and parents had negative gender attitudes and accepted GBV as a part of their daily lives. However, despite the high levels of GBV experienced and the likelihood that perpetrators would be someone who lived in or close to their home, adolescent girls reported feeling safe at home, suggesting violence in the home has become normalised.

Most girls had some friends and family members that they could talk to, though they were uncomfortable talking about topics such as personal conflicts or sexual health, and few knew of someone they could talk to if they experienced sexual violence. Knowledge of and access to GBV services was low, and adolescent girls and parents were more likely to first seek help from family or community leaders than service providers if GBV occurred. In addition, in Ethiopia and DRC, adolescent girls had limited aspirations for their futures around education and age for marriage.

24. Self-esteem was assessed though the Rosenberg self-esteem scale (Rosenberg, 1979). The 10-item Likert scale has been used in over 50 countries, and higher scores indicate greater self-esteem (Rosenberg, 1979; Schmitt & Allik, 2005).
25. Hope was measured by the Children's Hope Scale. An average score above 4.7 indicates respondents have a strong positive perception of his or her own capacity to achieve goals. A score of 3.0–4.7 indicates medium perception of self-capacity to achieve goals, and a score below 3.0 indicates low perception of self-capacity. On average, adolescent girls in DRC scored 2.3; in Pakistan, the average was 3.67.

Photo credit: Meredith Hutchison

Girls play together in Tongo refugee camp. Helping girls to make friends was a key impact of COMPASS, and was often described by girls as a highlight of the programme.

CHAPTER 3:

WHAT WORKS TO ADDRESS GBV AGAINST ADOLESCENT GIRLS: LEARNING FROM COMPASS

Key findings from COMPASS:

- COMPASS had a positive impact on adolescent girls' lives. As a result of COMPASS, girls felt more positive about themselves and their future, had stronger social networks and a safe space to go to – all important steps to reducing girls' exposure to GBV, and helping them recover from GBV. (page 28)
- The programme improved knowledge of GBV services among adolescent girls in Ethiopia and Pakistan, and made services more adolescent friendly. (page 37)
- Adolescent girls expressed a clear demand for the tailored support provided by COMPASS (page 40).
- Parents who took part in the programme had greater warmth and affection and lower overall rejection of their daughters. (page 44)
- Consultation with adolescent girls throughout implementation was essential to ensure programming was responsive, flexible and addressed the needs of girls from diverse backgrounds (page 45).

In this chapter, learning is presented from the implementation and evaluation of the COMPASS programme, specifically: how effective the interventions were in reducing adolescent girls' exposure to GBV and improving other social and health outcomes that can help protect them from GBV; how feasible and acceptable such programming is in humanitarian settings and what was learnt from day-to-day implementation of the programme.

Effectiveness and change: the impact of COMPASS

COMPASS featured three core interventions: the life skills sessions with adolescent girls; the group discussions with their parents; and training and support for professionals providing GBV response services. This section presents findings on effectiveness and change for each of these groups as a result of these interventions.

The impact of COMPASS on adolescent girls

This chapter discusses the changes in the adolescent girls who participated in COMPASS in all three countries. The findings from Ethiopia compare the outcomes for adolescent girls who participated in the life skills sessions (intervention group) with the girls who did not (waitlist group). This comparison enables any differences between groups to be attributed to the COMPASS programme.

For DRC, which had a different research question, findings compare the outcomes for adolescent girls whose parents participated in the complementary caregiver sessions (intervention groups) with girls whose parents did not (waitlist group); girls in both the intervention and waitlist group participated in the life skills sessions. In Pakistan, which did not use the the same study design, the results compare the baseline data and endline data from the same adolescent girls. Although this study design does not prove if outcomes are directly attributable to COMPASS interventions, it provides important information on trends and changes experienced by the adolescent girls during the programme.

COMPASS helped adolescent girls to develop their support network.

The safe space provided adolescent girls a place where they could make friends, speak to a mentor about their problems, and learn about who can support them if they experience GBV. This is essential to ensure girls are not isolated, and have people they can turn to for support and advice.

In all three countries, there were improvements in girls' support network. In Ethiopia, girls who participated in the intervention group were nearly twice as likely to report having friends, and twice as likely to report having a trusted non-family female adult than those in the waitlist group. In DRC, the number of girls who had four or more friends rose from 54% to 96% from the beginning to the end of the programme. By the end of the programme, girls in DRC and Pakistan were more likely to report that they had a trusted adult to talk to, and that they had friends of their own age outside their family.

In all three countries, interviews with adolescent girls revealed they had a strong sense of companionship with other adolescent girls in the programme, and that the quality of their friendships, and in some cases family relationships, had improved. Some adolescent girls in Pakistan explicitly attributed improved relationships to what they had learned in the programme, as well as the time spent together at the centre and the opportunity to work on projects together.

Across the three countries, the adolescent girls who participated in the programme expressed gratitude towards the COMPASS mentors, and described their mentors as people who they could go to if they needed help. In Pakistan, for example, girls talked about how their mentor was good for giving advice, even if they could not solve problems. In one instance, a 16-year-old girl talked about a mentor intervening on behalf of a girl whose parents did not allow her to go to school: "Baji [mentor] went to her home and discussed with her parents. After discussion, they agreed to Baji and she got admission in the school."

> *Previously, before we began participating in the programme, we didn't have a good relation; we didn't have also the culture to visit each other; but now, after we got a lesson about the importance of neighbourhood, we realise that we should support each other like relatives.*
> **Adolescent girl, 13 years old, evaluation interview, Ethiopia**

Figure 4: Adult and peer support

> *Initially, I was telling her limited things. After taking these sessions, I came to know how to recognise trusted friends, and after this our relationship is better because I came to know that she could be trusted. Now I share more things with her.*
>
> **Adolescent girl, 19 years old, evaluation interview, Pakistan**

In Ethiopia, it was evident that if an adolescent girl was raped or physically abused by a boyfriend and decided to disclose this information to someone, she would turn to friends for support before an adult. This underscores the critical importance of quality friendships, of girls having the right information to support their peers, and the need for additional work on improving the dynamic between adolescent girls and parents, or other trusted adults in their lives.

In all three countries, monitoring activities also emphasised that the friendships adolescent girls made through the life skills sessions were a key part of their enthusiasm about the programme. At the end of the programme, adolescent girls had a stronger understanding of quality friendships: they often mentioned that good friends give good advice, help each other stay safe and share ideas with each other.

COMPASS improved adolescent girls' expectations for the future and increased their hope.

In Ethiopia, adolescent girls who participated in COMPASS had higher expectations of opportunities for girls, compared to those who did not participate. They reported that girls should complete, on average, one additional year of schooling; they had twice the odds of reporting that girls should be 18 or older before having their first child, and almost twice the odds of reporting that girls should be 18 or older before getting married. In interviews, they also reported that through the programme they had learned about the appropriate age of marriage and girls around marriage, including support they could access to contest their family's plans for an early or forced marriage.

In Pakistan, girls were significantly more likely to believe they should be given the same life opportunities as a boy after the programme (82% agreement) than before (58% agreement.) They were also much more likely to agree to girls working outside the home after marriage following completion of the programme (77%, up from 55% before the programme.)

In all three countries, adolescent girls felt more hopeful about their futures as a result of participating in the programme. This was measured in terms of the girls' confidence in their ability to achieve their goals.[26] While girls in DRC in particular still had low levels of hope, this increase is an important finding, as hope is key to adolescent girls' resilience and ability to recover from GBV.[xv]

Monitoring activities in all three countries showed that girls were able to identify a number of positive attributes about themselves. Their responses covered a wide range of skills and abilities, from education and study, to being a good friend, to planning for the future. In Pakistan, girls' self-esteem also increased significantly from the beginning to the end of the programme.

Although girls gave positive feedback about the safe space, exposure to GBV and harmful gender norms remain a concern.

Considering the levels of GBV perpetrated against adolescent girls by intimate partners and parents, it was extremely important the girls had a neutral, safe space they could go to in their community. In Ethiopia, some adolescent girls explained how IRC safe spaces could be useful for girls when they felt unsafe at home and in other spaces in the community. In emergency sites in DRC, where finding an appropriate space was more challenging, teams noted the importance of adolescent girls having a safe space to express themselves, even if this space was temporary and informal.

In Pakistan, as a result of the safe spaces, the average number of places outside the home that girls could visit rose from one to two. Girls said they felt safe in the safe spaces, indicating that it provided them a unique opportunity to learn and make friends away from threats in the community. In DRC, girls were also more likely to report having a safe place to spend time with other girls.

26. Hope was measured by the Children's Hope Scale. An average score above 4.67 indicates respondents have a strong positive perception of his or her own capacity to achieve goals. A score of 3.0–4.67 indicates medium perception of self-capacity to achieve goals, and a score below 3.0 indicates low perception of self-capacity. On average, adolescent girls in DRC scored 2.34 at baseline and 2.54 at endline; in Pakistan, scores were 3.67 at baseline and 4.00 at endline.

Despite these encouraging findings, the evaluation could not demonstrate that COMPASS made adolescent girls safer outside the safe space. While there was an overall reduction in girls' reported exposure to GBV in DRC from the beginning of the programme to the end of it, there was no statistically significant difference between the intervention and waitlist groups. This suggests the reduction in GBV cannot be directly attributed to the programme intervention: the life skills sessions in Ethiopia, or the parent group discussions in DRC. In addition, the evaluation did not show a statistically significant improvement in girls' feelings of safety outside the safe space.

There was also little improvement in any of the countries on inequitable attitudes towards gender and GBV. At the end of the programme in DRC and Ethiopia, there continued to be a high level of agreement with statements indicating acceptance of gender inequality by all adolescent girls, with a majority in both countries agreeing that females are responsible for avoiding pregnancy, men should have the final word on decisions in the home and females should tolerate violence to keep the family together. There was also little change in the levels of agreement with statements that deemed it acceptable for a man to hit his wife in certain circumstances.

At the end of the programme in Pakistan, adolescent girls still associated safety with restriction of movement, saying that they felt safer if they did not leave the house alone. Girls also continued to associate these restrictions with gender norms related to a woman being 'good' and 'modest'.

Due to the limited scope of the intervention and the short time between the end of the life skills sessions and the evaluation, these findings are unsurprising. Adolescent girls live in environments where attitudes towards gender equality are entrenched in deep-rooted social norms, and continually reinforced across generations. Sustained, long term interventions are required to transform these norms.

In addition, COMPASS programme implementation took place over 8–10 months in Ethiopia and DRC. Girls were asked to recall experiences of violence over the past 12 months, meaning that the results may have included experiences before the adolescent girls began participating in the life skills sessions.

Importantly, at the end of the programme, adolescent girls across all three countries were able to talk about many of the key messages in the life skills curriculum which focused on strategies for keeping safe. It is possible that a follow-up survey conducted 12 months after completion may detect a greater, longer-term impact of the life skills sessions programme on girls' exposure to GBV.

These findings raise several important issues with respect to both the design of the programme and the evaluation. Programme implementation took place over 8–10 months in Ethiopia and DRC. This a relatively short time period in which to see significant changes in gender norms and attitudes that are deeply entrenched and are continually reinforced in the environments in which the adolescent girls live. The endline survey also was conducted only one month following the programme, leaving little time for the programme learnings to take root. In addition, girls were asked to recall experiences of violence over the past 12 months, meaning that the results may have included experiences before the adolescent girls began participating in the life skills sessions.

Importantly, at the end of the programme, adolescent girls across all three countries were able to talk about many of the key messages in the life skills curriculum which focused on strategies for keeping safe. It is possible that a follow-up survey conducted 12 months after completion may detect a greater, longer-term impact of the life skills sessions programme on girls' exposure to GBV.

Summary: The impact of COMPASS on adolescent girls

The baseline results from the Ethiopia study showed that COMPASS had a positive impact on adolescent girls. At the end of the programme in all three countries, adolescent girls reported having expanded support networks with more friends and trusted adults, higher expectations and hope for the future, and a safe place to spend time with other girls. Although the evaluation did not detect significant changes in exposure to violence or attitudes towards GBV and gender attributable to the life skills sessions, the positive changes that occurred for adolescent girls are important steps towards the ultimate goal of reducing GBV.

> *They have taught us that how to take care of our children. We should take care of our children choice in food, clothes, etc. We should not get angry with them. We should always talk to them politely. We should avoid cruelty with them.*
> **Parent, evaluation interview, Pakistan**

Effectiveness and change: The impact of COMPASS on parents and their relationships with adolescent girls

COMPASS helped parents learn how to support and care for their adolescent girls.

In all three countries, parents learned in group discussions how to support and care for their adolescent girls, and about their girls' development and puberty.[27]

Compared to the waitlist group, parents who took part in the programme in DRC showed more warmth and affection in their parenting styles, and lower overall rejection of their daughters.[28] This was even more prominent for parents who attended more of the sessions. This is an important finding that may indicate how to achieve positive outcomes for adolescent girls in future programmes.

In Ethiopia, adolescent girls who took part in COMPASS were more likely than girls who did not participate to feel comfortable discussing certain sensitive topics with their parent: puberty, education, and earning a living for the future. Although in Pakistan there was little change in girls' levels of comfort discussing these topics with their parents, in individual interviews some girls reported that they believed their relationships with their parents had improved after the programme. Reasons for improved relationships, according to both the adolescent girls and parents, included acknowledging their own faults, improving respect for each other and controlling anger. Parents also said they developed a better understanding of their daughter and how to care for them.

In all three countries, parents demonstrated increased knowledge of issues affecting adolescent girls. The parent group discussions covered topics such as the developmental needs of adolescent girls and how to effectively raise and care for them. When parents in all three countries were asked about curriculum topics as part of programme monitoring, they all demonstrated a strong knowledge of key messages. Issues around puberty and sexual and reproductive health were more difficult for parents to talk about, so it was important that extra support was given to help them feel comfortable in discussing these topics.

Despite parents in DRC having increased knowledge about issues affecting adolescent girls, their overall knowledge of basic facts about puberty remained low; while in Pakistan, mothers stated that much of the information about menstruation was new to them. This suggests that adult women may need more information about their own bodies and reproductive health systems to enable them to support their daughters. In all three countries, parents expressed that it was primarily the responsibility of mothers to support their daughters, with fathers having a less important role.

Attitudes towards gender and GBV remain a concern.

Despite these positive changes, the evaluation in DRC showed that parent participation had no statistically significant impact on girls' exposure to GBV, or on the attitudes of girls and parents towards gender equality. In focus group discussions, parents often reiterated the importance of a girl conducting household chores and her ability to manage a household and her children. In interviews in Ethiopia, participating parents continued to talk about violence within intimate partnerships as normal, and expressed a perception that girls were themselves ultimately responsible for preventing such violence. Mothers in Pakistan also talked about how a wife should "bear it" if her husband is violent towards her, stating that she has few other options or may even be responsible, due to poor manners, lack of respect, or inadequate housework skills.

27. In Ethiopia and DRC, when adolescent girls were asked to identify a parent to participate in the parent group discussions, they overwhelmingly selected their mothers or another female caregiver (93% in DRC and 67% in Ethiopia). In Pakistan, only female caregivers of the adolescent girls were invited to attend the parent/caregiver discussions groups due to cultural considerations.
28. As measured by Parental Acceptance-Rejection Questionnaire (PARQ), where a higher value indicates greater rejection/greater lack of affection towards children.

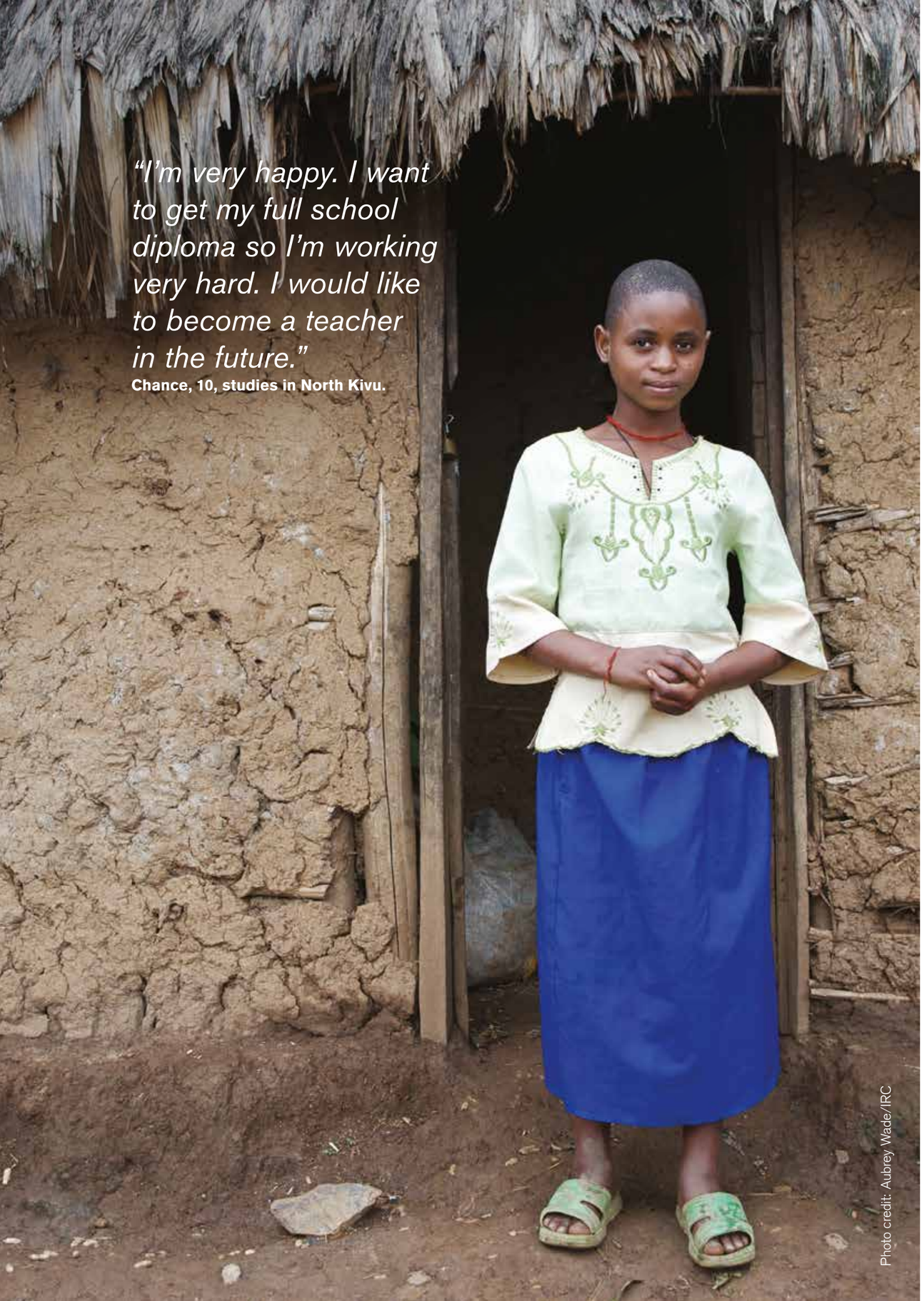
> *Like during menstruation, she used to get rude whenever I asked her to do anything for me. I was not aware about the change in mood during menstruation. I was not aware that she would be having pain in back or lower abdomen. Now I know these things and I don't ask her to do work during those days*
> **Parent, evaluation interview, Pakistan**

These responses are concerning, considering adolescent girls' perception of their parents and wider community's attitudes towards GBV. At the beginning of the programme, 46% of adolescent girls in DRC, 30% in Ethiopia and 20% in Pakistan thought their families would blame them if they experienced sexual violence or sexual harassment. There was little to no change in this perception by the end of the programme, and no significant differences between those in the intervention and waitlist groups in DRC. While adolescent girls in Ethiopia did not change their belief that their community would force them to marry a perpetrator of rape against them (remaining between 20–25%);in DRC, this dropped from 38% to 28%.

In addition to the programmatic and research methodology limitations mentioned in the previous section, it is important to highlight that parents and caregivers in the programme were predominantly women, who may exert little power within a family or a household, and may not be involved in decisions which affect a girl's life or safety. This raises several important issues that warrant further exploration and learning, particularly with respect to the role mothers and fathers can play in situations where they themselves are not the perpetrators of GBV against girls. Furthermore, the COMPASS curriculum for the parent sessions was designed to ensure parents had access to the same information that was being shared with the girls, and to improve relationships between parents and their adolescent girls. It was not designed to transform entrenched gender norms and attitudes. This finding highlights the importance of delivering corresponding programmes which address gender roles and power dynamics and directly target female and male parents.

> *We imagine ourselves as a root and hope to support our girls to grow as a tree.*
> **Parent, monitoring discussion, Ethiopia**

> *This is mainly the problem of the girls; girls go to the boys' homes on her own will.*
> **Parent, evaluation interview, Pakistan**



> *If anything like this happens, then I would say to her that no husband beats his wife without any reason. I would ask her first and then go to her husband. Like my daughter-in-law always argues back with my son and he hits her. She comes and complains to me. I always tell her if you stay quiet and don't argue back, then he would not beat you.*
> **Parent, evaluation interview, Pakistan**

> *Many a times they [mothers] can't raise their voices for girls because in their social settings women are used to bearing violence of their males and in-laws, which make them think that obeying them is the way of their life. They remained silent on the abuse and violence which directly or indirectly becomes learnt behaviour for adolescent girls.*
> **Facilitator, monitoring report, Pakistan**

Summary: The impact of COMPASS parent group discussions

In DRC, parents who took part in the programme were more likely to express greater warmth and affection for their daughters than those who had not.

In all three countries, data revealed that parents had a better understanding of adolescent girls and how to care for them as a result of the programme. Adolescent girls in Pakistan reported feeling that their relationships with their parents had improved, and in Ethiopia, girls felt more comfortable discussing some topics with parents. However, adolescent girls continued to think that their families would blame them if they were survivors of GBV, and parents continued to hold harmful gender attitudes.

Overall, findings point to the need for targeted adolescent girl programming to be accompanied by wider gender transformative programmes that explicitly address power dynamics between men and women in the household and the community, engage mothers and fathers, and seek to transform entrenched gender norms and attitudes.

> *Because I felt guilty and no longer slept; but after the service, I felt innocent and slept well.*
> **Adolescent girl, child client satisfaction survey, DRC**

Effectiveness and change: The impact of COMPASS on GBV service provision for adolescent girls

COMPASS trained GBV service providers to make services more adolescent girl friendly.

In all three countries, the IRC worked to improve the knowledge, attitudes and approach of GBV services for adolescent girl survivors. The model varied in each country: in DRC, the IRC supported women-led community based organisations (CBOs) to provide services, while in Ethiopia and Pakistan, the IRC directly provided case management to survivors within women's and girls' centres which also accommodated COMPASS activities. In Ethiopia and DRC, support was also provided to health facilities, and education service providers. operating in the camps were supported in Ethiopia.

In all countries, IRC WPE staff used standardised materials to train service providers, making adaptations to ensure they were relevant to adolescent girls. Topics covered in the training included GBV case management, clinical care for sexual assault survivors, and caring for child survivors of sexual abuse, as well as some context specific topics.[xvi] IRC staff carried out training for first responders at several points throughout the programme, and conducted regular visits to provide ongoing support and supervision. Health and case management service providers were assessed every quarter on their knowledge of and attitudes towards GBV services for adolescent girls. They were also assessed on their attitude towards GBV survivors, their beliefs on the causes of GBV, and what they felt a positive experience with a service provider should entail for an adolescent girl. Following the delivery of training and support, the majority of professionals in all three countries achieved the minimum standards expected of them – see figure 5.

Figure 5: IRC trained providers reaching minimum standards, according to knowledge and attitude assessments

94%
DRC (December 2016)

77%
Ethiopia (March 2017)

89%
Pakistan (November 2016)

> *[As a result of the programme], I and other girls became aware of the places where we can go and report whenever we face any type of problem in our life. Even when our parents arrange marriage for us without our goodwill, we are now aware of where we can go to report such things.*
> **Adolescent girl, 14 years old, evaluation interview, Ethiopia**

Preventing violence in schools, Ethiopia

The IRC in Ethiopia spent a significant amount of time working with schools and education providers because of their essential role in empowering adolescent girls and helping them protect themselves. Schools and other educational environments are places that can help protect adolescent girls from GBV but also potentially increase their risk to it. The training and capacity building IRC provided was based on the Good School Toolkit (developed by Raising Voices), which focuses on creating safer schools.[xvii] As a result of IRC's support, education providers in the refugee camps agreed to implement a new code of conduct, including a zero tolerance policy to corporal punishment and sexual harassment.

Adolescent girl survivors provided very positive feedback on their experiences with services, with 94% of adolescent girls reporting satisfaction with the services they received in DRC, 100% in Ethiopia and 75% in Pakistan. In DRC, adolescent girls most commonly named medical referrals as the most useful service, followed by individual counselling. Adolescent girls reported that counselling helped them relieve feelings of guilt and stress.

All of the adolescent girl survivors that provided feedback in DRC described their psychosocial counsellor as understanding, welcoming or empathetic, and stated that they felt the counsellor believed what they said; 98% of all girls reported that they felt better after meeting with the counsellor. In Pakistan, adolescent girl survivors were most likely to seek psychosocial support and counselling, help accessing health services or support with acquiring official documents (e.g. marriage certificates, etc). They were highly satisfied with the performance and attitudes of the counsellors, and reported feeling comfortable and respected in sessions; they also trusted their caseworkers with the information they were sharing. Overall, adolescent girl survivors in Pakistan reported that women's community centres not only offered them access to vital services, they also provided them with a safe, comfortable and peaceful environment where they could get together with their peers and openly share their views and experiences. As a result, they said this helped to relieve stress and enhance their knowledge on many topics.

COMPASS increased adolescent girls' knowledge of and access to professional GBV services.

By the end of the programme, adolescent girls in all three countries were more likely to report knowing where to go if they experienced physical or sexual violence. In comparison to girls from the waitlist group, adolescent girls who participated in the programme in Ethiopia were almost twice as likely to report knowing a place to go to for help if a girl had experienced sexual violence and more than twice as likely to report knowing a place if physical violence had occurred.

In all three countries, there was an increase in the number of adolescent girl survivors accessing services in programme sites.[29] In Ethiopia, the number of adolescent girls (10–19 years old) accessing GBV case management services increased from just three at the beginning of the programme to 23 after the first programme cycle; in North Kivu in DRC, approximately 118 girls aged 10–19 sought services between January and June 2016, a figure which rose to 216 between July and December. In Pakistan, 34 adolescent girl survivors accessed health or case management services from the IRC or COMPASS partners in the first six months of the programme (up to May 2015); this figure increased to 263 by January 2016.

29. The data and statistics represented here include only information from survivors who have consented to share their aggregate information, as collected through the gender-based violence information management system. Data reported in this trend includes adolescent girl survivors (age 10–19) in programme areas, not only girls who attended COMPASS activities. This data is reported incidents and should not be considered to represent the prevalence of violence.

> *I am telling you that she cannot go and report him because she is afraid of her mother and she is afraid of this man; it happens that she reports him and the day after this man meets her again on the road and can hit her again; she cannot do anything, she must forget it and let it go.*
> **Adolescent girl, evaluation interview, DRC**

In interviews, adolescent girls and parents predominantly said in the event of an incident of GBV against an adolescent girl they would first refer it to family or community leaders, or they would hide that it happened. Although this has not changed at the end of the programme, the increase in girls' knowledge and use of professional services is an encouraging finding and shows that more girls have already started to receive the professional and life-saving care they need after experiencing GBV.

The impact of COMPASS on GBV service provision for adolescent girls

In all three countries, considerable training was conducted to increase the capacity of service providers, in terms of the case management, psychosocial support, education, and health and other services they offer. Training was also provided to ensure service providers had the knowledge and skills to tailor their care, support and information to meet the specific needs of adolescent girls. As a result of the training and ongoing support, providers demonstrated improved knowledge of and attitudes towards adolescent girls and provided a more adolescent girl friendly service.

The programme also improved girls' knowledge of where to go if they experienced physical or sexual violence. This was reflected in an increase in adolescent girl survivors accessing essential services in all three countries during the intervention period. Adolescent girl survivors who did access services reported high levels of satisfaction with the services they received.

Feasibility and acceptability

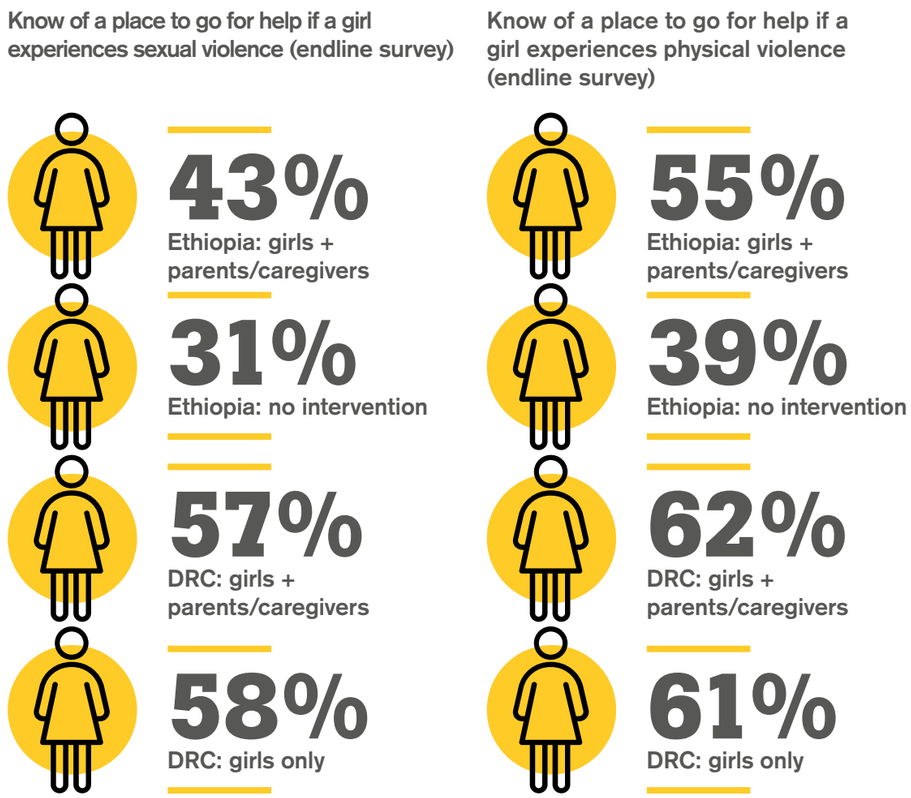
Populations in humanitarian settings are often in a state of flux, with high levels of mobility, uncertainty and instability. In addition, programming specifically targeted at adolescent girls and focused on topics such as puberty, sexual health, healthy relationships and violence can be controversial and met with resistance in some communities. With these factors in mind, the IRC explored the extent to which safe spaces and related adolescent girl programming were feasible and acceptable. Feasibility refers to adolescent girls having safe, consistent access and the ability to participate. Acceptability refers to adolescent girls, families and communities being open to learning about programme topics and developing related skills, as well as community leaders, authorities and other influential actors supporting their participation.

COMPASS proved to be feasible and acceptable in humanitarian settings.

In many communities across the three country contexts, the concept of programming for adolescent girls was new. As a result, there were examples in all countries where parents voiced concerns about the appropriateness of the activities, which initially limited the programme's acceptability. However, IRC's extensive awareness-raising with communities, including group discussions, house-to-house visits and meetings with local authorities and community leaders, increased acceptance of the programme by parents and the community, and resulted in high levels of interest and enrolment by adolescent girls. Acceptance by communities in DRC and Ethiopia was also due to the positive relationships IRC WPE staff had built up in these countries over time and the positive attitudes communities already had towards IRC's previous programming for women and adolescent girls.

> *They [community members] were of the view that girls should remain inside the home to learn and help their mothers in domestic chores; and they also feared that this programme may persuade our daughters and make them stand against their culture and tradition.*
> **Facilitator, curriculum review, Pakistan**

Figure 6: Knowledge of services



> *I feel safe because centre vehicle provides pick up and drop off, and that's the reason that I feel safe.*
> **Adolescent girl, 19 years old, in-depth interview, Pakistan**

Enrolment and attendance of adolescent girls and parents

Enrolment rates are a good indication of the accessibility of and interest in the programme, as they show whether adolescent girls and parents could access safe spaces / group discussions at specified times, and whether they had the motivation to do so. Attendance, absence and dropout rates give an indication of barriers to participation in a programme.

High enrolment and attendance demonstrated adolescent girls' and parents' enthusiasm for the programme.

Across all three countries, 2,977 adolescent girls took part in the first programme cycle of COMPASS, and 2,156 adolescent girls took part in the second and third cycles. High levels of interest were retained for subsequent cycles of the programme following the initial delivery. Average attendance of adolescent girls' life skills sessions was very high: over 75% in all three countries, showing their enthusiasm for the intervention.

Barriers for adolescent girls attending some sessions included resistance from parents, scheduling challenges, competing priorities (chores or tasks) and health problems. Also in Ethiopia and DRC, a small number of girls missed sessions because they were getting married or giving birth. In Pakistan, some adolescent girls reported difficulties accessing remote sites; in response, implementing teams provided transport to the sites, which reportedly improved girls' ability to access sessions. Generally, attendance rates improved over the course of the life skills sessions in all countries, demonstrating adolescent girls increasingly valued the programme and the importance of concerted follow-up activities with individual adolescent girls to encourage them to attend.

When an adolescent girl missed a number of sessions, their mentors and peers contacted her and her family to find out the reasons why and encourage her to attend again. Mentors in Ethiopia reported that if an adolescent girl had been away for a longer period, for example, when they had been temporarily relocated, it was difficult for them to provide the support needed for the girl to catch up with their peers when they returned.

Dropout of adolescent girls was overwhelmingly due to them moving away from the area where the programme was delivered, meaning they were no longer able to participate. This emphasises the challenges of a curriculum implemented over a set period of time with transient populations and the importance of ensuring that adolescent girls have good knowledge and information about programme topics before they relocate and, wherever possible, helping them access relevant services in their new location. It also highlights that programming must be flexible so it can adapt to unique and sometimes changing contexts, and the need for methods which can anticipate and manage dropouts.

This was particularly true for Pakistan, as an area the programme took place in was the focus of a government initiative to return displaced people to their communities of origin, which subsequently led to the closure of the Jalozai camp. As a result, IRC WPE staff moved the women's community centres to outside the camp, but unfortunately, many adolescent girls did not re-join the programme.

In Ethiopia and DRC, adolescent girls were asked to select a parent that they would like to take part in the programme. Overwhelmingly, adolescent girls selected their mothers, and some reports from DRC suggest that when adolescent girls selected their fathers, attendance was actually delegated by the husband to the wife. In North Kivu in DRC, a number of the adolescent girls were the head of the household and could not easily identify someone to participate in the parents' curriculum. In Pakistan, it was decided that only mothers would be invited to participate in the corresponding parent group discussions, as this was seen as the most culturally appropriate way of engaging the families of adolescent girls. Across all three countries, 1,725 parents took part in the first programme cycle of COMPASS, and 2,436 parents took part in the second and third cycles.[30]

30. Note that in DRC, some parents/caregivers of girls who took part in the first programme were waitlisted to the second cycle. This was due to the design of the research.

Figure 7: Average attendance

Adolescent girls' life skills sessions	Parent/caregiver group discussions
78% DRC (across all sites, cycle 1)	**70%** DRC (across all sites, cycle 1)
83% Ethiopia (across all camps, cycle 1)	**91%** Ethiopia (across all camps, cycle 1)
87% Pakistan (across all sites, cycles 2/3)	**86%** Pakistan (across all sites, cycles 2/3)

Parent attendance was also fairly high, but varied between sites.[31] Parents were less likely than their daughters to attend in DRC because of competing priorities, but those that did attend recognised the value of the programme, and were even successfully mobilised to encourage non-attenders to participate. In Ethiopia, there was a challenge in consistency, with different parents attending different sessions for the same girl. In Pakistan, implementing teams had some challenges in engaging parents to be less responsive and less interested maintaining their interest in the sessions: some mothers felt that the focus on adolescent girls was misplaced. Similar to the adolescent girls, dropout of parents was mostly due to them moving away from the area where the programme was delivered.

Adolescent girls' experience of COMPASS

Adolescent girls gave positive feedback about COMPASS

Adolescent girls provided very positive feedback on the life skills sessions in all three countries. In Ethiopia and Pakistan, girls were reportedly quite shy at the beginning of the programme, but became more responsive and confident as sessions went on and their relationships with mentors developed. In Ethiopia, when girls were asked how they were feeling following each session: 100% said they were happy after the fifteenth session, up from only 45% at the first session. The girls stated that this was because they initially did not know what to expect and therefore felt shy and afraid at the first session, but that their impression of the programme and their comfort levels improved as they attended more sessions. This was corroborated by comments from mentors that the sessions became more interactive as the programme went on, with activities such as drawing, singing, dancing, role play and games. When asked what subjects they had studied, adolescent girls talked about the topics they found the most interesting: puberty and hygiene, friendship, early marriage and unwanted pregnancy. They also expressed that they were happy to learn about their rights in relationships and how to protect themselves from unintended pregnancy. In Ethiopia, the most popular sessions were being a good friend, setting goals, communication skills, safety skills and health and hygiene. Adolescent girls also mentioned enjoying specific activities during the

31. In DRC, average parent attendance was 67% across sites in South Kivu and 72% in North Kivu, although there was a large range between sites. In Ethiopia, average attendance across the three camps was 91%. In Pakistan average attendance was 86%, although again this varied across different districts.

Photo credit: Meredith Hutchison

Enas, 13, comes to the safe space to learn and pursue her dream of being a teacher.

COMPASS sessions, including drawing, singing, writing and drama. Topics around sexual health, and particularly discussions around contraception, made the adolescent girls in Ethiopia uncomfortable, which in turn made the mentors feel the same. In Pakistan, the session on GBV and abuse was difficult: discussing sexual abuse, rape and sexually transmitted infections was new to the girls, which meant they felt shy talking about these topics and struggled to understand learning related to them.

In Pakistan, all adolescent girls reported being satisfied or very satisfied with the women's community centres. They perceived the greatest benefits to be learning new and useful things and meeting peers at the centre. In DRC, over 90% of girls reported satisfaction with the accessibility and quality of the safe space, the materials and mentors, and the time they spent with their peers.

Adolescent girls retained important information through COMPASS.

Monitoring activities showed that adolescent girls were generally able to remember key messages from life skills sessions. In Ethiopia, adolescent girls could recall an impressive amount of information from the sessions, including hygiene, identifying safe and unsafe places, saying "no" if they felt negative pressure from a friend, and dealing with changes during puberty. Similarly, in Pakistan, adolescent girls had a good knowledge of physical changes in puberty (though less so behavioural changes), and could outline strong reasons for marriage to take place at 18 or older. Adolescent girls described safety planning as identifying risks, planning journeys, asking for help from a 'safe person' and talking to service providers.

> *In our family there were a few people who stopped us from coming to the centre and said, 'Learn these things at home and don't go outside.' But now, they saw the difference that we have learned different skills, like beautician course. They realised that this is a good thing, because such things could not be learned at home.*
>
> **Adolescent girl, 14 years old, evaluation interview, Pakistan**

> *I think these were good things. With these [sessions], we came to know how we would make ourselves safe and how we would make a right decision… After learning from the sessions, we have told this to our elders: 'Don't go for early marriages.*
>
> **Adolescent girl, 17 years old girl, evaluation interview, Pakistan**

> *When I came to [COMPASS] I found my friends… I like interacting with my friends there. I like the programme very much. I like drawing, playing with my friends, and anything we do inside the safe space is enjoyable.*
>
> **Adolescent girl, monitoring focus group, Ethiopia**

Acceptability of COMPASS to parents and community members

Parents supported adolescent girls participation in the life skills sessions.

Despite some initial concerns, parents in all three countries were supportive of their girls' participation the programme. In Ethiopia, there was some concern about what girls did when they told their parents they were going to COMPASS, as there were some rumours that they were going to meet boys. Although these rumours initially led to some parents prohibiting their daughters from attending, this became less common as the programme gained a more positive reputation. In Pakistan, there was some resistance to activities in sessions which involved physical movement, such as games, as they were seen as inappropriate for girls. Mothers in Pakistan were also initially reluctant to allow their daughters to attend sessions separately from them. In interviews in DRC, some adolescent girls spoke about how their families were unsupportive of the programme because it was taking them away from household chores, or because they suspected the programme was providing inappropriate information.

Pakistan: vocational training to improve acceptability

In Pakistan, vocational activities were offered to women and adolescent girls at the centres from the outset. This was partially in response to a demand for skills training by women and girls, but also as an attractive and acceptable entry point into other activities, with vocational classes taking place alongside life skills sessions, counselling and case management services. Skills taught at the centres included sewing, embroidery, beautician courses and cooking, as well as basic numeracy and literacy.

> *Whatever I have learnt in the centre and I have shared earlier are good things. Whenever I go to community, I tell people that this centre is a very good place and your daughters can learn good things in the centre.*
>
> **Female caregiver, in-depth interview, Pakistan**

Parents gave positive feedback about COMPASS group discussions.

In general, parents provided positive feedback about the group discussion they attended, and most seemed comfortable with the majority of topics. In Pakistan, women expressed gratitude for the centre and recognised the value of the topics learned and the services provided by centre staff. They also talked about the benefits of meeting and talking to their peers, which helped them cope with stress and forget their problems.

There were some topics which did make parents uncomfortable. In DRC, there were some challenges with discussing topics such as menstruation, harmful traditional practices and sexual health (especially contraception).This was particularly so when group discussions included men and women together. However, reports from South Kivu suggested that some parents were also grateful that these topics were being addressed, as they had no other opportunity to do so, and it allowed them to share their own experiences on difficult subjects such as labia extension. In Pakistan, there were concerns about sessions on changes in girls' bodies (puberty) and on traditional practices (early and forced marriage and Sara).[32] Mothers said they did not want to discuss these subjects in the session or with their daughters, or stated that these traditional practices were not harmful.

Summary: The feasibility and acceptability of COMPASS

COMPASS proved to be feasible and acceptable in these three varied humanitarian settings. Across the three countries, there was a high level of interest in the programme: adolescent girls were keen to enrol, and there were high levels of attendance (75%) throughout the programme. Barriers to girls attending some sessions included initial resistance from parents, scheduling challenges, competing priorities (chores or tasks) and health problems. Dropout of the girls was overwhelmingly due to them moving away from the area, which meant they could no longer participate. This highlights the importance of recognising the needs of highly mobile populations, for example, ensuring adolescent girls have good knowledge and information about programme topics before they relocate and, wherever possible, helping them access relevant services in their new location. Girls also provided very positive feedback on the sessions in all three countries, and became more engaged the more they attended and as their relationships with mentors developed.

Parent attendance was also fairly high, but varied between sites and centres. They were also positive about the programme, in terms of them developing new knowledge and seeing changes in their daughters.

Overall, learning from COMPASS suggests that adolescent girl programming is feasible and acceptable in this context: adolescent girls had interest in and the ability to attend the COMPASS programme, their parents were engaged, and wider communities showed acceptance of their participation.

32. Custom where girls are forcibly married as compensation or restitution to another family for a crime committed by a male member of her family.

> *I don't remember exact wordings, but she said that it is not good to send your daughters to this centre because it is not considered good in our culture; but I told her that I, myself, have visited that centre. I have met all the ladies there and become satisfied.*
>
> **Female parent, evaluation interview, Pakistan**

Lessons from the implementation of COMPASS

Implementing a new approach and working with vulnerable populations in refugee and displacement camps, and in conflict-affected and host communities, is challenging, particularly when diverse populations, multiple languages and low literacy levels are involved. This section includes lessons learnt from the day-to-day implementation of the programme, particularly in relation to developing safe spaces, flexible curriculum design and delivery, and mentor capacity and support.

Safe spaces

Adolescent girls were consulted on the best place to hold life skills sessions. In Ethiopia, girls selected women-only spaces, but they also asked for a separate area for themselves.

This resulted in new adolescent girl tukuls (traditional round huts) being built and located within IRC women and girls wellness centres. In contrast, adolescent girls in DRC identified existing community spaces as the best place to hold COMPASS activities, within women-led CBOs, schools, health centres or churches, which were then renovated and equipped to make them ready for the life skills sessions. In Pakistan, girls' life skills sessions were held within women's community centres, which were established as part of the COMPASS programme.

Safe spaces gave adolescent girls a place to feel safe, learn, and make friends.

These spaces proved effective, with adolescent girls reporting that they appreciated a physical space where they could build friendships, have fun, play games and develop new skills, such as writing and drawing. In Ethiopia, some adolescent girls explained how IRC safe spaces could be useful for girls when they felt unsafe at home and in other spaces in the community. In emergency sites in DRC, where finding an appropriate space was more challenging, teams noted how important it was for adolescent girls to have a safe space to express themselves, even if this space was temporary and informal.

Curriculum design and delivery

Curricula had to be designed and implemented in a way that acknowledged the diversity of adolescent girls, and responded to their feedback.

The adolescent girls' life skills curriculum and accompanying curriculum for the parent group discussions were developed at a global level and then adapted by each implementing team to the relevant context. The curricula were heavily contextualised to achieve cultural acceptance yet still consistently address key elements of the programme. This was done by drawing on expertise from the IRC's WPE teams and health and education technical units, as well as gathering feedback from women and adolescent girls in target communities.

Where the context presented challenges, innovative solutions were found. For example, in Ethiopia, where many of the adolescent girls spoke unwritten languages, the delivery of the curriculum was adapted to an audio format.

The adolescent girls' life skills curricula were also adapted throughout the programmes in the three countries, and particularly in Ethiopia. There, the curriculum evolved over the course of the entire first programme cycle: it was written, adapted, edited and revised in a fluid, responsive manner, with the final sessions written just one month prior to the programme's completion. This allowed the team to closely observe what was working well, to adapt it to the right level for the adolescent girls and respond to new themes and needs that emerged.

Following the first cycle of the curriculum in Pakistan, a comprehensive review was conducted, identifying challenges and successes of curriculum implementation to date. The curriculum was adapted according to this feedback, and a mentorship guide was developed for supporting mentors who participated in the second cycle of the programme. Given the unstable security situation in eastern DRC, a shortened curriculum for use in emergency contexts was developed and used in emergency response missions in North Kivu.[33] Key individual modules were selected and adapted for use in a single session or over the course of two to three weeks, as a full 10-month long curriculum proved infeasible in a period of acute emergency. The emergency curriculum was well received, with high levels of interest and positive feedback from the adolescent girls. However, it was challenging to cover all the topics the adolescent girls had identified as important within the two to three-week timeframe.

In all countries, a flexible and responsive approach to the girls' life skills and parent curricula was required, given the unique needs of the girls at this age and the settings they lived in.

Using mentors to deliver the adolescent girl life skills sessions

In all three countries, criteria for mentors included that they were close to the age of the adolescent girls, from the same area/neighbourhood and held positive attitudes towards the girls.

In DRC, mentors were required to have completed secondary school and possess a basic literacy level, whereas in Ethiopia and Pakistan this was not a realistic criterion. Due to low levels of education and knowledge on these topics in Pakistan, a different model was used: IRC staff facilitated the first cycle and then older girls (18–19 years old) who successfully completed the life skills course were enrolled to be mentors for the second cycle.

Mentors grew in confidence during the programme, and developed strong relationships with girls.

In all three countries, mentors were used to didactic approaches to teaching: methods involving a large amount of lecturing and repetition. This often meant the participatory approaches used in COMPASS sessions were new to them and the girls they were mentoring. Reports from Ethiopia suggested that at the beginning of the programme the girls were very shy, low in self-confidence and uncomfortable around new people. As the mentors gained confidence, they were able to encourage the girls to participate, and mentors reported seeing confidence in the girls grow. Girls developed trust and good interpersonal relationships with mentors, with some girls commenting that they viewed their mentor as a role model. Importantly, girls started going to their mentors for help, including when they experienced violence. Mentors also reported that they benefited personally from the programme: they enjoyed working with other mentors and the adolescent girls, and learning new things from the curriculum.

Mentors required ongoing support and supervision to deliver challenging content.

There were some challenges in the delivery of more sensitive topics. For example, mentors in Pakistan reported feeling uncomfortable discussing sexual health topics with the girls, particularly as they were unmarried. They also reported that this topic seemed inappropriate to them and was difficult to explain. Ongoing training and high levels of one-on-one support were required to overcome this. Over the course of the programme, monitoring showed that mentors considerably improved their ability to deliver the curriculum, (see box on page 47 opposite for criteria).

There were also concerns in all three countries that because the mentors came from similar backgrounds to the adolescent girls, they may share an acceptance of gender equality and actually reinforce harmful gender norms, instead of challenging them. A short monitoring survey conducted with mentors in the third cycle of the programme in Pakistan found that while mentors were enthusiastic about working with adolescent girls and saw the importance of supporting them in relation to the COMPASS topics, including keeping them safe from GBV and learning what to do if they face violence, they also still held some harmful attitudes towards gender and GBV at the end of the programme. While IRC WPE staff trained mentors on the content of the adolescent girls' life skills sessions, there was initially no specific training curriculum for mentors that featured an introduction to GBV, gender norms and attitudes, gender-related power dynamics in families and communities, or facilitation techniques, etc. IRC staff addressed these challenges during the programme by providing extra training and support to mentors.

In DRC, the WPE staff developed a conversation guide to support mentors' facilitation of more difficult subjects. A system was also introduced where an IRC staff member co-facilitated sessions with mentors which covered challenging topics such as gender norms and violence. In Ethiopia, IRC WPE staff organised and delivered additional training for girls aged over 14 on understanding the risk of unhealthy sexual behaviour and unsafe sexual practice, which received positive feedback from the girls. These adaptations in implementation highlight the importance of providing training for mentors which recognises their backgrounds and the support they may need to challenge their own harmful views on gender norms and violence.

Quality criteria used to evaluate mentors' capacity to deliver the COMPASS curriculum

- The mentor is warm and welcoming towards the adolescent girls.
- All content of the session is covered.
- Ice-breaker/energiser is held at the beginning of the session.
- Group work is used throughout the session.
- Theme and objectives are clearly stated at the beginning of the session.
- At end of the session, mentor proposes how ideas from the session can be applied in girls' everyday lives.
- Mentor asks the group questions.
- Mentor gives the group enough time to respond to questions.
- Mentor validates girls' responses.
- Mentor speaks with girls individually or in small groups.
- All girls have an opportunity to speak, either in a big or small group.

Summary: Lessons from COMPASS implementation

In each of the three countries, safe spaces were essential to the intervention as it was important to adolescent girls to have a place where they felt safe, could learn and make friends.

The global COMPASS curriculum was adapted to each country context through a consultation process with IRC staff, adolescent girls and communities. The curriculum continued to be reviewed and adapted throughout implementation, in response to learning and feedback. The adoption of a mentorship approach gave adolescent girls the opportunity to connect with young, local women, and mentors showed commitment and positive attitudes towards the girls they came into contact with. However, low levels of education and knowledge of the subjects meant that mentors required considerable training and support, particularly on sensitive or difficult topics.

Overall, the flexible and responsive approach used in COMPASS resulted in a high-quality and appropriate programme being developed and delivered in each of the three countries.

33. Note this was delivered in additional sites, which were not included in the external evaluation.

A life skills session takes place in an IRC safe space in Tongo refugee camp, Ethiopia. Mentors from the girls' own community helped make the sessions relevant for girls.

Photo credit: Meredith Hutchison

CHAPTER 4:

CONCLUSIONS AND RECOMMENDATIONS

This chapter summarises the key conclusions from the implementation and evaluation of the COMPASS programme and makes recommendations to donors, policy makers, practitioners and researchers on supporting a robust programming and research agenda for adolescent girls in humanitarian settings.

1 Adolescent girls as young as 10 are experiencing GBV in humanitarian settings.

- 45% of adolescent girls in Ethiopia and 37% in DRC have experienced sexual violence in their lifetime.
- Over half of adolescent girls in Ethiopia (52%) and DRC (61%) had experienced at least one form of sexual, physical or emotional violence in the past 12 months alone. Experience of sexual violence in this period was particularly high: 29% in Ethiopia and 26% in DRC.
- One in every two girls in DRC (52%) and one in three in Ethiopia (33%) had experienced emotional abuse, such as aggressive shouting. Over 40% in both DRC and Ethiopia felt uncared for in the past 12 months.

Intimate partners were most likely to be the perpetrators of nearly all types of violence against adolescent girls.

- In Ethiopia, 43% of sexual violence was perpetrated by intimate partners, followed by parents/caregivers or relatives (29%), and friends/neighbours (9%). Similarly, in DRC, 49% of sexual violence was committed by intimate partners, 17% by parents/caregivers, and 14% by friends/neighbours.
- There was low reporting of other perpetrators, such as community officials (police, teachers, local leaders) or armed actors. In DRC, less than 5% of GBV was reported to be committed by these individuals.

Adolescent girls as young as 10 are highly exposed to sexual violence.

- While all adolescent girls experienced high levels of GBV, very young girls, some as young as 10, were particularly at risk.
- Girls aged 10–12 in DRC were twice as likely to have experienced coerced sex and unwanted sexual touching at some point in their lives than girls aged 13–14.
- In Ethiopia, adolescent girls aged 13–14 were more than twice as likely to have ever experienced sexual exploitation than adolescents aged 15–19.

2 COMPASS improved the lives of adolescent girls.

Adolescent girls expressed a clear demand for the tailored support provided by COMPASS.

- Many adolescent girls enrolled in the life skills sessions maintained high attendance rates throughout the programme; overall, attendance rates for sessions increased over the course of the programme.
- Dropout rates were low across all three countries, and when girls did stop attending sessions, this was predominantly due to external factors.
- COMPASS's strong retention of adolescent girls and the absence of similar adolescent-girl specific programming in each country highlights the need for programmes which aim to understand and meet the particular needs of adolescent girls in humanitarian settings.
- Adolescent girls participated enthusiastically in the programme: they were eager to learn life skills, make connections with supportive adults, and spend time in a safe space with their female peers. In Ethiopia, every participant (100%) said they felt happy at the life skills sessions. Many adolescent girls also gave positive feedback about the safe spaces, with 90% in DRC saying they were satisfied with their safe space, and girls in Pakistan reporting they felt safe in their designated spaces.

As a result of participating in the programme:

Adolescent girls had better knowledge of professional GBV services.

- The programme significantly increased girls' knowledge of professional GBV services, including legal and health support. These services play a vital role in preventing violence from occurring when a risk emerges and helping adolescent girls recover when violence does occur.
- In all three countries, there was a considerable increase in the number of adolescent girl survivors accessing services in programme sites during the period of COMPASS implementation, as monitored through service delivery records. While this increase cannot be uniquely attributed to COMPASS, it is an encouraging trend, showing that more girls started to receive the life-saving care they needed by the end of the programme.

Adolescent girls felt more positive about themselves and their future.

- In all three countries, girls could identify a number of positive attributes about themselves. In Pakistan, girls had much higher self-esteem at the end of the programme.
- In all three countries, girls felt more hopeful about their future. In DRC, the impact was greatest with young girls aged 10–12. This change is critical to increasing the resilience of girls, encouraging them to speak out when they feel threatened and supporting their recovery if they experience GBV.
- In Ethiopia and Pakistan, girls also had higher expectations for their future. In Ethiopia, participants in the programme were twice as likely as those who didn't take part to say that girls should be 18 or older before they married or had a child. In comparison to non-participants, they also believed, on average, that girls should be in school for one year longer. At the end of the programme in Pakistan, girls were significantly more likely to believe that they deserved the same opportunities as boys (82% agreement from 58% at the beginning of the programme.)

Adolescent girls had stronger social networks and a safe space to go to.

- COMPASS helped girls to meet safe and trusted adults, including mentors, which subsequently helped them to build a network of support. In Ethiopia, participants in COMPASS were nearly twice as likely as those who didn't take part to report having friends, and twice as likely to say they knew a trusted adult who was not a family member. These support networks are critical to ensuring girls are not isolated when threatened or affected by GBV.
- In all three countries, the safe space provided adolescent girls with a place to go to where they could be safe from threats in their community, meet with other girls their age and make friends, learn new skills and plan for their future.
- In Pakistan, access to a safe space resulted in girls visiting twice as many places outside of their home, from an average of one per month to two.

These outcomes are evidence that COMPASS led to improvements in girls' social, emotional and psychological wellbeing. Ultimately, these are important steps to reducing girls' exposure to GBV and helping them recover when they experience violence.

3 Consultation with adolescent girls throughout implementation was essential to ensuring programming was responsive, flexible and addressed the needs of girls from diverse backgrounds.

- COMPASS was implemented in three countries and three very different humanitarian settings: refugee camps, conflict-affected sites and among internally displaced populations living in host communities and camps. Within each of these sites, there was huge diversity among the adolescent girls that the programme reached, in terms of language, ethnicity, education, family life, ability and life experience.
- In all three countries, the COMPASS programme was responsive and flexible. This included listening and responding to girls' views on the design and delivery of the programme throughout the first cycle in each country. This was crucial to ensuring necessary adaptations were made to make the programme relevant to the unique needs of the girls. For example, direct input from the girls determined the location of safe spaces and led to the recruitment of young female mentors.

Flexibility and adaptation was essential to ensuring the feasibility, acceptability and effectiveness of the programme. In Ethiopia, the curriculum content and delivery was designed and adapted in a fluid, responsive manner. For example, sessions were delivered through audio recordings because many girls spoke non-written languages. In DRC, a shortened curriculum for emergency contexts was developed and delivered to girls who had recently been affected by conflict or displacement. In Pakistan, the content of sessions was heavily contextualised to aid cultural acceptance but also developed to ensure key messages were consistently delivered.

4 The existence of quality GBV services and trained staff was critical to ensuring the safety and wellbeing of adolescent girls targeted by COMPASS.

- Given the high levels of GBV affecting adolescent girls in the targeted contexts, it was essential to ensure the presence of quality GBV response services. The COMPASS life skills curriculum tackled issues around GBV, including early marriage, sexual exploitation and intimate partner violence. This is likely to have led to a higher level of awareness among girls of the violent nature of some of their experiences. Ensuring access to specialised GBV services that are confidential and girl friendly is a critical and potentially life-saving component of any programme that aims to promote the safety and wellbeing of adolescent girls.
- COMPASS benefited from being implemented by well-established IRC Women's Protection and Empowerment (WPE) teams, and especially in DRC and Ethiopia. Their understanding of GBV and gender inequality, and how these issues affect women and adolescent girls, allowed IRC to effectively support mentors who might have inadvertently reinforced negative gender norms, due to their own backgrounds. The WPE team's existing relationship with communities is also likely to have contributed to the acceptance of COMPASS.

5 COMPASS has made a valuable contribution to the evidence of what works to promote the health, safety and empowerment of adolescent girls in humanitarian settings.

However, further programming and research is needed to build on this learning and increase understanding of which strategies and interventions are most effective in reducing GBV against adolescent girls in humanitarian settings.

- Despite an overall reduction in girls' self-reported exposure to GBV in DRC, the evaluation did not conclusively attribute this reduction to COMPASS. This finding could be due to the limited scope of COMPASS.
- Qualitative research showed that harmful gender norms remain deeply entrenched in the communities where COMPASS participants lived, including among girls and their mothers.
- Parent/caregiver participation in the programme was found to have no additional impact on the reduction of GBV against adolescent girls. This could be due to the fact that their curriculum was not designed to transform entrenched social and gender norms, or attitudes and related behaviours. It also wasn't developed in a way which viewed participating parents/caregivers as potential perpetrators of violence. Instead, the aim of the curriculum was to improve parents/caregivers' relationships with their adolescent girls by providing them with the same information. In addition, the majority of parents who participated in the programme were female. They are likely to have limited power within their family and community, making it difficult for them to make decisions or changes that will reduce their girls' exposure to GBV.
- These findings suggest that to see meaningful shifts in GBV against adolescent girls and harmful attitudes and behaviours towards young survivors, it is necessary to address wider community and family norms. This underlines the need for further research and evaluation that builds on COMPASS learning and explores the impact of social and behavioural change programming.

Based on these conclusions, the IRC has developed a programme model and resource package called Girl Shine. It builds on the positive practices in COMPASS and bridges the gaps identified during the implementation of the programme and by associated research. Girl Shine is intended to be a practical and flexible resource for practitioners. It includes step-by-step guides on how to design, implement and monitor a life skills programme for adolescent girls and parents/caregivers living in humanitarian settings. It also features a training component for mentors and staff (See Annex 6).

Recommendations

IRC makes the following recommendations to donors and policy makers, (including donor governments, UN bodies and humanitarian bodies) and practitioners (including INGOs, national, local and women's organisations in emergency-affected contexts):

1 Donors and policy makers should commit to the development of a strategy or government-wide policy dedicated to adolescent girls in humanitarian settings.

Truly addressing the needs of adolescent girls in humanitarian settings requires a much more intentional approach than ad-hoc, piecemeal research or programmes. It requires a dedicated strategy that recognises adolescent girls as a distinct group with unique needs and perspectives. Such a strategy would allow donors and policy makers to define and adopt a comprehensive approach to transform girls' lives. It should include relevant government departments, including policy, strategic and budgetary planning, operational emergency response, country and regional teams, staff training and capacity building, and monitoring and evaluation of results.

2 Donors and policy makers should provide long-term, dedicated funding to programmes like COMPASS that specifically address GBV against adolescent girls in humanitarian settings.

Programming like COMPASS requires flexible funding so it can adapt to different contexts, meet the diverse needs of adolescent girls and have sufficient time to change deep-rooted, harmful gender norms. It also requires dedicated and trained human and financial resources. Existing programmes which target violence against women and girls, children or other groups should not be deemed suitable for responding to the specific risks faced by adolescent girls.

3 Donors and practitioners should ensure adolescent girl programming is driven by adolescent girls' needs and voices and is responsive to ongoing monitoring.

Donors should require, and practitioners should ensure, the participation of adolescent girls from the very beginning of the design of a programme, as well as create opportunities with girls throughout implementation. This effort should consider the human, financial resources and time required to design, implement, monitor and evaluate a responsive and context-specific programme. The funding and programme, including the curriculum and method of delivery, must be flexible enough to adapt to this feedback and support the feasibility, acceptability and effectiveness of the programme in various settings.

4 Practitioners should ensure that adolescent girl programming also targets younger adolescent girls.

While the risk of GBV is high for adolescent girls aged 15–19, in some cases it is even higher for younger adolescent girls aged 10–14. This underscores the need for programming that does not overlook younger adolescent girls, and ensures they can access the same services and support as older girls.

5 Donors and practitioners should invest in safe spaces for adolescent girls.

Adolescent girls should be given a safe space in humanitarian settings that is away from threats in their community or at home, and which is distinct from safe spaces for women or children. This type of space will allow them to talk openly with their peers, develop social networks, understand healthy and unhealthy relationships, know where they can go if they feel unsafe or experience violence, and learn about themselves and their bodies. All of these benefits are valuable to the girls building a better future for themselves.

6 Donors and practitioners should invest in mentorship approaches.

Mentors are an important resource for programmes and a key role model for adolescent girls, as well as someone who may help to expand the girls' support network. Programmes should consider selecting mentors from existing women's groups or networks in communities and assess their personal commitment to promoting women's and girls' rights. Practitioners should invest in training and ongoing support for mentors which acknowledges their own experiences with violence and disempowerment.

7 Practitioners should ensure staff implementing adolescent girl programming have GBV knowledge and skills, and receive training on how to work appropriately and effectively with adolescent girls.

Staff implementing adolescent girl programming should have in-depth knowledge on the causes and consequences of GBV, including a strong understanding of gender equality concepts. They should also have experience of implementing GBV programming, and hold and convey values and attitudes that will help to transform gender norms and empower girls.

8 Donors, policy makers and GBV service providers should ensure adolescent girls can access quality GBV services that are tailored to meet their needs.

As well as there being a gap in services that meet the specific needs of adolescent girl survivors of GBV, adolescent girls are often unaware that services are available to them, reliant on an adult providing access to them, or avoid using the services because they fear judgement, blame or stigmatisation. GBV services must be made more accessible to adolescent girls and providers must convey warmth, non-judgement and approachability to ensure the girls use them.

9 Donors, policy makers and practitioners should ensure holistic programming exists that tackles wider harmful norms.

Alongside targeted life skills programming for adolescent girls, there is a need for more comprehensive programming that acknowledges and addresses the root causes of GBV. This programming should seek to transform harmful social gender norms that lead to gender inequality, devaluing of women and girls and acceptance of GBV. This should involve working with all levels of the community and society, including fathers of adolescent girls, religious and local leaders, and men and boys in general.

10 Donors, practitioners and researchers should pilot further programmes and research to better understand how female and male parents/caregivers can contribute to the safety and wellbeing of adolescent girls.

There is still a need for extra research to better understand the role that male and female parents/caregivers can play in GBV reduction. In particular, it should look at how parents/caregivers can support girls when GBV is perpetrated by an intimate partner, the different roles of female and male parents/caregivers, and how to encourage them both to participate. Research should also consider power dynamics between women and men in the home and the existing harmful gender attitudes parents hold towards women and adolescent girls.

11 Donors and researchers should continue to invest in research to improve programme models before moving to large-scale impact evaluations.

Evaluations should recognise that programme design is an iterative process, and that good programmes are likely to be adapted in the early stages in response to learning and consultation with adolescent girls. To allow for this kind of responsiveness, donors should provide funds for smaller scale research to be carried out on pilot programing. This will allow for learning to be adopted, and design and delivery to become more established, before large-scale impact evaluations take place.

12 Donors, practitioners and researchers should prioritise the following areas of research on strategies and interventions that reduce GBV against adolescent girls in conflict and humanitarian settings:

- Another cycle of COMPASS data collection to better measure the long-term effects of the intervention.
- The effectiveness and impact of mentorship models on the empowerment, community status and gendered attitudes of mentors themselves.
- The ways in which mothers, fathers and caregivers influence girls' exposure to violence and how this is mediated by gender and power dynamics in the household.
- Further develop qualitative research methods to better understand the needs of younger adolescent girls in order to inform programming.

ANNEX 1: ADOLESCENT GIRLS' LIFE SKILLS SESSIONS AND PARENTS/CAREGIVERS DISCUSSION TOPICS

The curricula for the adolescent girls' life skills sessions and parents/caregivers group discussions were developed by IRC at a global level and adapted to each context by the implementing WPE team, a process which involved consultation with adolescent girls, parents and community members. The table below provides the contents of the curricula used in each country.

Life skills curriculum

DRC	Ethiopia	Pakistan
Level 1: The Foundation - Creating a Context for Change		
Session 1: Welcome to COMPASS!	**Session 1:** Welcome to GirlShine!	**Session 1:** Welcome to COMPASS!
Session 2: Creating Our Safe Space	**Session 2:** Creating Our Safe Space	**Session 2:** Creating Our Safe Space
Session 3: What Makes Me Special	**Session 3:** I Am Special!	**Session 3:** What Makes Me Special
Session 4: My Friends and Support	**Session 4:** My Self-Esteem and Confidence	**Session 4:** My Friends and Support
Session 5: People I Can Turn To	**Session 5:** I am a Good Friend	**Session 5:** People I Can Turn To
Session 6: Addressing Risks in the Community	**Session 6:** My Safety	**Session 6:** Decision-Making
Session 7: Positive Peer Power	**Session 7:** My Emotions	**Session 7:** Addressing Risks in the Community
Session 8: Feelings and Emotions	**Session 8:** Smart Decision-Making	**Session 8:** Positive Peer Power
Session 9: Conflict Resolution	**Session 9:** Smart Problem-Solving	**Session 9:** Understanding Feelings and Emotions
Session 10: Setting My Goals	**Session 10:** Managing Pressure from my Friends	**Session 10:** Managing Your Emotions
Session 11: Whom to Turn to for My Health Needs	**Session 11:** Conflict Resolution	**Session 11:** Conflict Resolution
Session 12: Planning Use of Money	**Session 12:** Talking with my Caregivers	**Session 12:** Setting My Goals
Session 13: My Learning So Far	**Session 13:** My Goals	**Session 13:** Whom to Turn to for My Health Needs
		Session 14: Planning Use of Money
		Session 15: My Learning So Far
Level 2: Applying Our Skills - Challenging Realities, Developing Alternatives		
Session 14: Puberty, My Body, and Hygiene	**Session 14:** My Health and Hygiene	**Session 16:** Growing Up
Session 15: Cultural/Traditional Pressures Around Me	**Session 15:** My Changing Body	**Session 17:** Communicating Difficult Choices with My Family
Session 16: Communicating Difficult Choices with My Family	**Session 16:** My Reproductive Health	**Session 18:** Gender Roles and Norms
Session 17: Planning For a Family at the Right Time	**Session 17:** My Reproductive Health (Part 2) for 13-19 year olds only	**Session 19:** Cultural Pressures Around Me
Session 18: Sexually Transmitted Infections (STIs) and HIV / AIDS	**Session 18:** My Marriage	**Session 20:** Healthy Relationships
Session 19: Healthy Relationships	**Session 19:** My Role Models	**Session 21:** Gender Based Violence and Abuse
Session 20: Gender Roles and Norms	**Session 20:** Understanding Gender Roles	**Session 22:** Responding to and Dealing with Gender Based Violence
Session 21: Gender Based Violence	**Session 21:** Understanding Gender-based Violence	**Session 23:** Child and Early Marriage
Session 22: Early Marriage	**Session 22:** Harmful Traditional Practices	**Session 24:** Money Management and Savings
Session 23: Money Management and Savings	**Session 23:** Healthy Relationships	**Session 25:** Savings Plan & Keeping Money Safe
Session 24: Savings Plan & Keeping Money Safe	**Session 24:** My Safety Plan	**Session 26:** My Learning So Far
Session 25: My Learning So Far		
Level Three: Building Our Life Journey - Consolidation		
Session 26: Finalising My Safety Network	**Session 25:** My Life Journey	**Session 27:** Finalising My Safety etwork
Session 27: Developing My Life Journey	**Session 26:** Smart Problem-Solving on My Life Journey	**Session 28:** Developing My Life Journey
Session 28: Addressing Possible Barriers in My Life Journey	**Session 27:** Managing Resources on My Life Journey	**Session 29:** Addressing Possible Barriers in My Life Journey
Session 29: Creating Safety Plans for Journeys	**Session 28:** Happiness on My Life Journey	**Session 30:** Creating Safety Plans for Journeys
Session 30: Creating Savings Plans for Journeys	**Session 29:** Kindness on my Life Journey	**Session 31:** Creating Savings Plans for Journeys
Session 31: Visiting Key Service Providers in My Community	**Session 30:** I am a Shining Role Model!	**Session 32:** Meeting Key Service Providers in My Community
Session 32: Presenting Life Journeys to Family Members		**Session 33:** Presenting Life Journeys to Family Members
Session 33: Building a Community Event or Action		**Session 34:** Building a Community Event or Action
Session 34: Building a Community Event or Action		**Session 35:** Building a Community Event or Action
Session 35: Planning Community Actions		**Session 36:** Planning Community Actions
Session 36: Implementing Community Actions of Event		**Session 37:** Implementing Community Actions of Event
Session 37: Implementing Community Actions of Event		**Session 38:** Implementing Community Actions of Event
Session 38: Preparing Presentation or Outcomes of Community Actions or Event		**Session 39:** Preparing Presentation or Outcomes of Community Actions or Event
Session 39: Celebrating Our Journeys and Community Actions		**Session 40:** Celebrating Our Journeys and Community Actions

Parents/caregivers discussions topics

DRC	Ethiopia	Pakistan
Session 1: Introduction to the COMPASS Parenting Program	**Session 1:** Introduction to the COMPASS Parenting Program	**Session 1:** Introduction to COMPASS Parenting Program & Let's Start Understanding our Daughters Better!
Session 2: Let's Start Understanding Our Girls Better	**Session 2:** Let's Start Understanding Our Girls Better	**Session 2:** Relationship Building: Having Fun Together and Creating Spaces for Dialogue
Session 3: Relationship Building: Having Fun Together and Creating Spaces of Dialogue	**Session 3:** Relationship Building: Having Fun Together and Creating Spaces of Dialogue	**Session 3:** Helping Girls to Build Essential Life Skills: Managing our own feelings
Session 4: Helping Girls to Build Essential Life Skills: Communication and Empathy	**Session 4:** Helping Girls to Build Essential Life Skills: Communication and Empathy	**Session 4:** Helping Girls to Build Essential Life Skills: Communication and Empathy
Session 5: Respecting Girls and their Changing Bodies	**Session 6:** Harmony in the Home: Guidance Supports Healthy Choices: • Gender Roles • Family Meeting and Family Rules • Praise and Encouragement • Supervision and Freedom • Privileges	**Session 5:** Harmony in the Home: Guidance Supports Healthy Choices & Making Choices as Parents
Session 6: Harmony in the Home: Guidance Supports Healthy Choices: • Gender Roles • Family Meeting and Family Rules • Praise and Encouragement • Supervision and Freedom • Privileges	**Session 6:** Respecting Girls and their Changing Bodies	**Session 6:** Respecting Girls and their Changing Bodies
Session 7: Protecting the Health, Dignity, and Well Being of Girls	**Session 7:** Protecting the Health, Dignity, and Well Being of Girls	**Sessions 7:** Respecting Girls and their Changing Bodies (Part 2)
Session 8: Recognising and Responding to Risks, Abuse, and Trauma	**Session 8:** Recognising and Responding to Risks, Abuse, and Trauma	**Session 8:** Gender Roles and Norms
Session 9: Establishing Protective Relationships and a Safety Plan	**Session 9:** Establishing Protective Relationships and a Safety Plan	**Session 9:** Recognising and Responding to Gender Based Violence
Session 10: Thinking About Traditional Practices and Adolescent Wellbeing: Early Marriage	**Session 10:** Thinking About Traditional Practices: Early Marriage	**Session 10:** Recognising and Responding to Gender Based Violence (Part 2)
Session 11: Continuing to Think About Traditional Practices and Adolescent Wellbeing: Other Traditional Practices. e.g. labia elongation	**Session 11:** Continuing to Think about Traditional Practices: Female Genital Cutting (FGC)	**Session 11:** Thinking About Traditional Practices and the Well Being of Adolescent Girls: Anti Women Practices (Early and Forced Marriage, Marriage to Settle a Blood Feud (Swara/Vani)
Session 12: Supporting Girls' Roles in Our Families and Communities	**Session 12:** Supporting Girls' Roles in Our Families and Communities	**Session 12:** Understanding Trauma and its impact on Adolescent Girls
Session 13: The COMPASS Community Event and Commitment to our Girls and Positive Parenting	**Session 13:** The COMPASS Community Event and Commitment to our Girls and Positive Parenting	**Session 13:** Establishing Protective Relationships and Mapping our Community
		Session 14: The COMPASS Community Event and Commitment to our Girls and Positive Parenting

ANNEX 2: THE COMPASS THEORY OF CHANGE

Problem

Violence against adolescent girls in humanitarian settings in Ethiopia, Pakistan and the Democratic Republic of Congo inflicts long-lasting physical and emotional harm, violates their rights, and impedes their ability to pursue safe, healthy and productive lives.

Risks	Interventions	Outputs	Outcomes	Impact
Lack of safe and empowering opportunities for adolescent girls to increase their resilience to violence	Provide opportunities for girls to protect against and respond to violence through mentorship and peer interaction in safe spaces	Girls have increase human, social, physical and financial assets to protect themselves from violence and respond to threats of incidents of violence	**Improved prevention of and response to violence against adolescent girls in humanitarian settings, particularly in Ethiopia, Pakistan and DRC**	**Adolescent girls in humanitarian settings are safer from violence and the threat of violence**
Negative attitudes and lack of capacity of service providers to meet the needs of adolescent girls at risk of violence	Implement capacity building activities to improve the attitudes, skills and practices of service providers	Existing service providers (eg. health, education, case management) have increased capacity to provide safe, girl-friendly and life-saving services		
Negative beliefs, attitudes and behaviours among girls' family members, partners, etc. that increase risk of violence	Conduct targeted engagement (eg. discussion sessions) with girls' family members, partners, etc. to change negative beliefs, attitudes and behaviours	Influential people in girls' lives have improved attitudes, knowledge and skills to protect girls from violence and support girls to be safe from violence		
Weak knowledge base on prevention of and response to violence against adolescent girls in humanitarian settings	Conduct rigorous and participatory research, monitoring and evaluation to produce applicable and transferable learning for the broader humanitarian community	Humanitarian community has improved knowledge of the risks of violence faced by adolescent girls in humanitarian settings and how to respond effectively to those risks		

ANNEX 3: EXTERNAL EVALUATION METHODOLOGY

Ethiopia

Hypothesis

The study is based on the hypothesis that adolescent girls' participation in the COMPASS programme will reduce their risk of being exposed to violence in comparison to adolescent girls who do not participate in COMPASS.

The overall aim of the research is to understand the feasibility, acceptability and effectiveness of safe space programming in humanitarian settings. The specific research objectives are as follows:

- To assess the impact of adolescent girls' life skills sessions on a) girls' experiences of physical, sexual and emotional violence; b) confidence and self-esteem; c) girls' support networks; and d) gender attitudes.
- To explore qualitatively the process and pathways by which the Adolescent Girl Groups may influence levels of violence and support networks.

Particular outcomes of interest, derived by consensus upon reviewing the theory of change at a programme kick-off meeting in London, include:

- reduction in adolescent girls' experiences of physical and emotional abuse
- reduction in adolescent girls' experiences of sexual abuse and exploitation
- increase in adolescent girls' skills and sense of agency
- increase in number of peers and adults adolescent girls can turn to for emotional support.

For the purposes of assessing the intervention, the research team (Columbia University and the IRC) identified the key primary and secondary outcomes to be measured and assessed regarding intervention impact. Further discussion of measurement of all variables is included throughout the report.

Study design overview

The study design is a two-arm randomised control trial involving three refugee camps: Sherkole, Bambasi and Tongo in the Benishangul-Gumuz region of Ethiopia.

Following programme enrolment and the completion of baseline data collection, adolescent girls were grouped into COMPASS groups and then randomly assigned to one of two arms 1) intervention group – adolescent girls receive life skills sessions and parents/caregivers take part in group discussions, 2) waitlist group – no intervention (COMPASS was then delivered after completion of the endline). A baseline survey was conducted with 919 girls in July–August 2015, and an endline survey was conducted following completion of the programme's first year. Qualitative focus groups and participatory activities were conducted with girls and parents/caregivers at the beginning and end of the programme. Adolescent girls and their parents/caregivers in the waitlist group will begin the programme after completion of the evaluation.

Community selection, participant enrolment and consent

The IRC selected three refugee camps in the Benishangul-Gumuz region of Ethiopia with large populations of displaced Sudanese and South Sudanese people. Refugees in Sherkole, Bambasi and Tongo camps were sensitised to the programme and girls aged 10–19 were invited for enrolment to the programme, while girls aged 13–19 were invited to take part in the research. Columbia University's Institutional Review Board (IRB), IRC's IRB, and the Administration for Refugees and Returnee Affairs (ARRA), the government body responsible for refugee populations, approved the study. All parents/caregivers were asked to provide informed consent for adolescents under the age of 18 to participate in the study. Subsequently, girls were asked to provide assent for their participation in the study. Adolescents aged 18 or over could consent directly. Informed consent and assent were read to potential participants through pre-recorded audio files, then verbal consent and assent were obtained. Parents/caregivers were also asked to provide informed verbal consent for their own participation in qualitative research activities.

Figure 1: Primary and secondary outcomes and measures[xviii]

Outcomes	Source of measure
Past-Year Sexual Violence	Adapted from CDC Violence Against Children Survey [39]
Past-Year Positive Interpersonal Relationships	Adapted from CDC Violence Against Children Survey [39] & Sisters of Success Liberia survey [40]
Past-Year Early Marriage	Adapted from CDC Violence Against Children Survey [39]
Past-Year Physical Violence & Emotional and Verbal Abuse	Adapted from IPSCAN Child Abuse Screening Tools [41]
Self-Esteem	Rosenberg Self-Esteem Scale [42]
Gender Equitable Norms	Gender Relationship Scale [43]
Hope and Future Orientation	Children's Hope Scale [44]
Accepting Attitudes towards domestic violence	Demographic and Health Surveys (DHS) Domestic Violence Module [45]
Parental Acceptance	Parental Acceptance-Rejection Questionnaire (Parent Short Form) [46]
Accepting Attitudes of Negative Discipline	Adapted from Child Protection Knowledge, Attitudes, and Practices (KAP) in Liberia Survey [47]
Gender Equitable Norms	Gender Norms and Attitudes Scale [43]

Measures and tool development: formative research

Columbia University and the IRC conducted formative research prior to implementation of the baseline survey to obtain a deeper understanding of adolescent girls' lives in the three camps, cultural perceptions of violence and vulnerability, and the acceptability of baseline evaluation tools. This formative phase included extensive work to understand what languages girls spoke, and what languages were likely to be most successful for communicating the complex and sensitive questions that were likely to be included in the baseline survey. Piloting also included testing the qualitative activities intended for the baseline survey, to determine cultural relevance and ease of understanding.

The formative research process also included extensive cognitive interviewing with 50 adolescent girls, and scale testing with an additional 30 girls across the three camps. Cognitive interviewing was used to determine the ease of understanding survey questions, contextual relevance of examples or word choice used in question items, and appropriateness of asking more sensitive questions about violence victimisation. This process illuminated the difficulty in understanding questions with complex sentence structures or double-negatives, and provided information on appropriate languages for data collection. Researchers were also able to assess the reliability of proposed scales when used with adolescent girls living in the camps. Following formative data collection, a list of recommended changes in the quantitative and qualitative tools was presented to the IRC, and the final tools were created based on IRC feedback to Columbia University researchers. Qualitative tools that were developed for the baseline survey were piloted, including nine participatory activities, one in-depth interview with girls, and three in-depth interviews with parents/caregivers.

Following this process, the IRC conducted a language assessment across the three camps. The main aim of the language assessment was to determine how many languages the research tools needed to be conducted in, and to select the most widely spoken languages for the survey to be completed by its target sample size.

The language assessment identified various ethnic languages in each camp, with the four most widely spoken languages being selected for the survey: Ingessena Kulelek, Funj/Berta, Maban and Regarig. Given that all four of these languages are non-written, a team of IRC staff and female refugees carried out major translation work and audio-recorded each of the questions for the survey. Qualitative researchers worked with translators for participatory activities and focus group discussions.

Data collection methods

Three methods were utilised in the evaluation process: a survey instrument, (at baseline) a participatory mapping exercise and focus group discussions, and (at endline) in-depth interviews.

Female survey administrators were trained by Columbia University and matched to participants by language. The interview was administered to participants using Audio Computer Assisted Self-Interviewing (ACASI) computer programs, where a girl would hear survey questions through headphones and follow instructions to select an appropriate response on her tablet by tapping on visually coded response options. IRC staff remained in the interview area to answer questions and provide support as needed. As mentioned above, the survey was administered in Ingessena Kulelek, Funj/Berta, Maban and Regarig.

Two qualitative methods were introduced with a sub-sample of adolescent girls and their parents/caregivers. The first activity was a participatory social mapping in which girls worked together to map their community and then identify and discuss areas on the map where they felt safe and unsafe. The second activity was a focus group discussion with parents/caregivers that included a participatory component to brainstorm ways in which the safety of their female children could be increased. Qualitative discussions were conducted in private spaces, using a trained professional interviewer, translator and note-taker. Due to the absence of female refugees with the skills and experience to provide rapid translation between English or Amharic and their tribal language, only Funj and Regarig speakers were included in qualitative activities.

All participants in both quantitative and qualitative activities were provided with information on available psychosocial support services and offered an opportunity to speak confidentially with a female, IRC-trained social worker from IRC's WPE team, who was skilled in responding to disclosures of GBV.

Data analysis

The research team conducted an intent-to-treat analysis on all individuals surveyed at baseline and endline according to their randomly assigned treatment arm. Logistic regression models were used to estimate the effect of the intervention on primary and secondary outcomes at endline. The team first estimated all effects of the intervention on the outcomes of interest at endline; these associations were then studied separately, according to girls' outcome of interest at baseline. This made it possible determine whether the intervention affected girls differently according to their baseline vulnerabilities, for example, whether a girl who was not living with her mother at baseline was impacted by the intervention differently than a girl who was living with her mother at baseline.

After calculating unadjusted odds ratios (ORs), researchers controlled for a set of factors expected to be correlated with outcomes in order to estimate adjusted odds ratios (AORs). The following factors were controlled in the adjusted logistic regressions: baseline age, years of education completed, presence of biological mother in the home, presence of biological father in the home, co-habitation with an intimate partner, and previous engagement in a romantic relationship. Standard errors in all models are adjusted for clustering at the group level of randomisation, which also served as the programme session group. All first-order effects of the intervention on the outcomes of interest at endline were examined, followed by stratification of effects based on girls' self-report of the outcome of interest at baseline. All analysis was conducted using Stata version 12.

All of the qualitative transcripts were translated and transcribed by the qualitative team in Ethiopia. Qualitative transcripts were then analysed using inductive thematic analysis (Charmaz 2011). The research team developed a basic coding scheme with responses form the data coded into descriptive codes. The initial descriptive codes were discussed, evaluated, and reconfigured by the research team. Once there was agreement, a codebook was completed and two independent coders coded subsets of the transcripts to ensure inter-coder reliability before coding the full data set. After consensus was reached, the data were coded again using axial coding to develop analytical themes and determine the recurrence of issues within each of the major themes identified (Charmaz 2011). Narrative data were analysed in NVivo 10.1.

Limitations

This report relies entirely on the self-report of adolescent girls and parents/caregivers participating in the COMPASS programme, which may result in response or recall biases. Verifying the ages of the adolescent girls participating in the programme was difficult, due to lack of official documentation, among other challenges, meaning respondents may be older than they indicated at the time of programme enrolment. Girls also reported being unmarried at the time of programme enrolment, but during the ACASI reporting process, many reported being married; again, this was difficult to verify. Girls may have been concerned about being excluded from the programme if they told programme staff they were married; it is also possible that there are different definitions of 'marriage' (e.g. marriage promised/planned, ceremony vs. informal, etc.). Finally, randomisation was conducted at group level, and groups within the same camp and zone were allocated to different intervention groups, leaving some potential for spill over effects.

DRC

Hypothesis

This study is based on the hypothesis that participating girls whose parents/caregivers also participate in the monthly group discussions will be better protected from violence compared to participating girls whose parents/caregivers do not participate in the monthly group discussions.

The overall aim of the research evaluation is to understand the feasibility, acceptability and effectiveness of safe space programming in humanitarian settings. The specific research objectives are as follows:

- To assess the incremental impact of the parent/caregiver group discussions when delivered alongside the adolescent girls' life skill sessions on a) girls' experiences of physical, sexual and emotional violence; b) confidence and self-esteem; c) girls' support networks; and d) gender attitudes.
- To explore qualitatively the ways that parent/caregiver group discussions may influence levels of violence against adolescent girls and build their support networks.

Particular outcomes of interest were identified by the project team during an inception workshop in London by examining the theory of change and identifying outcomes that aligned with the underlying theoretical processes. These are:

- reduction in adolescent girls' experiences of physical and emotional abuse
- reduction in adolescent girls' experiences of sexual abuse and exploitation
- increase in adolescent girls' skills and sense of agency
- increase in number of peers and adults adolescent girls can turn to for emotional support.

Study design overview

The study design was a two-arm cluster-randomised control trial across 14 sites in South Kivu, DRC. Following programme enrolment and the completion of baseline data collection, adolescent girls were divided into COMPASS groups, and the groups were randomised into two arms 1) waitlist group – only adolescent girls receive life skills sessions, or 2) intervention group – adolescent girls receive life skills sessions and parents/caregivers attend group discussions. A baseline survey was conducted with 869 girls and 764 parents/caregivers in May and June 2015, and an endline survey was completed from August to October 2016. Qualitative focus groups and participatory activities were also conducted at the beginning of the programme, and individual interviews were conducted with adolescent girls and parents/caregivers at the end of the programme. Parents/caregivers of adolescent girls in the waitlist group were eligible to join group discussions after the first cycle was completed.

Community selection, participant enrolment and consent

The IRC selected 14 sites in South Kivu with conflict-affected communities, and where the population largely consisted of internally displaced people. Communities were introduced to the programme and adolescent girls aged 10–14 were invited to enrol for COMPASS. Ethical approval was provided by Columbia University's Institutional Review Board (IRB) and the Ministry of Gender in South Kivu, DRC. All parents/caregivers were asked to provide informed consent for the girls' participation in the study. Subsequently, adolescent girls were asked to assent for their participation in the study. Informed consent was read to potential participants through trained enumerators and written consent was obtained. Parents/caregivers were also asked to provide written informed consent for their own participation in the quantitative survey and qualitative research activities.

Data collection methods

Female survey enumerators were trained by Columbia University and matched to participants by language. Interviewers orally administered less sensitive questions from the baseline survey to adolescent girls using Computer-Assisted Personal Interviewing (CAPI). More sensitive sections of the survey were self-administered by the girls using Audio Computer Assisted Self-Interviewing (ACASI) computer programs, where a girl would hear survey questions through headphones and follow instructions to select an appropriate response on her tablet by tapping on a colour or image coded response option. Only older girls in the sample (aged 13–14) were invited to respond to questions on violence and sexual health items that were deemed inappropriate for younger participants. Parent/caregiver surveys were entirely administered by an interviewer who used CAPI. Surveys were translated into French, Swahili and Mashi, and verified before use with adolescent girls and parents/caregivers. Specific measures may be found in Figure 1 above.

At the end of the programme, in-depth interviews were conducted with a sub-sample of adolescent girls and their parents/caregivers. The interview guides explored parents'/caregivers' and adolescent girls' impressions of the COMPASS programme, and their attitudes towards physical and sexual abuse perpetrated by a stranger, a boyfriend or husband; perceptions of appropriate responses to different cases of abuse; and recommendations for how to mitigate such violence. Qualitative interviews were conducted in private spaces, using a trained interviewer, translator and note-taker.

All participants in both quantitative and qualitative activities were provided information on available psychosocial support services, and offered an opportunity to speak with a social worker.

Data analysis

Summary statistics were generated for all adolescent girl and parent/caregiver characteristics at the beginning of the programme. These results are presented for the full sample as well as separately for the intervention and waitlist groups. Chi-square tests and two-sided t-tests were used, when appropriate, to determine baseline differences between intervention and waitlist groups.

To assess the effects of the intervention, both intent-to-treat (ITT) and per-protocol (PP) analyses were implemented. ITT analysis was carried out for all adolescent girls and parents/caregivers for whom data were collected at the beginning and end of the programme. The effects of the intervention were examined using logistic regression analysis for binary outcomes and linear mixed models for continuous variables. Baseline covariates controlled for in the adolescent girls' ITT model were selected based on those demographic characteristics determined not to be balanced between intervention and waitlist groups using Pearson chi-squared and two-sample t-tests. PP analysis for adolescent girls' outcomes examined the effect of both the adolescent girl and her parent/caregiver attending at least 75% of programme sessions. This means PP analysis assesses differences in outcomes across three groups: adolescent girls in waitlist group, adolescent girls in the intervention group who attended less than 75% of programme sessions or whose parents/caregivers attended less than 75% of group discussions (low treatment adherence), and adolescent girls and parents/caregivers in the intervention group who both attended at least 75% of programme sessions (high treatment adherence). Adolescent girls' PP logistic regressions control for age and having ever worked for pay, which were the only two baseline covariates found to be significantly associated with high vs. low adherence to protocol.

PP analysis for parent/caregiver outcomes looked at the effect of parents/caregivers attending at least 75% of parent/caregiver sessions. It compares outcomes across the waitlist group, low attendance of intervention and high attendance of intervention. ITT and PP models for parents/caregivers control for the outcome of interest at the beginning of the programme only, as all baseline characteristics for parents/caregivers were balanced across intervention and waitlist groups. All models adjust for clustering at the group level of randomisation, which also served as the programme session group. All quantitative data were analysed using Stata14.

Qualitative transcripts were analysed using thematic content analysis (Smith 1992). Emerging themes in the transcripts were identified as central categories; these were used to identify recurring patterns in the data.

A research team of two graduate students, a senior research associate and a co-investigator from Columbia University reviewed the transcripts. After developing an initial coding scheme through individual transcript review, the team then came together to agree on emerging categories. Two members of the research team then coded subsets of transcripts from both DRC and Ethiopia to ensure inter-coder reliability before coding the full data set. Narrative data from the group discussions were analysed in NVivo 10.1.

Of the 446 and 423 adolescent girls assigned to the intervention and waitlist groups at the beginning of the programme, 408 (91.5%) and 377 (89.1%) participated in endline data collection, respectively. Among the 389 and 375 parents/caregivers assigned to the intervention and waitlist groups at the beginning of the programme, 369 (94.9%) and 341 (90.9%) participated in endline data collection. Relocation was the most common reason for non-completion among adolescent girls and parents/caregivers. No statistically significant differences in loss to follow-up were observed between intervention groups for adolescent girls or parents/caregivers.

Additionally, analysis was conducted to determine whether any baseline characteristics for intervention participants were associated with adhering to protocol. Younger girls and those who reported never having worked for pay at the beginning of the programme were more likely to adhere to protocol at $p<0.05$. No baseline characteristics were associated with adhering to protocol for parents/caregivers.

Limitations

The findings rely entirely on the self-reporting of sensitive measures amongst adolescent girls and parents/caregivers participating in the COMPASS programme, which may result in response or recall biases and may also be susceptible to social desirability bias. The number of out-of-school girls may be over reported due to misinformation in the target communities about the programme's intention to provide financial assistance for school fees. Data collectors reported difficulty in participants' understanding of scale items. Additionally, staff had difficulty verifying the ages of the girls participating in the programme. This means girls who participated may be older than they indicated when they enrolled for the programme.

Pakistan

Hypothesis

The overall aim of the research is to understand the feasibility of the safe space programming in humanitarian settings. The specific research objective was as follows:

- To determine the feasibility and acceptability of the adolescent girl groups and caregiver discussion groups

Study design overview

The study design was a two-arm cluster-randomised control trial across 14 sites in South Kivu, DRC. Following programme enrolment and the completion of baseline data collection, adolescent girls were divided into COMPASS groups, and the groups were randomised into two arms 1) waitlist group – only adolescent girls receive life skills sessions, or 2) intervention group – adolescent girls receive life skills sessions and parents/caregivers attend group discussions. A baseline survey was conducted with 869 girls and 764 parents/caregivers in May and June 2015, and an endline survey was completed from August to October 2016. Qualitative focus groups and participatory activities were also conducted at the beginning of the programme, and individual interviews were conducted with adolescent girls and parents/caregivers at the end of the programme. Parents/caregivers of adolescent girls in the waitlist group were eligible to join group discussions after the first cycle was completed.

Methods

Adolescents aged 12–19 living in the Kohat, Nowshera and Peshawar districts of Khyber-Pakhtunkhwa province, Pakistan, were enrolled in the study from 2–18 February 2016. Girls were excluded if they did not speak Urdu or Pashto, had already completed a previous cycle of the programme, or were not capable of responding to the questions in an interview . All study procedures were approved by the Ethics Review Committee of the Collective for Social Science Research, and the IRC's IRB (Protocol # WPE1.00.004).

Procedures

The IRC and other NGO staff introduced the intervention to adolescent girls and their parents/caregivers through existing programming at nine women's community centres throughout the three districts. Adolescent girls who registered for the intervention were invited to participate in the study. In accordance with ethical protocols for research with minors, consent was obtained in confidential spaces from guardians, married girls, and females aged over 18, and assent was obtained for unmarried girls aged 12–17. Trained interviewers from Khyber-Pakhtunkhwa province administered a paper-based questionnaire in Urdu and Pashto. Interviewers administered the post test survey approximately 10 months after completion of the baseline survey (5–9 December 2016).

For in-depth interviews, 15 girls who had completed the quantitative post test were sampled to maximise diversity in age, level of education and marital status. Consent and assent for qualitative activities were requested after completion of the post test survey in the same manner detailed above, and trained researchers with fluency in Urdu and Pashto administered the interview (26 December 2016 to 16 January 2017).

At the beginning of the programme and ahead of the post test, all research staff completed a two-week training on procedures for the study, which included ethical guidelines for working with children and how to ask sensitive questions.

Quantitative measures

The primary outcomes of interest were self-reported feelings of safety, movement in participants' communities and comfort discussing topics from the life skills sessions with parents/caregivers. Adolescent girls reported if they felt safe at their home, school, a friend's house, relative's house and neighbour's house. These binary measures were summed to create a continuous measure of the number of different spaces where participants felt safe (possible range 0–4). Similarly, adolescent girls were asked to report all of the places within their communities that they had visited in the previous month. These places included a school, friend or neighbour's home, relative's home, market, an IRC or other NGO's women and girls' centre, or another place. Since the sample size of many individual categories were too small for binary analysis, these places were summed to produce a continuous measure of the number of places that participants had visited in the previous month (possible range 0–6). Adolescent girls also reported four binary items on their comfort discussing with parents/caregivers their education, earning a living, marriage and puberty.

Secondary outcomes included girls' attitudes towards gender equality, social support networks, perceptions and knowledge of support for survivors of violence, and psychosocial wellbeing. Attitudes towards gender were assessed through agreement with statements on whether girls should have opportunities to attend school, have the same opportunities as boys overall, work outside the home after marriage. Girls were also asked what the appropriate age of marriage is; the appropriate age of marriage was transformed from a multi-level categorical variable to a binary variable indicating appropriate age as less than 18, compared to 18 and above. Social support networks were assessed through three binary items on presence of non-familial friendships, trusted non-familial female adult to regularly consult about problems, and access to a trusted community member to discuss sexual violence. Perceptions of support for survivors of violence were assessed through binary items on adolescent girls' beliefs that family members would blame them for experiencing street harassment and problems in their marriage. Knowledge of support for survivors of violence was assessed through two binary items on knowledge of services for physical violence and sexual violence.

Psychosocial wellbeing was assessed through quantitative scales on self-esteem and hope. Self-esteem was assessed though the Rosenberg self-esteem scale. The 10-item Likert scale has been used in over 50 countries, and higher scores indicate greater self-esteem (Rosenberg, 1979; Schmitt & Allik, 2005). To facilitate comprehension, statements were phrased as questions, and double-negative statements were rephrased into positive statements. Baseline measures for this scale had a Cronbach's alpha of 0.80, indicating sufficient reliability. Adolescent girls' feelings of hope and future orientation were assessed through the Children's Hope Scale, a six-item scale that measures feelings of agency and perceptions of pathways to achieve goals (Snyder et al., 1997). Baseline Cronbach's alpha for this scale was 0.69, indicating medium reliability.

Demographic information included continuous measures of adolescent girls' age at the beginning of the programme and years of education completed, and binary items on ever attending school, working without payment, and attending safe space activities prior to starting the programme. Adolescent girls also self-reported school attendance in the previous year (binary). Due to small cell counts in categories of the multi-level variable on marital status, a binary item was used (married or not married/widowed). District of residence was documented through programme registration sheets.

Qualitative interview guide

A semi-structured interview guide was developed to understand the feasibility, acceptability and effectiveness of the IRC violence prevention programme for adolescent girls in Pakistan. Opening questions focused on understanding programme experience and any positive and negative effects as a result of participating in the sessions. The next set of questions was framed by hypothetical scenarios involving physical and sexual (e.g. catcalling, touching and soliciting a relationship without marriage) violence perpetrated against adolescent girls. Closing questions focused on understanding how girls' lives could be improved in their communities.

Data analysis

The estimated quantitative sample size was 180 participants, assuming a 0.05 alpha, 80% power, and no loss to follow-up. In anticipation of a 25% attrition rate, this figure was inflated to 225 adolescent girls.

Quantitative analysis was completed on individuals who completed both the baseline survey and post test. Pearson chi-squared tests and t-tests were used to examine independence of baseline characteristics based on attrition. Wilcoxon signed rank tests were chosen to examine pre-post test differences for continuous outcomes because they are well-suited to paired non-parametric data without a control group (Wilcoxon, 1945). McNemar's tests were used for categorical outcomes, and Exact McNemar's tests were used when combined cell counts of discordant pairs were lower than 20.

Qualitative transcripts were translated into English and entered into NVivo 11.3.2. Using inductive thematic analysis (Charmaz, 2006), the research team developed a basic coding scheme. The initial descriptive codes were discussed, evaluated and reconfigured by the research team. Once there was agreement, a codebook was completed and all the narrative data coded. Data were organised into themes pertaining to the feasibility and accessibility of the IRC programme.

Limitations

Study findings should be interpreted with caution. While the one-group pre-post study design was selected as the most feasible research design in this context, it does not allow for comparison to a counterfactual. The small sample size at post test may have yielded insufficient power to measure some outcomes. Lastly, social desirability bias and small sample size may have affected content of qualitative interviews.

ANNEX 4: DATA TABLES

Figure 1. Demographics of participating adolescent girls, according to external evaluation baseline survey

Figure 1.1: Demographics of participating girls in Ethiopia

	Total (N = 919)		Intervention (N = 457)		Control (N = 462)		OR	p-value*
	(mean)	(sd)	(mean)	(sd)	(mean)	(sd)		
Age (average)	14.61	1.51	14.65	1.51	14.56	1.5		NS
	(n)	%	(n)	%	(n)	%		
Languages spoken								**<0.001**
Ingessena Kulelek	93	10.12	52	11.38	41	8.87		
Funj	609	66.27	327	71.55	282	61.04		
Maban	154	16.76	68	14.88	86	18.61		
Regarig	63	6.86	10	2.19	53	11.47		
Marital status								**NS**
Unmarried	527	57.41	258	56.46	269	58.35		
Married and living with partner	149	16.23	73	15.97	76	16.49		
Married and not living with partner	97	10.57	53	11.6	44	9.54		
Living with partner as if married	53	5.77	19	4.16	34	7.38		
Living with a biological parent								0.01
Both parents	173	18.85	79	17.29	94	20.39		NS
Mother only	240	26.14	135	29.54	105	22.78	1.43	0.02
Father only	395	43.03	196	42.89	199	43.17		NS
Neither parent	72	7.84	26	5.69	46	9.98	0.55	0.02
Education								
Ever attended school	637	69.31	320	70.02	317	68.61		NS
Enrolled in school in last year	502	78.81	260	81.25	242	76.34		NS
	(mean)	(sd)	(mean)	(sd)	(mean)	(sd)		
Years of school completed in Sudan/South Sudan	2.81	1.93	2.81	1.97	2.81	1.88		NS
Years of school completed in Ethiopia	3.03	1.82	3.08	2.02	2.98	1.6		NS
	(n)	%	(n)	%	(n)	%		
Reasons for non-enrollment in last school year								NS
Family could not afford	29	19.73	10	15.38	19	23.17		
Got pregnant or married	20	13.61	8	12.31	12	14.63		
Too many domestic responsibilities	34	23.13	17	26.15	17	20.73		
School too far/no school in vicinity	12	8.16	4	6.15	8	9.76		
Family does not approve	17	11.56	8	12.31	9	10.98		
Other	11	7.48	4	6.15	7	8.54		

Figure 1.2: Demographics of participating girls in DRC

	Total (N = 869)		Intervention (N = 446)		Control (N = 423)		OR	p-value*
	(mean)	(sd)	(mean)	(sd)	(mean)	(sd)		
Age (average)	12.03		11.96		12.12			0.11
Marital status	**(N = 377)**		**(N = 177)**		**(N = 200)**			**0.85**
	(n)	%	(n)	%	(n)	%		
Unmarried	263	69.76	126	71.19	137	68.5		
Married and living with partner	46	12.2	23	12.99	23	11.5		
Married and not living with partner	25	6.63	10	5.65	15	7.5		
Living with partner as if married	16	4.24	7	3.95	9	4.5		
Living with a biological parent	**(N = 869)**		**(N = 446)**		**(N = 423)**			**0.54**
	(n)	%	(n)	%	(n)	%		
Both parents	520	59.84	263	58.97	257	60.76		
Mother only	242	27.85	121	27.13	121	28.61		
Father only	28	3.22	16	3.59	12	2.84		
Neither parent	79	9.09	46	10.31	33	7.8		
Education	**(N = 869)**		**(N = 446)**		**(N = 423)**			
	(n)	%	(n)	%	(n)	%		
Ever attended school	691	79.52	352	78.92	339	80.14		0.66
Older girls	310	82.23	139	78.53	171	85.5		0.08
Younger girls	381	77.44	213	79.18	168	75.34		0.31
Enrolled in school in last year	388	56.15	191	54.26	197	58.11		0.31
Older girls	160	51.61	67	48.2	93	54.39		0.28
Younger girls	153	59.84	89	58.22	64	61.9		0.47
	(mean)	(sd)	(mean)	(sd)	(mean)	(sd)		
Years of school completed	3.40	2.06	3.18	1.89	3.63	2.21		0.005
Reasons for non-enrollment in last school year	**(N = 303)**		**(N = 161)**		**(N = 142)**			**0.47**
	(n)	%	(n)	%	(n)	%		
Family could not afford	270	89.11	148	91.93	122	85.92		
Got married	0	0	0	0	0	0		
Too many domestic responsibilities	9	2.97	3	1.86	6	4.23		
School too far/no school in vicinity	1	0.33	0	0	1	0.7		
Family does not approve	7	2.31	4	2.48	3	2.11		
No school places available	0	0	0	0	0	0		
Got pregnant	0	0	0	0	0	0		
Finished school	0	0	0	0	0	0		
Failing school	3	0.99	1	0.62	2	1.41		
Other	11	3.63	4	2.48	7	4.93		

Figure 1.3: Demographics of participating girls in Pakistan

	Baseline (N = 192)		9Endline (N = 78)		Difference (p-value)	
	(mean)	(sd)	(mean)	(sd)	(mean)	(sd)
Age at baseline	15.15	2	15.31	2.2		NS
Years of school completed (average)	4.14	3.38	4.98	3.75		0.008
	n	%	n	%		
Ever attended school						**NS**
Yes	142	74	62	79.5		
No	50	26	16	20.5		
Attended school in the previous year	**(N = 142)**		**(N = 62)**			**NS**
Yes	46	32.4	20	32.3		
No	96	67.6	42	67.7		
Ever worked for money or other payment						**NS**
Yes	29	15.1	10	12.8		
No	163	84.9	68	87.2		
Attended safe space activities prior to baseline						**NS**
Yes	118	61.8	52	66.7		
No	73	38.2	26	33.3		
Marital status						**NS**
Never been married	181	94.3	76	97.4		
Married or widowed	11	5.7	2	2.6		
Living with at least one biological parent						**NS**
Yes	173	90.1	73	93.6		
No	19	9.9	5	6.4		
District of residence						**<0.001**
Kohat	45	23.4	25	32.1		
Nowshera	75	39.1	0	0		
Peshawar	72	37.5	53	67.9		

Figure 2: Perpetrators of violence, by violence type and country

Figure 2.1: Perpetrators of violence in Ethiopia

Perpetrator of physical violence	Total			10.32Intervention			Control			OR	P-value
	N	(n)	(%)	N	(n)	(%)	N	(n)	(%)		
Boyfriend or husband	250	102	40.80	126	54	42.86	124	48	38.71		0.507
Parent, caregiver or other relative	250	66	26.40	126	6	28.57	124	30	24.19		0.434
Friend or neighbour	250	32	12.80	126	1	10.32	124	19	15.32		0.238
Member of an armed group	250	13	5.20	126	4	3.17	124	9	7.26		0.147
Official	250	19	7.60	126	10	7.94	124	9	7.26		0.84
Other	250	27	10.80	126	13	10.32	124	14	11.29		0.805

Perpetrator of emotional violence	Total			10.32Intervention			Control			OR	P-value
	N	(n)	(%)	N	(n)	(%)	N	(n)	(%)		
Boyfriend or husband	293	94	32.08	151	48	31.79	142	46	32.39		0.912
Parent, caregiver or other relative	293	113	38.57	151	61	40.40	142	52	36.62		0.508
Friend or neighbour	293	48	16.38	151	7	17.88	142	21	14.79		0.477
Member of an armed group	293	15	5.12	151	6	3.97	142	9	6.34		0.360
Official	293	16	5.46	151	6	3.97	142	10	7.04		0.249
Other	293	21	7.17	151	11	7.28	142	10	7.04		0.936

Figure 2.2: Perpetrators of violence in DRC

Perpetrators (at baseline)

	Undifferentiated (%)	Intervention	Control	OR	P-value
Unwanted sexual touching					
Boyfriend or husband	49.07	49.09	49.04		0.99
Parent or caregiver	22.43	20.00	25.00		0.38
Other relative	7.94	8.18	7.69		0.90
Friend or neighbour	13.55	13.64	13.46		0.97
Member of an armed group	3.27	1.82	4.81		0.27
Official (police, teacher, religious or local leader)	2.80	1.82	3.85		0.44
Other	6.54	9.09	3.85		0.12
Coerced Sex					
Boyfriend or husband	48.63	55.17	42.71		0.09
Parent or caregiver	16.94	11.49	21.88		0.06
Other relative	7.65	6.90	8.33		0.72
Friend or neighbour	14.21	12.64	15.63		0.56
Member of an armed group	4.37	3.45	5.21		0.72
Official (police, teacher, religious or local leader)	2.73	3.45	2.08		0.67
Other	9.29	9.20	9.38		0.97
Physical violence					
Boyfriend or husband	37.35	35.39	39.51		0.43
Parent or caregiver	28.82	30.90	26.54		0.38
Other relative	13.24	13.48	12.96		0.89
Friend or neighbour	14.12	13.48	14.81		0.73
Member of an armed group	3.24	2.25	4.32		0.28
Official (police, teacher, religious or local leader)	2.94	3.37	2.47		0.75
Other	7.94	6.74	9.26		0.39
Emotional abuse - loud or aggressive screaming					
Boyfriend or husband	35.26	37.71	32.75		0.33
Parent or caregiver	34.68	34.29	35.09		0.88
Other relative	12.43	13.14	11.70		0.68
Friend or neighbour	12.72	10.86	14.62		0.29
Member of an armed group	4.05	5.71	2.34		0.11
Official (police, teacher, religious or local leader)	2.60	1.14	4.09		0.10
Other	3.76	2.29	5.26		0.15
Emotional abuse - insults					
Boyfriend or husband	34.19	34.88	33.33		0.78
Parent or caregiver	28.71	24.42	34.06		0.06
Other relative	14.19	18.60	8.70		0.01
Friend or neighbour	16.45	17.44	15.22		0.60
Member of an armed group	1.94	0.58	3.62	2.40	0.09
Official (police, teacher, religious or local leader)	0.65	1.16	0.00		0.50
Other	5.81	4.07	7.97		0.14

Figure 3. Girls' (age 13-14) agreement to statements on gender

Figure 3.1. Girls' agreement to statements on gender in Ethiopia

	Total			Intervention			Control			OR	P-value
	N	(n)	(% agree)	N	(n)	(% agree)	N	(n)	(% agree)		
Females are responsible for avoiding pregnancy	829	414	49.94	411	203	49.39	418	211	50.48		0.754
Men should have the final word about decisions in his home	832	486	58.41	419	261	62.29	413	225	54.48	1.38	0.022
Females should tolerate violence to keep the family together	835	484	57.96	411	247	60.10	424	237	55.90		0.219
A man can hit his wife if she will not have sex with him	814	282	34.64	403	135	33.50	411	147	35.77		0.497
Males and females should share household chores[&]	834	569	68.23	416	293	70.43	418	276	66.03		0.172

& Reverse-coded (response shows those who disagree with the statement)

Figure 3.2. Girls' (age 13-14) agreement to statements on gender in DRC

	Total		Intervention		Control		P-value
	N	(% agree)	N	(% agree)	N	(% agree)	
Females are responsible for avoiding pregnancy	371	72.24	171	70.76	200	73.50	0.56
Men should have the final word about decisions in his home	368	86.96	173	87.28	195	86.67	0.86
Females should tolerate violence to keep the family together	377	95.23	177	94.35	200	96.00	0.45
A man can hit his wife if she will not have sex with him	367	67.03	170	65.88	197	68.02	0.67
Males and females should share household chores	376	17.02	176	17.61	200	16.50	0.78

Note: (N) signifies the number of girls who responded to the relevant question.

Figure 4: Adolescent girls' agreement to statements on social networks

Figure 4.1: Adolescent girls' agreement to statements on social networks in Ethiopia

Sources of social support, endline

	Total			Intervention			Control			OR	P-value
	N	(n)	(% yes)	N	(n)	(% yes)	N	(n)	(% yes)		
Have adult who gives them advice	797	455	57.09	406	243	59.85	391	212	54.22		0.108
Have female figure in community to go with problems on a regular basis	764	397	51.96	388	231	59.54	376	166	44.15		0.000
Have female friends their age outside the family	782	546	69.82	402	303	75.37	380	243	63.95	1.86	0.001

Sources of social support, adjusted odds ratios

	Intent-to-treat		
	N	aOR	95% CI
Have adult who gives them advice	628	1.28	[.83-1.98]
Have female figure in community to go with problems on a regular basis	613	2.05	[1.47-2.86]***
Have female friends their age outside the family	620	1.83	[1.28-2.62]**

The reference group for all adjusted odds ratios is the control arm. Beta coefficients are significant at *p<0.05, **p<0.01, and ***p<0.001. All analyses adjusted for baseline status of presence of mother in the home, presence of father in the home, living with intimate partner, age, years of education completed, and ever having a boyfriend. All analyses adjusted for clustering at the programme level.

Figure 4.2: Adolescent girls' agreement to statements on social networks in DRC

Sources of Social Support at Baseline, by Treatment Status

	Total		Intervention		Control		P-value
	N	(% agree)	N	(% agree)	N	(% agree)	
Have adult who gives them advice	863	67.09	441	68.03	422	66.11	0.55
Have female figure in community to go with problems on a regular basis	869	45.34	446	46.19	423	44.44	0.61
Have an adult they regard as mentor	866	68.71	443	67.95	423	69.50	0.62
Have friends to talk to about important things	867	89.85	444	88.06	423	91.73	0.07
Have friends they can rely on for emotional support	868	82.49	445	82.25	423	82.74	0.85
Have female friends their age outside the family	868	85.94	446	87.00	422	84.83	0.36

Sources of Social Support at Endline, by Treatment Status

	Total		Intervention		Control		P-value
	N	(% agree)	N	(% agree)	N	(% agree)	
Have adult who gives them advice	785	76.43	408	78.92	377	73.74	0.09
Have female figure in community to go with problems on a regular basis	785	47.26	408	48.77	377	45.62	0.38
Have an adult they regard as mentor	785	78.47	408	78.68	377	78.25	0.88
Have friends to talk to about important things	785	93.89	408	92.89	377	94.96	0.23
Have friends they can rely on for emotional support	783	89.91	407	90.66	376	89.10	0.47
Have female friends their age outside the family	785	92.74	408	92.16	377	93.37	0.51

Figure 4.3: Adolescent girls' agreement to statements on social networks in Pakistan

Changes in perceptions of social support from pretest to posttest

Outcome	Total	No to Yes (T1/T2)		Yes to No (T1/T2)l				95% CI	
		N	(% agree)	N	(% agree)	OR	LL[a]	UL[a]	p-value
Have non-familial female friends of own age	78	18	23.1	5	6.41	1.27	1.07	1.50	0.007
Have non-familial female adult to confide in	77	17	22.1	7	9.09	1.63	1.02	2.60	0.041
Have trusted person to disclose sexual violence	72	13	18.1	9	12.5	1.09	0.89	1.33	0.394

a Table presents lower limits (LL) and upper limits (UL) of confidence intervals.

Figure 5: IRC trained providers reaching minimum standards, according to knowledge and attitude assessments

	(%)
DRC (December 2016)	94
Ethiopia (March 2017)	77
Pakistan (November 2016)	89

Figure 6: Knowledge of services

	Know of a place to go for help if a girl experiences sexual violence		Know of a place to go for help if a girl experiences physical violence	
	Baseline (%)	Endline (%)	Baseline (%)	Endline (%)
Ethiopia: girls + parents/caregivers	26	43	35.89	55
Ethiopia: no intervention	23	31	36.96	39
Ethiopia aOR		1.86		2.2
DRC: girls + parents/caregivers	46	57	50	62
DRC: girls only	44	58	46	61
DRC aOR		0.85		1.114
Pakistan: girls + parents/caregivers*	28	34	38	62
Pakistan aOR		1.36		1.62

Figure 7: Attendance

	Adolescent girls' life skills sessions (%)	Parent/caregiver group discussions (%)
DRC (across all sites, cycle 1)	78	70
Ethiopia (across all camps, cycle 1)	83	91
Pakistan (across all sites, cycles 2/3)	87	86

ANNEX 5: COMPASS JOURNAL ARTICLES

1. Falb KL, Tanner S, Ward L, Erksine D, Noble E, Assazenew A, Bakomere T, Graybill E, Lowry C, Mallinga P, Neiman A, Poulton C, Robinette K, Sommer M, Stark L. (2016). Creating opportunities through mentorship, parental involvement, and safe spaces (COMPASS) program: multi-country study protocol to protect girls from violence in humanitarian settings. BMC Public Health. 16:231. Doi 10.1186/s12889-016-2894-3.

2. Falb KL, Tanner S, Ashgar K, Souidi S, Mierzwa S, Assazenew A, Bakomere T, Mallinga P, Robinette K, Woinishet T, Stark L. (2017). Implementation of audio-computer assisted self-interview (ACASI) among adolescent girls in humanitarian settings: feasibility, acceptability, and lessons learned. Conflict & Health. Doi: 10.1186/s13031-016-0098-1.

3. Stark L, Asghar K, Meyer S, Yu G, Bakomore T, Poulton C, Falb KL. (2017). The effect of gender norms on the association between violence and hope among girls in the Democratic Republic of Congo. Global Mental Health 4(e1)1-10.

4. Stark L, Sommer M, Asghar K, Assazenew A, Abdela G, Tanner S, Falb KL. (2017). Disclosure bias for group versus individual reporting of violence amongst conflict-affected adolescent girls in DRC and Ethiopia. PloS One. 12(4): e0174741.

5. Falb KL, Asghar K, Laird B, Tanner S, Graybill E, Mallinga P, Stark L. (2017). Caregiver parenting and gender attitudes: associations with violence against adolescent girls in South Kivu, Democratic Republic of Congo. Child Abuse & Neglect. 69: 278-84.

6. Sommers M, Stark L, Munoz-Laboy M, Rudahindwa N, Arp J, Falb KL. (Epub ahead of print). How narratives of fear shape girls' participation in community life in two conflict-affected populations. Violence Against Women.

7. Stark L, Asghar K, Yu G, Assazenew A, Bora C, Falb KL. (2017). Prevalence and associated risk factors of violence against conflict-affected female adolescents: a multi-country, cross-sectional study. Journal of Global Health. 7(1): 010416.

8. Stark L, Seff I, Assazenew A, Tanner S, Eoomkham J, Ssewamala F, Falb KL. (in press). Effects of a social empowerment intervention on economic vulnerability for adolescent refugee girls in Ethiopia. Journal of Adolescent Health.

9. Landis D, Yu G, Tanner S, Bakomere T, Mallinga P, Falb KL, Stark L. (under review). The 'school exposure' effect: examining the impact of formal education on girls' experiences with gender-based violence in the Democratic Republic of Congo.

10. Gauer Bermudez L, Yu G, Zhi Ning Lu L, Falb KL, Eoomkham J, Abdella G, Stark L. (under review). HIV risk among displaced adolescent girls in Ethiopia: the role of gender norms and self-esteem.

11. Stark L, Asghar K, Seff I, Yu G, Cislaghi B, Assazenew A, Falb KL. (under review). How gender- and violence-related norms affect self-esteem among adolescent refugee girls living in Ethiopia.

12. Sommer M, Munoz Labory M, Williams A, Mayevskaya Y, Falb KL, Abdella G, Mallinga P, Stark L. (under review). How gender norms are reinforced through violence against adolescent girls in two conflict-affected populations.

13. Stark L, Asghar K, Seff I, Yu G, Tesfay Gessesse T, Ward L, Assazenew A, Neiman A, Falb KL. (under review). Preventing violence against refugee adolescent girls: findings from a cluster-randomized control trial in Ethiopia.

14. Stark L, Seff I, Asghar K, Roth D, Bakomere T, MacRae M, Fanton D'Anton C, Falb KL. (under review). Engaging caregivers to prevent violence against adolescent girls: findings from a cluster-randomized control trial in Democratic Republic of Congo.

15. Asghar K, Mayevskaya Y, Sommer M, Razzaque A, Laird B, Khan Y, Qureshi S, Falb KL, Stark L. (under review). Promoting adolescent girls' well-being in Pakistan: a mixed methods effectiveness and acceptability study of the COMPASS program.

ANNEX 6: GIRL SHINE PROGRAMME MODEL AND RESOURCE PACKAGE

The International Rescue Committee is delighted to present Girl Shine – a programme model and resource package that seeks to support, protect, and empower adolescent girls in humanitarian settings. The goal of Girl Shine is to reduce the risk of violence for adolescent girls and provide them the skills and assets needed to ensure their wellbeing as they transition to adulthood. The Girl Shine programme model and resource package can be used in multiple humanitarian settings, including conflict and natural disasters, as well as within the various phases of emergency response. It is based on the latest global research on the experiences of adolescent girls facing emergencies, research on what works to reduce girls' exposure to violence and promote better health and social outcomes and builds from proven gender-based violence (GBV) interventions used in the field.

This Girl Shine programme model and resource package supports practitioners in designing, implementing and monitoring a girl-driven intervention that:

- Engages with the most vulnerable and isolated adolescent girls
- Assesses for the most pertinent risks and dangers for adolescent girls in each context
- Involves adolescent girls in all aspects of programme design and implementation
- Strengthens protective mechanisms that include the key stakeholders impacting the lives of girls
- Empowers girls to steer and guide their own wellbeing and safety once the programme is complete

The 5 Girl Shine Programme Model Components:

1. The Girl Shine Safe Space.
A "girl-only" safe space allows for consistent access to programming and provides a trusted environment where girls can express and be themselves. Girl-only spaces help to reduce risks and prevent further harm during acute emergency responses.

2. The Girl Shine Life Skill Groups.
The Girl Shine life skills groups are the heart of the programme. Girls participate in a collection of learning sessions that have been tailored to their needs (age range, experience and situation). The learning sessions help to build upon the existing assets that girls have and equip them with key skills to prevent, mitigate and respond to GBV.

3. The Girl Shine Mentors and Facilitators.
Girl Shine encourages the recruitment of older adolescent girls or young women from the local community to facilitate the Girl Shine Groups. Young women as mentors will expand the safety network for the girls in their communities and allow for sustainability and ongoing solidarity.

4. The Girl Shine Male and Female Parent-Caregiver Engagement.
Male and female parents and caregivers should be engaged with Girl Shine whenever it is safe and possible. This will help to ensure that girls are not put at greater risk for participating in the programme, and that their new skills and knowledge will be supported and reinforced in their home environment.

5. The Girl Shine Community Outreach.
Community support of the programme is essential to ensuring that girls who participate are safe. Staff are encouraged to work with the community and service providers to enable girls to access the programme and other critical services.

This resource package is presented in four parts:

Part One – Designing Girl Driven Programming for Adolescent Girls in Humanitarian Settings.
This provides a detailed overview of **how to design effective adolescent girl programming** in a variety of humanitarian settings.

Part Two – Girl Shine Life Skills Curriculum.
This is **the core curriculum** for working with adolescent girls that focuses on 6 topic areas and up to 48 sessions for life skill group meetings.

Part Three – Girl Shine Family Curriculum.
This is a curriculum that can be used when working with male and female parents and caregivers of unmarried adolescent girls.

Part Four – Girl Shine Training Package.
This is a resource that can be used with mentors and facilitators of the adolescent girl core curriculum to help strengthen the capacity of those working directly with girls.

The four parts of the resource package have been designed to be used together but can be referenced separately as well.

ANNEX 7: ENDNOTES

i. For further information, see Stark L, Asghar K, Yu G, Assazenew A, Bora C, Falb KL. (2017). Prevalence and associated risk factors of violence against conflict-affected female adolescents: a multi-country, cross-sectional study. Journal of Global Health. 7(1): 010416.

ii. The GBV response training materials used in COMPASS can be found here: http://gbvresponders.org/response/

iii. Inter-Agency Standing Committee. (2015) Guidelines for integrating gender-based violence interventions in humanitarian action: reducing risk, promoting resilience and aiding recovery.

iv. UN Women. Violence against Women & Millennium Development Goals. http://www.unwomen.org/~/media/Headquarters/Media/Publications/UNIFEM/EVAWkit_02_VAWandMDGs_en.pdf.

v. Available from http://gbvresponders.org/

vi. Falb, K., Tanner, S., Ward, L., Erksine, D., Noble, E., Assazenew, A., Bakomere, T., Graybill, E., Lowry, C., Mallinga, P., Neiman, A., Poulton, C., Robinette, L., Sommer, M., and Stark, L. (2016) Creating opportunities through mentorship, parental involvement, and safe spaces (COMPASS) programme: multi-country study protocol to protect girls from violence in humanitarian settings. BMC Public Health 2016.

vii. ibid

viii. UNHCR Population of Concern Statistics, September 2015.

ix. Peterman, A., Palermo, T., Bredenkamp, C. (2011) Estimates and determinants of sexual violence against women in the Democratic Republic of Congo, 101, 1060-7. Am J Public Health.

x. Erikson, A., Rastogi, S. (January 2015) Private violence, public concern: practice brief. In addition, since the outbreak of conflict in North Kivu in April 2012, records from the International Rescue Committee's GBV information management system show the percentage of GBV reports made by girls aged 12 to 17 has increased from 13% to 19%. Note this figure is not representative of girls experiencing violence, only those seeking help.

xi. See the following links on GBV Responders for more information about IRC's GBV research in the DRC: http://gbvresponders.org/wp-content/uploads/2014/07/Bass-NEJM.pdf; http://gbvresponders.org/wp-content/uploads/2015/12/EMAP-Research-Brief.pdf

xii. Internal Displacement Monitoring Centre. Pakistan IDP figures analysis (no date). http://www.internal-displacement.org/south-and-south-east-asia/pakistan/figures-analysis. (accessed 8 June 2017)

xiii. National Institute of Population Studies (NIPS) [Pakistan] and ICF International. (2013) Pakistan demographic and health survey 2012–13. NIPS and ICF International. Islamabad, Pakistan and Calverton, Maryland, USA.

xiv. For more information, see the websites of PAIMAN (http://paiman.jsi.com/) and Kwendo Kor (http://www.khwendokor.org.pk/).

xv. Hobfoll SE, Watson P, Bell CC, Bryant RA, Brymer MJ, Friedman MJ, Friedman M, Gersons BP, de Jong JT, Layne CM, Maguen S, Neria Y, Norwood AE, Pynoos RS, Reissman D, Ruzek JI, Shalev AY, Solomon Z, Steinberg AM, Ursano RJ (2007). Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. Psychiatry 70, 283–315.

xvi. For details and training packages, visit http://gbvresponders.org/resources/

xvii. The Raising Voices Good School Toolkit can be found at http://raisingvoices.org/good-school/download-good-school-toolkit/

xviii. Falb, K., Tanner, S., Ward, L., Erksine, D., Noble, E., Assazenew, A., Bakomere, T., Graybill, E., Lowry, C., Mallinga, P., Neiman, A., Poulton, C., Robinette, L., Sommer, M., and Stark, L. (2016) Creating opportunities through mentorship, parental involvement, and safe spaces (COMPASS) programme: multi-country study protocol to protect girls from violence in humanitarian settings. BMC Public Health 2016.

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