A Safe Place to Shine

Learning from the COMPASS programme for Adolescent Girls in Refugee Camps in Ethiopia

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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
ARRA Administration for Refugees and Returnee Affairs
COMPASS Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces
CM Community Wellbeing Initiative
DRC The Democratic Republic of Congo
DFID UK Department for International Development
GBV Gender-based violence
GBV IMS Gender-based violence information management system
IRC International Rescue Committee
NGO Non-governmental organisation
OR Unadjusted odds ratio
STI Sexually transmitted infection
UN United Nations
UNHCR United Nations High Commissioner for Refugees
VPRU Violence Prevention and Response Technical Unit
WPE Women's Protection and Empowerment

TABLE OF CONTENTS

Acknowledgements XX
Acronyms XX
Table of contents XX
Executive summary XX

CHAPTER 1: Introduction
Responding to an urgent need XX
The COMPASS programme XX
Programme partners XX
Generating data: methods XX
Context of programme areas XX
Demographics of adolescent girl participants XX

CHAPTER 2: The state of adolescent girls in refugee camps in Ethiopia: findings from the COMPASS baseline study XX
Fear and experiences of violence XX
Gender norms and attitudes XX
Formal services and informal support networks XX
Girls’ confidence and expectations XX

CHAPTER 3: What works for adolescent girls: learning from the COMPASS programme XX
Effectiveness and change XX
Feasibility and acceptability XX
Lessons from implementation XX

CHAPTER 4: Conclusions and recommendations XX
Annex 1: Impact evaluation methodology XX
Annex 2: Demographics of the girls XX
Annex 3: COMPASS theory of change XX
Annex 4: Tables XX
Annex 5: COMPASS journal articles XX
Annex 6: Girl Shine XX
Endnotes XX
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. Nearly half of all sexual assaults across the world are committed against girls younger than 16 years.¹

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 conflict-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.¹

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 Bambasi camp, Ethiopia, girls use a megaphone to get their message across.

¹ According to UNICEF, early (or child) marriage is defined as a formal marriage or an informal union that happens before the age of 18 years.
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 evidence available specific to adolescent girls in humanitarian settings. In addition, programmes focusing on GBV prevention and response in humanitarian settings often focus on adult women rather than adolescent girls. 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 evaluation 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 refugee camps on the Ethiopia/Sudan 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 global knowledge, programming and resources on adolescent girls and GBV, adapting for the complex contexts of diverse humanitarian settings. COMPASS was implemented by IRC’s Community Wellbeing Initiative (CWI) programme teams, supported by IRC evaluators and technical advisors, and evaluated by Columbia University.

This report shares learning from the implementation and evaluation of COMPASS in Ethiopia, implemented with refugees living in Sherko, Bambasi and Tonge refugee camps in the Benishangul-Gumuz region, near the border with Sudan.

The state of adolescent girls in refugee camps in Ethiopia: findings from the COMPASS baseline study

Adolescent girls in refugee camps are at high risk of GBV.

The study conducted prior to the beginning of the programme revealed that adolescent girls in refugee camps near the Ethiopia / Sudan border are exposed to extremely high levels of GBV.15% of adolescent girls reported having experienced physical violence in the past 12 months, and 38% had experienced emotional abuse over the same period. 45% of adolescent girls reported experiencing some type of sexual violence in their lives, including forced sex, unwanted sexual touching and/or coercion. Forced sex (or rape), was the form of sexual violence most frequently reported to have taken place in the past year (16%). Nearly 40% of those who had experienced forced sex reported that the most recent occurrence was within the past week. The study also revealed an acceptance by both adolescent girls and parents of violence as a part of everyday life.

Adolescent girls in camps near the Sudanese border are also experiencing sexual violence at a young age. 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 GBV against adolescent girls, followed by parents and other relatives. 43% of sexual violence was perpetrated by intimate partners, followed by parents or relatives (30%) or friends/neighbours (5%). Fewer than half of the perpetrators were known to the adolescent girls.

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

Adolescent girls reported having social networks comprising peers, family members and community leaders, but few options for support when GBV occurred. Only 43% of adolescent girls had an adult they could turn to for advice, and 41% knew a trusted person they could talk to if they were forced to have sex. Adolescent girls also had limited knowledge of the services available for those who experience GBV, with only one in three (31%) knowing a place they could go to for help if they experienced sexual violence. Group discussions revealed that even when adolescent girls knew about services, they were reliant on a parent to facilitate access to them.

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

Despite having average levels of self-esteem compared to global levels, adolescent girls had limited expectations about opportunities for the future, including the level of education a girl should complete, and the opportunities available to girls compared to boys. Girls also had low levels of hope for the future, measured in terms of their belief in their ability to achieve their goals.

Overview of COMPASS Ethiopia

COMPASS was implemented with two groups of adolescent girls and their parents. Evidence in this report is based on data and learning from the first group, or programme cycle. Overall, the programme reached 978 adolescent girls representing a range of backgrounds, living situations, and experiences, and 919 of their parents.

To generate learning on the effectiveness, feasibility and acceptability of the COMPASS interventions and how best to implement them, an external mixed-methods evaluation was carried out along with routine programme monitoring. Columbia University led the evaluation, which included a randomised control trial to measure how effective the adolescent girl life skills sessions were at changing social and health outcomes of adolescent girls.2 This involved an ‘intervention group’ of adolescent girls which received the life skills sessions and parents who attended group discussions, and a ‘waitlist group’ which received no intervention until the evaluation was complete. Baseline and endline surveys were complemented by qualitative group discussions, participatory activities and in-depth interviews.

Programme monitoring data were also collected throughout implementation to assess how change is achieved, inform programme adaptations and feed into wider learning.

COMPASS included the following core interventions:

- Adolescent girls’ life skills sessions: weekly discussions with groups of adolescent girls in allocated safe spaces. These were facilitated by young female mentors.
- Parent/caregiver discussion groups: monthly discussions with parents and caregivers of participating adolescent girls.
- 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.

Adolescent girls’ life skills sessions included the following topics:
- GBV awareness workshops
- Gender norms and GBV
- Peer counselling
- Sexual and reproductive health
- Mental health
- Education and future plans
- Career development

Adolescent girls and their parents were also provided with external sessions on GBV, including community health workers, Bravo and價格，oration workshops, and youth leaders.

External Evaluation Methodology.

4. The term parent will be used from here on in the report to indicate parent/caregiver.
5. The Women’s Protection and Empowerment team is known as the Community Wellbeing Initiative.
6. 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 survey questions asked to assess exposure to violence, please see Annex 3: External Evaluation Methodology.
7. Self-esteem was assessed through the Rosenberg self-esteem scale (Rosenberg, 1978). The 10-item Likert scale has been used in over 50 countries, and higher scores indicate higher self-esteem (Rosenberg, 1978; Smith & Ala, 2005).
What works for adolescent girls: learning from the COMPASS programme

Effectiveness and change: The impact of COMPASS on adolescent girls

COMPASS helped adolescent girls to develop their support networks.

By the end of the programme, adolescent girls 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 evaluation interviews, adolescents asserted that the programme had a positive impact on their social networks and family relationships. These findings are important because the role that friends and trusted adults can play reducing girls’ risk of GBV as well as supporting their healing and recovery should they be victimized.

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

Adolescent girls who completed the programme had higher expectations for the future than the waitlist group. They reported that girls should stay at school for an average a year longer compared to the waitlist group: 5.3 years compared to 4.3 years.

In addition, 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. Girls also showed increased levels of hope after the programme.

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

Adolescent girls gave positive feedback about the safe spaces. Girls explained how IRC safe spaces could be useful for girls when they felt unsafe at home and in other spaces in the community. Importantly, at the end of the programme, girls 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. The evaluation did not show a statistically significant reduction in girls’ exposure to violence, or improvement in girls’ feelings of safety outside the safe space. In addition, at the end of the programme, adolescent girls continued to hold attitudes that indicated acceptance of gender inequality. 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.

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 daughters.

Adolescent girls reported improved relationships with their parents following the programme. However, in some cases, girls attributed this change to modifying their own behaviour. While girls reported increased comfort in discussing education, puberty and earning a living for the future with their mothers, there was no significant difference between the intervention and waitlist groups on conversations about sex and sexual health, including sexually transmitted infections (STIs) and pregnancy.

Adolescent girls’ perception of attitudes and knowledge of parents and influential community members regarding sexual violence against adolescent girls remained at similar levels at the end of the programme: about 30% of adolescent girls continued to think that their parents would blame them if they were forced to have sex. At the end of the programme, participating parents continued to talk about violence within intimate partnerships as normal, and said that adolescent girls were themselves ultimately responsible for preventing such violence.

Such attitudes may explain the similar views held by adolescent girls, and also why adolescent girls continued to assume they would be blamed by parents and community members in cases of GBV. The short term nature of the parent intervention and the timeframe of the study may have contributed to these results. In addition, most participating parents were women, who are unlikely to hold the power in the family to make decisions about their daughter, or to influence others around her who may perpetrate GBV or expose her to risk. This may have limited mothers’ ability to put their learning into practice.

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.

The IRC’s CWI teams provided GBV case management services and referrals for adolescent girls who experienced GBV, as well as training to health and GBV case management service providers. This training was designed to improve their attitudes towards adolescent girls, and to help them to strengthen the quality of support provided to girls who had experienced GBV.

Through the IRC’s support, knowledge and attitudes towards adolescent girls survivors improved among GBV service providers. Ongoing monitoring, mentorship and refresher training sessions were required. The IRC staff also spent a significant amount of time working with schools and education providers in the refugee camps. As a result, they made an agreement to implement a new code of conduct including a zero tolerance policy to corporal punishment and sexual harassment.

The external evaluation found that COMPASS significantly increased knowledge of services: girls who completed the programme were almost twice as likely as those in the waitlist group to know a place to go for help if they experienced sexual violence, and over twice as likely to know a place if they experienced physical violence. Access to services also increased: according to the GBV information management system (GBVIMS), there was an overall increase in the number of adolescent girls who had survived GBV accessing health and case management services. The IRC’s continued activities to raise awareness among adolescent girls and parents on available services, coupled with efforts to strengthen the quality of these services, seems to have led to an increase in awareness and use.

Feasibility and acceptability of COMPASS

The IRC assessed the extent to which a programme like COMPASS was feasible in Ethiopian refugee camps, in terms of girls having safe, consistent access and the ability to participate. The IRC also assessed how acceptable adolescent girls, families and communities would be to learning information and skills relating to the topics of the programme, and whether they would apply what they learned in their lives.

COMPASS proved to be feasible and acceptable in the refugee camps.

In many communities, the concept of programming for adolescent girls was new. As a result, there were examples 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. Acceptance by communities was also due to the positive relationships IRC CWI staff had built up 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.

Enrolment of both adolescent girls and their parents was successful, with a total of 978 girls and 919 of their parents in the first programme cycle. Adolescent girls were asked to identify a parent/caregiver of their choice to attend the corresponding COMPASS sessions. As a result, the majority of parents/caregivers were the mothers of girls (81%), although a large percentage of fathers enrolled too (33%).

Overall, session attendance during the first programme cycle was very high: 85% for adolescent girls and 91% for parents. Reasons for adolescent girls missing sessions included being away from the area, health issues, household chores, getting married, becoming pregnant or giving birth. The first few sessions were the most poorly attended, but numbers stabilised and the girls’ active participation in sessions increased, following work by programme teams to maintain attendance. In total, only 59 of 978 adolescent girls dropped out of the programme (6%) of the total, which was mostly due to them leaving the camp. There were some cases where a different parent/caregiver would attend different sessions for the same adolescent girl, meaning each individual parent/caregiver only received part of the curriculum.
Adolescent girls and parents gave positive feedback about COMPASS. Adolescent girls provided very positive feedback about the sessions, reporting that sessions were a time when they could be with their friends and learn new skills and knowledge. Mentors reported that their relationship with the adolescent girls became stronger over the course of the programme, with the girls more willing to trust and talk to them. Popular topics among the girls included friendship, setting goals, communication skills, safety skills and health and hygiene. Adolescent girls were able to 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. Some topics were more challenging, notably finance and savings and sexual health.

Parents reported feeling positive about their girls’ attendance, and reported that the programme generally had a positive reputation within the community. Facilitators reported receiving positive feedback on the sessions from parents, in terms of their own knowledge improving and the positive behavioural change they saw in their daughters.

Lessons from the implementation of COMPASS

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 who enrolled in the programme spoke a wide range of languages including more than 20 dialects, many of them unwritten, making it challenging to deliver the curriculum. This was overcome by recording and translating sections of each session into informal Arabic, the working language of all the camps. These were then passed on to mentors to support their delivery of a session. Parent/caregiver sessions were facilitated by IRC staff, working alongside trained female and male translators/facilitators. These people were refugees aged 18–30 who spoke the same languages as the participants.

The life skills curriculum remained a living document that evolved over the course of the entire first programme cycle. This allowed the team to closely observe what was working well, adapt it to the right level for the adolescent girls, and respond to new themes and needs that emerged.

Mentors helped deliver COMPASS key messages, and developed strong relationships with girls. Implementing the programme in refugee camps with diverse populations, multiple languages and low literacy required ongoing adaptations and high levels of resources. COMPASS used a mentorship approach, hiring female mentors aged 18–30 who lived in the same camps, spoke the same languages and held positive attitudes about working with adolescent girls to facilitate the life skills sessions.

Many of these young women were not literate and had little education themselves, so considerable training and support was required to build their capacity and confidence to deliver elements of the life skills sessions. This included ongoing supervision and in some cases co-facilitation with an IRC staff member, as well as additional support to help them understand the curriculum content and how best to facilitate a group. Receiving this comprehensive training and support resulted in strong relationships developing between the mentors and adolescent girls. The mentors also developed their skills and knowledge and improved their status in the community, which was an unintentional but positive consequence of the programme.
**Recommendations**

IRC makes the following recommendations to donors and other relevant stakeholders, (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 other relevant stakeholders should commit to the development of a strategy dedicated to adolescent girls in humanitarian settings.

2. Donors and other relevant stakeholders 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, GBV service providers other relevant stakeholders should ensure adolescent girls can access quality GBV services that are tailored to meet their needs.

9. Donors, practitioners and other relevant stakeholders should ensure holistic programming exists that tackles wider harmful norms.

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

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

12. Donors, practitioners and academics should prioritise the following areas of study 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 evaluation methods to better understand the needs of younger adolescent girls in order to inform programming.

“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 against our will, we are now aware of where we can go to report such things.”

14-year-old adolescent girl, when asked what knowledge she had gained from the programme
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 (GBV) (page 1).

COMPASS sought to address this need by developing safe spaces for adolescent girls and delivering a life skills curriculum through a mentorship approach, as well as working with their parents and GBV service providers (page 3).

Columbia University and the International Rescue Committee (IRC) worked together to generate evidence on the effectiveness of COMPASS programming and ways of improving outcomes for adolescent girls in humanitarian settings. Columbia University led an impact evaluation and the IRC led monitoring of the programme for learning (page 5).

COMPASS was implemented in three refugee camps, which were established in response to years of conflict and displacements in Sudan and South Sudan (page 8).

Responding to an urgent need

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.

Nearly half of all sexual assaults across the world are committed against girls younger than 16 years. Furthermore, girls rarely have the appropriate knowledge, support and confidence to navigate their way through adolescence, access help when they need it and challenge issues they face.

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 conflict-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.
Ensuring safety from violence is critical for adolescent girls to develop and live full and productive lives.

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 evidence 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.

Given the limited available evidence, the IRC has been carrying out programming and studies to establish what works to improve the wellbeing of adolescent girls during conflict, instability and displacement. As part of this effort, the IRC developed and implemented a pilot programme entitled Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces (COMPASS). The three-year programme (2014–2017) was funded by the UK Department for International Development (DFID) and took place in Ethiopia, Democratic Republic of Congo (DRC) and Pakistan. It sought to test effective strategies and interventions for protecting adolescent girls from GBV in humanitarian settings. It also aimed to generate much needed evidence on the acceptability and impact of such interventions.

In Ethiopia, COMPASS was implemented with refugees living in the Sherkole, Bambasi and Tonga refugee camps in the Benishangul-Gumuz region of the country, near the border with Sudan. The report provides a comprehensive overview of learning from COMPASS in Ethiopia, to inform policy and practice for adolescent girls programming in humanitarian settings. In the introduction, there is an outline of the COMPASS programme and study 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 study on adolescent girls’ exposure to GBV, gender norms and attitudes, knowledge of service providers, informal support networks and girls’ confidence and self-esteem.

Chapter 3 presents the findings from the COMPASS programme and evaluation carried out in refugee camps in Ethiopia. They focus on the effectiveness of the interventions, the feasibility and acceptability of programming in this context, 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 studies 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 global knowledge, programming and resources on adolescent girls and GBV, adapting for the complex contexts of diverse humanitarian settings. Before launching the programme, a theory of change was developed by identifying the causal pathways to reduce adolescent girls exposure to GBV and the interventions needed to prevent 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 3.

The full COMPASS curriculum was implemented with two cohorts of adolescent girls and parents. Evidence in this report is based on data and learning from the first programme cycle, which was implemented from November 2015 to July 2016.

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 Ethiopia, Pakistan 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 have improved attitudes, knowledge and skills to protect these girls from violence and help them keep themselves safe from violence.
3. SERVICE PROVIDERS have increased capacity to provide safe, girl friendly and lifesaving services.
### Programme interventions:

<table>
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<tr>
<th>Intervention</th>
<th>Purpose</th>
<th>Structure</th>
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<tr>
<td><strong>Adolescent girls’ life skills sessions</strong></td>
<td>To increase adolescent girls’ human and social assets, including social networks and safety, by creating opportunities for girls to engage with peers and mentors, providing information that helps reduce girls’ risk of being exposed to violence, and building adolescent girls’ self-esteem and leadership skills.</td>
<td>Adolescent girls were grouped by age (10–12, 13–14 and 15–19) and language, and paired with two female mentors aged approximately 18–30. The groups met weekly for 30 sessions, in a designated adolescent girl “safe space” built by the IRC. They discussed content ranging from decision-making and disagreement resolution, to reproductive health, puberty, gender norms, cultural pressures, healthy relationships, life goals and violence prevention.</td>
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<td><strong>Parent/caregiver discussion groups</strong></td>
<td>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 girls.</td>
<td>One parent/caregiver per participating adolescent girl took part in monthly group conversations, conducted by IRC officers, with the support of facilitators who could speak the appropriate languages. The curriculum focused on positive relationship building, empathetic communication, non-violent discipline methods and specific developmental and cultural issues experienced by adolescent girls.</td>
</tr>
<tr>
<td><strong>Service provider support</strong></td>
<td>To ensure the provision of responsive and high-quality essential services to adolescent girls, preventing violence and supporting survivors of violence.</td>
<td>The IRC provided targeted training and ongoing support to develop knowledge, capacity and skills on responding to the specific needs of adolescent girls, particularly after experiencing violence. In addition, other providers were engaged, such as the education and legal sectors, to promote a holistic approach to referral and response, as well as working towards shifting unequal gender norms and improving support provided to adolescent girls.</td>
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### Programme learning:

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

**Effectiveness:**
- extent to which the programme builds adolescent girls’ human and social assets
- extent to which these assets contribute to decreasing adolescent girls’ risks of and exposure to violence
- 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 programming to adolescent girls and their families
- perceptions of adolescent girls, families and the wider community about programme content and delivery

**Pathways to change:**
- analysis of the ways that 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.

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8. Parent/caregivers shall be referred to singly as “parents” from this point in the report, although it should be recalled that caregivers such as aunts, siblings, cousins and other non-blood-related persons are included in this group.

### Programme partners

**The International Rescue Committee (IRC)**

The IRC is a humanitarian organisation dedicated to helping people whose lives and livelihoods have been shattered by conflict and disaster to survive, recover and regain control of their future. Since 1998, the IRC has implemented specific programmes to empower and protect women and girls affected by GBV 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 programming to prevent and respond to violence against women and girls.

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 90 WPE technical advisors, specialists, and other experts 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.

The IRC’s Community Wellbeing Initiative (CWI) in Ethiopia implements a holistic set of GBV services to respond to the needs of women and girl survivors, and works with all actors to minimise their vulnerability to ongoing violence. The IRC has been implementing GBV programmes in Ethiopia since 2005, and has expanded to 14 refugee camps in three regions in the past five years: Tigray Region, Benishangul-Gumuz Region, and Southern Nations, Nationalities and Peoples’ Region. The IRC led the implementation of COMPASS in Ethiopia and overall management of the programme.

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

The study partner (Columbia University Mailman School of Public Health, led by Dr Lindsay Stark and Dr Marni Sommerville) brings expertise in the fields of epidemiology, qualitative studies, measurement of sensitive topics including GBV, and randomised trials. The CPC Learning Network, headquartered at Columbia University, seeks to build evidence about children, youth and families living in adversity. In this study, Columbia University, as the principal investigators, led on evaluation and tool design and testing, ethical approaches and approvals, quality and data analysis and training for the evaluation component.
Generating data: methods

The learning presented in this report is drawn from the external mixed-methods evaluation led by Columbia University, as well as from monitoring data collected by IRC programme staff throughout implementation. Note that all data included are from the first programme cycle; subsequent programme cycles drew on this learning to further develop and improve the programme.

External evaluation

Columbia University led a two-arm waitlist cluster randomised controlled trial to evaluate the impact of COMPASS in the refugee camps. The trial was complemented by qualitative data collection from adolescent girls and parents. The overall aim of the evaluation was to understand the effectiveness of COMPASS programming in humanitarian settings, with the following objectives:

1. To assess the impact of the adolescent girls’ life skills sessions and parent group discussions on a) girls’ experiences of physical, sexual and emotional violence; b) confidence and self-esteem; c) girls’ support networks; d) gender attitudes.
2. To explore qualitatively how adolescent girls’ life skills sessions and parent group discussions may influence adolescent girls’ exposure to violence and support networks.

Following programme enrolment and completion of baseline data collection, adolescent girls were randomly divided into two groups:

- intervention group – adolescent girls receive life skills sessions and parents attend group discussions
- waitlist group – no intervention provided to girls or parents.

Those in the waitlist group took part in the second cycle of the programme, after completion of the evaluation. The baseline survey was conducted with 919 girls aged 13–19 in July/August 2015, and the endline survey was completed with 812 girls aged 13–19 in July/August 2016, following completion of the first programme cycle. The individual baseline and endline quantitative surveys were administered to participants using the Audio Computer Assisted Self-Interviewing (ACASI) computer programme, 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. The surveys were available in the four non-written languages most widely spoken in the camps: Funj/Berta, Ingessena Kulelek, Maban and Regari.

The following qualitative methods were used:

- focus group discussions (nine groups) with 68 female and male parents at the beginning of the programme
- participatory mapping activities with 12 groups and a total of 78 adolescent girls at the beginning of the programme
- in-depth interviews with 36 adolescent girls at the end of the programme
- in-depth interviews with 57 participating parents at the end of the programme (18 female, 9 male).

A detailed methodology can be found in Annex 1.

Terms used in this report:

- intervention group – group which received the full intervention during the period evaluated. In the COMPASS Ethiopia evaluation, this refers to adolescent girls and their parents that took part in the first programme cycle.
- waitlist group – group which did not receive the full intervention during the period evaluated (the ‘control’ group). In the COMPASS Ethiopia evaluation, this refers to adolescent girls and parents who were waitlisted and participated in COMPASS in the second programme cycle, after the evaluation of the first programme was completed.

9 Among the 919 girls who completed the baseline survey, 107 (11.6%) did not complete the endline survey, which falls well below the expected rate of 25% used to calculate the sample size. The most common reason for non-completion of the endline survey was temporary or permanent relocation out of the camps (n = 56). Additionally, 34 girls from the control group were excluded from analysis because they mistakenly joined the intervention group.

6 Chapter 1: Introduction
Programme monitoring data sources

Throughout programme implementation, monitoring data were collected with adolescent girls, parents, mentors and service providers to assess progress, improve programming, generate learning about best practice and help trace the pathways to change. The following sources of monitoring data inform this report:

- attendance data for adolescent girls’ life skill sessions and parent group discussions
- participatory group activities with adolescent girls, held at the mid-point of the curriculum to assess their knowledge and competencies on COMPASS life skill topics
- discussions with parents, held at the end of the programme to assess their understanding of the core concepts and the skills taught by the curriculum
- supervision reports and session observations of mentors, reported qualitatively on a quarterly basis
- service provider knowledge and attitude assessments, conducted following training sessions
- quarterly and annual narrative reports

Context of programme areas

Sherkole refugee camp in Benishangul-Gumuz, Western Ethiopia, was established in 1997 in response to the decades of civil war occurring in Sudan. Following the peace agreement signed in 2005, the refugee population in Sherkole camp declined significantly, and voluntary returns facilitated by the United Nations High Commissioner for Refugees (UNHCR) began in 2008.

In September 2011, Sherkole camp was re-established and expanded, as refugees began to arrive in Ethiopia again, due to an outbreak of fighting and air bombardment around contentious border areas between Sudan and South Sudan. With the tremendous increase of refugees flowing into the area, Sherkole was soon at capacity, leading to additional sites opening in the region, including Tongo Camp in October 2011 and Bambasi Camp in June 2012. The situation remained relatively volatile in the region, with increased tension in South Sudan beginning on 15 December 2013, when clashes between armed groups intensified. The conflict spread to 10 states in South Sudan, displacing 1.3 million individuals. With the continued influx of South Sudanese refugees, additional new camps were established in the region.

As of 30 September 2015, prior to the start of COMPASS, the UNHCR sub office in the area hosted a total of 46,726 refugees in Benishangul-Gumuz. These refugees were mainly from Blue Nile state in Sudan, as well as Kordofan state in Sudan. Upper Nile state in South Sudan and a small number from countries of the Great Lakes region: DRC, Rwanda and Burundi. They are currently hosted in four camps in Assosa. Sherkole, Bambasi, Tongo and the recently established Tsore camp. New arrivals and government sources reported that security remains tense in Blue Nile state and South Sudan, which could result in an influx of additional new arrivals into these camps.10

COMPASS was implemented in Sherkole, Bambasi and Tongo camps, where refugees have access to health centres and schools, water, sanitation and hygiene facilities, shelter, and livelihoods and protection programming. Services are implemented and maintained by a range of government, UN and non-governmental actors.

The IRC has documented significant levels of GBV in the refugee camps, with assessments carried out in 2012 identifying adolescent girls as particularly vulnerable to sexual exploitation and abuse, sexual violence, early marriage and intimate partner violence. Like women, adolescent girls are often stigmatised after surviving violence and receive little understanding and support from their community. Adolescent girls not only experienced serious and varied forms of violence prior to arrival in Ethiopia, they also continued to live in fear of physical and sexual violence and harassment in the refugee camps.

Table 1: Characteristics of refugee camps where COMPASS was implemented

<table>
<thead>
<tr>
<th>Camp</th>
<th>Population</th>
<th>Date established</th>
<th>Nationalities</th>
<th>Languages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sherkole</td>
<td>11,269</td>
<td>Re-established</td>
<td>Sudanese, South Sudanese, Congolese, Rwandese and Burundian.</td>
<td>Informal Arabic and ethnic languages: mostly Meban, followed by Funj, Dinka, Uduk, Engesena, Shelu, Nuba, Nuer, Agnisak and Jumjum.</td>
</tr>
<tr>
<td>Bambasi</td>
<td>15,063</td>
<td>June 2012</td>
<td>Sudanese</td>
<td>Informal Arabic and ethnic languages: mostly Funj, followed by Mumuse, Fajud, Fatmata, Jumjum, Pajareg, Dewala, Regang, Fanzigir, Engesena and Batur.</td>
</tr>
<tr>
<td>Tongo</td>
<td>11,470</td>
<td>October 2011</td>
<td>Sudanese and South Sudanese</td>
<td>Informal Arabic and ethnic languages: mostly Engesena Kualik, followed by Funj, Dewalla, Hamej, Batur, Nuer, Regang, J follows, Bert, Gumuz and Uduk.</td>
</tr>
</tbody>
</table>

Demographics of adolescent girl participants

The first programme cycle of COMPASS included 978 adolescent girls and 919 of their parents, representing a diverse range of girls: those who were in and out of school, married and unmarried, with children and without, as well as representation from a range of ethnic groups. According to the baseline survey of 919 adolescent girls, most of the adolescent girls were living with at least one parent, though 27% reported that they were already married. Overall, the adolescent girls had low levels of education.

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

Summary of introduction

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

In Ethiopia, the programme was implemented as a multi-sector intervention targeted at adolescent girls, their parents, wider members of the community and service providers from diverse populations living in refugee camps on the border with Sudan. In particular, it brought together adolescent girls and their parents from a wide range of ethnic, language, educational and family backgrounds.

The IRC and Columbia University formed a partnership to evaluate COMPASS. This involved a randomised controlled trial on how effective the programme’s life skills sessions were at changing the health and social outcomes of adolescent girls. This was complemented by qualitative data. In addition, programme monitoring data were collected throughout implementation to assess how processes could be changed to improve outcomes, inform programme adaptations and feed into wider learning.

This report presents learning from implementing and evaluating COMPASS in Ethiopia. In particular, the report focuses on the effectiveness of the COMPASS interventions, feasibility and acceptability of programming in this context, and lessons learnt from implementation.

11. Please note that for all figures in this report, complete data can be found in Annex 4.

12. Note that these are only the languages spoken by girls who participated in the evaluation. The total number of languages spoken by girls participating in the programme is significantly higher (see Table 1 and Annex 4, Figure 11).
CHAPTER 2:

THE STATE OF ADOLESCENT GIRLS IN REFUGEE CAMPS IN ETHIOPIA

Key findings from the baseline study:

- A high number of adolescent girls in refugee camps have experienced sexual, physical and emotional violence, and GBV is normalised by adolescent girls and their families (page 14).
- Adolescent girls have attitudes characterised by acceptance of gender inequality. Girls are likely to agree that men are decision makers, women should accept violence, and domestic chores are the responsibility of women and girls (page 16).
- Adolescent girls have friends and family members they trust, but generally they have no one to talk to about sensitive topics, and nowhere to go to if they experience violence; they also have a low level of knowledge and trust of service providers (page 17).

In this chapter, key findings are presented from the quantitative and qualitative data collection carried out at the beginning of the programme, which provide an insight into the prevalence of violence, as well as adolescent girls’ views on gender norms, knowledge of GBV services and hopes for the future.

As the evaluation intended to understand the overall status and experiences of adolescent girls before the programme started, the results presented consider all adolescent girls who participated (919 girls). The results do not disaggregate data by whether the adolescent girls were in the intervention group (took part in the first programme cycle) or the waitlist group (took part in the second programme cycle after the evaluation).
Much of the qualitative data suggest that both adolescent girls and parents viewed the girls as being responsible for protecting themselves against sexual violence. Despite concerns in group discussions about exposure to GBV in isolated locations away from home and fear of strangers, all types of violence experienced by the adolescent girls in the camps were most likely to be at the hands of someone they knew. Across experiences of sexual and physical violence, the most commonly reported perpetrator was an intimate partner (boyfriend or husband). Adolescent girls reported that parents or other relatives were most likely to be the perpetrators of emotional abuse (39%), while 26% reported that parents had perpetrated physical abuse against them (second most likely perpetrators after intimate partners). In group discussions, some adolescent girls shared that parents beat them as punishment for bad behaviour.

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

**Fear and experiences of violence**

The baseline study revealed extremely high levels of exposure to violence for adolescent girls in the refugee camps, alongside an acceptance by both adolescent girls and parents of violence as a part of everyday life.

Adolescent girls in the camps reported high levels of physical and emotional violence. 30% of adolescent girls reported experiencing physical violence in the past 12 months, and 36% had experienced emotional abuse within the past 12 months. 45% of adolescent girls reported experiencing some type of sexual violence, including forced sex, unwanted sexual touching and/or coercion at some point in their lives, and 29% had experienced sexual violence in the past 12 months (see Figure 2). For those who experienced sexual violence, it often happened regularly: nearly 40% of those who had experienced forced sex in the past 12 months reported that the most recent occurrence was within the last week. 16% of adolescent girls had received money, food or gifts in exchange for sex, and nearly 43% of these girls reported that this had occurred in the past 12 months.

Most of the adolescent girls living in the camps reported feeling safe at home (75%), at their school (86%) and in friends’ and neighbours’ houses (85% and 57%, respectively). When asked where they felt safe and unsafe in group discussions, girls’ responses generally matched these findings: adolescent girls indicated homes, schools and mosques as places of safety, and roads, forests, rivers, sports fields and the grinding mill as unsafe. In some cases, adolescent girls also identified homes as unsafe, stating that strangers might come and harm them inside their homes. These concerns led to adolescent girls and parents suggesting that restricting adolescent girls’ movement, and stopping them interacting with men and boys, was the best way to keep adolescent girls safe. Several adolescent girls reported the physical discipline of their parents was sometimes intended to ‘protect’ the girls from these risks: they were beaten by their parents for going places without permission or for seeing their boyfriends.

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

**Figure 2: Girls’ reported experience of sexual violence**

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported experiencing sexual violence</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>Reported experiencing sexual violence in past 12 months</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Reported experiencing forced sex</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Of those girls experienced forced sex in past 12 months</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 3: Girls’ reported experience of physical violence, emotional abuse, and neglect**

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaten or hit in past 12 months</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Screamed at loudly or aggressively in past 12 months</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>Felt uncared for in past 12 months</td>
<td>36%</td>
<td></td>
</tr>
</tbody>
</table>

**Perceived safe spaces and risk-prone areas in the community**

Girls do all household chores, but boys work out of the house and bring money. If a boy has no work, he spends all his time playing and wandering all over the road.

Female parent/caregiver, baseline focus group discussion

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 caregiver, baseline focus group discussion

Gender norms and attitudes

Around half of the adolescent girls that participated in the study agreed to each of the gender inequitable statements, aligning with views that men are decision makers, and women are responsible for avoiding pregnancy and keeping the family together, even if violence is the cost (see Annex 4, Figure 4). 71% of adolescent girls agreed with at least one statement deeming it was acceptable for a man to hit his wife in certain circumstances, for example, if she refuses to have sex, goes out without telling him, neglects her children or burns the food.

In qualitative discussions, parents discussed the traditional gender roles that adolescent girls are expected to play from a young age, including gendered household tasks. Adolescent girls also talked about the chores they carry out within and outside the home that boys did not have to do, such as firewood and water collection and going to the market. Adolescent girls highlighted that many of their chores take them to unsafe places like the forest or the grinding mill, which, for safety reasons, they only travel to in groups or with an adult. Parents/caregivers highlighted the importance of their guidance and discipline in raising girls, focusing largely on controlling their movement to reduce risks, ensuring they listen to advice and guidance, and ensuring their future is secured through marriage.

Formal services and informal support networks

Adolescent girls reported having social networks comprising peers, family members and community leaders, but few options for support when violence occurred. Only 43% of adolescent girls reported having an adult who gave them advice, and 41% a trusted person they could talk to if they were forced to have sex. This may relate to expectations of blame or further violence: in the survey, 29% of adolescent girls believed that their family would blame them if they were forced to have sex, and 23% believed their community would force them to marry the perpetrator if they had been forced to have sex. During group discussions with both adolescent girls and parents, marrying the perpetrator came up frequently as a response to sexual violence.

Adolescent girls were uncomfortable discussing sensitive topics with parents: while the majority of adolescent girls felt comfortable discussing puberty (89%), only slightly more than half felt comfortable discussing sex (57%), marriage (58%) and pregnancy (61%) with parents. 66% of adolescent girls reported having at least one friend of their own age outside of their family. Group discussions revealed that peers were integral to supporting an adolescent girl if she had a problem, and helping her find the best course to resolve it. Peers were also someone to carry out chores with, and offered protection as part of a group when adolescent girls moved around their camp.

Figure 4: Adolescent girls’ agreement to statements

58% Of girls agreed that men should have the final word about decisions in his home

58% Of girls agreed that females should tolerate violence to keep the family together

35% Of girls agreed that a man can hit his wife if she will not have sex with him

Girls’ confidence and expectations

Despite having average levels of self-esteem compared to global levels, adolescent girls had low expectations about opportunities for girls. They thought a girl should have her first child before 18. On average, they stated that adolescent girls should complete slightly more than four years of schooling. 45% of adolescent girls stated that a girl should get married before 18, and 49% thought a girl should have her first child before 18.

13. Self-esteem was assessed through 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).
Adolescent girls face unique risks in humanitarian settings, due to their age and transition into adulthood, an acceptance of violence against women and girls in these environments, and the rupturing of traditional family, community or state support structures.

The baseline survey in refugee camps on the Ethiopia/Sudan border revealed that over 45% of adolescent girls had experienced sexual violence, and 30% had experienced physical violence. Perpetrators of the violence were overwhelmingly people that the adolescent girls knew (predominantly intimate partners, followed by parents).

Harmful gender norms and attitudes were pervasive among the adolescent girls and their parents, and violence in the home was normalised: 71% of adolescent girls agreed with at least one statement deeming it was acceptable for a man to hit his wife in certain circumstances.

Adolescent girls had low aspirations for themselves, and although they had social networks comprising of friends, families and communities, they reported they had little access to support if they were experienced violence, and very little knowledge of formal support structures that could help them.

These findings point to the urgent need for tailored programming to reduce violence against adolescent girls and improve their wellbeing and future prospects. The next chapter examines how COMPASS helped to achieve these goals.
Learning from the COMPASS programme:

- COMPASS had a positive impact on adolescent girls’ social networks, hopes and expectations for the future – all important outcomes for protecting them against GBV and helping them recover if they experience GBV (page 22).
- Parents retained some knowledge on COMPASS topics, and adolescent girls reported some improvements in their relationships with parents (page 26).
- COMPASS improved knowledge of services among adolescent girls, and services became more adolescent girl friendly (page 27).
- There was high demand for COMPASS programming among the adolescent girls and their parents, demonstrating the feasibility and acceptability of the programme (page 30).
- Programming for adolescent girls in humanitarian settings requires a flexible and responsive approach, to ensure content and delivery is appropriate, relevant and effective (page 35).

In this chapter, learning is presented from implementing and evaluating the COMPASS programme according to: (i) effectiveness and change; (ii) feasibility and acceptability, and (iii) lessons from implementation of the programme.
Effectiveness and change

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

Adolescent girls

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 to help prevent GBV and help girls recover if they experience GBV.

COMPASS increased adolescent girls' access to social networks and support, in terms of friendships and trusted adults. In comparison to the waitlist group, adolescent girls in the intervention group were 83% more likely to report having at least one friend at the end of the programme. These adolescent girls were also twice as likely to report knowing a trusted non-family adult to speak to about problems. Adolescent girls in interviews asserted that the programme had a positive impact on their social networks and family relationships, stating that they had become close with peers that participated in the programme with them. Many of the adolescent girls also expressed gratitude towards the COMPASS mentors, and described their mentors as people who they could go to for help if they needed it.

However, in cases of rape or physical abuse by a boyfriend, adolescent girls said they would predominantly turn to friends for support rather than an adult. This underscores the critical importance of quality friendships, as well as the need for additional work on improving the dynamic between adolescent girls and parents or other trusted adults in their lives. It also highlights the need for quality information about GBV and support services to be provided to adolescent girls, as they are likely to seek information from and share it with each other. Friendships were a key element to adolescent girls enjoying COMPASS, according to programme monitoring. Adolescent girls had a strong understanding of quality friendships, highlighting that good friends give good advice, help each other stay safe and share ideas with each other.

Adolescent girls' opinions on working outside the home.

Previously, our parents used to argue with us because we used to spend our days doing nothing. But now, after we started participating in the programme, no one argues with us. There were no other programmes we used to go to before this programme.

Previously, before we began participating in the programme, we didn't have a good relationship; nor did we have 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.

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

Overall, adolescent girls who had received the programme had higher expectations of opportunities for adolescent girls like them in the future. Compared to the waitlist group, those who completed COMPASS reported that they believed adolescent girls should complete, on average, one additional year of schooling (5.26 years compared to 4.33 years). They were also twice as likely to report that girls should be 18 or older before having their first child, and almost twice as likely to report that girls should be 18 or older before getting married. In interviews, girls said that through the programme they had learned about the appropriate age of marriage, and support they could access to contest their family’s plans for an early or forced marriage.

Adolescent girls’ opinions on working outside the home. This may be because of structural barriers such as lack of work opportunities for refugees or gender norms related to women working after marriage.
resilience and ability to recover from GBV. An important finding, as hope is key to adolescent girls’ confidence in their ability to achieve their goals. This is increased levels of hope, measured in terms of the girls’ strengths. By the end of the programme, girls had their imagination and vision for themselves, and identify opportunity to create artwork. This helped them to explore during the programme, adolescent girls were given the opportunity to create artwork. This helped them to explore their imagination and vision for themselves, and identify their strengths. By the end of the programme, girls had increased levels of hope, measured in terms of the girls’ confidence in their ability to achieve their goals. This is an important finding, as hope is key to adolescent girls’ resilience and ability to recover from GBV.

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. Girls talked about how safe spaces could be useful when they felt unsafe at home and in other spaces in the community.

Despite these encouraging findings, the evaluation did not show a statistically significant reduction in girls’ exposure to GBV, or improvement in girls’ feelings of safety. The programme also didn’t lead to positive changes in the attitudes of adolescent girls towards gender equality or changes in their acceptance of intimate partner violence. Within the timeframe of the study and scope of the programme, this finding is unsurprising. The perseverance of harmful gender attitudes and the normalisation of violence against women and girls require comprehensive, multi-year interventions which involve all levels of society and aim to make sustained shifts in cultural norms.

Methodological issues are also significant; the short time frame of less than one month between the end of the life skills sessions for adolescent girls and the endline data collection meant that girls were asked to report exposure to GBV experienced within the past 12 months, when they had only started the programme eight months before. This means the girls were reporting exposure to violence in the endline survey that they may have experienced before their participation in the programme. It is also significant that parents/caregivers who attended the programme were mainly women, despite the fact that girls living with only one biological parent were predominantly living with their father (43%) rather than their mother (56%). This could suggest that the person who would have the most contact with and influence over the girl was not engaged in the programme. In addition, it is likely that women 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. In future programmes, in order 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.

**Summary of effectiveness and change on adolescent girls**

**COMPASS** had a significantly positive impact on the lives of adolescent girls who completed the programme. As a result, they had a safe place to spend time with other girls and had better support networks, comprising trusted adults and good friends. They had increased expectations for the future regarding education and marriage, and had increased hope for the future.

Although a change in levels of violence was not evident in the short timeframe of the programme, findings indicate that life skills sessions for adolescent girls can increase their wellbeing, resilience and ability to stay safe. These are all important steps to reducing their exposure to violence.

14. 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.

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**Parents/caregivers**

**Relationships between girls and their parents/caregivers improved.** Adolescent girls reported improved relationships with their parents in some aspects. At the end of the programme, adolescent girls in the intervention group were more likely to feel comfortable discussing education, puberty and earning a living in the future than those in the waitlist group. There was no significant difference between the intervention and waitlist groups on conversations about sex and sexual health, including STIs and pregnancy. Continued difficulty to discuss sensitive topics such as sexual health may indicate that additional support is required to help adolescent girls and parents feel comfortable with these subjects. It also emphasises the importance of other sources of information and support for the adolescent girls on sensitive areas.

In interviews, adolescent girls talked about how relationships with family members had improved as a result of COMPASS. However, some adolescent girls attributed this change to modifying their own behaviour so they were more respectful or obedient. This could suggest that adolescent girls from the intervention group have learnt to identify risks, and know how better to navigate them within the home. However, it also implies that adolescent girls believe their own actions are the primary cause of violence against them.

In IRC, we learned to take care of our safety. Adolescent girl, 13 years old, endline interview

My relationship with my family has changed a lot, due to my participation in the programme. Before I began participating in the programme, I often made mistakes and my mother hit me. But now, after I began participating in the programme, I don’t make mistakes at home and nobody hits me.”

Adolescent girl from the Funj ethnic group, 14 years old, Sherkole Refugee Camp

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**Figure 9: Adolescent girls’ comfort talking to parents/caregivers, by topic**

<table>
<thead>
<tr>
<th>Intervention (endline study)</th>
<th>Waitlist (endline study)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>80%</strong> Education</td>
<td><strong>69%</strong> Education</td>
</tr>
<tr>
<td><strong>71%</strong> Earning a living</td>
<td><strong>66%</strong> Earning a living</td>
</tr>
<tr>
<td><strong>71%</strong> Puberty</td>
<td><strong>63%</strong> Puberty</td>
</tr>
</tbody>
</table>

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24 CHAPTER 3: What works for adolescent girls

25 CHAPTER 3: What works for adolescent girls
Adolescent girls’ perception of others’ attitudes: agreement to statements

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Statement Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>girls felt their family would blame them if they were forced to have sex</td>
</tr>
<tr>
<td>22%</td>
<td>girls believed their community would force them to marry the perpetrator if she was forced to have sex</td>
</tr>
</tbody>
</table>

Parents/caregivers retained knowledge about COMPASS topics. In focus groups, parents were asked about COMPASS curriculum topics. This was to assess whether they had retained knowledge, strongly aligned themselves with some key programme messages and felt competent talking about topics covered. Issues around puberty and sexual and reproductive health were particularly difficult areas for parents, so it was important to provide them with extra support to help them to feel comfortable discussing these topics.

In the focus groups, traditional gender norms persisted in some responses from parents. For example, recurring themes included the need for adolescent girls to do household chores and know how to manage a household and children. Parents felt that it was primarily the responsibility of mothers to support their daughters, with fathers having a less important role.

Attitudes on gender and violence remain challenging.

Adolescent girls’ perception of the attitudes of parents and influential community members regarding sexual violence remained similar by the end of the programme, with no significant difference between intervention and waitlist groups (see figure 9).

At the end of the programme, participating parents continued to convey that adolescent girls were themselves ultimately responsible for preventing such violence. Parents also articulated attitudes that physical abuse of wives within the home can sometimes be justified. Such attitudes may explain the similar views about abuse of wives within the home can sometimes be justified. Such attitudes may explain the similar views about abuse of girls believed if they were forced to have sex.

Parents expressed that one way to respond to violence was to consult adolescent girls. This suggests programming may need to make a more concerted effort to overcome entrenched gender norms among adolescent girls, parents and the wider community.

Summary: effectiveness and change of parents/caregivers

Adolescent girls reported some improvements in their relationships with their parents, including feeling more comfortable about discussing some topics covered by COMPASS. Parents also demonstrated strong levels of knowledge of programme areas. However, the attitudes of parents remained challenging: they retained a high acceptance of violence within relationships and a perception that adolescent girls were to blame if they experienced violence. This suggests programming may need to make a more concerted effort to overcome entrenched gender norms among adolescent girls, parents and the wider community.

Service providers

COMPASS helped develop adolescent girl friendly services.

In addition to providing case management services and referrals for adolescent girls who experienced GBV, the IRC trained and worked with existing GBV service providers to help them prevent violence and improve their response to adolescent girls.

Training for health and GBV service providers included:

- Clinical care for sexual assault survivors
- GBV case management services
- Caring for child survivors of sexual abuse
- GBV and Ethiopian law
- Preventing sexual exploitation and abuse
- Interagency standing committee guidelines on GBV
- Skills for communication with GBV survivors

However, at the end of the programme some concerning attitudes still remained among service providers. For example, 42% of service providers agreed or strongly agreed that “girls who go out with boys are putting themselves at risk of violence” and “girls often make up stories about being sexually abused”. In addition, 40% agreed that “sometimes the girl is at fault for the violence she experiences”.

On the more positive side, 92% of service providers agreed or strongly agreed to the following statements: “I am responsible for believing and supporting girls who are abused, no matter what the community thinks!” and “adolescents should be consulted to make treatment and services more effective.” There were also positive scores in areas related to early marriage, education and decision making.

These findings emphasise the importance of specific training on adolescent girls and long-term support and supervision for service providers. Victim blaming attitudes are often deeply entrenched in communities, and it will take time and concerted efforts to transform these harmful social norms.

The IRC also spent a significant amount of time working with schools and education providers. This is because they are essential to empowering adolescent girls and helping them protect themselves. Also, schools and other educational environments are places that can help protect adolescent girls from violence but also potentially increase their risk to it.

Training for schools and education providers was based on the Good School Toolkit (developed by Raising Voices), which focuses on creating safer schools. As a result, education providers in the camps agreed to implement a new code of conduct including a zero tolerance policy to corporal punishment and sexual harassment.
Adolescent girls had increased knowledge of GBV services, and used these services more.
The external evaluation found the programme significantly increased knowledge of GBV services. Adolescent girls in the intervention group were 86% more likely than the waitlist group to report knowing a place to go for help if a girl had experienced sexual violence; they were also 120% more likely to know a place if physical violence occurred. In interviews, adolescent girls often responded to hypothetical cases of girls experiencing violence by suggesting they access IRC’s GBV, health and legal services. However, despite these positive changes, at the end of the programme still only 43% of adolescent girls from the intervention group knew where to go if they had experienced sexual violence, suggesting there is still a long way to go to achieve the desired goal in this area (see figure 13).

The use of professional services by women and girl survivors of violence in programme locations was monitored through the GBV Information Management System (GBV IMS). Prior to the start of the programme, fewer than five adolescent girls in intervention areas had accessed health and case management services, but by July 2016 more than 20 girls had done so. This suggests that continued activities to raise awareness of available services among adolescent girls and parents, coupled with efforts to strengthen the quality of these services, led to an increase in their use.

According to monitoring data, parents’ knowledge of services and willingness to use them also improved over the course of the programme. Prior to the programme 68% of parents identified a professional service when asked where a girl should go if someone had hurt her; by the end of the programme this figure had risen to 95%, with 80% of parents specifically naming IRC services. Findings from the baseline study highlighted that adolescent girls are likely to go to their parents first if something happens to them, so this finding is very encouraging. COMPASS improved the knowledge and acceptance of professional services as a source of support for adolescent girls among parents, and built up trust in the services the IRC provides.

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### Summary: effectiveness

Ongoing training and support resulted in schools adopting a new code of conduct including a zero tolerance policy towards corporal punishment and sexual harassment.

Training delivered to health and GBV case management service providers improved their attitudes towards adolescent girls, although some providers tended to still blame the girls if they experienced violence.

The programme increased adolescent girls’ knowledge and willingness to use services, and parents, who tend to be gatekeepers to accessing services, displayed an increased knowledge of services that could help adolescent girls in the event of sexual and physical violence, and particularly IRC services.

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15. The data and statistics represented here only include information from survivors who have consented to share their aggregate information, as collected through the Gender-based Violence Information Management System. Data reported include all survivors accessing services in these areas, not just those participating in COMPASS. This data has been reported internally and should not be considered to represent the prevalence of violence.
Feasibility and acceptability

By definition, refugee populations tend to be in a state of flux, with high levels of mobility, uncertainty and instability. Programming specifically targeting adolescent girls and focusing on topics such as puberty, sexual health, healthy relationships and violence can be controversial and met with resistance in some communities. 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.

Enrolment and attendance

High enrolment demonstrated that COMPASS filled an unmet need. Enrolment rates are a good indication of accessibility and interest in the programme, both whether adolescent girls and parents were able to access the safe spaces at the specified time, and whether they had the motivation to do so.

Enrolment was initially conducted by providing information to the community about the upcoming programme, its purpose, content and target group. House-to-house visits were then conducted to reach as many adolescent girls as possible, and parents were provided with further information and invited to sign up to the programme. The IRC also received referrals from Save the Children to ensure the inclusion of the most vulnerable adolescent girls. In total, 333 adolescent girls in Sherkole, 348 in Bambasi and 297 in Tongo were enrolled to the programme’s first cycle.

Due to the diversity of languages across the three camps, a language assessment was carried out to identify the most common languages. Figure 14 shows the diversity of languages spoken by enrolled adolescent girls. Initially, there was some misunderstanding as to why some languages, which are often aligned to ethnic group, were selected for the evaluation over others, so the team enhanced sensitisation and information activities to reassure communities that there was no selection bias. The camp authority, ARRA, and UNHCR were included in the enrolment process for the second cycle, minimising tensions and ensuring no groups felt excluded.

Adolescent girls were asked to identify a parent/caregiver of their choice to attend the COMPASS parent/caregiver group discussions. As shown in figure 15, the majority were the mothers of the adolescent girls (61%), though a large proportion of fathers also enrolled (33%).

16. Note that these are only the languages spoken by girls who participated in the evaluation. The total number of languages spoken by girls participating in the programme is significantly higher (see Table 1 and Annex 4, Figure 11).
High attendance demonstrated the feasibility and acceptability of the programme. Attendance data provides a strong insight into feasibility and acceptability of this programme, as it shows whether adolescent girls and parents could access safe spaces at specified times, and whether they had the motivation to do so. Reasons of non-attendance and drop-out can point to possible barriers to participating in the curriculum.

Overall, session attendance of adolescent girls during the first cycle was very high (83%) across all three camps. The most common reasons for missing sessions were that adolescent girls had moved or left the camp (14% of all non-attendance), health issues (10%), household chores (7%) and getting married, becoming pregnant or giving birth (8%). In total, 21 adolescent girls out of 978 missed one or more sessions because of these reasons. In addition, some of the sessions clashed with other camp activities such as food ration distribution and other non-governmental organisation (NGO) events, such as 16 days of activism against GBV. This led to field teams improving the scheduling of COMPASS sessions. Adolescent girls also became more positive about COMPASS, and were subsequently more likely to attend sessions, as they became more familiar with it.

In total, only 59 of 978 adolescent girls dropped out of the programme (6% of the total). About three quarters of drop-outs were due to them leaving the camp. However, a few of the adolescent girls stated that attending the programme had been forbidden by their parent or their husband. A very small number of adolescent girls reported not liking the topics and not having time to attend.

Parent/caregiver attendance was high. Parent attendance throughout the programme was also very high (91%) across all three camps. One parent/caregiver per adolescent girl was invited to attend, as selected by the adolescent girl, and on the assumption that they would attend all of the sessions. In some cases a different parent/caregiver would attend different sessions for the same adolescent girl, meaning each individual only received part of the curriculum. It is likely that this was decided by the parents’ availability, given that parents are likely to be responsible for collecting the food ration, attending community events, household chores and, in some cases, generating income.

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Acceptability to parents and community members

The programme was widely accepted by adolescent girls, parents and community members, and ongoing communication by the IRC helped to improve its perceived value. Parents talked about some negative programme rumours, which were more common at the beginning of the programme, including that adolescent girls attended the programme to meet boys. These rumours became less common as the programme gained a more positive reputation.

Facilitators reported receiving positive feedback in parent group discussions, with parents saying that the programme had improved their own knowledge and created positive behavioural change in their daughters. Facilitators reported that parents were committed to being positive towards and supportive of their daughters.

Summary of feasibility and acceptability

Thanks to committed enrolment activities and ongoing communication work, the IRC was able to reach and sustain the participation of nearly 1,000 adolescent girls in the first cycle, including the most vulnerable. Attendance of the sessions by adolescent girls and their parents was very high, suggesting accessibility as well as enjoyment, usefulness and relevance. Adolescent girls themselves confirmed this, reporting that they enjoyed the sessions, though there were some misconceptions about the programme among wider community members. This learning suggests that adolescent girl programming is feasible and acceptable in this context: adolescent girls had the interest in and ability to attend COMPASS, their parents were engaged, and wider communities showed acceptance of their participation.

Lessons from implementation

Implementing the programme in refugee camps with diverse populations, multiple languages and low literacy required ongoing adaptations and high levels of resources. This section outlines lessons learnt on the programme side, particularly in relation to mentor capacity and support, tools for delivering the curriculum and adolescent girls’ views on what worked.

Contextualising a life skills programme

Curricula had to be designed and implemented in a way that acknowledged the diversity of adolescent girls, and responded to their feedback. Though the teams were able to mobilise communities and generate demand for the programme, there were also challenges in delivering the curriculum in a safe and effective way. When consulted about the location of the safe spaces, adolescent girls said they wanted somewhere that was specifically for adolescent girls. Traditional round huts called tukuls were constructed in each camp for the adolescent girl groups, which were themselves located within Women and Girls Wellness Centres: safe, female-only compounds with case management services available on-site.

Language barriers were also an issue with parents. To overcome this challenge, parent group discussions were facilitated by IRC staff, working alongside trained female and male translators/facilitators aged 18–30 years. These translators/facilitators were also refugees and spoke the same languages as the participants.

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 writing and drawing skills.

Language was a major challenge. Following the language assessment and some consultation, it was decided that the curriculum would be translated into Meban and informal Arabic (the working language of all the camps) and audio recorded, in a bid to overcome the challenge of people’s literacy and use of non-written languages. Groups listened to the audio recording and discussed the key points afterwards in their ethnic language. Discussion was supported by visual materials, including pictures and photographs. Where adolescent girls’ understanding of informal Arabic was low, sessions took much longer, as much of the content had to be repeated in full. While this approach addressed one challenge, it created others: namely the creation of the audio files took considerable time and human resources and required specialised equipment that could be used without a power source, such as laptops/tablets and chargeable speakers.

Lessons from implementing the programme in refugee camps with diverse populations, multiple languages and low literacy required ongoing adaptations and high levels of resources. This section outlines lessons learnt on the programme side, particularly in relation to mentor capacity and support, tools for delivering the curriculum and adolescent girls’ views on what worked.

Alewya, 14, lives in Bambasi 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.

“A adolescent girls need to come to the safe space to learn and to make friends.”

Alewya, 14

“Adolescent girls need to come to the safe space to learn and to make friends.”

Alewya, 14

CHAPTER 3: What works for adolescent girls
Summary of programme components

Engaging mentors who come from the same community as the adolescent girls was important, as it allowed the girls to connect with someone of a similar background and encouraged a continuing relationship beyond the COMPASS sessions. A high level of training and support was required to enable the mentors to deliver the curriculum, but this investment paid off. The curriculum, delivered in multiple languages with audio and visual teaching aids, was adapted in real time throughout the first cycle, responding to the adolescent girls’ and mentors’ feedback and other learning from implementation. A key component of delivering adolescent girls’ life skills sessions in such a diverse population was careful monitoring, and flexibility and responsiveness to ongoing learning. High levels of time and resources were required to do this, but this approach ensured potential barriers to engagement were overcome as they emerged.

Supporting young refugee mentors

Mentors were women aged 18–30, who lived in the same camps and spoke the same languages as the adolescent girls, and held positive attitudes towards working with them. Many of these young women were not literate and had little education themselves. Much support and training was required to prepare them for their work with COMPASS, and additional mentors were required to cover those who needed extra support in delivering the curriculum, or were away for periods of the implementation, for example, because of pregnancy/child birth.

During the initial sessions, mentors were not confident enough to lead the sessions by themselves, and as a result an IRC staff member was present in all sessions for almost two months. However, during programme monitoring sessions with mentors, IRC staff provided technical support and ongoing training which resulted in the mentors’ capacity improving, and eventually their facilitation skills and commitment reached a level at which they could deliver sessions independently and confidently. IRC staff met weekly with the mentors to review the previous session and plan for the next one.

The participatory approaches used in COMPASS sessions were new for both the mentors and the adolescent girls, and at the beginning the girls were very shy, low in self-confidence and uncomfortable among new people. As the mentors gained confidence, they were able to encourage the adolescent girls to participate, and mentors reported seeing the confidence of the girls improve as well. Adolescent girls developed trust and good interpersonal relationships with mentors, and started to seek help regarding challenges in their lives. In interviews, adolescent girls spoke highly of their mentors.

Anecdotal evidence suggests mentors have themselves benefited from taking part in COMPASS, in terms of what they learned and their status in the community. Further assessments are being conducted in subsequent COMPASS cycles to establish the effects of participating in the programme for mentors.
CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS

This chapter summarises the key conclusions from the implementation and evaluation of COMPASS in Ethiopia and makes recommendations to donors, practitioners and other relevant stakeholders on supporting a programming and learning for adolescent girls in humanitarian settings.
Adolescent girls in refugee camps are experiencing high levels of GBV.
- Nearly half (45%) of adolescent girls in the camps reported experiencing sexual violence at some point in their lives. Nearly 1 in 5 (18%) had experienced rape.
- Over half (52%) of girls in the camps reported having experienced GBV in the past 12 months; 25% reported experiencing sexual violence, 30% reported experiencing physical violence, 36% reported experiencing emotional abuse; 48% reported feeling unca red for.
- Younger girls reported higher levels of victimisation: adolescent girls aged 13-14 were more than twice as likely to report ever experiencing sexual exploitation compared to girls aged 15-19.
- Perpetrators were overwhelmingly male intimate partners (43%), followed by parents (26%). Over one in four girls (28%) did not feel safe in the home.

COMPASS improved the lives of adolescent girls. As a result of participating in the programme, adolescent girls had increased awareness about GBV services, stronger social networks, and improved expectations and hope for the future.
- Adolescent girls expressed a clear demand for the tailored support provided by COMPASS. They expressed high levels of interest in enrolling, and participated actively in the programme. Girls’ feedback was very positive; every participant (100%) said they felt happy at the life skills sessions.
- COMPASS’s strong retention of adolescent girls and the absence of similar adolescent-girl-specific programming highlights the need for programmes which aim to understand and meet the particular needs of adolescent girls in humanitarian settings.
- 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.
- There was also 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.

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 with a variety of ethnic groups, resulting in implementation in multiple languages and with girls and families with very different cultural backgrounds.
- The programme, including curriculum content and delivery, had to be responsive and flexible. This required time, space, resources and different methods to monitor progress, and learn and adapt accordingly. For example, sessions were delivered through audio recordings because many girls spoke non-written languages.
- COMPASS provided a space where adolescent girls’ unique perspectives were heard. Their voices helped shape adaptations to the programme to meet their needs safely and effectively. For example, direct input from the girls determined the location of safe spaces and the design and delivery of the curriculum.

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 amongst 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. 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.

COMPASS has made a valuable contribution to the evidence of what works to promote the health, safety, wellbeing and empowerment of adolescent girls in humanitarian settings. However, further programme development and learning is needed to increase understanding of which strategies and interventions are most effective in reducing GBV against adolescent girls in humanitarian settings.
- The evaluation did not show a reduction in girls’ exposure to GBV. This could be due to the limited scope of COMPASS to transform deeply entrenched gender norms.
- The evaluation showed that girls and mothers continued to hold attitudes that accepted gender inequality at the end of the programme.
- There were also limitations in the methodology of the evaluation, most importantly, the short time frame (less than 1 month) between the end of the interventions for adolescent girls and parents and the endline data collection. This is significant due to the fact that in the endline survey adolescent girls were asked to report exposure to violence experienced within the past 12 months and had only started COMPASS eight months before. This means the girls were reporting exposure to violence in the endline survey that they may have experienced before or during their participation in the programme.
- These findings suggest that to see meaningful shifts in GBV against adolescent girls and harmful attitudes and behaviours towards young survivors, it’s necessary to address wider community and family norms. This underlines the need for further learning that builds on COMPASS learning and explores the impact of social and behavioural change programming.
Recommendations

IRC makes the following recommendations to donors and other relevant stakeholders, (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 other relevant stakeholders should commit to the development of a strategy 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 studies 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 other relevant stakeholders to define and adopt a comprehensive approach to transform girls’ lives. It should include 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 other relevant stakeholders 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. 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 in humanitarian settings should be given a safe space 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, GBV service providers other relevant stakeholders 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, practitioners and other relevant stakeholders 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 academics should pilot further programmes and studies 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 more studies to better understand the role that male and female parents/caregivers can play in GBV reduction. In particular, they 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. Studies 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 academics should continue to invest in studies 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 evaluations to be carried out on pilot programming. 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 academics should prioritise the following areas of study 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 evaluation methods to better understand the needs of younger adolescent girls in order to inform programming.
Hypothesis

The study is based on the hypothesis that adolescent girls' participation in COMPASS will reduce their risk of being exposed to violence in comparison to adolescent girls who do not participate in the programme. The overall aim of the study is to understand the feasibility, acceptability and effectiveness of safe space programming in humanitarian settings. The specific study 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 what areas of the adolescent girls' life skills sessions most effectively prevent violence and improve 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 from parents/caregivers
- reduction in adolescent girls' experiences of sexual abuse and exploitation
- reduction in adolescent girls' experiences of intimate partner violence
- increase in adolescent girls' skills and power to reduce the risk of experiencing violence
- increase in number of peers and adults adolescent girls can turn to for emotional support.

For the purposes of assessing the intervention, the evaluation 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.

Primary outcomes:

The four primary outcomes of interest are if adolescent girls experienced any form of sexual violence, forced sex, unwanted sexual touching or coerced sex in the past 12 months. All primary outcomes are self-reported and binary, and experiencing any form of sexual violence is a composite of forced sex, unwanted sexual touching and coerced sex.

Secondary outcomes:

Secondary outcomes of the study are: experiencing physical violence, emotional violence, engaging in exploitative sex and entering into early marriage in the past 12 months. Early marriage is defined as getting married before 18. A number of other secondary outcomes were also included in the external evaluation:

- Gender norms and attitudes: adolescent girls' attitudes towards gender equity, including equity and power in intimate relationships and household decision-making, were measured using five items from the Gender Relations Scale.
- Attitudes towards intimate partner and sexual violence: five statements from UNICEF's Multiple Indicator Cluster Survey (MICS) module on attitudes towards intimate partner violence (IPV) were used to assess adolescent girls' attitudes towards the acceptability of IPV, and two items assessed adolescent girls' attitudes towards sexual violence.
- Confidence and decision-making: assessed using the Rosenberg self-esteem scale, a 10-item Likert-scale measure which asked girls to "Strongly agree", "Agree", "Disagree" or "Strongly disagree" with statements such as "I feel that I have a number of good qualities".
- Future orientation: assessed by asking adolescent girls what level or grade they think a girl should complete before leaving school, at what age a girl should have her first child, and whether they thought girls could work outside the home, even after marriage.
- Perceived social support: captured using three indicators – two binary variables regarding whether an adolescent girl reports having friends and whether she has a trusted non-family female adult in her life who she can talk to, and a categorical variable representing the number of friends a respondent reported having (0, 1–3, 4–10 or more than 10).
- Feelings of safety: the external evaluation examines if the intervention changed girls' self-reported feelings of safety in their home, at school, at a friend's house and at a neighbour's house, and whether they feel they have access to a safe place to spend time with other girls.
- Knowledge of services: adolescent girls were asked whether they knew of a place where girls could go to for help if they experienced sexual violence, or if they had been hit by someone else.

Study design overview

The study design is a two-arm randomised control trial involving three refugee camps: Sherkole, Bambasi and Tongi in the Benishangul-Gumuz region of Ethiopia. The estimated sample size was 704 adolescent girls, assuming a power of 80%, two-sided alpha of 0.05, a design effect of 0.0, and with the intention of detecting a Cohen's effect size of 0.3 on sexual violence between treatment and control arms. In anticipation of a 10% study refusal rate at onset and 25% attrition over the 12-month period of follow-up, the target enrolment was 940 adolescent girls.

Following programme enrolment and the completion of baseline data collection, adolescent girls were randomly assigned to two groups: 1) intervention group – adolescent girls receive life skills sessions and parents/caregivers take part group discussions, 2) waitlist group – no intervention provided. A baseline survey was conducted with 919 girls in August 2016, and an endline survey was conducted in August 2016. Qualitative focus group discussions and participatory activities were also conducted with girls and parents/caregivers at the beginning and end of the programme. This report focuses on the endline findings, and in particular what impact the intervention had on primary and secondary outcomes for adolescent girls.

Inclusion and exclusion criteria and participant recruitment

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 Tongi 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 study. Girls were excluded if they lacked verbal proficiency in Fungi, Regarig, Ingessana Kulele or Maban. Language exclusion criteria was based on the primary languages spoken by girls in the camps, as well as data collectors' language abilities. Individuals with significant cognitive impairments or physical disabilities were excluded for ethical reasons.

Following completion of baseline data collection (July to September 2016), adolescent girls were divided into programme groups of 20 to 25 girls, based on household proximity, age (13–14 or 15–19 years), and primary language. Sixty-two groups were randomly chosen to be an intervention or waitlist group using uniform distribution. Randomisation was conducted separately for each language and age group within each camp. To reduce the potential of contamination, siblings were randomised to the same group. Programme groups including sisters in different age brackets were paired together and randomised to the same intervention or waitlist group.

Ethics

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 evaluation activities.

Columbia University's Institutional Review Board (IRB), IRC’s Institutional Review Board and the Administration for Refugees and Returnee Affairs (ARRA), the government body responsible for refugee populations, approved the study.

Measures and tool development: formative study

Columbia University and the IRC conducted formative study 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 vulnerabilility, and the acceptability of baseline evaluation tools. This formative study included extensive work to understand what languages girls spoke, and what languages were likely to be most successful for communicating the conditions that were likely to be included in the baseline survey. Pictographs also included testing the qualitative activities intended for the baseline study, to determine cultural relevance and ease of understanding.

The formative study 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. Data collectors 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 data collection tools was developed.
the qualitative and quantitative tools was presented to the IRC, and the final tools were created based on IRC feedback. Columbia University data collectors. Qualitative tools that were developed for the baseline study were piloted, including nine participatory activities, one in-depth interview with girls, and three in-depth interviews with 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 evaluations needed to be conducted in, and to select the most appropriate 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 Kulele, Fury/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. Data collectors 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 were assigned to participate in each survey horizontally and vertically. The interview was administered to participants using Audio Computer Assisted Self-Interviewing (ACASI) computer programs. An audio-visualised selection process included 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 Kulele, Fury/Berta, Maban and Regarig. The survey instrument included modules on demographics, feelings of safety, experience of violence, gender roles, and social networks. Measurement of all domains of the survey is presented throughout this report.

The evaluation team employed a series of methods to track and retain adolescent girls in both the intervention and waitlist groups. In particular, the team checked in with programs, where a girl would hear survey questions and waitlist groups. In particular, the team checked in with

Data analysis

The evaluation team conducted an intent-to-treat analysis on all individuals surveyed at the beginning and end of the programme, according to whether they were in the intervention or waitlist group. Logistic regression models were used to estimate the effect of the intervention on primary and secondary outcomes at the end of the programme. All effects of the intervention on the outcomes of interest at the end of the programme were first estimated; these associations were then studied separately, according to adolescent girls’ outcome of interest at the beginning of the programme. The latter made it possible to determine whether the intervention affected adolescent girls differently who reported different vulnerabilities at the beginning of the programme, for example, whether a girl who was not living with her mother at baseline was impacted by the intervention differently to a girl who was living with her mother at baseline.

After calculating unadjusted odds ratios (ORs), data collectors controlled for a set of factors expected to be correlated with outcomes in order to estimate adjusted odds ratios (aORs). We controlled the following factors 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 adolescent girls’ self-report of the outcome of interest at the beginning of the programme. All analysis was conducted using Stata version 12.

All the qualitative transcripts were translated and transcribed by the qualitative team in Ethiopia. Qualitative transcripts were then analysed using inductive thematic analysis. The evaluation team developed a basic coding scheme with responses from the data coded into descriptive codes. The initial descriptive codes were discussed, evaluated and reconfigured by the evaluation 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. Narrative data were analysed in NVivo 10.1.

In total, 1,938 adolescent girls and 1,876 of their parents/caregivers were enrolled in the programme over the course of two cycles. Life skills sessions brought together a diverse range of adolescent girls: those who were in and out of school, married and unmarried, with children and without, and from many different ethnic groups.

Adolescent girls included in the evaluation spoke one of four languages (Fury/Berta, Ingessena Kulele, Maban or Regarig). But adolescent girls who spoke any language were invited to enrol in the wider programme. According to the baseline results (N=919 adolescent girls), the vast majority of adolescent girls in the first programme cycle (88%) were living with at least one parent, with 43% living with only their father and 26% living with only their mother. At the beginning of the project, nearly 60% of adolescent girls were unmarried and not living with a man if they were married.

During programme enrolment, girls were asked whether they were married. Those that said they were married were not included in the evaluation. However, in the baseline survey nearly 27% reported being married, and 5% of girls said they were living with a man as if married. It is likely that the concept of marriage varies within the cultures in the camp, and it is possible that girls reported being married when they were ‘promised’ to someone, or living with someone as if married. It is also possible that, as a result of participating in the programme, girls understood that early marriage was illegal and were therefore more reluctant to report it. This has important programming implications, as girls who are already married may need different messaging and support than unmarried girls, and understanding a girls’ relationship status may be an important indication of her risk of exploitation and violence.

Only 69% of adolescent girls in the baseline survey said they had attended school, of which 79% had attended school in the past year. On average, girls had completed fewer than three years of school in their home country, and slightly more than three years of school in the camp. Girls who weren’t attending school gave domestic responsibilities, school costs, marriage, pregnancy and family disapproval as reasons for non-attendance.

Almost 40% of girls in the baseline survey had spent one or more nights working for money or other payment (doing housekeeping, childcare, making handicrafts or farm work), and the vast majority of girls (92%) had worked without pay in the past 12 months (again doing housekeeping, childcare, making handicrafts or farm work).
ANNEX 3: 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**
- Lack of safe and empowering opportunities for adolescent girls to increase their resilience to violence.
- Negative attitudes and lack of capacity of service providers to meet the needs of adolescent girls at risk of violence.
- Negative beliefs, attitudes and behaviour among girls’ family members, partners, etc. that increase risk of violence.
- Weak knowledge base on prevention of and response to violence against adolescent girls in humanitarian settings.

**Interventions**
- Provide opportunities for girls to protect against and respond to violence through mentorship and peer interaction in safe spaces.
- Implement capacity building activities to improve the attitudes, skills and practices of service providers.
- Conduct targeted engagement (e.g., discussion sessions) with girls’ family members, partners, etc. to change negative beliefs, attitudes and behaviours.
- Conduct monitoring and evaluation to produce applicable and transferable learning for the broader humanitarian community.

**Outputs**
- Girls have increased human, social, physical and financial assets to protect themselves from violence and respond to threats of incidents of violence.
- Existing service providers (e.g., health, education, case management) have increased capacity to provide safe, girl-friendly and life-saving services.
- Influential people in girls’ lives have improved attitudes, knowledge and skills to protect girls from violence and support girls to be safe from violence.
- 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.

**Outcomes**
- 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.

**Impact**
- 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.

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ANNEX 4: TABLES

**Table 1. Demographics of adolescent girls, according to the baseline study**

<table>
<thead>
<tr>
<th>Total (N = 919)</th>
<th>Intervention (N = 427)</th>
<th>Control (N = 492)</th>
<th>OR p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age (average)</td>
<td>14.61</td>
<td>14.66</td>
</tr>
<tr>
<td></td>
<td>% (n)</td>
<td>90%</td>
<td>91%</td>
</tr>
<tr>
<td>Languages spoken</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ingessena Kulelek</td>
<td>93</td>
<td>10.12</td>
<td>52</td>
</tr>
<tr>
<td>Funj</td>
<td>609</td>
<td>66.27</td>
<td>327</td>
</tr>
<tr>
<td>Maban</td>
<td>154</td>
<td>16.76</td>
<td>68</td>
</tr>
<tr>
<td>Regarig</td>
<td>63</td>
<td>6.86</td>
<td>10</td>
</tr>
<tr>
<td>Marital status</td>
<td>NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmarried</td>
<td>527</td>
<td>57.41</td>
<td>258</td>
</tr>
<tr>
<td>Married and living with partner</td>
<td>149</td>
<td>16.23</td>
<td>73</td>
</tr>
<tr>
<td>Married and not living with partner</td>
<td>97</td>
<td>10.57</td>
<td>53</td>
</tr>
<tr>
<td>Living with partner as if married</td>
<td>53</td>
<td>5.77</td>
<td>19</td>
</tr>
<tr>
<td>Living with a biological parent</td>
<td>NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both parents</td>
<td>375</td>
<td>18.81</td>
<td>79</td>
</tr>
<tr>
<td>Mother only</td>
<td>240</td>
<td>26.49</td>
<td>106</td>
</tr>
<tr>
<td>Father only</td>
<td>395</td>
<td>43.03</td>
<td>196</td>
</tr>
<tr>
<td>Neither parent</td>
<td>72</td>
<td>7.84</td>
<td>26</td>
</tr>
<tr>
<td>Education</td>
<td>NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever attended school</td>
<td>637</td>
<td>69.31</td>
<td>320</td>
</tr>
<tr>
<td>Enrolled in school in last year</td>
<td>502</td>
<td>78.81</td>
<td>260</td>
</tr>
<tr>
<td>(mean) (sd)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of school completed in Sudan/South Sudan</td>
<td>2.81</td>
<td>1.95</td>
<td>2.81</td>
</tr>
<tr>
<td>Years of school completed in Ethiopia</td>
<td>3.03</td>
<td>1.92</td>
<td>3.03</td>
</tr>
<tr>
<td>Reasons for non-enrolment in last school year</td>
<td>NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family could not afford</td>
<td>29</td>
<td>19.73</td>
<td>10</td>
</tr>
<tr>
<td>Girl pregnant or married</td>
<td>20</td>
<td>13.61</td>
<td>8</td>
</tr>
<tr>
<td>Too many household responsibilities</td>
<td>34</td>
<td>23.13</td>
<td>17</td>
</tr>
<tr>
<td>School late/far school in proximity</td>
<td>12</td>
<td>8.16</td>
<td>4</td>
</tr>
<tr>
<td>Family does not approve</td>
<td>17</td>
<td>11.56</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>7.48</td>
<td>4</td>
</tr>
</tbody>
</table>
**Figure 2. Girls’ reported experience of physical violence, emotional abuse, and neglect in the last 12 months**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(N) (%)</td>
<td>N (n)</td>
<td>N (n) (%)</td>
<td>N (n) (%)</td>
</tr>
<tr>
<td><strong>Physical violence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beaten or hit in past 12 months</td>
<td>830</td>
<td>296 (35.47)</td>
<td>415</td>
<td>127 (30.90)</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screamed at loudly or aggressively in past 12 months</td>
<td>839</td>
<td>303 (36.11)</td>
<td>435</td>
<td>152 (35.76)</td>
</tr>
<tr>
<td>Neglect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt uncared for in past 12 months</td>
<td>807</td>
<td>380 (47.48)</td>
<td>404</td>
<td>192 (47.52)</td>
</tr>
<tr>
<td>Frequency in past 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>373</td>
<td>172 (46.11)</td>
<td>183</td>
<td>46 (25.14)</td>
</tr>
<tr>
<td>Never</td>
<td>373</td>
<td>80 (21.73)</td>
<td>183</td>
<td>46 (25.14)</td>
</tr>
</tbody>
</table>

**Figure 3. Girls’ reported experience of sexual violence**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(N) (%)</td>
<td>N (n)</td>
<td>N (n) (%)</td>
<td>N (n) (%)</td>
</tr>
<tr>
<td>Ever experienced any form of sexual violence</td>
<td>843</td>
<td>378 (44.84)</td>
<td>412</td>
<td>191 (46.36)</td>
</tr>
<tr>
<td>Experienced any form of sexual violence in the past 12 months</td>
<td>740</td>
<td>215 (29.05)</td>
<td>389</td>
<td>104 (26.81)</td>
</tr>
</tbody>
</table>

**Figure 4. Adolescent girls’ agreement to statements**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(N) (%)</td>
<td>N (n)</td>
<td>N (n) (%)</td>
<td>N (n) (%)</td>
</tr>
<tr>
<td>Female are responsible for avoiding pregnancy</td>
<td>829</td>
<td>414 (49.94)</td>
<td>411</td>
<td>203 (49.59)</td>
</tr>
<tr>
<td>Men should have the final word about decisions in his home</td>
<td>833</td>
<td>456 (54.81)</td>
<td>419</td>
<td>201 (48.39)</td>
</tr>
<tr>
<td>Women should tolerate violence to keep the family together</td>
<td>835</td>
<td>484 (57.96)</td>
<td>411</td>
<td>247 (60.10)</td>
</tr>
<tr>
<td>A man can hit his wife if she will not have sex with him</td>
<td>814</td>
<td>282 (34.64)</td>
<td>403</td>
<td>135 (33.50)</td>
</tr>
<tr>
<td>Men and females should share household chores*</td>
<td>834</td>
<td>569 (68.23)</td>
<td>416</td>
<td>293 (70.43)</td>
</tr>
</tbody>
</table>

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

**Figure 5. Expectations of adolescent girls their age**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(N) (%)</td>
<td>N (n)</td>
<td>N (n) (%)</td>
<td>N (n) (%)</td>
</tr>
<tr>
<td>Appropriate age to marry</td>
<td>873</td>
<td>479 (54.87)</td>
<td>436</td>
<td>246 (56.55)</td>
</tr>
<tr>
<td>Appropriate age to have first child</td>
<td>864</td>
<td>441 (51.04)</td>
<td>427</td>
<td>227 (53.18)</td>
</tr>
<tr>
<td>Do you think it is okay for a girl try to earn money or have a job outside of the home, even after marriage?</td>
<td>845</td>
<td>489 (57.87)</td>
<td>426</td>
<td>246 (56.75)</td>
</tr>
</tbody>
</table>

**Figure 6. Adolescent girls’ agreement to statements on social networks**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(N) (%)</td>
<td>N (n)</td>
<td>N (n) (%)</td>
<td>N (n) (%)</td>
</tr>
<tr>
<td>Have female friends their age outside the family</td>
<td>829</td>
<td>546 (66.82)</td>
<td>403</td>
<td>309 (76.37)</td>
</tr>
</tbody>
</table>

**Figure 7. Adolescent girls’ aspirations**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(N) (%)</td>
<td>N (n)</td>
<td>N (n) (%)</td>
<td>N (n) (%)</td>
</tr>
<tr>
<td>What grade in school do you think a girl should complete before leaving school?</td>
<td>883</td>
<td>4.23 (3.25)</td>
<td>436</td>
<td>4.28 (3.26)</td>
</tr>
</tbody>
</table>

ANNEX 4: Tables

51
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.

**Table 8. Intent-to-treat analysis of adolescents’ perception of others’ attitudes: agreement to statements**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(%) agree</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My family would blame me if I was forced to have sex</td>
<td>772</td>
<td>165</td>
<td>21.37</td>
<td>394</td>
</tr>
<tr>
<td>My community would force me to marry a man if he forced me to have sex</td>
<td>773</td>
<td>226</td>
<td>29.62</td>
<td>393</td>
</tr>
<tr>
<td>I have someone in the community I would trust to talk to if I was forced to have sex</td>
<td>786</td>
<td>356</td>
<td>45.93</td>
<td>391</td>
</tr>
</tbody>
</table>

**Table 9. Percentage of girls who knew where to go if they had been hurt**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(%) agree</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Know of a place to go for help if a girl experienced sexual violence</td>
<td>766</td>
<td>383</td>
<td>49.59</td>
<td>395</td>
</tr>
<tr>
<td>Know of a place to go for help if a girl experienced physical violence</td>
<td>769</td>
<td>383</td>
<td>49.39</td>
<td>395</td>
</tr>
</tbody>
</table>

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 8. Adolescent girls’ comfort talking to parents/caregivers, by topic**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(%) agree</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>780</td>
<td>587</td>
<td>75.73</td>
<td>385</td>
</tr>
<tr>
<td>Earning a living</td>
<td>776</td>
<td>533</td>
<td>68.69</td>
<td>393</td>
</tr>
<tr>
<td>Marriage</td>
<td>754</td>
<td>410</td>
<td>54.64</td>
<td>391</td>
</tr>
<tr>
<td>Puberty</td>
<td>777</td>
<td>521</td>
<td>67.06</td>
<td>394</td>
</tr>
<tr>
<td>Sex</td>
<td>755</td>
<td>321</td>
<td>42.52</td>
<td>382</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>755</td>
<td>321</td>
<td>42.52</td>
<td>382</td>
</tr>
</tbody>
</table>

**Figure 10. Percentage of girls who knew where to go if they had been hurt**

<table>
<thead>
<tr>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>OR</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>(%) agree</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Know of a place to go for help if a girl experienced sexual violence</td>
<td>792</td>
<td>280</td>
<td>36.10</td>
<td>390</td>
</tr>
<tr>
<td>Know of a place to go for help if a girl experienced physical violence</td>
<td>794</td>
<td>363</td>
<td>46.34</td>
<td>395</td>
</tr>
</tbody>
</table>

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.
ANNEX 5: COMPASS
JOURNAL ARTICLES


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 evidence on the experiences of adolescent girls facing emergencies, evidence 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.13,14

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

1. Engages with the most vulnerable and isolated adolescent girls
2. Assesses for the most pertinent risks and dangers for adolescent girls in each context
3. Involves adolescent girls in all aspects of program design and implementation
4. Strengthens protective mechanisms that include the key stakeholders impacting the lives of girls
5. 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.13,14

2. The Girl Shine Life Skill Groups.
   The Girl Shine life skill 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.17

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 program and other critical services.

This resource package is presented in four parts:

   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.

   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.

17. An asset is a store of value that is related to what a person can do or be (their “human stock”). Building Assets Toolkit: Developing Positive benchmarks for Adolescent Girls. Population Council 2015.


v UNOCHA. South Sudan Crisis: Situation Report. (as of 11 September 2014)


xii CCSAS resource: https://www.dropbox.com/s/ho1k2806encgwko/Facilitator%E2%80%99s%20guide%20(English).pdf


xiv Learn more about Raising Voices here http://raisingvoices.org/
