Global Executive summary

A Safe Place to Shine

Creating Opportunities and Raising Voices of Adolescent Girls in Humanitarian Settings

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

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

EXECUTIVE SUMMARY

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

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

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

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

COMPASS included the following core interventions:

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

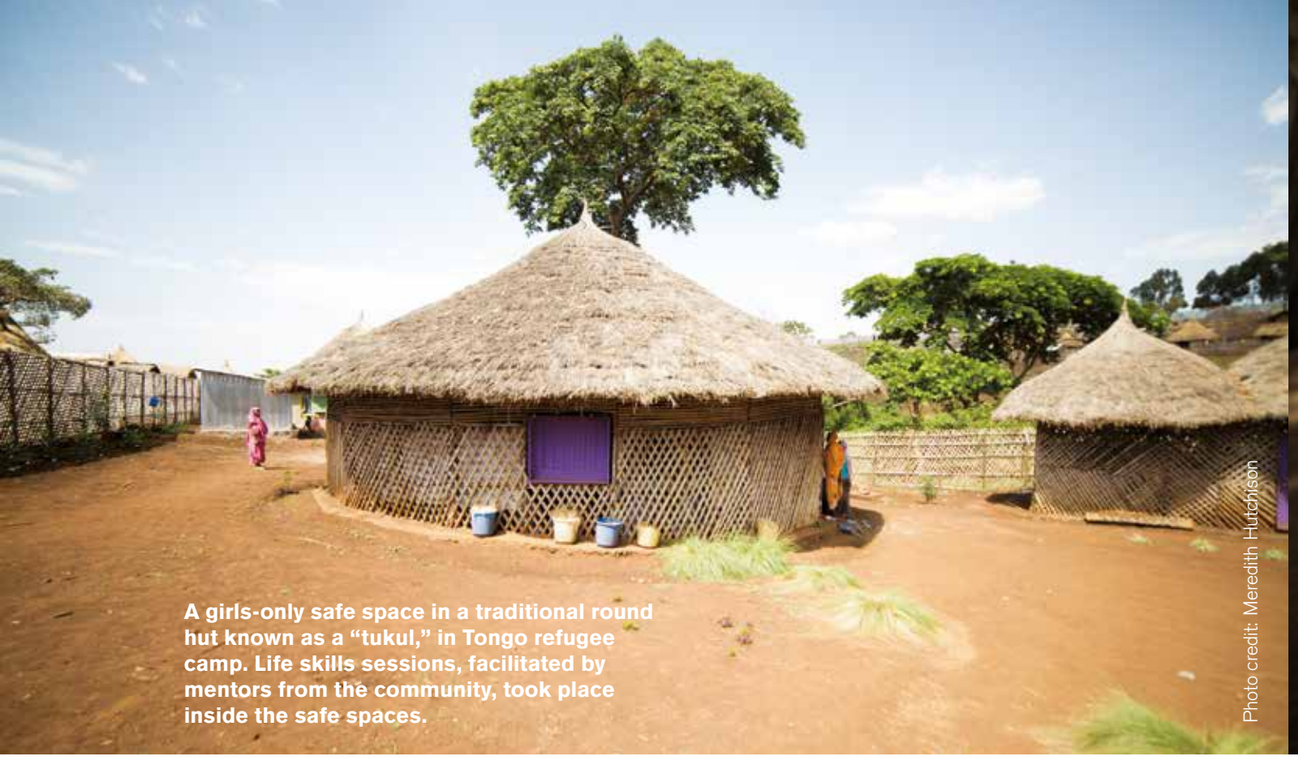
An external evaluation, led by Columbia University, was carried out across the three programme locations to assess the effectiveness, feasibility and acceptability of the above programme interventions. The evaluation in each programme location had different objectives and different designs. Methodologies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

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

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

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

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



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

Photo credit: Meredith Hutchison

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

Photo credit: Meredith Hutchison

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effectiveness and change: The impact of COMPASS on adolescent girls

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

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

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

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

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

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

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

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

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

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

Adolescent girl, 13 years old, evaluation interview, Ethiopia

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

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

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

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

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

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

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

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

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

Feasibility and acceptability of COMPASS

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

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

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

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

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

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

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

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

Lessons from the implementation of COMPASS

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

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

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

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

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

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

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

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

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

Photo credit: Meredith Hutchison

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

Conclusions and Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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