A Safe Place to Shine

Creating Opportunities and Raising Voices of Adolescent Girls in Humanitarian Settings in eastern Democratic Republic of Congo

November 2017
This report was written by Sophie Tanner and Meghan O’Connor.

With thanks for review and inputs to: Theresita Bakomere, Kathryn Falb, Elizabeth Graybill, Helen Lindley, Helena Lupton, Ilaria Michelis, Meghan O’Connor, Ilana Seff, Marni Sommer, Lindsay Stark, Sam Underwood.

IRC would like to thank the following for their hard work on the COMPASS programme and evaluation:

▪ Members of DRC research team for implementing the evaluation: Theresita Bakomere, Caroline Bora, Justin Lushombo, Pamela Mallinga, Katie Robinette, Nadine Rudahindwa.

▪ Columbia University team members for leading DRC impact evaluation: Lindsay Stark (principal investigator), Marni Sommer (co-investigator), Khadeja Agha, Mark Canavera, Kathryn Davis, Cecile Fanton d’Andon, Debbie Landis, Matthew MacFarlane, Sarah Meyer, Ilana Seff, Craig Spencer, Gary Yu.

▪ IRC Women’s Protection and Empowerment technical and coordination staff who supported COMPASS DRC: Annie Barber, Dorcas Erskine, Kathryn Falb (co-investigator), Shelby French, Sophie Hug Williams, Meheen Jasawal, Betsy Lard, Helena Lupton, Mari Macrae, Caterina Mansueti, Ilaria Michelis, Tamah Murfet, Meghan O’Connor, Catherine Poulton, Sophie Tanner, Leora Ward.

▪ Qualitative and quantitative data collectors, support staff and translators who worked on the evaluation: Justin Lushombo, Caroline Bora, Nadine Rudahindwa, Liliane Wimba, Boss Mastaki, Emile Abasimine Gubanja, Beatrice Nampala, Lola Mwana Shafali, Francine Mapendo Bahati, Chanceline Bahati Mitima, Clementine Mwamini Mupenda, Manyi Byamungu Barhebwa, Noela Nabintu Mukaya, Sifa Nabazairwa, Beatrice Cigangu Furaha, Prodigel Sindano Aridja, Jaelle Nyota Amani, Edward Feza Mpunuta, Denise Heri Naami, Odette Nao, Estace Kihuza Loyoja, Esperance Kahumba Tunani, Alime Kihumaini Mukanisa, Miracle Katabi Mbuya, Cecile Masirika Mwamini, Elisce Machoi Wabiwa, Rehema Bagula, Rosette Kalamba.

▪ The Population Council Information Technology team for developing CAPI and ACASI programmes for data collection on Android-based tablets: Stan Mierzwa, Samir Soudi.

▪ The COMPASS programme and this report was funded with UK aid from the UK government, however the views expressed do not necessarily reflect the UK government’s official policies.

Finally, we would like to thank the adolescent girls, their parents/caregivers and the communities who took part in the programme and evaluation.

ACKNOWLEDGEMENTS

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.

Front cover image: Charmante, age 12, participated in the Vision Not Victim project with photographer Meredith Hutchison. The project encouraged girls to explore their ambitions for the future. Charmante’s vision was to be a teacher. Photo credit: Meredith Hutchison 2014.
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.
Overview of COMPASS in eastern Democratic Republic of Congo

COMPASS was implemented with two groups of adolescent girls and their parents/caregivers. Evidence in this report is based on data and learning from the first group, in programme cycle. Overall, the programme reached 1,444 adolescent girls representing a range of backgrounds, living situations, and experiences, and 764 of their parents/caregivers. 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 controlled trial to measure the additional impact of the parent/caregiver component on changing social and health outcomes of adolescent girls. This involved an ‘intervention group’ of adolescent girls who received the life skills sessions and parents who attended group discussions, and a ‘waitlist group’ of adolescent girls who participated in the life skills sessions but their parents 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 to bring change, inform programme adaptations and feed into wider learning.

The State of adolescent girls in eastern Democratic Republic of Congo: findings from the COMPASS baseline survey

The COMPASS baseline survey, carried out prior to the implementation of the COMPASS intervention, 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.

Adolescent girls as young as ten are experiencing GBV.

The baseline survey revealed a high number of adolescent girls exposed to gender-based violence (GBV) (37%) of girls reported that they had experienced sexual abuse at some point in their life. Many girls had recent experiences of GBV; a majority (61%) reported having experienced some form of violence in the past 12 months. 42% of girls had experienced physical violence, 44% emotional abuse, and 49% neglect over the same period. Intimate partners (boyfriends and husbands) were most often the perpetrators (49% for sexual violence, 37% for physical violence, 36% for emotional violence), followed by parents/caregivers (22% for sexual violence, 29% for physical violence, 36% for emotional violence). Fewer than 10% of girls reported sexual violence by armed actors, or an official such as a police officer or teacher.

Despite this exposure to GBV and the likelihood of the perpetrators being someone they knew, the majority of adolescent girls said that they felt ‘safe’ in most places, and particularly in their home (93%). In group discussions, adolescent girls were more likely to identify unsafe places as remote and unfamiliar, such as isolated fields or areas near military camps.

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

Adolescent girls and parents showed high levels of agreement to statements that indicated acceptance of gender inequality and GBV. 95% of adolescent girls agreed that women should tolerate violence to keep the family together, suggesting that men’s violence in the home was an accepted part of life. Most parents also supported physical violence against children as a form of discipline.

Adolescent girls and parents also expressed agreement with clear divisions in the roles of boys and girls, including that women needed a man’s permission for protection, and that men should make decisions in the home. This division was also clear in parents’ expectations for their children, with slightly fewer than half (47%) believing that sons should have more education than daughters, and a majority (83%) believing that daughters should only be sent to school if they are not needed to help at home.

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

Adolescent girls reported having good relationships with their parents, and parents expressed warmth for their daughters. In addition, most adolescent girls reported having friends of their own age and an adult outside of the family they could go to if they had problems. However, fewer than half of the adolescent girls interviewed (40%) indicated that they had someone they trusted to talk to if they were forced to have sex, and many adolescent girls reported that they felt that their family would blame them if they were forced to have sex.

In cases of physical or sexual violence, less than half of the girls reported knowing a place to go for help. Both adolescent girls and parents reported it was usually a parent who provided access to a professional service, suggesting a need to educate parents around services, and to empower adolescent girls to seek services on their own.

The high levels of GBV and little available support point to the urgent need for tailored programming to reduce violence against adolescent girls and improve their wellbeing and future prospects.

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

In general, adolescent girls had average levels of self-esteem compared to global levels. However, girls had very low hope for the future, measured in terms of their perceived capacity to achieve their goals. They also had low expectations for other girls their age; only about half of the girls stated that girls should complete the final year of primary school before discontinuing their education, and 30% believed that girls should complete a university education. On average, girls considered 30–21 years old to be an appropriate age for marriage.

Parents seemed to have higher aspirations for their daughters than the girls had for themselves. More than half of the parents interviewed said they wanted girls to complete a university education, and, on average, delay marriage until 23 years of age.

1. Parent/caregivers shall be referred to simply as “parents” from this point in the report, although it should be recalled that caregivers such as aunts, siblings, cousins and other non-familial trusted persons are included in this group.
2. In the first programme cycle only 25 parents/caregivers participating in discussion sessions in South Kivu were male. Data on participants’ gender is unavailable for North Kivu.
3. The evaluation measured 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). Date rape is a type of experiencing violence. For more information on the research questions asked to assess exposure to violence, please see Annex 2: Executive summary
Evidence of change for adolescent girls
At the end of the programme, fewer adolescent girls reported experiencing GBV. After completing COMPASS, fewer adolescent girls reported that they had experienced physical, emotional or sexual violence in the past 12 months, compared to the beginning of the programme. This could be linked to the girls learning about strategies to keep themselves safe, as well as having a better understanding of what constitutes GBV and how it may occur.

Adolescent girls developed their support networks.
Adolescent girls were more likely to report having a supportive social network after completing the programme. The percentage of girls who said they had an adult who gave them advice rose from 67% to 76%. In addition, the percentage of girls who had four or more friends rose from 54% to 96% from the beginning to the end of the programme. This is essential to ensure girls are not isolated and have the social assets needed to prevent and recover from GBV.

Adolescent girls improved their hopes and expectations for the future.
There was also an increase in adolescent girls’ feelings of self-esteem and hope for the future. This was particularly notable for the youngest girls, aged 10-12. While hope remained low, this is an important finding, as hope for the future is key to adolescent girls’ resilience and ability to recover from GBV.

COMPASS provided girls with a safe place, but its broader impact on girls’ safety was unclear.
Girls provided positive feedback about the safe space, and valued it as a place to make friends, play and learn away from threats in the community. However, the evaluation did not show a statistically significant improvement in girls’ feelings of safety outside the safe space. In addition, adolescent girls also continued to accept gender inequality and tolerate violence at the end of the programme.

The retention of harmful social norms and acceptance of GBV is unsurprising, as these attitudes are deeply entrenched in the societies where adolescent girls live. It highlights the importance of holistic, gender-transformative and long-term approaches which include families and communities as well as adolescent girls.

Effectiveness and change: The impact of COMPASS on parents/caregivers and their relationships with adolescent girls
The primary objective of the external evaluation in DRC was to assess the additional impact of the parent group discussions on the lives of adolescent girls. Although the evaluation showed a reduction in GBV against adolescent girls from the beginning to the end of the programme, it did not show that parent participation in group discussions had a statistically significant additional impact. In addition, parents’ acceptance of equitable gender norms or the physical disciplining of children did not change.

There are a number of possible reasons for this finding relating to the programme scope, context and methodology. First, the parents/caregivers curriculum was designed to ensure that parents had access to the same information provided to the adolescent girls and to improve relationships with the girls, not to transform deeply entrenched gender norms. Second, parents that participated in the programme were predominantly mothers, who likely had limited power within their family and community to make decisions or changes necessary to reduce girls’ exposure to GBV. Third, the timeframe of the programme and evaluation may have been too short to see significant changes in the adolescent girls’ lives as a result of their parent’s/caregiver’s participation in the programme.

Encouragingly, parents who took part in the group discussions did show greater warmth and affection towards their daughters than those in the control group by the end of the programme. This could indicate that the impact of the programme on adolescent girls’ exposure to GBV would be more noticeable over a longer time period. Monitoring showed that parents had some knowledge of the key messages of the COMPASS curriculum, but gaps remained in their understanding and attitudes around gender roles, as well as some basic facts on female bodies and reproductive health.

These findings suggest that while it is important to engage parents and caregivers when implementing targeted adolescent girl programming to ensure acceptance and minimize any risks related to the girls’ participation in the activities, to achieve a meaningful reduction in violence experienced by adolescent girls, this must be accompanied by wider gender transformative programmes that explicitly address power dynamics between men and women in the household and the community and seek to transform entrenched gender norms and attitudes.

8. As there was no comparison group for the adolescent girls’ life skills intervention (i.e. adolescent girls who did not receive the programme), it is not possible to attribute changes directly to the COMPASS programme. But data over time provides information on trends and changes for the girls.

Photo credit: Aubrey Wade/IRC 2010
Evidence of change: GBV service provision for adolescent girls

IRC WPE staff worked with health and GBV case management service providers to ensure adolescent girls received tailored, appropriate and professional services to prevent and respond to violence. The IRC worked closely with community-based organisations (CBOs) to support psychosocial support, case management and referrals for adolescent girls GBV survivors. The IRC conducted training on case management, caring for child survivors of violence, clinical care and GBV core concepts, and provided ongoing supervision and monitoring to service providers throughout the programme. This led to a huge increase in the knowledge of participating service providers, and improved their attitudes towards adolescent girls. Adolescent girls also provided very positive feedback on services, particularly in terms of counselling and medical care.

The number of girls reporting that they knew where to go if a girl experiences GBV increased during the programme. By the end of the programme 87% knew where to go if sexual violence was experienced, compared to 62% for physical violence. There was also an increase in adolescent girls survivors accessing case management services over the course of the programme. In North Kivu, there was an 83% increase between January and June 2016. Increased knowledge about services, their purpose, what constitutes GBV and how services can provide support may have all contributed to this.

Feasibility and acceptability

The IRC explored the extent to which adolescent girls’ life skills programming in conflict-affected communities in North and South Kivu was feasible, in terms of girls having safe, consistent access and the ability to participate. The IRC also assessed how accepting adolescent girls, families and communities would be to learning information and skills relating to the topics of the programme, and whether community leaders, authorities and other influential actors would support their participation.

COMPASS proved to be feasible and acceptable in humanitarian settings.

As a result of the IRC’s targeted awareness raising, including community meetings and discussions with local authorities, there was considerable interest in COMPASS from adolescent girls. Despite some false rumours of incentives, and a time lag between enrolment and the first COMPASS sessions, for the most part adolescent girls were keen to attend, with 1,119 girls enrolling for life skills sessions in the first programme cycle. Adolescent girls were asked to identify one parent or caregiver that they would most like to attend the corresponding parent group discussions. Most selected their mother (82%). In emergency sites, including communities recently affected by conflict or displacement or communities of internally displaced people (IDPs), a number of adolescent girls were the head of their household and couldn’t easily identify someone to participate in the parent group discussions.

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

Overall attendance for COMPASS was very high among the adolescent girls, demonstrating their enthusiasm and perception that the programme was relevant to them. They were most likely to miss sessions because they had to run errands or were sick – a noticeable issue in sites where access to clean water was poor. Parent attendance was lower and more variable, due to work, harvest, access to welfare distributions (in refugee camps), community events and sickness or pregnancy. Despite these competing priorities, parents participating in the group discussions were interested in the sessions and the value in promoting life skills lessons to their daughters, and their level of participation did increase over time.

Adolescent girls provided very positive feedback on the life skills sessions, in terms of the accessibility and quality of the safe space where sessions were delivered, the materials used, mentors and spending time with their peers. On the completion of the programme, adolescent girls were generally able to remember the content they had learned. However, gender norms remained important for some topics; for example, many girls still assigned their self-worth to how capable they were at performing domestic tasks.

Engaging and sensitising parents, community members, local leaders and authorities was key to this programme, both in terms of increasing acceptability of the programme itself and changing attitudes and norms that surround adolescent girls and their lives. IRC WPE staff held a number of sensitisation activities throughout this programme to highlight its importance and the injustices and threats women and girls often encounter in the community.

The high demand and ongoing interest from adolescent girls in COMPASS, and the general support from families and communities for their ongoing participation, demonstrate that adolescent girl programming is both feasible and acceptable in conflict-affected communities in eastern DRC.

Lessons from the implementation of COMPASS

Implementing the programme with adolescent girls in conflict-affected settings required ongoing adaptations and high levels of resources. Extensive consultation with the girls was conducted prior to the start of the programme to maximise the relevance and usefulness of the programme. As a result, it was decided that existing community spaces (within CBOs, schools, health centres and churches) were the best place to hold COMPASS activities. In emergency sites, where finding an appropriate space was more challenging, teams noted the importance of adolescent girls having a safe space to express themselves, even if this space was temporary and informal.

A process of contextualising the curriculum was carried out before finalising it for use in the first cycle. This included consultation with adolescent girls and parents. Through this process, IRC decided that topics related to sexual and reproductive health would be discussed primarily with older girls (10–14 years old), and that they would also be discussed with a parent prior to the adolescent girls’ sessions. A shortened curriculum for was also developed for use in emergency sites and implemented in IDP camps, as a full 10-month long curriculum was deemed unrealistic in a period of acute emergency. Positive feedback was received from parents and adolescent girls on both curricula.

While IRC staff facilitated parent group discussions, mentors were engaged to facilitate the life skills sessions with the adolescent girls. Mentors were identified through recommendations from the adolescent girls and their parents using the following criteria: proximity in age to the girls, levels of literacy, ability to empathise and willingness to commit to the duration of the curriculum. During the implementation of COMPASS, mentors’ facilitation style and interaction with girls continued to evolve and improve, and mentors showed strong skills and positive attitudes.

There were some concerns that because the mentors came from similar geographical and social backgrounds as the adolescent girls, they may actually reinforce harmful social norms instead of challenging them. In relation to this issue, implementing teams found that mentors needed additional training and greater technical support, particularly when discussing issues related to gender norms and violence. For this kind of mentor model to be successful, a tailored and transformative curriculum which takes into account the backgrounds and prejudices of mentors is essential, as is providing ongoing support for facilitating particularly sensitive or challenging topics.
Adolescent girls as young as 10 are experiencing GBV in humanitarian settings. Adolescents’ lives improved after participating in COMPASS. At the end of the programme, girls experienced less GBV and had stronger social networks, increased awareness about GBV services and more hope for the future. The existence of quality GBV services and trained staff was critical to ensuring the safety and wellbeing of adolescent girls targeted by COMPASS. Consultation with adolescent girls throughout implementation was essential to ensuring programming was responsive, flexible and addressed the needs of girls from diverse backgrounds. 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. Based on these conclusions, the IRC has developed a programme model and resource package called Girl Shine, intended to be a practical and flexible resource for practitioners. It builds on the positive practices in COMPASS and bridges the gaps identified during the implementation of the programme and by associated research. More information about Girl Shine is included in Annex 6.

Conclusions

1. Adolescent girls as young as 10 are experiencing GBV in humanitarian settings.
2. Adolescent girls’ lives improved after participating in COMPASS. At the end of the programme, girls experienced less GBV and had stronger social networks, increased awareness about GBV services and more hope for the future.
3. The existence of quality GBV services and trained staff was critical to ensuring the safety and wellbeing of adolescent girls targeted by COMPASS.
4. Consultation with adolescent girls throughout implementation was essential to ensuring programming was responsive, flexible and addressed the needs of girls from diverse backgrounds.
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.

Based on these conclusions, the IRC has developed a programme model and resource package called Girl Shine, intended to be a practical and flexible resource for practitioners. It builds on the positive practices in COMPASS and bridges the gaps identified during the implementation of the programme and by associated research. More information about Girl Shine is included in Annex 6.

Recommendations

The 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:
   - 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.
Adolescents in humanitarian settings require tailored programming, as the combination of their age, gender, and environment leaves them extremely vulnerable to violence (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/caregivers and service providers (page 3).

Columbia University and the International Rescue Committee (IRC) worked together to generate rigorous evidence on the effectiveness of COMPASS programming and identify ways to improve outcomes for adolescent girls in humanitarian settings. This involved Columbia University leading an external evaluation and the IRC constantly monitoring its programme for learning (page 5).

COMPASS was implemented by WPE staff in North Kivu and South Kivu in the Democratic Republic of Congo (DRC), which have experienced years of conflict and uncertainty (page 7).

Introducing the Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces Programme (COMPASS):

- Adolescent girls in humanitarian settings require tailored programming, as the combination of their age, gender, and environment leaves them extremely vulnerable to violence (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/caregivers and service providers (page 3).
- Columbia University and the International Rescue Committee (IRC) worked together to generate rigorous evidence on the effectiveness of COMPASS programming and identify ways to improve outcomes for adolescent girls in humanitarian settings. This involved Columbia University leading an external evaluation and the IRC constantly monitoring its programme for learning (page 5).
- COMPASS was implemented by WPE staff in North Kivu and South Kivu in the Democratic Republic of Congo (DRC), which have experienced years of conflict and uncertainty (page 7).

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.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 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 for girls’ access to education, participation in society, employment prospects, and family life. Although there is a growing body of information on the prevalence...
Ensuring safety from violence is critical for adolescent girls to develop and live full and productive lives.

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 conflict-affected communities in eastern Democratic Republic of Congo (DRC), refugees living in camps on the Sudan/Ethiopia border, and displaced populations in north-west Pakistan.

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

Chapter 2 outlines findings from the survey conducted at the beginning of the programme on adolescent girls' fear of and exposure to GBV, gender norms and attitudes, support networks and knowledge of service providers, and girls' self-esteem and expectations for the future.

Chapter 3 presents findings from the COMPASS programme and evaluation carried out in conflict-affected communities in DRC. 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 research needed to develop and implement strong, effective and relevant programmes which will improve the lives of such a critical yet overlooked population.

The COMPASS programme

The IRC developed and implemented the interventions used in COMPASS by building on existing 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 violence against adolescent girls in humanitarian contexts. The theory of change diagram is included in Annex 3.

The IRC WPF staff implemented the full COMPASS curriculum 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 September 2015 to July 2016.

### Table 1: Programme interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Purpose</th>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent girls' life skills sessions</td>
<td>To increase adolescent girls' self-esteem and safety, by creating opportunities for adolescent girls to engage with peers and mentors, providing information that helps reduce adolescent girls' risk of being exposed to gender based violence and victimisation, and building adolescent girls’ self-esteem and leadership skills.</td>
<td></td>
</tr>
</tbody>
</table>

Adolescent girls were grouped by age and location (10–12 or 13–14). In groups facilitated by a female mentor aged 16–30, adolescent girls met weekly in a designated “safe space” in existing community structures, to take part in life skills sessions tailored for adolescent girls. The same group of adolescent girls met weekly with their mentor for 22 weeks to discuss programme content, which ranged from decision-making and drug use to reproductive health and gender norms and safety planning. A shortened and more flexible version of the curriculum was also developed for use in emergency sites in North Kivu.

| Parent/caregiver group discussions | To create spaces for parents/caregivers to talk about the experiences of raising and caring for adolescent girls, and to foster attitudes that are supportive of adolescent girls | The parent/caregiver group discussions were structured monthly conversations with the parent/caregivers of adolescent girls who participated in COMPASS. The content of these discussions focused on positive relationship building, empathetic communication, non-violent discipline methods, and specific developmental and cultural issues experienced by adolescent girls. One parent/caregiver per girl was invited to participate in the programme; they were selected by the adolescent girls, who could choose a male or female parent/caregiver. |

| Service provider support | To ensure the provision of responsive and high-quality essential services to adolescent girls, preventing violence and supporting survivors of violence. | The IRC provided targeted training and ongoing support to develop knowledge, capacity and skills in responding to the specific needs of adolescent girls, particularly after experiencing violence. In addition, wider community actors, including professional service providers and community leaders, were engaged 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. |
Programme learning:

Through the external evaluation and routine programme monitoring, the global COMPASS programme sought to generate learning on 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 the 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 how adolescent girls’ assets were built and violence reduced
- assessment of how programme implementation contributed to changes in the adolescent girls
- experiences of implementing adolescent girl programming in this context.

The International Rescue Committee (IRC)

The IRC is a humanitarian organisation dedicated to help those whose lives and livelihoods have been affected by conflict and disaster to survive, recover and gain control of their future. Since 1996, the IRC has implemented specific programmes to empower and protect women and girls affected by GBV in various contexts of acute and protracted emergencies. The IRC has gained a wealth of experience in this 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 girl’s protection and empowerment (WPE) programming in 31 countries across Africa, Asia, Europe and the Middle East, and has over 20 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, 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 led the implementation of the COMPASS programme in the three countries and the overall management of the programme.

The IRC has been programming in DRC since 1996, and specifically on women’s protection and empowerment since 2002, providing support to over 130,000 GBV survivors since inception. Services, empowerment activities and prevention approaches address all types of violence against women and girls, including sexual violence and intimate partner violence. The IRC WPE team led the implementation of COMPASS in DRC and overall management of the programme.

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

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

Generating data: methods

The learning presented in this report is drawn from the external mixed-method evaluation led by Columbia University, as well as from monitoring data collected by programme staff throughout implementation. Note that all data included are from the first programme cycle. This was the first time the IRC and community partners had worked on programmes specifically targeting adolescent girls. Subsequent programme cycles have drawn on this learning to further develop and improve the programme.

External evaluation design

Columbia University led a mixed-method evaluation to evaluate the impact of the COMPASS programme in South Kivu. The trial was complemented by qualitative data collection from adolescent girls and parents. The hypothesis under evaluation was that participating adolescent girls whose parents also participated in the monthly group discussions would be better protected from violence compared to participating adolescent girls whose parents did not participate in the monthly group discussions.

There has been evidence of parenting programmes reducing violence against children in low to middle income countries, and in some humanitarian contexts, but studies have tended to focus on outcomes for early and middle childhood. Little is known about the impact of parenting programmes on adolescents, and in particular on the outcomes of adolescent girls.

The specific research objectives were:

1. To assess the incremental impact of delivering the parent group discussions along with the adolescent girls’ life skills session on a) adolescent girls’ experiences of physical, sexual and emotional violence; b) confidence and self-esteem; c) adolescent girls’ support networks; and d) gender attitudes.
2. To explore qualitatively the processes and pathways by which the addition of the parent group discussions may influence levels of gender based violence and build support networks

The study design was a two-arm waitlisted cluster randomised controlled trial across 14 sites in South Kivu. North Kivu was not included in the evaluation due to security restrictions. Following programme enrolment and completion of baseline data collection, adolescent girls were divided into programme groups based on age, language and geographic location. Programme groups served as clusters, which were then randomised into two groups:

- **intervention group** – adolescent girls receive life skills sessions and their parents attend group discussions.
- **waitlist group** – adolescent girls receive life skills session but their parents received no intervention until the evaluation was complete.

The parents in the waitlist group took part in the second cycle of the programme, after completion of the evaluation. The baseline survey was conducted with 869 adolescent girls and 764 parents/caregivers in May and June 2015, before programming activities began. The endline survey was conducted with 786 adolescent girls and 710 parents, following completion of the first programme cycle. The individual baseline and endline surveys with adolescent girls were administered to participants using a combination of Computer Assisted Personal Interviewing (CAP) and Audio Computer Assisted Self-Interviewing (ACASI), where a girl would hear survey questions through headphones and follow instructions to select an appropriate response on her tablet by tapping on a visually coded response option.

Parent surveys were entirely administered by interviewers using CAP. Surveys were translated into French, Swahili and Malawian and verified before use with adolescent girls and parents.

The following qualitative methods were used:

- focus group discussions (16 groups) with 97 male and female parents/caregivers at the beginning of the programme
- participatory mapping activities with 16 groups and a total of 87 adolescent girls at the beginning of the programme
- in-depth interviews with 30 adolescent girls at the end of the programme
- in-depth interviews with 31 participating male (seven) and female (24) parents/caregivers at the beginning of the programme.

A detailed methodology can be found in Annex 1.

Research terms used in this report:

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

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

- attendance rates for life skills sessions for adolescent girls and group discussions for parents
- a check-in with participating adolescent girls to assess their perceptions of delivery methods and relevance of the topics
- knowledge verification exercises with adolescent girls and parents to ascertain understanding of key curriculum topics
- observations of adolescent girls’ life skills sessions and parent group discussions to assess the quality of curriculum implementation
- client satisfaction surveys with adolescent girl survivors receiving case management and psychosocial services to assess their experiences.

Programme context

 Civilians in eastern DRC, including the provinces of North Kivu and South Kivu, have been affected by conflict and uncertainty for almost 20 years. Despite a period of relative calm since 2009, the security situation deteriorated in the wake of the 2011 national elections, and was further undermined by increased action by armed groups following the creation of the M23 (Congolese Revolutionary Army) in April 2012.

In 2016, the ongoing humanitarian situation in eastern DRC was worsened by a volatile security environment, due to an increase in armed group movements and inter-ethnic tensions. As of December 2016, there were 2.1 million internally displaced persons (IDPs) in the country, largely concentrated in North Kivu, South Kivu and Tanganyika provinces, with North Kivu hosting up to 40% of all IDPs. The demographical profile of the displaced population in the eastern region shows that most IDPs are children under 18 (60.5%), while 52% of IDPs are women and girls.

In 2014, as many as 30 armed groups were reported to be operating in the country’s eastern provinces; by 2015, this had increased to more than 70. Several military campaigns against these groups, especially against the Forces Démocratiques de Libération du Rwanda (FDLR), Allied Democratic Forces (ADF) and various factions of Mai Mai armed groups, were conducted by the Forces Armees de la République Démocratique du Congo (FARDC). These campaigns also led to an increase of violence against civilians, resulting in further displacement. Further instability in the broader Great Lakes region resulted in an influx of people into DRC from Central African Republic and Burundi, with approximately 250,000 refugees and asylum seekers living in DRC by 2016.

The normalisation of violence in conflict settings, alongside the separation of families, the collapse of traditional community protection systems and displacement, all contribute to increased risks for women and girls. Despite high levels of attention focusing on sexual violence perpetrated by armed forces, recent research reveals that in humanitarian settings worldwide, intimate partner violence is the most common type of gender-based violence women experience. An estimated 1.8 million women in DRC have been raped in their lifetime, and over three million women have reported experiencing intimate partner sexual violence.

The IRC’s service provision records show a stark increase of GBV reports during outbreaks of conflict. A DRC Ministry of Gender, Family Affairs and Children study found that 44% of reported GBV cases were from children under 18. Such findings have called attention to the acute vulnerability of adolescent girls to GBV in this setting, underscoring an urgent need for evidence-based prevention and response programmes.

Furthermore, 27% of girls aged 15–19 years in DRC had already started to have children, according to the Demographic and Health Survey conducted in the country in 2013–14. Such high adolescent childbearing rates have important negative consequences for the health and well-being of girls, and that of their families and communities. Girls’ exclusion from decision-making processes and lack of control over their own lives also limit their physical, intellectual and social development, and also constitute forms of violence against them. In addition, when adolescent girls experience GBV, they often have limited access to essential services, due to a lack of availability or information, or because parents, relatives, husbands or partners deny them access. Even if they are able to access them, such services are rarely adapted to their specific needs.
Demographics of adolescent girl participants

In the first programme cycle of COMPASS, a total of 1,444 adolescent girls registered in North and South Kivu. 869 adolescent girls in South Kivu participated in the baseline survey for the evaluation, along with 764 of their parents/caregivers. According to the baseline survey, the majority of adolescent girls were either living with both biological parents (60%) or with just their mother (28%).

Of the 13–14 year-old girls who completed the baseline survey, over one in five reported being married: 16% reported living with a husband or partner, and 7% reported being married but not living with their husband. Adolescent girls had low levels of education and school attendance, and about a fifth of adolescent girls reported that at some point in their lives they had worked for money or payment. Adolescent girls selected one parent or caregiver to participate in the corresponding group discussions; the majority of parents/caregivers who took part were female (92%) and the mother of the girl (81%).

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 GBV and what can help them if they experience GBV.

In DRC, the COMPASS programme was implemented with conflict-affected communities in North Kivu and South Kivu. Adolescent girls aged 10–14 were invited to enroll and take part in life skills sessions facilitated by a mentor, while their parents participated in corresponding group discussions. The first programme cycle included 1,444 adolescent girls. Most girls who took part in the baseline survey in South Kivu lived with their parents and had very little education.

The IRC and Columbia University formed a partnership to evaluate COMPASS. An external evaluation led by Columbia University was conducted in South Kivu to assess the added value of the parent/caregiver component and how it affected the outcomes for adolescent girls. Monitoring data were also collected throughout implementation to assess how the programme intervention could be changed to improve outcomes, inform programme adaptations and feed into wider learning.

This report presents findings from implementing and evaluating COMPASS in DRC. 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.
THE STATE OF ADOLESCENT GIRLS IN EASTERN DEMOCRATIC REPUBLIC OF CONGO

Key findings from our baseline study:

- 61% of adolescent girls have experienced some form of violence in the past 12 months. More than one in three (37%) have experienced sexual violence in their lifetime. Perpetrators were most often intimate partners or parents (page 12).
- Adolescent girls and parents hold traditional attitudes towards gender: they are likely to agree that men are decision makers, women should accept violence, and domestic chores are the responsibility of women and girls (page 14).
- Fewer than half (40%) of the adolescent girls had someone trusted to talk to if they were forced to have sex (page 16).

In this chapter, we present key findings from the quantitative and qualitative data collection carried out at the beginning of the programme in South Kivu, which provide an insight into the frequency and nature of GBV experienced by girls, as well as adolescent girls’ views on gender norms, knowledge of GBV services and hope for the future. The quantitative baseline survey was completed with 869 adolescent girls and 764 parents/caregivers in May and June 2015, alongside qualitative focus group discussions and participatory activities. As the evaluation intended to understand the overall status and experiences of adolescent girls before the programme, the results presented consider all girls that participated.
Adolescent girls as young as ten are experiencing high levels of GBV.

The baseline survey revealed extremely high frequency of GBV, alongside an acceptance by both adolescent girls and parents of these types of violence as part of everyday life.

The majority of adolescent girls (61%) reported that they had experienced some form of violence in the past 12 months (see figure 3). Over one in three (37%) adolescent girls had experienced unwanted sexual touching, unwilling sex and/or coerced sex at some point in their lives. Over 1 in 4 (26%) reported being a survivor of sexual violence in the past 12 months, and 16% reported exchanging sex for money, food or other goods. In addition, 42% of adolescent girls aged 10–14 had experienced physical violence in the past 12 months.

Nearly half (44%) reported experiencing emotional abuse (insults and/or loud or aggressive screaming), and over 49% reported feeling uncared for in the same period.

While levels of GBV were high for adolescent girls of all ages, very young girls, some as young as 10, were particularly at risk. Girls aged 10–12 in DRC were twice as likely to have experienced coerced sex and unwanted sexual touching at some point in their lives than girls aged 13–14.

Intimate partners (boyfriends and husbands) were the most likely perpetrators of GBV for all types of violence (37% of physical violence; 49% of sexual violence), followed by parents (29% of physical violence; 17% of sexual violence) and friends and neighbours (14% for both physical and sexual violence). In contrast, fewer than 5% of girls reported experiencing sexual violence by a member of the armed forces or an official such as a police officer or teacher.

Given that the majority of perpetrators (intimate partners, parents) are often present in the home, this finding indicates that girls feel safest in familiar places despite a constant, underlying threat of violence. This points towards a normalisation of violence in the home, which may be due to a high acceptance of GBV and harmful gender norms and attitudes, as described in the following section.

Figure 3: Girls’ reported experience of sexual violence, physical violence, emotional abuse

<table>
<thead>
<tr>
<th>Experience</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaten or hit in last 12 months</td>
<td>42%</td>
</tr>
<tr>
<td>Experienced sexual violence in the past 12 months</td>
<td>26%</td>
</tr>
<tr>
<td>Screamed at loudly or aggressively in past 12 months</td>
<td>44%</td>
</tr>
</tbody>
</table>

Figure 4: Perpetrators of violence against adolescent girls

- **Coerced sex**
  - Intimate partners: 49%
  - Parents/caregivers: 17%
  - Friends/neighbours: 14%

- **Physical violence**
  - Intimate partners: 38%
  - Parents/caregivers: 29%
  - Friends/neighbours: 14%
There is a high acceptance of gender inequality and tolerance of violence against women and girls.

Adolescent Girls

Adolescent girls were asked if husbands were justified in beating their wives under certain circumstances: for example, if she burns the food or neglects her children. 81% of adolescent girls agreed that husbands were justified in beating wives in at least one of the examples provided in the survey. Sadly, only 17% of girls seemed to think sharing household chores equally between men and women was appropriate, once again demonstrating the very early age at which strict gendered social norms are internalised.

It is often the case that a girl works from 8am to 8pm while a boy goes to school early in the morning and returns at 3pm. When he comes back he will not care that there is no firewood, water, and sometimes doesn’t even bring goats back home. Rather he will go and play soccer, and after playing he will come and ask if food is ready.

Parents / caregivers

Adolescent girls and parents expressed clear divisions in the roles of boys and girls, and supported inequitable statements about men and women. Many parents (82%) agreed with the statement that, “a woman has to have a husband or sons or some other male kinsman to protect her, because she is unable to do so for herself”, and 73% agreed that, “a good woman never questions her husband’s opinions, even if she is not sure she agrees with them”. In addition, the majority of parents supported beating children as a form of discipline, with 91% agreeing that a parent has the right to beat a child if the child steals, 90% if the child does not want to go to school, and 82% if the child is sexually exploited by an adult.

Around half (47%) of parents believed that sons should have more education than daughters, and a majority (63%) believed that daughters should only be sent to school if they are not needed to help at home. Discussions with parents also indicated that investing in boys’ education was prioritised over girls’ education because of future expectations that the male will take care of the family.12

The gender norms and attitudes expressed by parents are likely to reflect their own experiences and status in the community, and the structural forces which continue the cycle of oppression against women and girls. Findings suggest a level of acceptability or normality of GBV, and reflect the pressure women feel to maintain a family structure, even if they experience violence by their intimate partner or caregiver.
Adolescent girls lack social support outside of their family.
Parents expressed warmth for their daughters and a clear desire to protect them from harm and provide opportunities for the future. Adolescent girls reported having good relationships with their parents, and were comfortable discussing a range of topics. Unfortunately, in a reality in which violence and discrimination against women and girls is the norm, many parents and adolescent girls see the restriction of an adolescent girls’ movements as the best available option to protect her from GBV and shame.

Adolescent girls reported having a number of friends of their own age, and many adolescent girls (45%) reported knowing a female adult outside of the family who they could go to if they had problems. For most girls, the adult who provided them with guidance, moral support and advice was a female family member, and most likely their mother (50%). Girls were most likely to talk to this adult figure about family problems; plans for the future and school, but they were not likely to discuss their boyfriends or husbands.

Given the high exposure of adolescent girls to intimate partner violence, this is an important finding: the adults in adolescent girls’ lives may not know about the girls’ intimate relationships or the challenges girls face within them. Fewer than half of the girls interviewed (60%) indicated that they knew a trusted person they could talk to if they were forced to have sex. Adolescent girls reported fearing negative consequences if they voiced their thoughts about sexual relationships or abuse, such as blame, stigma, and wider surveillance of their sexual behaviour. 46% of girls reported that they felt their family would blame them if they reported having been forced to have sex, while 58% of girls believed their community would force them to marry the perpetrator. 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.

Adolescent girls have limited knowledge of and access to GBV services.
Approximately 45% of girls reported knowing of a place to go to for help if they experienced physical or sexual violence. Almost 60% of parents felt comfortable telling girls about medical services, and 35% mentioned case management as a service they could refer their daughters to. Fewer parents felt comfortable discussing other forms of services, such as legal support. This represents another barrier to legal justice for adolescent girls, in addition to a general lack of legal services, discriminatory attitudes of police and court officials towards women and girls, and widespread impunity for perpetrators of GBV.

A small number of girls did mention specific service providers during participatory activities. However, both adolescent girls and parents identified that girls were reliant on their parents to access these services. This suggests a need to educate parents about professional services, and to empower adolescent girls to seek services independently. Shame and community-wide stigmatisation may play a part in the reluctance of adolescent girls and parents to access them. Additionally, services should be adapted to the needs of adolescent girls, as there are negative attitudes among providers about adolescent girls accessing services independently, or discussing their sexual activity, which can form a powerful barrier. Most community-based organisations who provide case management and psychosocial services target adult women. This may create a perception that these services are not available to adolescent girls.

Adolescent girls have low hope and expectations for the future.
In general, adolescent girls had average levels of self-esteem compared to global levels. However, girls had very low levels of hope for the future, measured in terms of their belief in their capacity to achieve their goals. This is unsurprising given the highly inequitable norms accepted by girls, as revealed by the baseline survey. Only about half of the girls stated that girls should complete the final year of primary school before discontinuing their education, and just 30% believed that girls should complete a university education. On average, girls considered 20–21 years old to be an appropriate age for marriage, though girls aged 13–14 were more likely to indicate a higher age of marriage than girls aged 10–12.

Parents seemed to have higher aspirations for their daughters than the girls had for themselves. More than half of the parents interviewed said they wanted girls to complete a university education and, on average, delay marriage until 25 years of age.

Summary: state of adolescent girls in eastern Democratic Republic of Congo
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 conflict affected communities in South Kivu found that 61% of girls had experienced some form of GBV in their lifetime, and 37% of girls had already experienced sexual violence. In the 10 months prior to the survey, over 40% of adolescent girls had experienced physical violence and emotional abuse. Intimate partners were the most likely perpetrators of all kinds of abuse, followed by parents.

Harmful gender norms and attitudes were pervasive among the adolescent girls and their parents, and violence in the home was normalised: 95% of adolescent girls agreed that females should tolerate violence in order to protect the family.

Adolescent girls have low aspirations for themselves, and although they had social networks comprising of friends, families and communities, they reported having little access to support if they experienced violence, and very little knowledge of professional 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.

---

13. Measured by the Rosenberg self-esteem scale. The score was calculated by averaging the individual scores of respondents. The possible range is 10–40, where 10 would indicate very low self-esteem, and 40 would indicate very high self-esteem.

14. Measured by the Children’s Hope Scale. An average score above 4.07 indicates respondents have a strong positive perception of their own capacity to achieve goals. A score of 3.0–4.07 indicates moderate perception of self-capacity to achieve goals, and a score below 3.0 indicates low perception of self-capacity. On average, adolescent girls in this study scored 3.3.

---
“I used to watch other children go to school and I was very sad. But now I can go to school.”

Chance, 10 years old, goes to primary school in North Kivu district. IRC helped her go to school by encouraging her step father to pay her school fees.

In this chapter, learning is presented from implementing and evaluating the COMPASS programme according to: (i) effectiveness and changes in outcomes for adolescent girls, their parents and service providers, (ii) feasibility and acceptability, and (iii) lessons from implementation of the programme.

Key findings from COMPASS:

- After participating in COMPASS adolescent girls reported less exposure to GBV, had more developed social support networks, and felt more positive about their futures. (page 20).
- Parents who took part in the programme had higher levels of warmth and affection towards their girls compared to those who did not take part (page 25).
- COMPASS improved knowledge and use of services among adolescent girls, and GBV services were made more adolescent girl friendly (page 27).
- There was a high demand for COMPASS programming among adolescent girls and their parents (page 30).
- Implementation of COMPASS required a flexible and responsive approach, to ensure content and delivery was appropriate, relevant and effective (page 35).
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. The evaluation studied the impact of parent participation in group discussions on outcomes for adolescent girls who attended life skills sessions. This section presents findings on effectiveness and change as a result of the interventions for each of these groups.

Adolescent girls

This section presents the changes in adolescent girls who attended the life skills sessions in South Kivu. While these changes are important, as adolescent girls who did not attend the life skills sessions were not included in the evaluation, it is not possible to attribute these directly to the COMPASS programme.\(^{15}\)

Girls reported less exposure to GBV. At the end of the programme fewer adolescent girls reported experiencing physical, emotional or sexual violence in the past 12 months (see figure 6).\(^{16}\) This reduction was especially significant for sexual violence: 7% of girls reported experiencing forced sex, compared to 18% at the beginning of the programme. 20% reported experiencing any kind of sexual violence, compared to 26% at the beginning of the programme.

Although the evaluation could not attribute these changes to COMPASS, the findings indicate encouraging trends that occurred during implementation. The life skills sessions may have contributed to this reduction, since adolescent girls shared that they learned strategies to keep themselves safe, and developed a better understanding of what constitutes GBV and the forms that it takes.

\[\begin{array}{c|c|c}
\hline
\text{Source of Social Support} & \text{Baseline} & \text{Endline} \\
\hline
\text{Have Adult who gives} & 67\% & 76\% \\
\text{them advice} & & \\
\hline
\text{Have Female figure in} & 45\% & 47\% \\
\text{community to go to with} & & \\
\text{problems on a regular} & & \\
\text{basis} & & \\
\hline
\text{Have an adult they} & 69\% & 78\% \\
\text{regard as a mentor} & & \\
\hline
\text{Have friends to talk to} & 90\% & 94\% \\
\text{about important things} & & \\
\hline
\text{Have friends they can} & 82\% & 90\% \\
\text{rely on for emotional} & & \\
\text{support} & & \\
\hline
\text{Have female friends} & 86\% & 93\% \\
\text{their age outside the} & & \\
\text{family} & & \\
\hline
\end{array}\]

15. As there was no comparison group for the adolescent girls’ life skills intervention (i.e. adolescent girls who did not receive the programme), it is not possible to attribute changes directly to the COMPASS programme, but data over time provides information on trends and changes for the girls.

16. Analysis revealed that adolescent girls who reported experiencing sexual violence in the baseline survey were less likely to participate in the endline survey compared to girls who did not report sexual violence in the baseline survey. This was not reflected in adolescent girls’ participation in the programme, only their willingness to participate in the endline survey.
Girls developed their social networks.
Adolescent girls were more likely to report having social support after completing the programme. The biggest changes related to having trusted adults (an adult who gives them advice; an adult they regard as a mentor) and good friends (friends for emotional support; female friends their own age). Following the completion of the programme, 76% of adolescent girls said they had an adult who gave them advice, compared to 67% before enrolling in COMPASS (see figure 7).

Girls also reported having more friends. In the baseline survey, 54% reported having four or more friends; in the endline survey this rose to 96%. In interviews, adolescent girls demonstrated a strong sense of companionship with other programme participants, though some reported there were tensions with non-participating adolescent girls in the community.

Girls had a safe space to spend time with other girls, but did not feel safer in other settings.
The safe space provided girls with a place to learn, play and make friends, safe from threats from family members or boys and men in the community. 90% of the adolescent girls who participated in COMPASS reported having a safe place to spend time with other adolescent girls, compared to 84% at the beginning of the programme. Given that adolescent girls usually knew, and often lived with, the perpetrator of a violent act against them, this was extremely important.

However, the evaluation did not demonstrate that girls felt safer in other settings as a result of the programme.

Girls felt more positive about their futures.
Overall, there was an increase in adolescent girls’ feelings of hope, with the greatest change taking place among younger adolescent girls (10–12 years old). While hope remained low, this is an important finding, as hope for the future is key to adolescent girls’ resilience and ability to recover from GBV.

Self-esteem, which was average compared to global levels at the beginning of the programme, rose slightly among all adolescent girls, from 31 points to 32 out of a possible 40. Though the increases were small, this shows encouraging trends in the right direction.

17 Measured by the Children’s Hope Scale. An average score above 4.67 indicates respondents have a strong positive perception of his or her own capacity to achieve goals. A score of 3.0–4.67 indicates medium perception of self-capacity to achieve goals, and a score below 3.0 indicates low perception of self-capacity. On average, adolescent girls in this study scored 3.49 at baseline and 3.54 at endline.
18 Measured by the Rosenberg self-esteem scale. The score was calculated by averaging the individual scores of respondents. The possible range is 10–40, where 10 would indicate very low self-esteem, and 40 would indicate very high self-esteem.

“If we are given the opportunity, we can succeed at school just as well as the boys.”
Mandala, 12 years old, goes to school through the “Vas y Fille” education project, also funded by UK aid.
Adolescent girl: He could ask her to have sex with him under the pretext that they are engaged, and she refuses, so he hits her.

Interviewer: Should a man hit a girl if she refuses to have a sex with him? 
Adolescent girl: Hum! (approval)

Interviewer: Should he hit her? 
Adolescent girl: The man should hit her.

Girl, 14 years old, evaluation interview

Gender norms persisted after the programme, and girls continued to accept gender inequality. Inequitable gender attitudes and acceptance of intimate partner violence were still observable in the endline survey. Further, adolescent girls whose parents participated in COMPASS were not more or less likely to agree with any of the statements on gender attitudes or acceptance of a husband beating a wife than those in the waitlist group.

During interviews, adolescent girls expressed attitudes that supported female submissiveness and tolerance of certain gender norms around the treatment of young women and new wives within the household. This included attitudes towards sexual intimacy with their husbands or partners, including scenarios in which violence is tolerated. Many adolescent girls believe violence perpetrated by a husband is acceptable or tolerated. Many adolescent girls believe that violence is acceptable or acceptance of GBV is unsurprising, given that these ideas are deeply entrenched in society and the reality of the world in which the adolescent girls live. However, this may also be an indication that there were challenges in delivering messages to counter these harmful attitudes. Mentors and adolescent girls are likely to bring their own bias to the room, and additional efforts to overcome harmful gender norms may be required (this is explored further in section 3.3). This finding further highlights the need for holistic, gender-transformative and long-term approaches which focus on families and communities.

Summary of effectiveness and change on adolescent girls

At the end of the programme, adolescent girls were less likely to report experiencing GBV, and more likely to say they had somewhere safe to spend time with other girls. They had better social support, in terms of trusted adults and friends of their own age, and higher hope for the future. Although it is not possible to unequivocally attribute these changes directly to COMPASS, these encouraging trends suggest improvements in girls’ lives during the time that COMPASS was implemented.

However, adolescent girls continued to agree with statements which promote harmful social norms and acceptance of GBV. This highlights the need for holistic, gender-transformative and long-term approaches which tackle the root causes of GBV using an ecological approach.

Parents/caregivers

Parents’ participation did not have a significant additional impact on girls’ exposure to GBV. Overall, adolescent girls who had parents that participated in the programme (intervention group) did not have different outcomes from adolescent girls whose parents didn’t participate (waitlist group). Parent participation had no statistically significant additional impact on adolescent girls’ exposure to physical, sexual or emotional violence, or the girls’ attitudes and aspirations.

There are a number of possible reasons for this finding relating to the programme scope, context and methodology. First, the parents/caregivers curriculum was designed to ensure that parents had access to the same information provided to the adolescent girls and to improve relationships with the girls, not to transform deeply entrenched gender norms. Second, parents that participated in the programme were predominantly mothers, who likely had limited power within their family and community to make decisions or changes necessary to reduce girls’ exposure to GBV. Third, challenges related to the consistent attendance of parents/caregivers may have limited the impact of the curriculum (see page 31). Finally, the timeframe of the programme and evaluation may have been too short to see significant changes in the adolescent girls’ lives as a result of their parent’s participation in the programme.

These findings suggest that while it is important to engage parents and caregivers when implementing targeted adolescent girl programming, to ensure acceptance and minimise any risks related to the girls’ participation in the activities, to achieve a meaningful reduction in violence experienced by adolescent girls this must be accompanied by wider gender transformative programmes that explicitly address power dynamics between men and women in the household and the community, and seek to transform entrenched gender norms and attitudes.

Parents/caregivers had improved relationships with their girls.

Encouragingly, parents who took part in the programme were more likely to exhibit parenting styles characterised by greater warmth and affection and lower overall rejection of their daughters than those who did not take part (see figure 8). This was even more prominent for parents who attended more of the sessions. This is significant as healthier child-parent relationships may improve lines of communication, which in turn could help protect girls from GBV, facilitate access to response services or help them to recover if they experience GBV.

Parents/caregivers learned about the developmental needs of adolescent girls.

During programme monitoring, parents demonstrated high levels of knowledge of key messages of the discussion groups, including those that focused on the physical development of adolescent girls, caring and parenting skills. However, challenges remained, including a lack of understanding on some topics and assumptions about the different gendered roles of the mother and father. There was low knowledge of basic facts about puberty, suggesting that women may need more information about their own bodies and reproductive health, enabling them to provide better support to their daughters. These findings also point to the need for programme staff facilitating parents’ discussion groups to be familiar and comfortable with the curriculum topics. As this was the first time the WPE team in the DRC implemented a parenting intervention, additional technical support and supervision might have been required.

Figure 8: Parent/caregiver warmth and affection

Parents who received the intervention | Parents who did not receive the intervention
--- | ---
Parents/caregivers | PARQ score\(^{20}\)
79% | 73%
Parents/caregivers | Warmth/affection subscale score\(^{21}\)
79% | 73%

\(^{19}\) As measured by Parental Acceptance-Rejection Questionnaire (PARQ), where a higher score indicates greater rejection/greater lack of affection towards children.
\(^{20}\) Note that a higher score indicates greater rejection
\(^{21}\) Note that a higher score indicates less warmth/ affection
Attitudes on gender and violence remain challenging.

At the end of the programme, parents from the intervention and waitlist groups did not exhibit differences in attitudes towards gender inequitable norms or the use of physical violence to discipline children. As noted earlier, for the most part, participating parents/caregivers were female (92%) and the mother of the girl (81%). Though mothers are likely to play an important supportive role for adolescent girls, they may have limited levels of control or decision making power in the household. Additionally, the COMPASS curriculum was designed to ensure parents had access to the same information that was being shared with the girls, and to improve relationships between parents and their daughters. It was not designed to transform entrenched gender norms and attitudes, or address gender roles and dynamics within the household. This finding highlights the need for corresponding gender transformative programmes that aim to address these issues directly and are targeted at female and male parents, as well as other influential members of the household and the community.

Adolescent girls’ perceptions of the influential people in their lives shifted during the course of the programme. Though there was no difference in their perceptions of how their family would respond to them if they experienced violence, they were more likely to agree that the community would force them to marry a perpetrator of sexual violence (see figure 9). This could suggest that adolescent girls have become more aware of the risks and attitudes that surround them.

Summary: The impact of COMPASS parent group discussions

Parents who took part in the programme had greater warmth and affection and lower overall rejection for their daughters than those who had not. However, their attitudes and behaviour towards genders norms and GBV did not change.

Parent participation in the programme did not result in statistically significant changes in outcomes for adolescent girls. This may be because of the focus of the caregiver curriculum, the limited power a mother has over her own life or her daughter’s, or the short timeframe of the intervention and evaluation.

Overall, these findings suggest that parent interventions need to be more responsive to existing power dynamics within the household and gender attitudes within society, and recognise the role of all influential people in the lives of adolescent girls, including men and boys who perpetrate violence.

GBV Service Providers

The quality of GBV service provision was improved.

To implement this programme, the IRC partnered with 14 community-based organisations (CBOs) in South Kivu and 13 CBOs in North Kivu. In some cases, partner CBOs provided the safe spaces for COMPASS activities, and conducted awareness-raising activities in the communities on women’s and girls’ rights. In addition, the CBOs’ psychosocial staff offered psychosocial support and case management to adolescent girls survivors of GBV and referred them to partner health facilities for medical care, when necessary. Partnerships were also formed in relation to specific interventions, such as the cash transfer pilot and economic asset building training.

IRC WPE staff provided training on psychosocial support and the case management of GBV survivors to CBO partners and health service providers throughout the programme. They also conducted monthly support and monitoring visits to improve the quality of services. During these visits, the IRC also focused on the well-being and self-care of psychosocial staff, who frequently listen to distressing stories and assist women and girls who have experienced trauma.

Psychosocial and health providers were assessed on their knowledge of and attitudes towards girls’ and survivor-friendly services. By the end of the first year (July 2016), 73% of those assessed met the minimum criteria. Concerted efforts and targeted support saw these figures rise significantly, with 94% of psychosocial focal points and 91% of health providers meeting the required standards by December 2016.

Figure 9: Girls’ perceptions of family and community, % of all girls that agreed to statements

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>% believed their family would blame them if they were forced to have sex</td>
<td>46%</td>
<td>44%</td>
</tr>
<tr>
<td>% believed their community would force them to marry the perpetrator if they were forced to have sex</td>
<td>38%</td>
<td>28%</td>
</tr>
</tbody>
</table>
Adolescent girls’ knowledge and use of services improved.

The number of adolescent girls who reported knowing where to go if a girl experiences GBV increased. By the end of the programme 57% knew where to go if sexual violence was experienced, compared to 45% before the programme (see figure 10). For physical violence, 62% knew a place to go, compared to 48% before the programme. Although this increase cannot be attributed directly to the programme due to the evaluation design, it may suggest that the knowledge shared in COMPASS and direct awareness raising work by service providers was effective. Normalisation of violence, alongside the perceived need for parental approval and the stigma related to using services, may all have contributed to adolescent girls being unsure of where to go for help if they experience GBV.

Parents’ levels of comfort discussing professional services with their daughters also increased. Although the difference was not statistically significant, parents who participated in the programme were more likely to discuss psychosocial and case management services than those who did not. In addition, parents who participated in more than 75% of sessions had 1.4 times greater odds than those in the waitlist group to feel comfortable about discussing psychosocial services with adolescent girls.

The GBV Information Management System recorded an increase in girls seeking case management services in both North and South Kivu during the course of the programme. In North Kivu, between January and June 2016, approximately 118 girls aged 10–19 sought services, and from July to December 2016, 216 girls in the same age group sought services, an 83% increase between the first and second half of the year.20

Although this increase cannot be attributed exclusively to COMPASS activities, this trend is in line with IRC’s experiences in other contexts where targeted activities for adolescent girls led to noticeable increases in the number of girls choosing to access case management services. Increased knowledge about services available, as well as a better understanding of what constitutes abuse and how services can support those who experience it may have all contributed to this observation.

In interviews, adolescent girls and parents continued to suggest that family or community members would be the first people they would tell in the event of GBV, or that they would hide the fact that violence had occurred. Endline discussions revealed that adolescent girls were still unlikely to report incidents of GBV, particularly when the perpetrator was someone they knew. Most girls in South Kivu suggested that if a boyfriend was violent, a girl should leave him and tell a friend, to help calm herself down; in the case of rape by a boyfriend, the most commonly suggested response was marriage between a girl and her boyfriend.

When discussing hypothetical scenarios, adolescent girls were unlikely to talk about using professional services such as legal recourse, unless the situation involved a perpetrator who was a stranger. In any case, a weak legal system and state structures, as well as traditional social and cultural norms which blame survivors, would make it challenging for both adult women and adolescent girls to pursue legal action against perpetrators.21

GBV services were made more adolescent girl friendly.

Adolescent girl survivors provided positive feedback about their engagements with services they accessed, particularly psychosocial support and medical care services. All of the adolescent girls that provided feedback had received psychosocial support at least once, and 100% of them stated that they were satisfied with their experience.22 Approximately 85% of the adolescent girl survivors had attended medical referrals, with 98% of this number stating satisfaction with the service they received. Medical referrals were most commonly named as the most useful service, followed by individual counselling. The adolescent girls provided varied reasons for why they considered these services useful, with preventing and healing illness often cited for medical referrals. Girls reported benefits of counselling including helping them to find solutions to problems and relieving them of feelings of shame and stress.

All of the girls described the psychosocial staff they spoke to as understanding, welcoming or empathetic, and stated that they felt the counsellor believed what they said. A minority of all girls (7.5%) felt that the psychosocial service provider made them feel responsible for the violence they’d experienced, or forced them to make decisions they did not want to make (12.5%). This suggests further training may be needed to ensure providers know how to provide survivor-centred support for younger clients, recognising this can pose additional challenges as they might feel “responsible” for the girl’s protection. Nonetheless, 98% of all adolescent girls reported that they felt better after meeting a psychosocial service provider.

Adolescent girls expressed a lack of confidence in seeking support from case management service providers who were much older than them. As a result, it was decided for future programming that younger women would be selected and trained as focal points for case management services, so adolescent girls would feel more confident and at ease about accessing this type of support.

Summary: service providers

Targeted training and monitoring resulted in strong improvements in service providers’ knowledge and attitudes towards adolescent girl survivors, allowing them to provide responsive, quality and appropriate services.

Adolescent girls who accessed services reported high levels of satisfaction and that they felt better as a result of using them.

There was a significant rise in adolescent girls (aged 10–19) accessing GBV response services during the programme. This demonstrates the importance of using targeted programming to increase adolescent girls’ knowledge of services and how to use them.

---

20. The data and statistics represented here include only information from survivors who have consented to share their aggregate information, as collected through the Gender-Based Violence Information Management System. Data included in this trend is an aggregate figure of all adolescent girls receiving services in the North and South Kivu region in 2016, not only COMPASS girls. This data is reported incidents and should not be considered to represent the prevalence of violence.

21. A total of 33 girls in South Kivu and nineteen girls in North Kivu took the survey. Note this sample was based on the availability and willingness of the girls who had received professional support to participate in the survey.
Feasibility and acceptability

By definition, communities affected by conflict and displacement are often in a state of flux, with high levels of mobility, uncertainty and instability. Programming specifically targeted at 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. With these factors in mind, the IRC explored the extent to which adolescent girls’ safe spaces and related programming in conflict affected communities in North and South Kivu was feasible and acceptable. Feasibility refers to adolescent girls having safe, consistent access and the ability to participate. Acceptability refers to adolescent girls, families and communities being open to learning about programme topics and developing related skills, as well as adolescent leaders, authorities and other influential actors supporting their participation.

Enrolment and attendance

High enrolment demonstrated that COMPASS responded to an unmet need for adolescent girls in humanitarian settings.

Enrolment rates are a good indication of accessibility and interest in the programme, both in terms of 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. Before enrolment to the programme, the IRC WPE staff conducted awareness raising activities, community meetings and discussions with local authorities in South Kivu and North Kivu to introduce adolescent girls and their families, and the wider community, to the programme. As a result, there was huge interest from adolescent girls who wanted to enrol in the first programme cycle. In total, 1,119 girls were enrolled in life skills programming in the first programme cycle, plus 395 girls in other activities (on economic empowerment). Adolescent girls who were not able to enrol due to capacity were invited to join the second programme cycle.

Identifying parents/caregivers

Adolescent girls were asked to identify one parent/caregiver of their choice to attend the COMPASS parent group discussions. Most adolescent girls selected their mother (82%); however, reports from staff indicate that when girls did identify their fathers, the men would sometimes delegate attendance to their wives. In North Kivu, and particularly in emergency sites, a number of adolescent girls were the head of the household and therefore could not easily identify someone to attend the parent group discussions.

During the first programme cycle, there were some rumours of monetary benefits to attending COMPASS. IRC staff worked hard to combat this rumour from the outset, but some adolescent girls and parents lost interest in the programme when they realised this was not the case. In addition, due to the design of the evaluation, there was a long gap between initial enrolment of the adolescent girls and the start of the curriculum sessions, which meant some adolescent girls had moved away in the interim or were no longer interested in the programme. However, for the most part, adolescent girls were keen to attend, regardless of their education status or rumours of incentives, as demonstrated by the high attendance rates.

Feasibility and acceptability

High attendance of adolescent girls demonstrated girls’ enthusiasm for 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, adolescent girls’ attendance of the life skills sessions was very high, showing enthusiasm for the programme. Average attendance rates were 74% across all sites in South Kivu and 81% across the sites in North Kivu. However, attendance was initially lower than expected, since many girls had already moved away, others had schedule conflicts and some parents had decided they no longer wanted their girls to attend. Adjusting the schedule of the programme and carrying out further sensitisation work with parents overcame these challenges, resulting in higher, more consistent attendance rates across the sites. In addition, attendance was closely monitored and mentors got in touch with absent adolescent girls to encourage them to attend.

The most common reason for missing sessions was having to run errands, most often for their parents or church, and sickness. This was particularly notable in sites where access to clean water was poor (see Figure 11). Other reasons included housework, rain, pregnancy, marriage, having moved site, scheduling conflict with school and holiday/travel. Parents mentioned in interviews that programme scheduling had been a concern, specifically in terms of conflicts with church and other sessions.

Figure 11: Adolescent girls’ reasons for absence

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick</td>
<td>14%</td>
</tr>
<tr>
<td>Errands for parents/church</td>
<td>8%</td>
</tr>
<tr>
<td>School</td>
<td>5%</td>
</tr>
<tr>
<td>Moved or travelling</td>
<td>7%</td>
</tr>
<tr>
<td>Marriage/pregnancy</td>
<td>2%</td>
</tr>
</tbody>
</table>

94. Low attendance was recorded in Kanapola, Kabilanga and Luvungi.
Adolescent girls’ experience of life skills sessions

Adolescent girls gave positive feedback about the life skills sessions.

Adolescent girls provided very positive feedback about sessions and the materials used, the accessibility and quality of the safe space, their mentors, and spending time with their peers. When asked about what they had studied, adolescent girls said the topics they found most interesting were puberty and hygiene, friendship, early marriage and unwanted pregnancy. Adolescent girls were happy to learn about their rights in relationships and how to protect themselves from pregnancy.

Adolescent girls retained important knowledge taught by COMPASS.

Overall, adolescent girls were able to retain the key messages of COMPASS, but entrenched gender norms did remain in relation to some topics — see box. Notably, many girls still accept harassment as part of everyday life and believe their self-worth is linked to their capability of performing domestic tasks. The endline survey’s findings on safety support those emerging from endline interviews, with adolescent girls stating that it is their responsibility alone to keep themselves safe, and that the best way to do this is through restricting their movement. This reinforces the point that changing harmful attitudes on gender and GBV, particularly in terms of victim blaming, is extremely difficult. Sustained, long-term interventions are required, which take a comprehensive approach to challenging deeply entrenched gender norms.

When she was 15, Uwizera was one of the only girls to go to school. Now, aged 23, she achieved her dream of becoming a teacher.

Photo credit: Aubrey Wade/IRC 2010

CHAPTER 3: What works to address GBV against adolescent girls: learning from COMPASS
Acceptability to parents/ caregivers and community members

Engaging and sensitising parents, community members, local leaders and authorities was key to this programme, in terms of increasing acceptability of COMPASS and changing attitudes held about adolescent girls and their lives. The IRC team held a number of sensitisation activities to highlight the importance of COMPASS and the injustices and threats women and girls face in the community. These included:

- Girl-led presentations such as sketches, theatre plays, poems and songs
- Discussion sessions with community leaders
- Community outreach sessions (presentations, group discussions)

Parents and community members did hold some negative perceptions of COMPASS throughout its duration. In interviews, some girls spoke about how their families were unsupportive of the programme because it was taking them away from household chores, or because of suspicions that topics were inappropriate. COMPASS staff shared feedback from parents that they felt the programme should also have included boys, particularly the brothers of participating adolescent girls.

In general, parents appeared to be comfortable in the sessions, but there were some challenges discussing topics such as menstruation, harmful traditional practices and sexual health, especially contraception. This was particularly notable when a group discussion included both men and women. However, reports from staff suggested that some parents were also grateful that these topics were being addressed, as they had no other opportunity to discuss them.

Summary: feasibility and acceptability

There was considerable interest in the COMPASS programme during the enrolment phase, thanks to efforts to sensitise adolescent girls and their communities in advance of the programme. Attendance rates of adolescent girls were high, and they expressed satisfaction with the delivery and content of the programme.

In comparison, parents’ attendance was lower at the beginning of the programme, primarily because they had more competing priorities and saw less benefit in attending. However, ongoing efforts to improve attendance paid off, leading to steady improvements in attendance among parents. Wider community engagement also increased the general acceptability of the programme.

The high demand and ongoing interest from adolescent girls in COMPASS, and the general support from families and communities for their ongoing participation, demonstrate that adolescent girl programming is both feasible and acceptable in conflict-affected communities in eastern DRC.

Lessons from Implementation

Implementing a life skills programme with adolescent girls in conflict-affected settings required ongoing adaptations and high levels of resources. This section outlines lessons learned during programme implementation, particularly in relation to safe spaces, curriculum design, and the approach to mentorship.

Safe spaces

Extensive consultation with the adolescent girls was conducted prior to the start of the programme to ensure the programme was relevant and effectively responded to their needs. As a result of this process, it was decided that existing community spaces were the best place to hold COMPASS activities: within CBOs, schools, health centres or churches. The IRC worked with these organisations to renovate the space and prepare it for COMPASS activities.

In emergency sites, where finding an appropriate space was more challenging, teams noted the importance of adolescent girls having a safe space to express themselves, even if this space was temporary and informal. 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.

Curriculum design

A process of contextualisation was conducted before finalising the curriculum for the first cycle; this included discussions with adolescent girls and parents. It was decided that issues concerning sexual and reproductive health issues should be discussed primarily with older girls (12–14 years old) participating in the programme. The parent curriculum was restructured so more sensitive issues such as sexual and reproductive health could be discussed prior to these topics being covered with the adolescent girls. A corresponding image book was developed to aid the implementation of the curriculum. The teams received positive feedback from both adolescent girls and parents on the content of the curriculum and the topics covered. Adolescent girls were particularly interested in sessions relating to puberty, sexual reproductive health and pregnancy, and financial management and savings.

Given the unstable security situation in eastern DRC, a shortened curriculum for use in emergency contexts was developed, as a full 10-month long curriculum was deemed unfeasible in a period of acute emergency. Key individual modules were selected for adaptation and used in one-off meetings or over the course of two to three weeks. This was implemented in IDP camps in North Kivu with a total of 600 14–19-year-old girls, and in South Kivu during emergency response missions. A shortened curriculum was well received, with adolescent girls keen to participate, and others in the community also showing an interest. Sessions were adapted to suit adolescent girls of different ages, and positive feedback was reported by camp managers in terms of girls’ knowledge and experiences of the sessions. However, it was challenging to get through all the topics that the adolescent girls had identified as important; for example, adolescent girls in North Kivu identified that they would have liked more information on family planning, abortion and girls’ rights.
Mentors

While IRC staff facilitated parent group discussions, mentors were recruited to facilitate the life skills sessions with adolescent girls. Mentors were identified based on recommendations from adolescent girls and their parents and using the following criteria: proximity in age to the girls, levels of literacy, ability to empathise and willingness to commit to the full duration of curriculum. Training took place at the beginning of each of the three levels of the curriculum, with one level comprising 12–14 curriculum sessions. This was followed by tests to assess knowledge retention, which showed high levels of understanding of the topics and methods.

During COMPASS implementation, mentors’ facilitation style and interaction with adolescent girls continued to evolve and improve. While all mentors had completed secondary school, many were used to didactic approaches to teaching, rather than the participatory methods developed for COMPASS, which encourage adolescent girls’ active engagement with the curriculum. As such, the IRC provided continual supervision and feedback to help mentors successfully support adolescent girls in their communities.

The quality of curriculum delivery was measured using a quality criteria check-list (see box). COMPASS staff conducted session observations every three months, recording their results and feeding back to the mentors on their approach. This was in addition to more frequent support-supervision visits. Mentors showed strong skills and positive attitudes, and warmth and respect towards the adolescent girls. The majority also gave the girls ideas and advice as to how to apply the themes of the curriculum for mentors that featured an introduction to GBV, gender norms and attitudes, gendered power dynamics. This may have impacted upon the quality of the information passed onto adolescent girls and how mentors responded to questions during sessions. During the programme, the IRC developed a conversation guide on more difficult subjects in response to this challenge, and introduced a system of co-facilitation with IRC staff when mentors were likely to need additional support.

Despite these positive findings, there were some concerns that because the mentors came from similar geographical and social backgrounds as the adolescent girls, they may have reinforced harmful social norms, instead of challenging them. Implementing teams found that mentors needed additional training and greater technical support when discussing issues related to gender norms and GBV. This may have contributed to the lack of change in adolescent girls’ attitudes to gender and their continued acceptance of GBV. Mentors were trained directly on the adolescent girls’ life skills curriculum, but there was no specific training curriculum for mentors that featured an introduction to GBV, gender norms and attitudes, gendered power dynamics. This may have impacted upon the quality of the information passed onto adolescent girls and how mentors responded to questions during sessions. During the programme, the IRC developed a conversation guide on more difficult subjects in response to this challenge, and introduced a system of co-facilitation with IRC staff when mentors were likely to need additional support.

Quality criteria for COMPASS curriculum implementation

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

Summary: Lessons from implementation

Extensive consultation with adolescent girls and parents was conducted at the start of the programme to ensure content and delivery of the life skills sessions were relevant and useful to the girls, and would allow them to participate in a meaningful and safe way. Both the life skills and parent curricula were adapted, with a specific focus on managing more sensitive topics. Due to incidents of instability in eastern DRC, a shorter and more flexible version of the life skills curriculum was adapted and implemented in emergency contexts. These adaptations highlight the need for programmes to be flexible and responsive to ongoing learning from the programme.

Selected female mentors were provided with intensive training to deliver the adolescent girl life skills sessions. Despite some challenges at the beginning concerning participatory facilitation methods, they were able to engage adolescent girls in the curriculum through group work and discussion. However, the backgrounds of mentors and the social norms they held may have influenced how they delivered messages to adolescent girls. This may have been a contributing factor to adolescent girls continuing to hold harmful attitudes about gender and GBV. In light of this, it is essential that future programmes provide additional, tailored training to mentors which takes into account their own background and attitudes, as well as ongoing support to mentors regarding particularly sensitive or challenging topics.

Overall, the flexible and responsive approach used in COMPASS resulted in a high-quality and appropriate programme being developed and delivered in DRC.
CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS

This chapter summarises the key conclusions from the implementation and evaluation of the COMPASS programme in DRC and makes recommendations to donors, policy makers, practitioners and researchers on supporting a robust programming and research agenda for adolescent girls in humanitarian settings.
Girls felt more hopeful about their future, and the safe space provided adolescent girls with increased awareness about GBV experiences. After participating in the programme, girls reported less exposure to GBV, had stronger social networks, increased awareness about GBV services and more hope for the future.

Adolescent girls in the COMPASS sites were excited about this programme, and there was a high level of interest in enrolling and participating. The girls were eager to learn life skills, make connections with supportive adults, and spend time in a safe space with their female peers.

The programme provided a space where adolescent girls could make friends and meet safe and trusted mentors. In the safe space, mentors taught girls about where to go in the case of physical and sexual violence. This significantly increased girls’ knowledge of professional GBV services, which play a vital role in preventing violence from occurring when a risk emerges and helping adolescent girls recover when violence does occur.

Although the evaluation design meant that these findings could not be unequivocally attributed to COMPASS, they provide important evidence of improvements in girls’ social, emotional and psychological wellbeing after participating in the programme.

Encouragingly, parents who participated in COMPASS exhibited more warmth towards their daughters. This indicates that COMPASS also had a positive impact on parents’ relationships with their daughters.

The existence of quality GBV services and trained staff was critical in 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 FPR. This is likely to have led to a higher level of awareness amongst girls of the violent nature of some of their experiences, as can be suggested by the 83% increase in adolescent girls’ reporting to GBV case management and psychosocial support services observed between January and June 2016.

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.

Consultation with adolescent girls throughout implementation was essential to ensuring programming was responsive, flexible and addressed the needs of girls from diverse backgrounds. The programme provided a space where adolescent girls’ unique perspectives were heard. Discussions with adolescent girls informed and influenced the design of the programme, including curriculum content, selection of safe spaces and mentors, and the participating parent. This was important given that there was huge diversity among the adolescent girls that participated in the programme, in terms of education, family life, and family experience.

Adaptations made to the curriculum, and ongoing learning resulting from consultations with the adolescent girls and their parents ensured the content of the curriculum and the methods used to deliver it were relevant and appropriate. For example, adolescent girls expressed their discomfort seeking support from much older women, so service provision was made more adolescent-girl friendly by recruiting younger women as the focal points of case management services.

In addition, the development of a shortened curriculum demonstrated that it is feasible to deliver life skills support to adolescent girls living in emergency contexts.

Sufficient time, space, resources and different methods were needed to monitor progress, respond to feedback and adapt accordingly.

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 what works on and interventions are most effective in reducing GBV against adolescent girls in humanitarian settings.

One area of reduction in girls’ self-reported exposure to GBV, the evaluation did not indicate that parent participation had a significant additional impact on levels of GBV experienced by the adolescent girls.

Qualitative research showed that harmful gender norms and victim-blaming attitudes remain deeply entrenched in the communities where COMPASS participants lived, including amongst girls and their mothers.

This could be due to the fact that the parent/caregiver curriculum was not designed to transform entrenched social and gender norms, or attitudes and related behaviours. It also was not developed to address participating parents/caregivers as potential perpetrators of GBV, and in particular sexual violence, against adolescent girls. Instead, the aim of the curriculum was to improve parents/caregivers’ relationships with their adolescent girls and increase acceptance of the programme by providing them with the same information.

In addition, the majority of parents who participated in the programme were female. They are likely to have limited power within their family and community, making it difficult for them to make decisions or changes that will reduce their girls’ exposure to GBV.

Notably, the evaluation was conducted on the first programme cycle, during which design was still being refined and learning continued to be made regarding implementation. Later iterations of the programme are likely to have been more efficient and effective, potentially leading to even more positive results.

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 tackle the root causes of GBV, including deeply-entrenched gender norms and victim-blaming attitudes. This underlines the need for further research and evaluation that builds on COMPASS learning and explores the impact of social and behavioural change programming.

Based on these conclusions, the IRC has developed a programme model and resource package called Girl Shine. It builds on the positive practices in COMPASS and bridges the gaps identified during the implementation of the programme and by associated research. Girl Shine is intended to be a practical and flexible resource for practitioners. It includes step-by-step guides on how to design, implement and monitor a life skills programme for adolescent girls and parents/caregivers living in humanitarian settings. It also features a training component for mentors and staff.
Recommenda...
ANNEX 1: IMPACT EVALUATION METHODOLOGY

Hypothesis

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

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

• To assess the incremental impact of the parent/caregiver group discussions when delivered alongside the adolescent girls’ life skill sessions on a) girls’ experiences of physical, sexual and emotional violence; b) confidence and self-esteem; c) girls’ support networks; and d) gender attitudes.

• To explore how the addition of parent/caregiver group discussions may influence levels of violence against adolescent girls and build their support networks.

Particular outcomes of interest were identified by the project team during a kick-off workshop in London which involved examining the theory of change and identifying outcomes that aligned with the underlying theoretical processes. These include:

1) reduction in adolescent girls’ experiences of physical and emotional abuse from parents/caregivers
2) reduction in adolescent girls’ experiences of sexual abuse and exploitation
3) reduction in adolescent girls’ experiences of intimate partner violence
4) increase in adolescent girls’ skills and sense of agency
5) increase in number of peers and adults adolescent girls can turn to for emotional support.

Study design overview

The study design was a two-arm cluster-randomised control trial across 14 sites in South Kivu, DRC. Following programme enrolment and the completion of baseline data collection, adolescent girls were divided into clusters, and the clusters were randomised into two groups:

1) waitlist group – only adolescent girls receive life skills sessions, or
2) intervention group – adolescent girls receive life skills sessions and parents/caregivers attend group discussions.

A baseline survey was conducted with 869 girls and 764 parents/caregivers in May and June 2015, and an endline survey was completed from August to October 2016. Qualitative focus groups and participatory activities were also conducted at the beginning of the programme, and individual interviews were conducted with adolescent girls and parents/caregivers at the end of the programme. Parents/caregivers of adolescent girls in the waitlist group were eligible to join group discussions after the first cycle was completed.

Community selection, participant recruitment and consent

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

Data collection methods

Female survey enumerators were trained by Columbia University and matched to participants by language. Interviewers orally administered less sensitive questions from the baseline survey to adolescent girls using Computer-Assisted Personal Interviewing (CAPI). More sensitive sections of the survey were self-administered by the girls using Audio Computer Assisted Self-Interviewing (ACASI) computer programs, where a girl would hear survey questions through headphones and follow instructions to select an appropriate response on her tablet by tapping on a colour or image coded response option. Only older girls in the sample (aged 13–14) were invited to respond to questions on violence and sexual health items that were deemed inappropriate for younger participants (aged 10–12). Parent/caregiver surveys were entirely administered by an interviewer who used CAPi. Surveys were translated into French, Swahili and Mashi, and verified before use with adolescent girls and parents/caregivers.

At the beginning of the programme, two qualitative methods were used with a sub-sample of adolescent girls and their parents/caregivers. The first activity was a social mapping in which girls worked together to map their community and identify and discuss areas on the map where they felt safe and unsafe. The second activity was a focus group discussion with parents/caregivers that included a participatory component to brainstorm ways in which the safety of adolescent girls could be increased. Qualitative discussions were conducted in private spaces, using a trained interviewer and note-taker.

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

Qualitative interviews were conducted in private spaces, using a trained interviewer, translator and note-taker. All participants in both quantitative and qualitative activities were provided information on available psychosocial support services, and offered an opportunity to speak with a social worker.

Data analysis

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

To assess the effects of the intervention, both intent-to-treat (ITT) and per-protocol (PP) analyses were implemented. ITT analysis was carried out for all adolescent girls and parents/caregivers for whom data were collected at the beginning and end of the programme. The effects of the intervention were examined using logistic regression analysis for binary outcomes and linear mixed models for continuous variables. Baseline covariates controlled for in the adolescent girls’ ITT model were selected based on those demographic characteristics determined not to be balanced between intervention and waitlist groups using Pearson chi-squared and two-sample t-tests.

PP analysis for adolescent girls’ outcomes examined the effect of both the adolescent girl and her parent/caregiver attending at least 75% of programme sessions. PP analysis therefore assesses differences in outcomes across three groups: adolescent girls in the waitlist group, adolescent girls in the intervention group who attended less than 75% of programme sessions or whose parents/caregivers attended less than 75% of group discussions (low treatment adherence), and adolescent girls in the intervention group who, along with their parents/caregivers, attended at least 75% of programme sessions (high treatment adherence).

Adolescent girls’ PP logistic regressions control for age and having ever worked for pay, which were the only two baseline covariates found to be significantly associated with high vs. low adherence to protocol.

PP analysis for parent/caregiver outcomes looked at the effect of parents/caregivers attending at least 75% of parent/caregiver sessions. PP results compare outcomes across the waitlist group, low attendance of intervention and high attendance of intervention. ITT and PP models for parents/caregivers control for the outcome of interest at the beginning of the programme only, as all baseline characteristics for parents/caregivers were balanced across intervention and waitlist groups. All models adjust for clustering at the group level of randomisation, which also served as the programme session group. All quantitative data were analysed using Stata14.
Qualitative transcripts were analysed using thematic content analysis (Smith 1992). Emerging themes in the transcripts were identified as central categories; these were used to identify recurring patterns in the data. A research team of two graduate students, a senior research associate and a co-investigator from Columbia University reviewed the transcripts. After developing an initial coding scheme through individual transcript review, the team then came together to agree on emerging categories. Two members of the research team then coded subsets of transcripts to ensure inter-coder reliability before coding the full data set. Narrative data from the group discussions were analysed in NVivo 10.1.

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

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

Limitations
The findings rely entirely on the self-reporting of adolescent girls and parents/caregivers participating in the COMPASS programme, which may result in response or recall biases. The number of out-of-school girls may be over reported due to misinterpretation in the target communities about the programme’s intention to provide financial assistance for school fees. Data collectors reported difficulty in participants’ understanding of scale items, which may partially explain low Cronbach’s alpha scores on some of the scales and subscales. Additionally, staff had difficulty verifying the ages of the girls participating in the programme. This means girls who participated may be older than they indicated when they enrolled.

ANNEX 2: ADOLESCENT GIRL AND PARENT/ CAREGIVER DEMOGRAPHICS

26% of adolescent girl participants reported being exposed to some form of sexual violence in the 12 months preceding baseline data collection. Specifically, 17.6% of 13–14-year-olds experienced forced sex, 14.1% of 10–14-year-olds experienced coerced sex, and 15.3% of 10–14-year-olds experienced unwanted sexual touching during this period. Physical and emotional violence were reported by a higher proportion of girls, with 42.3% and 43.8%, respectively, reporting experiencing these forms of violence in the past 12 months. At the beginning of the programme, nearly half of the adolescent girls reported having experienced neglect. Finally, 14.6% of girls reported experiencing transactional sexual exploitation in the 12 months prior to the beginning of the programme. On average, parents/caregivers were 39.7 years old and 92% of parent/caregiver participants were female.
### Table 4.1.1. Baseline characteristics

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Intervention</th>
<th>Waitlist</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Girls (n=869)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td>12.035 [1.503]</td>
<td>11.955 [1.473]</td>
<td>12.118 [1.532]</td>
<td>0.110</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mashi</td>
<td>0.457 [0.498]</td>
<td>0.517 [0.500]</td>
<td>0.393 [0.489]</td>
<td></td>
</tr>
<tr>
<td>Swahili</td>
<td>0.543 [0.498]</td>
<td>0.483 [0.500]</td>
<td>0.607 [0.498]</td>
<td></td>
</tr>
<tr>
<td><strong>Attended school, past 12 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.795 [0.404]</td>
<td>0.789 [0.404]</td>
<td>0.801 [0.404]</td>
<td>0.657</td>
</tr>
<tr>
<td><strong>Years of schooling (years)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Worked for pay, ever</strong></td>
<td>0.198 [0.390]</td>
<td>0.231 [0.420]</td>
<td>0.163 [0.370]</td>
<td>0.012</td>
</tr>
<tr>
<td><strong>Parents in the household</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td>0.598 [0.491]</td>
<td>0.590 [0.492]</td>
<td>0.608 [0.489]</td>
<td></td>
</tr>
<tr>
<td>Mother only</td>
<td>0.278 [0.449]</td>
<td>0.271 [0.445]</td>
<td>0.286 [0.452]</td>
<td></td>
</tr>
<tr>
<td>Father only</td>
<td>0.032 [0.177]</td>
<td>0.028 [0.186]</td>
<td>0.028 [0.168]</td>
<td></td>
</tr>
<tr>
<td>Neither</td>
<td>0.091 [0.288]</td>
<td>0.103 [0.304]</td>
<td>0.078 [0.269]</td>
<td></td>
</tr>
<tr>
<td><strong>Live with intimate partner (13-14 year olds)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.177 [0.382]</td>
<td>0.181 [0.386]</td>
<td>0.174 [0.380]</td>
<td>0.688</td>
</tr>
<tr>
<td><strong>Exposure to violence, past 12 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forced sex (13-14 year olds)</td>
<td>0.176 [0.382]</td>
<td>0.199 [0.400]</td>
<td>0.157 [0.366]</td>
<td>0.328</td>
</tr>
<tr>
<td>Coerced sex</td>
<td>0.141 [0.348]</td>
<td>0.13 [0.336]</td>
<td>0.153 [0.366]</td>
<td>0.353</td>
</tr>
<tr>
<td>Unwanted sexual touching</td>
<td>0.153 [0.361]</td>
<td>0.158 [0.365]</td>
<td>0.149 [0.367]</td>
<td>0.746</td>
</tr>
<tr>
<td>Any sexual violence</td>
<td>0.265 [0.442]</td>
<td>0.268 [0.438]</td>
<td>0.272 [0.446]</td>
<td>0.664</td>
</tr>
<tr>
<td>Physical violence</td>
<td>0.423 [0.494]</td>
<td>0.43 [0.498]</td>
<td>0.415 [0.498]</td>
<td>0.677</td>
</tr>
<tr>
<td>Emotional violence</td>
<td>0.438 [0.496]</td>
<td>0.429 [0.496]</td>
<td>0.448 [0.498]</td>
<td>0.597</td>
</tr>
<tr>
<td>Neglect, past 12 months</td>
<td>0.492 [0.500]</td>
<td>0.495 [0.501]</td>
<td>0.488 [0.501]</td>
<td>0.840</td>
</tr>
<tr>
<td>Early marriage, past 12 months (13-14 year olds)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.203 [0.400]</td>
<td>0.199 [0.400]</td>
<td>0.207 [0.406]</td>
<td>0.858</td>
</tr>
<tr>
<td>Transactional sexual exploitation, past 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.146 [0.354]</td>
<td>0.15 [0.357]</td>
<td>0.142 [0.350]</td>
<td>0.776</td>
</tr>
<tr>
<td>Sample size</td>
<td>869</td>
<td>446</td>
<td>423</td>
<td></td>
</tr>
<tr>
<td><strong>Caregivers (n=764)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>0.918 [0.274]</td>
<td>0.928 [0.269]</td>
<td>0.908 [0.280]</td>
<td>0.340</td>
</tr>
<tr>
<td>Sample size</td>
<td>764</td>
<td>389</td>
<td>375</td>
<td></td>
</tr>
</tbody>
</table>

Note: mean values reflect proportions of the sample unless otherwise specified. Differences between treatment and control groups are significant at *p<0.05, **p<0.01, ***p<0.001.

19.79% of adolescent girls reported to have worked for money or other payment in their lifetime. Of these girls, the vast majority (89.53%) had worked for money or other payment in the past year (Table 4.2.2). The type of work most frequently done was farm work (40.38%), followed by working for a small business (32.05%). Adolescent girls in the intervention group were 1.54 times more likely to have worked outside the home for money or payment than girls in the waitlist group (1.08–2.20, p = 0.01). Of the respondents who had worked outside the home for money or other payment, those in the intervention group were 4.55 times more likely than girls in the waitlist group to have worked in the past year (1.42–17.02, p < 0.01). 12.31% of adolescent girls reported having worked outside the home without pay in the past year. Girls in the intervention group were also 1.69 times more likely to have worked outside the home without pay in the past 12 months than girls in the waitlist group (p = 0.01).
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
- Weak knowledge base on prevention of and response to violence against adolescent girls in humanitarian settings

Interventions

- Provide opportunities for girls to protect their self 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 behaviour
- Conduct rigorous research, 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

- Adolescent girls in humanitarian settings are safer from violence and the threat of violence
- Improved prevention of and response to violence against adolescent girls in humanitarian settings, particularly in Ethiopia, Pakistan and DRC
- Adolescent girls in humanitarian settings are safer from violence and the threat of violence

ANNEX 4: DATA TABLES

Figure 1. Adolescent girl demographics

<table>
<thead>
<tr>
<th></th>
<th>Total (N = 869)</th>
<th>Intervention (N = 446)</th>
<th>Control (N = 423)</th>
<th>OR p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (average)</td>
<td>12.03 (11.96)</td>
<td>12.12 (12.01)</td>
<td>11.98 (11.37)</td>
<td>0.11</td>
</tr>
<tr>
<td>Marital status</td>
<td>(N = 977)</td>
<td>(N = 477)</td>
<td>(N = 400)</td>
<td>0.48</td>
</tr>
<tr>
<td>Unmarried</td>
<td>263 (69.76)</td>
<td>126 (71.19)</td>
<td>137 (68.5)</td>
<td></td>
</tr>
<tr>
<td>Married and living with partner</td>
<td>46 (12.2)</td>
<td>23 (12.99)</td>
<td>23 (11.6)</td>
<td></td>
</tr>
<tr>
<td>Married and not living with partner</td>
<td>25 (6.63)</td>
<td>10 (5.65)</td>
<td>15 (7.5)</td>
<td></td>
</tr>
<tr>
<td>Living with partner as if married</td>
<td>16 (4.24)</td>
<td>7 (3.95)</td>
<td>9 (4.5)</td>
<td></td>
</tr>
<tr>
<td>Living with a biological/parent</td>
<td>(N = 869)</td>
<td>(N = 446)</td>
<td>(N = 423)</td>
<td>0.64</td>
</tr>
<tr>
<td>Both parents</td>
<td>520 (58.84)</td>
<td>263 (58.97)</td>
<td>257 (50.78)</td>
<td></td>
</tr>
<tr>
<td>Mother only</td>
<td>240 (27.49)</td>
<td>131 (29.15)</td>
<td>109 (26.02)</td>
<td></td>
</tr>
<tr>
<td>Father only</td>
<td>38 (4.24)</td>
<td>16 (3.59)</td>
<td>22 (5.23)</td>
<td></td>
</tr>
<tr>
<td>Neither parent</td>
<td>79 (9.09)</td>
<td>46 (10.31)</td>
<td>33 (7.8)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>(N = 869)</td>
<td>(N = 446)</td>
<td>(N = 423)</td>
<td>0.47</td>
</tr>
<tr>
<td>Ever attended school</td>
<td>691 (79.52)</td>
<td>352 (78.92)</td>
<td>339 (80.1)</td>
<td>0.66</td>
</tr>
<tr>
<td>–Older girls</td>
<td>310 (80.25)</td>
<td>139 (78.83)</td>
<td>171 (85.8)</td>
<td>0.04</td>
</tr>
<tr>
<td>–Younger girls</td>
<td>381 (77.44)</td>
<td>213 (79.18)</td>
<td>168 (75.34)</td>
<td>0.05</td>
</tr>
<tr>
<td>Enrolled in school in last year</td>
<td>388 (56.15)</td>
<td>191 (54.26)</td>
<td>197 (58.11)</td>
<td>0.31</td>
</tr>
<tr>
<td>–Older girls</td>
<td>185 (51.61)</td>
<td>97 (48.2)</td>
<td>88 (53.9)</td>
<td>0.29</td>
</tr>
<tr>
<td>–Younger girls</td>
<td>203 (59.84)</td>
<td>94 (56.22)</td>
<td>109 (61.9)</td>
<td>0.47</td>
</tr>
<tr>
<td>Years of school completed</td>
<td>3.40 (2.08)</td>
<td>3.18 (1.80)</td>
<td>3.63 (2.21)</td>
<td>0.005</td>
</tr>
<tr>
<td>Reasons for non-enrollment in last school year</td>
<td>(N = 903)</td>
<td>(N = 181)</td>
<td>(N = 142)</td>
<td>0.41</td>
</tr>
<tr>
<td>Family could not afford</td>
<td>270 (30.11)</td>
<td>148 (81.93)</td>
<td>122 (85.92)</td>
<td></td>
</tr>
<tr>
<td>No school places available</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Too many domestic responsibilities</td>
<td>9 (2.97)</td>
<td>3 (1.69)</td>
<td>6 (4.29)</td>
<td></td>
</tr>
<tr>
<td>School too far from school in vicinity</td>
<td>1 (0.33)</td>
<td>0 (0)</td>
<td>1 (0.7)</td>
<td></td>
</tr>
<tr>
<td>Family does not approve</td>
<td>7 (2.31)</td>
<td>4 (2.48)</td>
<td>3 (2.11)</td>
<td></td>
</tr>
<tr>
<td>No school places available</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Poor housing conditions</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Perversions or violence</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Falling behind</td>
<td>2 (0.69)</td>
<td>0 (0)</td>
<td>2 (1.41)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>11 (3.33)</td>
<td>4 (2.48)</td>
<td>7 (4.66)</td>
<td></td>
</tr>
</tbody>
</table>
### Figure 2: Parents/caregiver demographics

<table>
<thead>
<tr>
<th></th>
<th>Total (N = 869)</th>
<th>Intervention (N = 446)</th>
<th>Control (N = 423)</th>
<th>OR p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(mean) (sd)</td>
<td>(mean) (sd)</td>
<td>(mean) (sd)</td>
<td></td>
</tr>
<tr>
<td>Age (average)</td>
<td>38.52 10.36</td>
<td>38.50 10.38</td>
<td>38.55 10.34</td>
<td>0.94</td>
</tr>
<tr>
<td>Gender (female)</td>
<td>703 82.05</td>
<td>381 86.28</td>
<td>322 76.86</td>
<td>0.41</td>
</tr>
<tr>
<td>Relationship to girl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>616 80.63</td>
<td>312 80.21</td>
<td>304 81.07</td>
<td>0.76</td>
</tr>
<tr>
<td>Father</td>
<td>51 6.68</td>
<td>26 6.43</td>
<td>25 6.89</td>
<td>0.68</td>
</tr>
<tr>
<td>Grandparent</td>
<td>34 4.45</td>
<td>18 4.48</td>
<td>16 4.61</td>
<td>0.56</td>
</tr>
<tr>
<td>Step parent</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
<td></td>
</tr>
<tr>
<td>Sibling</td>
<td>25 3.27</td>
<td>13 3.34</td>
<td>12 3.2</td>
<td>0.11</td>
</tr>
<tr>
<td>Other relative</td>
<td>21 2.75</td>
<td>13 3.34</td>
<td>8 2.13</td>
<td>0.31</td>
</tr>
<tr>
<td>Nonrelated caregiver</td>
<td>1 0.13</td>
<td>0 0</td>
<td>1 0.27</td>
<td>0.49</td>
</tr>
<tr>
<td>Other</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
<td></td>
</tr>
<tr>
<td>Primary financial supporter of girl’s household</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>408 53.4</td>
<td>208 53.47</td>
<td>200 53.33</td>
<td>0.99</td>
</tr>
<tr>
<td>Father</td>
<td>265 33.25</td>
<td>135 33.31</td>
<td>130 32.35</td>
<td>0.84</td>
</tr>
<tr>
<td>Grandparent</td>
<td>35 4.58</td>
<td>16 4.63</td>
<td>19 4.63</td>
<td>0.77</td>
</tr>
<tr>
<td>Step parent</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
<td></td>
</tr>
<tr>
<td>Sibling</td>
<td>19 2.44</td>
<td>8 2.09</td>
<td>11 2.93</td>
<td>0.91</td>
</tr>
<tr>
<td>Other relative</td>
<td>14 1.83</td>
<td>6 1.54</td>
<td>8 2.13</td>
<td>0.19</td>
</tr>
<tr>
<td>Nonrelated caregiver</td>
<td>7 0.91</td>
<td>0 0</td>
<td>7 0.86</td>
<td>0.80</td>
</tr>
<tr>
<td>Other</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
<td></td>
</tr>
</tbody>
</table>

### Figure 3a: Sexual violence, early marriage, and transactional sex at baseline, by treatment status

<table>
<thead>
<tr>
<th></th>
<th>Total (N) (% agree)</th>
<th>Intervention (N) (% agree)</th>
<th>Control (N) (% agree)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced sex, last 12 months (13-14 years old)</td>
<td>329 (17.63)</td>
<td>151 (19.87)</td>
<td>178 (15.75)</td>
<td>0.33</td>
</tr>
<tr>
<td>Coerced sex, last 12 months</td>
<td>789 (14.07)</td>
<td>404 (15.05)</td>
<td>385 (14.91)</td>
<td>0.73</td>
</tr>
<tr>
<td>Unwanted sexual touching, last 12 months</td>
<td>769 (15.34)</td>
<td>450 (15.26)</td>
<td>319 (14.19)</td>
<td>0.75</td>
</tr>
<tr>
<td>Any form of sexual violence, last 12 months</td>
<td>765 (16.49)</td>
<td>395 (20.85)</td>
<td>370 (17.22)</td>
<td>0.36</td>
</tr>
<tr>
<td>Early marriage, last 12 months (13-14 years old)</td>
<td>259 (20.25)</td>
<td>129 (25.00)</td>
<td>130 (24.65)</td>
<td>0.05</td>
</tr>
<tr>
<td>Transactional sex, last 12 months</td>
<td>766 (14.62)</td>
<td>364 (26.87)</td>
<td>402 (26.78)</td>
<td>0.01</td>
</tr>
</tbody>
</table>

### Figure 3b: Experiences of physical violence, emotional abuse, and neglect at baseline, by treatment status

<table>
<thead>
<tr>
<th></th>
<th>Total (N) (% agree)</th>
<th>Intervention (N) (% agree)</th>
<th>Control (N) (% agree)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical violence, last 12 months</td>
<td>804 (42.29)</td>
<td>414 (45.50)</td>
<td>390 (41.54)</td>
<td>0.68</td>
</tr>
<tr>
<td>Emotional abuse, last 12 months</td>
<td>790 (43.80)</td>
<td>406 (42.89)</td>
<td>384 (44.76)</td>
<td>0.60</td>
</tr>
<tr>
<td>Neglected, last 12 months</td>
<td>771 (49.18)</td>
<td>404 (49.50)</td>
<td>367 (48.77)</td>
<td>0.84</td>
</tr>
</tbody>
</table>

### Figure 4: Perpetrators of violence against adolescent girls

#### Perpetrators (at baseline)

<table>
<thead>
<tr>
<th></th>
<th>Boyfriend or husband</th>
<th>Parent or caregiver</th>
<th>Other relative</th>
<th>Friend or neighbour</th>
<th>Member of an armed group</th>
<th>Official (police, teacher, religious or local leader)</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unwanted sexual touching</td>
<td>44.07</td>
<td>49.05</td>
<td>49.04</td>
<td>0.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coerced sex</td>
<td>23.43</td>
<td>29.00</td>
<td>25.00</td>
<td>0.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical violence</td>
<td>7.04</td>
<td>8.18</td>
<td>7.69</td>
<td>0.90</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early marriage</td>
<td>19.65</td>
<td>18.64</td>
<td>19.46</td>
<td>0.97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transactional sex</td>
<td>2.77</td>
<td>3.49</td>
<td>2.97</td>
<td>0.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - loud or aggressive screaming</td>
<td>2.97</td>
<td>2.50</td>
<td>2.95</td>
<td>0.97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - insults</td>
<td>35.26</td>
<td>37.71</td>
<td>32.75</td>
<td>0.93</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical violence</td>
<td>37.35</td>
<td>35.30</td>
<td>36.63</td>
<td>0.43</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - loud or aggressive screaming</td>
<td>38.63</td>
<td>35.77</td>
<td>32.75</td>
<td>0.93</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - insults</td>
<td>34.19</td>
<td>34.88</td>
<td>33.93</td>
<td>0.78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical violence</td>
<td>34.68</td>
<td>36.29</td>
<td>35.09</td>
<td>0.98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - loud or aggressive screaming</td>
<td>12.63</td>
<td>15.14</td>
<td>11.70</td>
<td>0.68</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - insults</td>
<td>12.72</td>
<td>19.86</td>
<td>14.84</td>
<td>0.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - loud or aggressive screaming</td>
<td>4.05</td>
<td>5.71</td>
<td>2.94</td>
<td>0.11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - insults</td>
<td>2.80</td>
<td>1.14</td>
<td>4.09</td>
<td>0.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - loud or aggressive screaming</td>
<td>3.76</td>
<td>2.59</td>
<td>5.06</td>
<td>0.16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse - insults</td>
<td>5.04</td>
<td>6.74</td>
<td>9.26</td>
<td>0.26</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 5: Girls’ attitudes towards gender equity at baseline, by treatment status

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N)</td>
<td>(% agree)</td>
<td>(N)</td>
<td>(% agree)</td>
</tr>
<tr>
<td>Females are responsible for avoiding pregnancy</td>
<td>371</td>
<td>72.24%</td>
<td>171</td>
<td>70.76%</td>
</tr>
<tr>
<td>Man should have the final word about decisions in his home</td>
<td>368</td>
<td>86.96%</td>
<td>175</td>
<td>87.08%</td>
</tr>
<tr>
<td>Females should tolerate violence to keep the family together</td>
<td>377</td>
<td>95.23%</td>
<td>177</td>
<td>94.35%</td>
</tr>
<tr>
<td>A man can hit his wife if she will not have sex with him</td>
<td>367</td>
<td>87.03%</td>
<td>176</td>
<td>83.88%</td>
</tr>
<tr>
<td>Males and females should share household chores</td>
<td>376</td>
<td>17.02%</td>
<td>176</td>
<td>17.01%</td>
</tr>
<tr>
<td>Transactional sex, last 12 months</td>
<td>766</td>
<td>14.62%</td>
<td>394</td>
<td>14.07%</td>
</tr>
</tbody>
</table>

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

### Figure 6: Percentage of adolescent girls reporting having experienced gender based violence in past 12 months

|                                % of all girls participating in COMPASS |
|--------------------------------|-----------------------------------------|
| Forced sex (13-14 years old only) | 17.63 | 7.4 |
| Coerced sex                      | 14.07 | 10.87 |
| Unwanted sexual touching         | 16.34 | 13.1 |
| Any form of sexual violence       | 25.46 | 20.23 |
| Early marriage (13-14 years old only) | 25.99 | 18.45 |
| Transactional sex                | 14.62 | 8.9 |
| Physical violence                | 42.56 | 38.87 |
| Emotional abuse                  | 43.8  | 38.23 |
| Neglect                          | 45.16 | 44.28 |

### Table 7a: Sources of social support at baseline, by treatment status

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N)</td>
<td>(% agree)</td>
<td>(N)</td>
<td>(% agree)</td>
</tr>
<tr>
<td>Have adult who gives them advice</td>
<td>863</td>
<td>76.04%</td>
<td>449</td>
<td>78.95%</td>
</tr>
<tr>
<td>Have female figure in community to go with problems on a regular basis</td>
<td>863</td>
<td>76.04%</td>
<td>449</td>
<td>78.95%</td>
</tr>
<tr>
<td>Have an adult they regard as mentor</td>
<td>863</td>
<td>86.71%</td>
<td>449</td>
<td>87.08%</td>
</tr>
<tr>
<td>Have friends to talk to about important things</td>
<td>863</td>
<td>89.40%</td>
<td>449</td>
<td>89.68%</td>
</tr>
<tr>
<td>Have friends they can rely on for emotional support</td>
<td>863</td>
<td>82.49%</td>
<td>449</td>
<td>82.25%</td>
</tr>
<tr>
<td>Have female friends their age outside the family</td>
<td>863</td>
<td>85.94%</td>
<td>449</td>
<td>87.00%</td>
</tr>
</tbody>
</table>

### Table 7b: Sources of social support at endline, by treatment status

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Intervention</th>
<th>Control</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N)</td>
<td>(% agree)</td>
<td>(N)</td>
<td>(% agree)</td>
</tr>
<tr>
<td>Have adult who gives them advice</td>
<td>785</td>
<td>76.43%</td>
<td>408</td>
<td>78.92%</td>
</tr>
<tr>
<td>Have female figure in community to go with problems on a regular basis</td>
<td>785</td>
<td>76.43%</td>
<td>408</td>
<td>78.92%</td>
</tr>
<tr>
<td>Have an adult they regard as mentor</td>
<td>785</td>
<td>78.47%</td>
<td>408</td>
<td>78.83%</td>
</tr>
<tr>
<td>Have friends to talk to about important things</td>
<td>785</td>
<td>93.89%</td>
<td>408</td>
<td>92.89%</td>
</tr>
<tr>
<td>Have friends they can rely on for emotional support</td>
<td>785</td>
<td>89.91%</td>
<td>407</td>
<td>90.66%</td>
</tr>
<tr>
<td>Have female friends their age outside the family</td>
<td>785</td>
<td>92.74%</td>
<td>408</td>
<td>92.16%</td>
</tr>
</tbody>
</table>
### Figure 10a: Girls' knowledge of services at baseline, by treatment status

<table>
<thead>
<tr>
<th></th>
<th>Total (N=754)</th>
<th>Intervention (N=383)</th>
<th>Control (N=371)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Know of a place to go for help if a girl experienced sexual violence</td>
<td>741</td>
<td>45.48</td>
<td>388</td>
<td>46.39</td>
</tr>
<tr>
<td>Know of a place to go for help if a girl experienced physical violence</td>
<td>751</td>
<td>48.34</td>
<td>387</td>
<td>50.39</td>
</tr>
</tbody>
</table>

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

### Figure 10b: Girls' knowledge of services at endline, by treatment status

<table>
<thead>
<tr>
<th></th>
<th>Total (N=704)</th>
<th>Intervention (N=358)</th>
<th>Control (N=346)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Know of a place to go for help if a girl experienced sexual violence</td>
<td>689</td>
<td>57.47</td>
<td>361</td>
<td>56.51</td>
</tr>
<tr>
<td>Know of a place to go for help if a girl experienced physical violence</td>
<td>691</td>
<td>61.51</td>
<td>364</td>
<td>62.09</td>
</tr>
</tbody>
</table>

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

### Figure 8a: Caregivers’ support of children at baseline, by treatment status

<table>
<thead>
<tr>
<th></th>
<th>Total (N=754)</th>
<th>Intervention (N=383)</th>
<th>Control (N=371)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARQ score</td>
<td>Mean (sd)</td>
<td>45.27 (8.01)</td>
<td>45.67 (8.16)</td>
<td>44.87 (7.85)</td>
</tr>
<tr>
<td>Warmth/affection subscale score</td>
<td>Mean (sd)</td>
<td>13.52 (4.12)</td>
<td>13.66 (4.13)</td>
<td>13.47 (4.09)</td>
</tr>
</tbody>
</table>

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

### Figure 8b: Caregivers’ support of children at endline, by treatment status

<table>
<thead>
<tr>
<th></th>
<th>Total (N=704)</th>
<th>Intervention (N=358)</th>
<th>Control (N=346)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARQ score</td>
<td>Mean (sd)</td>
<td>42.27 (7.61)</td>
<td>41.28 (7.56)</td>
<td>43.28 (7.65)</td>
</tr>
<tr>
<td>Warmth/affection subscale score</td>
<td>Mean (sd)</td>
<td>12.97 (3.95)</td>
<td>12.45 (3.76)</td>
<td>13.51 (4.08)</td>
</tr>
</tbody>
</table>

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

### Figure 9: Adolescent girls’ perceptions of blame

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(as per our original logframe calc)</td>
<td>(as per analysis above)</td>
</tr>
<tr>
<td>Family blame</td>
<td>46.25</td>
<td>44.27</td>
</tr>
<tr>
<td>Community/marriage</td>
<td>37.89</td>
<td>27.64</td>
</tr>
</tbody>
</table>

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


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.26,27

This Girl Shine programme model and resource package supports practitioners in designing, implementing and monitoring a girl-driven intervention that:
- Engages with the most vulnerable and isolated adolescent girls
- Assesses for the most pertinent risks and dangers for adolescent girls in each context
- Involves adolescent girls in all aspects of program design and implementation
- Strengthens protective mechanisms that include the key stakeholders impacting the lives of girls
- Empowers girls to steer and guide their own wellbeing and safety once the programme is complete

The 5 Girl Shine Programme Model Components:

1. The Girl Shine Safe Space.
A “girl-only” safe space allows for consistent access to programming and provides a trusted environment where girls can express and be themselves. Girl-only spaces help to reduce risks and prevent further harm during acute emergency responses.28,29

2. The Girl Shine Life Skill Groups.
The Girl Shine life skill groups are the heart of the program. 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.29

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:

- Part Two – Girl Shine Life Skills Curriculum.
- 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.

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.
ENDNOTES


iv Reports are available presenting findings from Ethiopia and Pakistan. A global summary report can be accessed at: https://gbvresponders.org/research-learning/completed-research

v Find out more at http://gbvresponders.org/empowerment/

vi http://gbvresponders.org/research-learning/completed-research/


xii ibid.


