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A group of six people, including three women, two children, and an elderly woman, are sitting in front of a traditional thatched hut. The hut's walls are decorated with colorful murals, including a large yellow and green flower and the words "I Love You" written in yellow. The people are dressed in traditional and modern clothing, and the scene is set in a rural, outdoor environment.

**WE KNOW WHAT
WE NEED**

**PROGRAMME DESIGN CONSULTATIONS
IN LAKES AND JONGLEI STATES,
SOUTH SUDAN**

August 2022

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CONSULTING WITH ADOLESCENTS IN SOUTH SUDAN: SUMMARY OF FINDINGS AND RECOMMENDATIONS

INNOVATIVE ADOLESCENT-CENTRED METHODOLOGY

The consultations in South Sudan took place in April 2022 and engaged a total of 107 people. Plan International's [Adolescent Programming Toolkit](#) was used to guide consultations and programme design with a **total of 56 adolescents** from Gumuruk (Greater Pibor Administrative Area, Jonglei state) and Amongpiny (Wulu county, Lakes state), including 32 adolescents aged 10 to 14 years (16 female, 16 male) and 24 older adolescents aged 15 to 19 years (12 female, 12 male). Among the adolescent girls were 16 married girls and young mothers. Additionally, 12 spouses of married girls were consulted along with 32 parents and caregivers of adolescents (16 female, 16 male) and seven key informants.

The toolkit offers a range of adolescent-responsive tools that support participatory consultations with adolescents and young people, including girls and young women. For the consultation in South Sudan, participatory tools were used. These included an activity called **H-assessment** where adolescents explored the services and programmes in their community and identified aspects they liked and disliked, as well as areas for improvement or suggestions for future programming. Following this activity, adolescents looked at **barriers and enablers** that support or challenge young people's ability to access services. With parents, caregivers and spouses, **focus group discussions** were held to better understand their perspectives and suggestions for supporting adolescents and young people's concerns. Key informants were interviewed using a **key informant interview**.

The consultations focused primarily on **sexual and reproductive health and rights (SRHR)** and **protection from violence** including child protection and gender-based violence (GBV). The methodology also included questions around preferences and potential risks relating to the use of **cash and voucher assistance (CVA)**.

This initiative was part of a global adolescent consultation process initiated by Plan International in East Africa, covering Ethiopia and South Sudan, as well as the Lake Chad basin, covering Cameroon, Niger and Nigeria, and the Venezuela response, covering Colombia, Peru and Ecuador.

KEY FINDINGS: WHAT WE LEARNED FROM ADOLESCENTS IN JONGLEI AND LAKES STATES

Adolescents, married girls and young mothers highlighted the following concerns:

ADOLESCENTS HAVE LIMITED ACCESS TO SRHR INFORMATION, SUPPLIES AND SERVICES

Adolescents in remote areas of Lakes and Jonglei reported **low availability and quality of basic healthcare services**, in particular sexual and reproductive health (SRH) services.

Facilities and services for survivors of violence, pregnant girls and women are often **located far** from where they live.

Access is further constrained by **financial barriers** for transport and the services themselves. **The lack of female staff** in health facilities, **limited confidentiality** of services and **negative attitudes of the community and service providers** towards adolescents seeking care (especially those who are unmarried) form major barriers for girls and survivors of violence in accessing SRH services and information.

Harmful social norms and gender inequality, exacerbated by food insecurity and general insecurity, form major risk factors for gender-based violence and child marriage, with devastating consequences for girls' SRHR.

FOOD INSECURITY INCREASES RISKS OF CHILD MARRIAGE AND GENDER-BASED VIOLENCE

Adolescents in Lakes and Jonglei face **numerous protection risks**, connected to conflict, inter-communal fighting and food insecurity.

Child marriage is a growing protection concern as food insecurity and economic hardship force families to marry off girls as young as possible.

Sexual violence is widespread but GBV survivors fear speaking out or seeking support due to the risk of **stigma** and rejection by their community.

To respond to violence, girls and female caregivers highlight that there are **not enough case workers** or functioning community-based protection mechanisms in the community to whom they can safely report concerns.

Only limited prevention services such as safe spaces, psychosocial support, life skills and economic empowerment are available for adolescents, even less so for girls.

CASH AND VOUCHER ASSISTANCE CAN SUPPORT ADOLESCENT HEALTH, PROTECTION AND WELLBEING

Adolescents of all ages and genders think that **cash and voucher assistance (CVA) can play a role** in enabling access to protection and SRH services and prevention of GBV, including when used for transportation, service fees or supplies.

Apart from using CVA for accessing services, many adolescents, parents, caregivers and spouses highlighted urgent demand for basic needs including food and non-food items such as blankets and shelter supplies.

Many adolescent girls and young mothers, as well as their spouses, would **prioritise CVA to pay school fees, access training opportunities or set up small businesses**.

While CVA was seen as an important modality to meet urgent needs, adolescents and young people, particularly adolescent girls and young women expressed a clear desire for more long-term and **sustainable economic opportunities** to prevent risk and cope with adversity.

RECOMMENDATIONS

During the consultations, adolescents, including married girls and young mothers, and youth developed programming priorities and shared solutions for the specific barriers they face in accessing services and support. This has resulted in the following recommendations:

SUPPORT US WITH INFORMATION AND SKILL-BUILDING OPPORTUNITIES

Increase adolescents' access to information and education

- Provide information and education to stay safe and promote sexual and reproductive health including menstrual health and hygiene (MHH)
- Offer adolescent clubs
- Create Safe Spaces
- Run peer-to-peer outreach
- Provide dignity kits, family MHH supplies and pregnancy kits

Increase the social assets of girls

- Promote girls' education
- Offer skill-building opportunities
- Provide psychosocial support
- Offer life skills programming
- Create dedicated spaces for girls
- Enable participation in design, implementation and feedback activities

Promote youth economic empowerment

- Provide cash and voucher support
- Create economic empowerment opportunities for adolescents
- Promote youth saving programmes

ENGAGE WITH OUR FAMILIES AND COMMUNITIES TO TRANSFORM HARMFUL PRACTICES

Support parents, caregivers and families

- Hold parenting sessions to share information and promote positive parenting skills
- Promote parent-to-parent support to address negative social norms

Engage with communities to address stigma and harmful social norms

- Promote community awareness-raising on available services
- Engage with boys and men to ease restrictions for girls
- Promote community dialogues to reduce stigma around services and address gender-based violence

Invest in community-level capacities

- Create adolescent-friendly spaces or corners within health clinics that offer multi-sectoral support
- Support community-level networks and organisations to lead prevention activities and facilitate referrals

IMPROVE THE QUALITY AND AVAILABILITY OF SERVICES IN REMOTE AREAS

Increase services at local level

- Rehabilitate health and protection facilities
- Establish or expand services to remote areas
- Equip health facilities with furniture, drugs and medication
- Hire and train staff, particularly female staff, at local level such as midwives and case workers
- Strengthen referral mechanisms and coordination between formal and informal actors

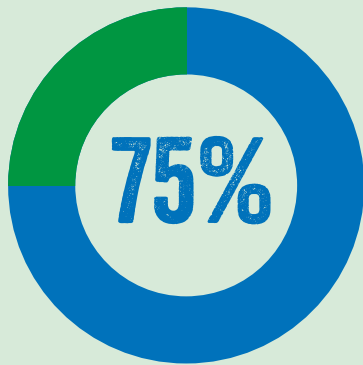
Promote adolescent-friendly services for adolescents

- Train service providers to deliver adolescent-friendly services and reduce barriers for girls
- Promote quality response services for survivors of violence by ensuring case management and referral services meet minimum standards

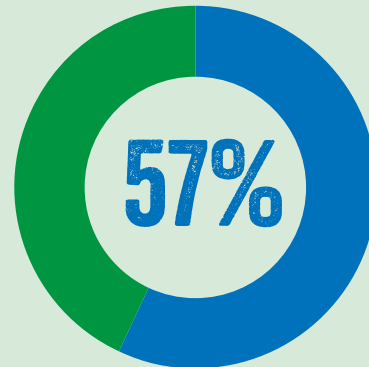
CONTEXT: SOUTH SUDAN

South Sudan has spent most of its first decade of independence at war. Since the conflict began in 2013, more than 4 million people have been forced to flee their homes, most of whom are women and children. Conflict and displacement, coupled with COVID-19 and food insecurity have led to serious violations of children's and adolescents' rights including a failure to meet basic needs such as for food and healthcare, school drop-out, recruitment of children into armed groups and the killing or injuring of children. Subjected to gender inequality and harmful social norms, many adolescent girls are forced to marry and risk experiencing other forms of sexual and gender-based violence.

CRISIS IN SOUTH SUDAN



75%
OF THE POPULATION ARE
FACING SEVERE FOOD
INSECURITY: 8.3 MILLION
PEOPLE¹



57%
OF SOUTH SUDAN'S
POPULATION IS BELOW THE
AGE OF 18²

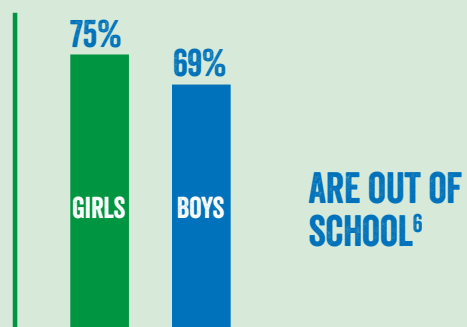
52%
OF GIRLS ARE
MARRIED BEFORE
THE AGE OF 18³



28%
OF GIRLS GIVE BIRTH BEFORE THE
AGE OF 18 YEARS⁴



2.8M
CHILDREN ARE AT
RISK OF VIOLENCE,
EXPLOITATION,
ABUSE AND
NEGLECT⁵



ADOLESCENT PROGRAMMING TOOLKIT

The [Adolescent Programming Toolkit](#) builds upon the great motivation, energy, innovation and capacity of adolescents and the agency and potential of girls. The toolkit offers guidance and tools that support adolescents to learn, lead, decide and thrive in crisis settings.

The toolkit promotes adolescent-responsive programming, through the intentional design and implementation of actions that meet the gender, age-specific and diverse needs, priorities and capacities of adolescents, with special attention to girls and at-risk adolescents.

The toolkit contains four parts:

1. **Rationale – why** we should invest in adolescents in crisis settings
2. **Theory of change** to support adolescents to learn, lead, decide and thrive in crisis settings
3. **Programmatic framework**, presenting our results framework and key interventions
4. **Step-by-step guide** for programming with and for adolescents in crisis settings throughout the humanitarian programme cycle, including 13 practical tools and key considerations for reaching and supporting adolescent girls.

In April 2022, the Adolescent Programming Toolkit was used to hold consultations with adolescents, married girls and young mothers from Greater Pibor Administrative Area, Jonglei state and in Amongpiny, Lakes state, with the specific purpose to inform the design of a new adolescent-responsive project.



Plan International's commitments with and for adolescents in crisis settings

The toolkit was developed based on the numerous recommendations of adolescents and girls in crisis settings, as well as evidence that suggests that humanitarian actors should do the following:

- **Place adolescents and girls at the centre of action**, address them as drivers of their own actions, and promote their participation and leadership.
- **Address specific risks and barriers for girls** and engage with boys and men to tackle gender inequality, discrimination and violence against girls and women.
- **Work at all levels** and engage with families and communities, local power holders, service providers, duty bearers and humanitarian actors to improve action for adolescents.
- **Deliver intentional, multi-sectoral programmes** covering protection, education, sexual and reproductive health and rights, and economic empowerment interventions, tailored to the needs and capacities of adolescents and girls in context.

CONSULTATIONS WITH ADOLESCENTS, MARRIED GIRLS AND YOUNG MOTHERS

The consultations explored how younger and older adolescent girls and boys, married girls and young mothers understand the unique impact that conflict and food insecurity have upon them. The participatory methodology enabled adolescents, particularly girls and young women, to raise their voices about their immediate needs and future priorities, with a specific focus on protection, and sexual and reproductive health and rights (SRHR).

THE CONSULTATIONS WERE DRIVEN BY THE FOLLOWING QUESTIONS:

- **What actions, activities and services do adolescents, particularly married, pregnant and caregiving girls, prioritise to improve their wellbeing, protection and sexual and reproductive health?**
- **What are the main (gendered) barriers and enablers for adolescent girls to access services and support?**
- **How can cash and voucher assistance support adolescent health, protection and wellbeing outcomes?**

METHODOLOGY

The consultations in Gumuruk (Greater Pibor Administrative Area, Jonglei state) and Amongpiny (Wulu county, Lakes state) in South Sudan took place in April 2022 and engaged a total of 107 people. The adolescent consultations were informed by a desk review and focused on qualitative data collection. The consultations were held using the **H-Assessment** tool with single-sex groups of six to eight participants each. During these, adolescents explored the services and programmes in their community and identified aspects they liked and disliked, as well as areas for improvement or suggestions for future programming. Following this activity, adolescents looked at **barriers and enablers** that support or challenge young people's ability to access services.

The adolescent groups were split according to age and gender: adolescent girls and boys aged 10 to 14

Adolescent Assessment Framework

This framework presents the pieces of information that we need to know about the situation of adolescents in crisis. This tool was used to conduct a desk review prior to the consultations.

H-Assessment

This activity helps adolescents to identify existing activities and services in their community, reflect on their strengths and weaknesses, develop recommendations for improvement and share new ideas.

Barriers and enablers

Following the H-assessment, adolescents ranked the most important activities or services for young people, discussed the possible challenges (barriers) and identified solutions (enablers) to these barriers, including social and gender norms.

For more information about the tools and methodology, see: [Adolescent Programming Toolkit](#).

years; and adolescent girls and boys aged 15 to 19 years to allow their unique perspective and experience to be at the centre of the consultation. Most of the older adolescent girls were married and some had young children. Therefore, it was decided not to separate older adolescent girls who were unmarried/without children from those who were married/with children during the consultations.

Parents and caregivers of adolescents and husbands of married girls were involved and consulted through **focus group discussions**. Key informants were interviewed using a **key informant interview**.

The consultations focused primarily on **sexual and reproductive health and rights** and **protection from violence**, including child protection and gender-based violence (GBV), and the use of **cash and voucher assistance (CVA)**.

CONSULTATION PARTICIPANTS

A total of 56 adolescents were consulted, including 32 adolescents aged 10 to 14 years (16 female, 16 male) and 24 adolescents aged 15 to 19 years (12 female, 12 male). Additionally, 12 spouses of married girls, and 32 parents and caregivers of adolescents (16 female, 16 male) were consulted through focus group discussions. Seven key informants were consulted through a key informant interview, including traditional birth attendants, health providers, teachers, religious and community leaders.

OVERVIEW OF CONSULTATION PARTICIPANTS IN JONGLEI AND LAKES STATES

STATE	COMMUNITY	FEMALE 10-14	MALE 10-14	FEMALE 15-19	MALE 15-19	FEMALE ADULTS	MALE ADULTS	TOTAL
JONGLEI	GUMURUK	8	8	6	6	8	14	50
LAKES	AMONGPINY	8	8	6	6	8	14	50

The participatory consultation methodology places the voices of adolescents, married girls and young mothers at the centre of needs assessment and programme design. Data collectors and Plan International staff from the same communities were trained as data collectors to conduct the consultations.

SAFEGUARDING AND ETHICS

The safeguarding and ethics protocols included conducting a safeguarding risk assessment during the planning phase, safeguarding policies and code of conduct signed by all staff and associates involved; informed consent obtained from both adolescents and their parents/caregivers; referral mechanisms in place for potential protection or safeguarding concerns; local safeguarding focal points in place during the consultations; design of adolescent-friendly consultation tools; COVID-19 prevention and control measures; and training of data collectors on safeguarding, reporting and referral procedures.





FINDINGS: THE PRIORITIES OF ADOLESCENTS IN SOUTH SUDAN

The consultations showed a strong connection between the multiple humanitarian crises and risks in South Sudan and poor health and protection outcomes for adolescents, particularly for girls and young women. Food security, floods, inter-communal fighting and COVID-19 affect adolescents' access to humanitarian assistance, education and healthcare, and increase negative coping mechanisms. Pervasive gender inequality and traditional practices further restrict girls' safety and access to services.

During the consultations adolescents demonstrated great capacity and motivation to improve their lives and contribute to the recovery of their communities. Despite often being denied the opportunity to do so, adolescent girls showed great insight into the gendered barriers that affect them and offered concrete ideas on how to overcome them.

FINDING 1: ADOLESCENTS HAVE LIMITED ACCESS TO SRHR INFORMATION AND SERVICES

Sexual and reproductive health and rights: main concerns

Adolescents and young people in South Sudan face **major gaps in accessing health information and services**, including adolescent sexual and reproductive health and rights (SRHR), with major barriers being the limited availability of services, far distances to services, costs of transportation and supplies, and social norms that hamper access for adolescent girls.

Both in Jonglei and Lakes, adolescents highlight multiple barriers to accessing SRH services and information. These include **inadequate** and **remote health facilities** that lack private rooms, medication, modern contraceptives and **female staff**. For young people in Amongpiny (Lakes state), it can take up to three hours by foot to reach the closest health facility.

Where services do exist, adolescent girls, parents, caregivers and spouses highlight that they **are not adolescent-friendly**, with providers often having negative attitudes regarding adolescent SRHR and demonstrating a lack of confidentiality. Married girls and young mothers face difficulties in accessing contraceptives from health providers if they do not have their husband's explicit permission.

Financial barriers were highlighted by adolescents and young people as a major reason why they struggle to access **SRH supplies and services**. This manifests itself both in challenges to pay for **transport** to health facilities, as well as payment for **services, medication and menstrual supplies**.

While one-off provision of SRH supplies such as menstrual health and hygiene (MHH) or dignity kits, are appreciated, adolescents, young mothers or their spouses do not consider these items to be sufficient to have a lasting impact.

Adolescents and their parents highlighted that adolescents have **limited access to SRH information** including about their reproductive and sexual rights, pregnancy prevention, menstrual health and hygiene (MHH), use of contraceptives, or even where to access SRH services (including in the case of sexual violence). Most girls and boys rely on activities provided by NGOs to receive information about their bodies, menstruation, safer sex and pregnancy.

Social norms and traditional practices form a major barrier to accessing SRH services and information, particularly for unmarried adolescents and survivors of violence. Culturally, it is preferred that adolescents do not receive SRHR information or services until they are married. Receiving such services or information is associated with sexual activity, and sexual activity outside the context of marriage is not considered acceptable, especially for girls. Even within the context of marriage, misinformation and stigma remain prevalent around SRH services such as contraception. **Child marriage** is very common in South Sudan, with 52 per cent of girls getting married while still under the age of 18. Marriage often occurs shortly after a girl's first menstruation.

Survivors of sexual and gender-based violence are particularly affected by all of these concerns _ and, they face additional **stigma** due to their experience of violence.

“She will be seen as a ‘spoiled’ girl and cannot be married by young men”.



Recommendations from adolescents, married girls and young mothers relating to their sexual and reproductive health and rights (SRHR)

Adolescents and young people want to receive **sexuality and health education** to learn about their bodies, their rights, safer sex and **menstrual health and hygiene (MHH)**, to identify and mitigate risks and to know how and where to access SRH services and support.

Adolescents, their parents, caregivers and spouses recommended that they receive **regular SRHR information and opportunities for dialogue**, so that they can make more informed decisions and better support their children and wives. Adolescents, their parents and caregivers also recommended increasing knowledge and accurate information about SRHR among community members, to change social norms that harm adolescents' SRHR.

For the **distribution of SRH supplies** such as dignity kits, contraceptives or MHH supplies (like sanitary pads), adolescent girls recommended having more frequent distributions or providing more sustainable materials to make a longer-lasting impact. Married girls recommended distributing **mother-child kits** with supplies for new mothers and their babies.

Adolescents recommended **scaling up existing health services**, for example by expanding existing infrastructure, hiring more female staff to provide services for girls and young women, and making services available in remote areas. They also suggested ensuring that health facilities have confidential **adolescent-only areas** where they can receive friendly and non-judgemental services and information.

Adolescents also highlighted that **improving the quality of services** is critical to increase access for young people. They recommended providing appropriate training of health workers, ensuring more confidentiality and privacy in health facilities, and ensuring the provision of adequate SRH supplies. Key informants also recommended working with traditional birth attendants to enable them to provide SRH information and services to adolescents, where formal health services are far away.

To improve SRH outcomes for adolescents, service providers interviewed suggested providing **free transport services** to health facilities in the case of SRH emergencies, especially for adolescents. In addition, nutritional support was recommended for pregnant and lactating adolescents.

Not only adolescents, but also parents, caregivers and spouses highlighted the importance of **addressing harmful social norms** in the community that restrict adolescents, particularly girls, from accessing their SRHR. Across different groups, participants stressed the importance of engaging with gatekeepers through parental education, interaction with spouses and community dialogues to demystify cultural beliefs and myths, and to promote equal access to SRHR for all.

To address financial barriers to accessing services, adolescent girls identified cash and voucher assistance as a possible solution, but they prioritised **economic empowerment** including skill building and income-generating opportunities for young people as a more sustainable way to improve their access to healthcare. This suggestion was supported by parents, caregivers and spouses of married girls and young mothers.

FINDING 2: FOOD INSECURITY INCREASES RISKS OF CHILD MARRIAGE AND GENDER-BASED VIOLENCE

CHILD PROTECTION AND GENDER-BASED VIOLENCE: MAIN CONCERNS

In South Sudan 2.9 million children need child protection services and nearly 30 per cent of child protection cases involve sexual and gender-based violence (SGBV). Protection risks such as **physical and sexual violence, child labour, family separation, psychosocial distress** and **recruitment into armed forces** are widespread and significant, often with life-long and devastating consequences. **Inter-communal fighting** is prevalent in rural areas of Jonglei and Lakes states, often linked to cattle-raiding and competition over land. This leads to (revenge) killings and the abduction of children and girls. According to adolescents, specific at-risk groups are children without parental care.

For older adolescent girls in Amongpiny and Gumuruk, **child marriage** was a key issue of concern, affecting both their protection and reproductive health and rights. Child marriage is associated with strong **social norms and cultural practices**. Parents, caregivers and key informants explained that bride price is highest when girls are younger, as younger girls (as well as those who are not educated) are believed to make more submissive wives. In areas like Pibor, **food insecurity** was identified as a key driving factor behind child marriage rates.

“Girls are looked at as property who do not have any decision-making rights, hence they can be married off anytime by their parents.” – Parent in Jonglei

While protection concerns are significant, both younger and older adolescents highlighted **gaps in child protection response services** such as case management, counselling and support for survivors of violence. Adolescent girls highlighted that in many locations there are **no case workers**. Survivors of sexual violence face particular challenges in accessing support services, due to financial barriers relating to transportation, as well as **stigma**, as explained above.

Prevention of violence programmes are limited in the consulted communities. Younger adolescents highlighted that unlike in other communities, there are no community spaces for adolescents where they can access **psychosocial support**, recreational activities, health or protection-related information. Adolescent girls as well as spouses highlighted that once married, there are few opportunities for them to develop skills or **earn an income**.

Recommendations from adolescents, married girls and young mothers relating to their protection from violence (child protection and gender-based violence)

Adolescents in both states prioritised the construction of **safe spaces** with tailored activities and space for adolescents, young people and married girls, including **psychosocial support (PSS) activities** and **information** to help them **prevent violence** and know where and how to seek support or access services.

Adolescents suggested creating **adolescent and child clubs** to promote health and protection messages. Married girls and their spouses highlighted that they would like to have **girl-friendly spaces** and once married, they should have access to **skill-building opportunities** such as life skills sessions.

Adolescents also suggested working with **foster parents** to support them in their caregiving role. Girls, boys and their parents and caregivers also recommended **parenting sessions** with parents and caregivers to promote girls' rights, positive parenting skills and positive discipline, and to address harmful cultural norms such as child marriage. Adolescents recommended strengthening and training **community-based child protection** networks on their roles, child rights and alternative care.

Adolescents, parents, caregivers and spouses recommended **addressing harmful social and gender norms** through awareness-raising, sensitisation and community dialogues with gatekeepers to influence and reduce harmful practices such as child marriage. They highlighted that awareness activities should be regular, systematic and community-wide, rather than one-off events.

In both states, adolescents recommended **scaling up case management services and PSS for vulnerable children**, including children who do not have appropriate parental care and survivors of (gender-based) violence. Adolescents suggested having case workers in the communities who can identify and register children, provide food and non-food items such as blankets, and facilitate access to education.

Cash and voucher assistance support was recommended as a short-term intervention to improve access to SRH and protection services and to support children, adolescents and survivors of SGBV to meet their basic needs.

To support sustainable change, adolescents, married girls and spouses felt that **economic opportunities** for young people and their families were critical to help prevent and respond to violence. They prioritised financial support, skill-building and small-scale business opportunities for married girls and young mothers, including providing agricultural assets, vocational training and youth saving programmes.

FINDING 3: CASH AND VOUCHER ASSISTANCE CAN SUPPORT ADOLESCENT HEALTH, PROTECTION AND WELLBEING

HOW CVA CAN SUPPORT THE HEALTH, PROTECTION AND WELLBEING OF ADOLESCENTS

Where a lack of financial means was identified as a barrier to accessing services or as a risk to their overall wellbeing, adolescents were asked about the role that cash and voucher assistance (CVA) could play in addressing this barrier.

Younger adolescent girls said they would use CVA for **transportation** to access services, to buy **hygiene materials** (such as soap and sanitary materials) or to buy contraceptives and access **SRH services** in private clinics, which are considered more confidential.

Older adolescent girls, married girls and young mothers agreed with this and added that cash could also help them to access **education**, purchase **food** or start their own **business**. Spouses added that cash could help in purchasing seeds and tools for **income-generating activities**.

Parents and caregivers of adolescents said that CVA support could help to address their children's protection and SRH concerns by addressing the families' basic needs, including purchasing food and **shelter materials, medication, transportation** or materials to **manage menstruation**, and help in accessing **education, SRH services** or to start a **small business**.

Key informants highlighted that CVA could play a critical role in **improving access to services** as it could cover the fees for **transportation** of adolescents and their families in remote areas where services are not available, or it could support children in **accessing education**.

MODALITIES, RECIPIENTS AND RISKS

Specific modalities were not specifically discussed but most participants indicated that they would **use cash and voucher assistance to meet various needs**. In Pibor, spouses warned that if cash was provided without restrictions, it could be used for the family budget and not for children.

Regarding who should receive the cash, adolescents and parents had different opinions. Some adolescents felt that they should be the direct recipients of cash, as parents were unlikely to consult them on how to spend the money or would use the money for other purposes. Parents and caregivers worried that if adolescents were given cash directly, they would not respect their parents anymore.

“Cash may spoil adolescents as they develop a love for money.” – Parent in Lakes State

Adolescents, parents and caregivers highlighted various protection risks associated with CVA, ranging from robbery to domestic or intimate partner violence. Hence, further assessment should be undertaken to inform a safe and appropriate use of CVA to support the protection, sexual and reproductive health and wellbeing of adolescents.

CONCLUSION AND RECOMMENDATIONS

In South Sudan, adolescents, particularly girls, face many challenges in realising their basic rights and accessing services related to their sexual and reproductive health, protection and wellbeing. Adolescents have limited access to comprehensive information, supplies and services to promote their sexual and reproductive health and protection. Gaps in humanitarian services and growing food insecurity prevent adolescents from accessing services when they need them.

Adolescent girls and young mothers are affected by pervasive gender inequality and harmful social norms that restrict their mobility, decision-making power and ability to access their basic needs and rights. Sexual and gender-based violence and child marriage rates are soaring, with limited prevention and response services for survivors at local level. Stigma and social norms prevent many adolescents and young people from accessing the services they need, even when they are available.

Despite these challenges **adolescents, including girls, are determined to make changes in their lives and communities.** During the consultations they highlighted their desire to speak for themselves and to be consulted regularly on programmes aimed at them. They prioritised actions that they themselves, the people around them and humanitarian actors should take to make these changes happen.

The following recommendations reflect the programmatic priorities shared by adolescents during the consultations as well as their suggested actions to break down barriers and improve access to services for girls.

1. SUPPORT US WITH INFORMATION AND SKILL-BUILDING OPPORTUNITIES

INCREASE ADOLESCENTS' ACCESS TO INFORMATION AND EDUCATION

Adolescent girls and boys of all ages need information and education about health, sexuality and protection including information about how and where to seek support or access services. Adolescent clubs, safe spaces and peer-to-peer outreach are important avenues for adolescents to access and share information. To practise positive health behaviours, adolescents require health and hygiene supplies such as dignity kits, MHH supplies, contraceptives, pregnancy kits and health supplies for young mothers and their babies.

INCREASE THE SOCIAL ASSETS OF GIRLS

Girls can be empowered to overcome feelings of shame, stigma and low self-esteem through **education** and **skill-building opportunities for girls** such as life skills sessions, vocational training and psychosocial support activities. **Safe spaces should be designed** with tailored activities for girls, particularly married girls and young mothers, where they can discuss issues and receive support for themselves and their children. To overcome gendered barriers to humanitarian services, adolescent girls should be supported to **participate** in planning, implementing and **providing feedback** on response activities.

PROMOTE YOUTH ECONOMIC EMPOWERMENT

To address short-term financial barriers to health and protection services, **cash and voucher assistance** can be an effective modality, particularly for survivors of violence. However, to prevent violence and promote long-term health outcomes, adolescents prioritised sustainable **economic empowerment opportunities** and **youth saving programmes** such as short-term vocational training, income-generating opportunities, provision of agricultural tools and local youth saving groups.

2. ENGAGE WITH OUR FAMILIES AND COMMUNITIES TO TRANSFORM HARMFUL NORMS

SUPPORT PARENTS, CAREGIVERS AND FAMILIES

Parenting sessions provide information about adolescent wellbeing, SRHR and protection, and promote positive parenting skills among parents and caregivers, including foster caregivers. **Parenting groups** also offer a platform to increase women's support for girls, and they they can help to re-negotiate and ease the restrictions on girls' and women's access to critical services. **Cash and voucher assistance** can ease financial pressure on families and help to meet the needs of adolescents.

ENGAGE WITH COMMUNITIES TO ADDRESS STIGMA AND HARMFUL SOCIAL NORMS

Community awareness-raising on integrated SRHR and protection should be promoted, particularly about the availability of services, safety precautions and referral mechanisms. It is important to **engage with boys and men** including adolescent boys, male caregivers, husbands and community leaders to promote girls' rights and ease restrictions on girls' access to education, protection, psychosocial and health services, including contraceptives. Regular **community dialogues** should be promoted to reduce stigma around services and to identify community-led actions to address gender-based violence risks for girls.

INVEST IN COMMUNITY-LEVEL CAPACITIES

Adolescent-friendly spaces or **adolescent-friendly corners** should be created in health clinics where girls and boys can safely access multi-sectoral support including recreational activities, psychosocial support, life skills sessions and referrals to services. **Community-level networks and organisations should be supported** to lead prevention activities and to identify, monitor and respond to health and protection risks for adolescents, particularly girls.

3. IMPROVE THE QUALITY AND AVAILABILITY OF SERVICES IN REMOTE AREAS

INCREASE SERVICES AT LOCAL LEVEL

Services in rural areas should be increased by rehabilitating infrastructure, establishing new health facilities, maternity wards and ambulance services, and equipping health facilities with furniture, drugs and modern contraceptives. It is important to **hire and train staff**, particularly female staff, such as midwives and case workers to enhance visibility of and access to service providers at community level. Where required, **mobile teams should be** (re-)established to provide roving health and protection support. **Referral mechanisms** and coordination between formal and informal actors should also be strengthened

PROMOTE ADOLESCENT-FRIENDLY SERVICES FOR ADOLESCENTS

Health and protection staff should be trained to deliver **adolescent-friendly services** and reduce barriers for adolescent girls including unmarried girls. The quality of services for survivors of GBV should be improved, by ensuring that service providers treat clients with respect, privacy and confidentiality and that services meet **minimum standards**.





ENDNOTES

1. World Food Programme (2022). WFP in South Sudan. <https://www.wfp.org/countries/south-sudan> [last accessed 21 September 2022]
2. World Vision International (2021). Child marriage and hunger crisis. South Sudan Case Study. <https://www.wvi.org/publications/case-study/hunger-crisis/child-marriage-and-hunger-crisis-south-sudan-case-study>
3. World Vision International (2021). Child marriage and hunger crisis. South Sudan Case Study. <https://www.wvi.org/publications/case-study/hunger-crisis/child-marriage-and-hunger-crisis-south-sudan-case-study>



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