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PROGRAMME DESIGN CONSULTATIONS WITH ADOLESCENTS IN DIFFA REGION, NIGER

October 2022

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CONSULTING WITH ADOLESCENTS AND YOUTH IN DISPLACED SETTINGS: SUMMARY OF FINDINGS AND RECOMMENDATIONS

INNOVATIVE ADOLESCENT-CENTRED METHODOLOGY

The consultation in the Diffa region in Niger took place in April 2022 and engaged a total of 102 people. Plan International's Adolescent Programming Toolkit was used to guide consultations and programme design with **a total of 48 adolescents and 24 married and pregnant girls** from the Sayam Forage Refugee Camp and N'guigmi community (comprising internally displaced people and the host community). The participants included 24 adolescents aged 10 to 14 years (12 female, 12 male) and 24 adolescents aged 15 to 19 years (12 female, 12 male). 24 married and pregnant girls and young mothers were also consulted. Additionally, 12 spouses of married girls were consulted along with 12 parents and caregivers of adolescents (six female, six male) and six key informants (three female, three male) across the two locations.

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 Niger, participatory tools were used. This 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 used to better understand their perspectives and suggestions for supporting adolescents' 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 the Lake Chad basin, covering Cameroon, Niger and Nigeria, in East Africa, covering Ethiopia and South Sudan, and in the Venezuela response, covering Colombia, Peru and Ecuador.

KEY FINDINGS: WHAT WE LEARNED FROM ADOLESCENTS IN THE DIFFA REGION, NIGER

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

SOCIAL NORMS LIMIT ADOLESCENTS' ACCESS TO SRHR INFORMATION, SUPPLIES AND SERVICES

Adolescents in the Diffa region have **limited access to SRHR information,** partly due to the strict social norms and **taboos** surrounding the sexual and reproductive health of adolescents. This particularly affects girls and young people who are not married.

Girls face severe restrictions on accessing information, activities and services, often enforced by their parents, caregivers or husbands.

Adolescents face major barriers to accessing support due to the **availability and quality of SRH services.**

Health clinics are **located far away, and lack equipment, supplies and trained staff.** Antenatal and postnatal care and family planning services are limited.

Single mothers, survivors of violence and girls who are not married face **stigma** when accessing services and report a **lack of confidentiality**.

Access is further constrained by **food insecurity** and **financial barriers** to transport and payment for health services.

GIRLS FACE SIGNIFICANT GBV RISKS IN AND OUTSIDE MARRIAGE

Adolescents face **numerous protection risks,** including kidnapping, forced recruitment, physical violence, **child labour** and **gender-based violence.**

Child marriage is a traditional practice that affects nearly all girls in Diffa region. Adolescents were particularly concerned about the **unequal treatment, oppression and violence** that girls face within their marriages.

Preventive protection activities are limited, such as safe spaces, psychosocial support and awareness activities. Parents highlight that they feel uninformed about existing services and activities.

Survivors of violence fear speaking out or seeking support due to the risk of **stigma** and **discrimination** by service providers and communities. Those who do report, do not always have the financial means to access services.

Adolescents highlight that **community-based protection mechanisms** are not always functional and that there is a **lack of trained community volunteers** to whom they can safely report concerns.

CVA AND EDUCATION ARE CRITICAL FOR ADOLESCENT HEALTH, PROTECTION AND WELLBEING

Adolescents think that **cash and voucher assistance** (CVA) can help them to **access protection and SRH services** by using it to cover costs of transportation, services and supplies such as dignity kits.

The consulted groups **prefer cash over vouchers** as it provides more flexibility. Adolescents identified risks such as mismanagement of the money, lack of parental involvement, diverting CVA to meet family food security needs instead of adolescents' other needs, and tension between married girls and their spouses.

Adolescents and young mothers also highlighted gaps in **basic needs** such as food assistance, water and sanitation, and livelihoods opportunities.

While CVA was seen as an important modality to meet urgent needs, adolescents of all ages have a strong desire for **education, skill-building opportunities** and **income-generating opportunities.**

Finally, adolescents have a strong desire to **participate in humanitarian action** and **improve accountability** of humanitarian actors towards their communities.

RECOMMENDATIONS

During the consultations, adolescents, including married girls and young mothers, 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)
- Create safe spaces with listening rooms
- Offer peer-to-peer learning
- Run community outreach activities
- Provide dignity kits, family MHH supplies and mother-child kits

Increase the social assets of girls

- Create girl-only spaces
- Access to (post) primary education
- Offer literacy classes, life skills and vocational training
- Provide income-generating opportunities
- Ensure a girl-friendly programme design, implementation and feedback activities

Promote youth economic empowerment

- Use cash and voucher assistance
- Create income-generating opportunities for older adolescents and young caregivers
- Implement youth employment programmes

ENGAGE WITH OUR FAMILIES AND COMMUNITIES TO TRANSFORM HARMFUL NORMS AND PRACTICES

Support parents, caregivers and families

- Hold parenting sessions to share information, promote positive parenting skills and build confidence to talk about SRHR with adolescents
- Run parenting groups to address harmful social and gender norms
- Provide CVA and food assistance for at-risk families

Engage with communities to address stigma and harmful social norms

- Conduct community awareness raising
- Engage with traditional and religious leaders to promote SRH and protection rights of adolescents and to promote girls' access to services
- Engage with boys and men including husbands to ease restrictions for girls and promote their rights including access to information and services

Invest in community-level capacities

- Increase community-level spaces and focal points who can identify and refer at-risk adolescents to services
- Support community-level groups and committees to lead prevention and response activities at local level

IMPROVE THE QUALITY AND AVAILABILITY OF SERVICES AT LOCAL LEVEL

Increase services at local level

- Expand health and protection services to have a presence at community level
- Provide health and protection facilities with equipment and supplies to ensure better care
- Hire and train additional health and protection staff and volunteers

Promote adolescent-friendly services for adolescents

- Train service providers to deliver adolescent-friendly services and reduce barriers for girls when accessing health and protection services
- Promote quality response services for (child) survivors of violence by ensuring that child protection and GBV case management and comprehensive response services meet minimum standards
- Promote adolescent participation and involve girls in designing, implementing and evaluating humanitarian assistance

CONTEXT: DIFFA REGION OF NIGER

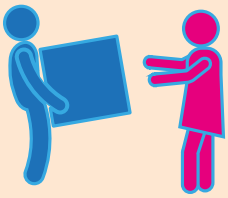
Since 2009, armed conflict in the Lake Chad region has displaced more than 3 million people across Cameroon, Nigeria, Chad and Niger and has left more than 10 million people in need of humanitarian assistance. As of 2022, Niger's Diffa region has been hosting around 235,000 displaced people, including 130,000 Nigerian refugees, more than 67,000 internally displaced people and more than 2,000 asylum seekers. Many refugees arrive in Sayam Forage Refugee Camp, which hosts in excess of 32,000 people, while many other refugees reside in host communities across the Diffa region.

The humanitarian context in the Diffa region is complex with continued violence against civilians, food insecurity and the aftermath of the COVID-19 pandemic. Displaced adolescents and their families, along with their peers in host communities struggle to meet their basic needs. Access to services for children and adolescents is further constrained by regular attacks on health centres and schools.

Children and adolescents represent about 57 per cent of the displaced population in the Diffa region. Adolescents are a vulnerable group as they are regularly exposed to risks of kidnapping, forced recruitment into armed groups and forces, physical violence, maiming and killing. Adolescent girls are subjected to strict cultural norms and exposed to gender-based violence (GBV) including sexual violence, rape and child marriage. These rights violations have significant and life-long consequences on the health and development of girls. Many GBV survivors and forcibly married girls suffer from severe psychological distress[1].

CRISIS IN THE DIFFA REGION[2]

10M



PEOPLE NEED HUMANITARIAN ASSISTANCE

130.000

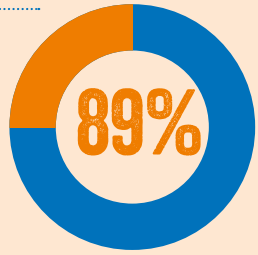
REFUGEES INCLUDING 32,000 IN SAYAM FORAGE REFUGEE CAMP

235.000

FORCIBLY DISPLACED PEOPLE IN DIFFA REGION

67.000

INTERNALLY DISPLACED PEOPLE



OF GIRLS IN NIGER MARRY BEFORE THE AGE OF 18 YEARS

THE 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 N'guigmi community and the Sayam Forage Refugee Camp in the Diffa region in Niger, 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 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 explore 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.

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?**

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.

METHODOLOGY

The consultations in N'guigmi Commune and the Sayam Forage Refugee Camp in the Diffa region in southeast Niger took place in April 2022.

The adolescent consultations focused on qualitative data collection. The consultations were held using the **H-Assessment** tool with single-sex groups of eight participants each 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.
The adolescent groups were split according to age and gender: adolescent girls and boys aged 10 to 14 years; adolescent girls and boys aged 15 to 19 years. Married and pregnant girls and young mothers were consulted separately to allow their unique perspective and experience to be at the centre of the consultation.

Spouses of married girls and parents and caregivers of adolescents were consulted through **focus group discussions.** Key informants were consulted through a structured **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), and the use of **cash and voucher assistance (CVA).**

CONSULTATION PARTICIPANTS

The consultation process involved a total of 102 persons including 96 community members and six key informants. A total of 48 adolescents were consulted, including 24 younger adolescents aged 10 to 14 years (12 female, 12 male) and 24 older adolescents aged 15 to 19 years (12 female, 12 male). In addition, 24 married and pregnant girls and young mothers were consulted. Additionally, 12 male spouses of married girls and 12 parents and caregivers of adolescents (six female, six male) were consulted. In addition to the 96 community members, six key informants (three female, three male) were consulted across the two locations, including local authorities, community leaders and local service providers.

Redion	Community	Female 10–14	Male 10–14	Female 15-19	Male 15-19	Married girls	Female adults	Male adults	Total
Diffa	N'guigmi Commune	6	6	6	6	12	3	9	48
Diffa	Sayam Forage Refugee Camp	6	6	6	6	12	3	9	48

SAFEGUARDING AND ETHICS

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. 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; and training of data collectors on safeguarding, reporting and referral procedures.

FINDINGS: THE PRIORITIES OF ADOLESCENTS IN NIGER

Adolescents in the Diffa region describe the impact they feel from ongoing violence and displacement along with decreasing humanitarian aid. Adolescents, married girls and young mothers talked about unequal treatment of girls and women in communities, and how this affects their health and protection. While child marriage is a major protection concern that affects most girls below the age of 18 years in Diffa region, it was not specifically highlighted as a concern by adolescents. One possible explanation is the level of acceptance of this traditional practice among all population groups. However, both adolescents and married girls raised concerns about the unequal treatment, oppression and violence that girls and women experience within their marriages and the urgent need to address this. More than anything, they want to continue their education and access professional opportunities.

During the consultations, adolescents demonstrated great motivation to be more involved in humanitarian action to ensure more equitable access to services, particularly for at-risk children, married girls and young caregivers. However, they are often denied the opportunity to do so. To improve this, adolescents of all ages have provided the following concrete suggestions for action.

FINDING 1: SOCIAL NORMS LIMIT ADOLESCENTS' ACCESS TO SRHR INFORMATION, SUPPLIES AND SERVICES

SRHR: Main concerns

Adolescents and married girls report that sexual and reproductive health and rights (SRHR) is considered a sensitive area in their communities, and sometimes even a taboo topic. Conservative **social norms** and **gender inequality** form significant barriers for young people in accessing health information and services, particularly for girls and adolescents who are unmarried.

Younger adolescent girls and boys aged 10 to 14 years in the Sayam Forage Refugee Camp reported that they have **limited access to information about health,** especially sexual and reproductive health. Adolescents added that there are not many activities specifically tailored for them, nor for their parents and caregivers, to promote adolescent health, including SRHR.

Married girls highlighted that when health-related information and sensitisation activities are organised in the community, often only their husbands attend these. Even when activities are open to girls and women, their **husbands often do not allow their spouses to participate.** Not only at home but also in the community, married girls have limited opportunities to engage in decision-making about issues that affect their lives.

Access to SRHR is constrained by **long distances to health facilities, lack of supplies, limited staffing and equipment, and low quality of services.** Adolescents and young married women across both locations reported that health centres are located far from their localities with limited local services. Where they

exist, health centres lack trained medical staff, equipment and medicines. Adolescents also highlighted that there are no counselling or listening rooms (salles d'écoute) in the health centres, where they can receive information and advice, and report concerns. Adolescent girls and married girls added **that health centres lack antenatal and postnatal contraceptives** to prevent pregnancy and **family planning services.**

Adolescent girls in the Sayam Forage Refugee Camp reported that SRHR and GBV **service providers lack confidentiality** and that staff members are under-trained and **do not treat young people with respect and dignity,** especially when they are unmarried and have experienced sexual violence.

Finally, some married young women highlighted that **food insecurity** and **lack of financial means** form major barriers to accessing healthcare. With food rations decreasing over time, many families are forced to prioritise food over access to health services.

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

Adolescents across all age groups and locations would like to receive **sexuality and health education.** They think that young people should know about the risks of early pregnancy, the importance of antenatal and postpartum consultations and care for pregnant women and young mothers, sexually transmitted infections (STIs), family planning, and girls' and women's right to be protected from violence. Young mothers also recommended specific sessions for mothers with babies to promote healthcare for the mother and child.

Adolescent girls aged 15 to 19 years suggested creating **clubs for married girls and young women** to share important information in a safe and accepted environment, such as information about pregnancy, safer sex and family planning. Adolescents and married girls suggested providing **hygiene and dignity supplies** to all young people, including soap, underwear, ointments, towels, brushes and menstrual health products. Furthermore, they recommended providing young mothers and couples with **mother-child kits and contraceptives** to support family planning.

Adolescents of all ages recommend **scaling up community awareness activities** with parents, caregivers, husbands of married girls and service providers. They want these gatekeepers to understand the SRHR needs of adolescents, the importance of health services for adolescents, and support efforts to prevent gender-based violence and promote the participation of girls and women. Some adolescents suggested that **incentives** such as biscuits, toys or health items could help to motivate parents, caregivers and other community members to participate in activities.

More specifically, adolescents highlighted that engaging parents and caregivers in information and **parenting sessions** would help them to have conversations with their children about SRHR. Similarly, married girls

recommended **involving husbands in SRHR programme activities** to ease the restrictions placed upon married girls and to promote family planning, equal participation and to promote "women's dignity" and their protection from violence. Key informants supported these recommendations and suggested that husbands should be involved in educating other men on SRHR.

Adolescents recommended **sensitising the community volunteers** on the importance of birth and death certificates for girls and young married women below the age of 18 years, especially in Sayam Forage Refugee Camp. They also suggested strengthening the **capacities of local child protection and GBV committees** to receive reports of protection cases and provide assistance to adolescents.

To **improve access to health and SRHR services,** married girls recommended offering free health treatment and free transportation to services, especially for pregnant girls and women and emergency cases. Adolescents also recommended that aid agencies improve targeting processes for health services to increase transparency and to ensure the inclusion of adolescent girls and young women. To **improve the quality of SRHR services,** adolescents recommended equipping existing health centres with hygiene supplies such as dignity kits (including sanitary pads, soap and perfume), medication, equipment and listening rooms where adolescents can safely access information, advice, services and referrals. In addition, adolescents suggested providing maternal and child healthcare services at community level. They also recommended hiring more staff in health clinics. Adolescents expect health service providers to treat them with respect, dignity and confidentiality. To change the poor behaviour of health personnel, adolescents suggested providing **professional training for staff.**

Finally, adolescents across both locations suggested that **food assistance, cash and voucher assistance (CVA) and income-generating activities** can help to reduce financial barriers to services and improve the reproductive health of adolescents. Adolescents in Sayam Forage Refugee Camp recommended creating more boreholes to improve the water supply in the camp to improve the health and wellbeing of adolescents.

FINDING 2: GIRLS FACE SIGNIFICANT RISKS OF GBV IN AND OUTSIDE MARRIAGE

CHILD PROTECTION AND GENDER-BASED VIOLENCE: MAIN CONCERNS

In the Diffa region, children and adolescents represent about 57 per cent of the displaced population. The ongoing armed attacks, displacement and food insecurity heighten protection risks for children and young people. Adolescents are exposed to risks of **kidnapping,** forced **recruitment** into armed groups and forces, **physical violence,** maiming and **killing. Child labour** is a protection concern in both the displaced and host communities. Adolescent girls are subjected to **strict cultural norms** and are exposed to gender-based violence (GBV) including **sexual violence** and **rape**. In both communities, adolescents reported that single adolescent mothers and GBV survivors are among the most vulnerable groups in the community.

During the consultations, younger adolescent boys in Sayam Forage Refugee Camp reported that they regularly witness **aggressions between adolescents** in the camp but that there is no response to violence between adolescents. Older adolescents and married girls report that many adolescents experience **domestic violence and intimate partner violence** in their families. Adolescents across both locations highlight that the **decrease in food assistance** by the United Nations and humanitarian organisations leads to increased protection concerns including tensions in the community and financial stress within families.

Younger adolescent girls report that their **access to information is limited,** and that they do not have information on existing safety risks, how to stay safe from violence and information about their health, including sexual and reproductive health. Married girls highlight that sensitisation activities in the communities mostly target adults and their husbands, but not them. Married girls are not the only ones to face restrictions; parents and caregivers of younger adolescents also reported that they do not give permission for their children to participate in activities if they are not informed about the activity.

During the consultations, adolescents in both communities reported that there is a **lack of safe spaces** in their communities where they can access information, participate in activities and connect with peers. Where they exist, spaces often **lack adequate materials** and recreational materials. Older adolescent girls also highlight that in their communities there are no listening rooms (salles d'écoute) where adolescents can receive advice or confidentially report concerns. For older adolescent boys, **lack of free time** is a major barrier to participating in activities as they have responsibilities to support their families. Adolescent girls have heavy domestic chores including fetching water, wood cutting, cooking and caregiving work. In Sayam Forage Refugee Camp, water facilities are insufficient which means that girls often need to walk for two hours to access water.

Niger has the highest prevalence rate of **child marriage** in the world (76% of girls marry before they reach the age of 18 years). In regions affected by humanitarian crises, child marriage is both a cultural practice and a coping mechanism for families in insecure and economically unstable situations. Child marriage has significant and life-long consequences for the health and development of girls. Many forcibly married girls live extremely isolated and restricted lives and suffer from **mental distress** including depression and suicidal ideation.

Other forms of **gender-based violence** such as **intimate partner violence** were raised as key concerns for adolescents of all ages in both locations. Married girls and young women, as well as adolescent boys, highlighted that married **men oppress their wives, mistreat them and restrict their participation** in community activities. Some girls are abandoned after they get married and have children, leaving them in an extremely vulnerable position. According to adolescent girls **support for single mothers** in the community is limited.

Girls who experience violence face major barriers to reporting and accessing support. Firstly, girls do not always know where and how to report concerns. When they report concerns, many girls face **prejudice, stigma** and **discrimination.** Others simply **lack the financial means** to access services. Some married girls fear that they will have to divorce if they report an incident, and therefore decide not to disclose the violence.

Older adolescent girls and married girls highlighted that **GBV survivors have limited access to services and support** such as medical and psychological support. Married girls added that there is often **no follow-up to reported cases of sexual violence** and that community volunteers who are tasked to identify and monitor GBV survivors during the case management process, are often under-trained. As a result, **many girls do not feel comfortable about accessing services.**

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

Younger and older adolescent girls and boys would like to have access to **safe spaces** where young people can meet, exchange views and participate in activities. They would like to have more **recreational materials** as well as **psychosocial activities.** However, they also recommended that activities should be culturally appropriate (some adolescents mentioned that dancing was not seen as an appropriate activity). In addition to safe spaces, adolescents and parents/caregivers both highlighted the importance of creating **listening rooms** (salles d'écoute) for adolescent girls and married girls to access information, receive advice and confidentially report concerns. They highlighted that listening rooms should enable access to multi-sectoral services, not just protection services.

Adolescent girls and boys want to have **information** that can help them to **stay safe from violence** and they recommend that this information is also provided to their parents and caregivers. Older adolescents and married girls emphasised that **access to education** and **literacy classes** are essential to increase their safety and protect them from violence. Parents and caregivers also highlighted that promoting girls' education and peer-to-peer learning can help to empower adolescent girls and **prevent child marriage.**

To **strengthen the protective environment in communities,** adolescents, parents and caregivers and key informants recommended strengthening community-level protection mechanisms. This involves supporting local awareness-raising initiatives, working with role models or mentors for adolescents, and strengthening local protection committees that play a role in the prevention of and response to violence, abuse, neglect and exploitation. Married girls highlighted that c**ommunity volunteers** should be better trained and supported.

Adolescents, parents and caregivers, and key informants recommended increasing **awareness raising** in the community, including through radio or megaphones. Key informants emphasised the importance of **working with the whole community,** instead of just focusing on displaced communities. They recommended focusing on key protection concerns such as discrimination, gender-based violence and child labour, as well as promoting **social cohesion.** Adolescents, parents and caregivers, and key informants also highlighted the importance of **engaging with community leaders and imams** in awareness raising and protection programming, to gain their trust and support in violence prevention initiatives.

To **improve the quality of case management services,** younger adolescents and married girls recommended establishing **case management committees** at local level. They explained that they would like to be accompanied by a focal point who can help them to access certain services in a practical and confidential manner. Married girls highlighted that **follow-up on reported cases** should be improved and that free transportation to services should be ensured for survivors of violence. Parents and caregivers added that more support for survivors of sexual violence, **including justice for survivors,** will help to reduce barriers to reporting for girls and young women.

To **increase the participation of adolescents,** especially girls, in protection programming and to address the lack of information about available services, it was recommended to raise more awareness among young people about available activities. Adolescents also suggested that organisations should involve young people more in project planning and implementation. Parents and caregivers highlighted that organisations should seek **parental permission** for involving adolescents, particularly girls, in their projects. Parents and caregivers want to be informed about the planned activities and services for adolescents before they give permission for their children to join.

Finally, adolescents, married girls and parents suggested providing **financial support** to at-risk families as well as to community volunteers to cover their costs and motivate them to do a good job.

FINDING 3: CVA AND EDUCATION ARE CRITICAL FOR 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.

All consultation groups supported the idea of providing CVA to meet the needs of at-risk adolescents, especially married girls, pregnant girls and young caregivers. They pointed out that CVA can **help girls to access protection and SRHR services or supplies** such as dignity kits. Some adolescents said that they would use it to buy school supplies. However, participants in both locations also highlighted that **food insecurity** was a major concern to them and that **food assistance** should be prioritised alongside economic support.

CVA MODALITIES, RECIPIENTS AND RISKS

Generally, the **groups preferred cash over vouchers.** Some argued that this would enable more **flexibility** in meeting hygiene needs of the family, while others highlighted that cash could also be used to support **small businesses.** It was not discussed whether cash should be distributed to adolescents and married girls directly or rather to their spouses, parents or caregivers. However, the groups did identify possible risks associated with CVA distribution.

Adolescents identified a potential **lack of parental involvement** and **mismanagement of money** as main risks. Some adolescents felt that the lack of saving skills and vulnerability of parents and caregivers could potentially mean that CVA would not be used appropriately. Others highlighted that **food insecurity** would likely influence how CVA would be spent. Food-insecure families prioritise spending CVA on food before health, as older adolescent boys in Sayam Forage Refugee Camp confirmed: “nothing can prevent the spending of cash on health except food [insecurity]”. This concern was shared by parents, caregivers and spouses. Married girls highlighted that if CVA or other economic activities specifically targets girls or women, this is a concern for them, as it increases the **risk of tension and conflict** with their spouses.

OTHER URGENT NEEDS

Adolescents, married girls, spouses, parents and caregivers all pointed out that **education** is of critical importance for young people to improve their health, protection and wellbeing. Parents and caregivers emphasised that girls’ education will help to reduce child marriage rates and improve community development. Adolescents, married girls and spouses specifically recommended **literacy classes** and **vocational training** for older adolescents aged 15 and above.

Although all consultation participants welcomed the idea of CVA, many adolescents, older adolescents, married girls and spouses said that they preferred **income-generating activities (IGA),** highlighting that it is a more sustainable way to meet their diverse needs and promote their health and protection. They mentioned IGA such as gardening, fish farming, small businesses and tailoring as areas of interest.

However, adolescents highlighted that when IGA programmes are set up, the **training cycles should be completed** and participants should be given **start-up kits for their businesses.** Particularly in Sayam Forage Refugee Camp, adolescents highlighted that IGA programmes often end or are cut short without a reason.

Across both locations adolescents of all ages emphasised that they have **limited opportunities to participate** in decision-making processes, both within humanitarian programmes and in their community. They want to be more informed about ongoing projects and take part in planning and implementing activities and services for young people in their communities.

Finally, adolescents highlighted that agencies lack **accountability** towards young people and that NGOs often do not keep their promises. For example, programme activities are often not implemented in the way they have been presented. Adolescents call for aid to be carried out as planned, for community feedback to be taken on board and for communication between communities and organisations to be improved. They also call for an end to clannism (i.e. favouring some population groups over others based on affiliation) and favouritism (unfair preferential treatment of individuals and/or population groups based on their connection to more powerful community members).

CONCLUSION AND RECOMMENDATIONS

In the Diffa region, **adolescents, particularly girls, face many challenges in accessing information and services** related to their sexual and reproductive health, protection and wellbeing. Cultural sensitivities, strict gender norms and gaps in humanitarian services negatively impact on adolescents' access to information, supplies and services.

Adolescent girls and young mothers are affected by pervasive gender inequality and harmful gender norms that restrict their mobility, decision-making power and ability to access their basic needs and rights. Gender-based violence and child marriage risks are significant for girls, while prevention and response services are extremely limited at community level. Stigma and discrimination prevent many adolescents, especially girls, from accessing the services they need.

Adolescents highlight that their health and protection cannot be seen as separate from their basic needs. **Food security, education and income-generating activities are priorities for all adolescents,** particularly older adolescents and married girls.

Adolescents have limited opportunities to engage in humanitarian action and feel that humanitarian actors are not always accountable to them and their communities. Despite these challenges **adolescents are determined to improve their lives and support the recovery of their communities.** During the consultations they highlighted their desire to speak for themselves and be consulted regularly on programmes aimed at them. They prioritised actions that they, 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. **Safe spaces,** including **listening rooms,** peer-to-peer learning and outreach activities are important ways for adolescents to access information. To practise positive health behaviours, adolescents require **health and hygiene supplies** such as soap, dignity kits, MHH supplies, contraceptives and supplies for young mothers and their babies.

INCREASE SOCIAL ASSETS FOR GIRLS

Girls need to be empowered with equal opportunities for developing knowledge, skills and social networks. This entails offering **(girl-only) safe spaces** with tailored activities for girls, including married girls and young mothers, where they can discuss issues, receive support, report concerns and access multi-sectoral services. **Skill-building opportunities for girls** including access to primary and post-primary education, literacy

classes, life skills sessions, vocational training and IGA programmes specifically designed for them should also be offered. To overcome the gendered barriers to humanitarian services, adolescent girls should be supported to **participate** in planning, implementing and **providing feedback** on programme activities.

ENHANCE YOUTH ECONOMIC EMPOWERMENT

To address short-term financial barriers to health and protection services **cash and voucher support** can be an effective modality, particularly for at-risk adolescents, single mothers and survivors of violence. In the longer-term programmes, more sustainable interventions such as **income-generating opportunities** and **youth employment** programmes should be supported.

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

SUPPORT PARENTS, CAREGIVERS AND FAMILIES

Parenting sessions provide information about adolescent development wellbeing and promote positive parenting skills to prevent harmful disciplining. Parenting education can give parents the knowledge and confidence to share SRHR information with their adolescents and provide them with age-appropriate care, protection and guidance throughout adolescence. **Parenting groups** can also provide a platform for parents and caregivers to discuss and challenge the strict social norms and taboos surrounding the SRHR and protection of adolescents, particularly girls. **CVA and food assistance** can help to ease financial pressure on families and help to facilitate access to services for adolescents.

ENGAGE WITH COMMUNITIES TO ADDRESS STIGMA AND HARMFUL SOCIAL NORMS

Large-scale **community awareness-raising** activities including radio and communal activities should be used to raise awareness on the importance of SRHR and availability of services for adolescents. Communities should be informed about the availability and importance of SRHR, psychosocial and protection services for all adolescents and to address stigma associated with these services. It is important to **engage with traditional and religious leaders** such as imams to promote the SRH and protection rights of all adolescents and to promote girls' access to services and support. **Engagement with boys and men** including male caregivers and husbands is also needed, to ease the restrictions placed upon girls, to prevent gender-based violence and to promote girls' access to services.

INVEST IN COMMUNITY-LEVEL CAPACITIES

Health and protection capacities at community level should be strengthened, by establishing safe spaces and local health and protection focal points that can identify and refer at-risk adolescents at local level. **Community-level groups and committees should be supported** to lead prevention and response activities at local level to identify, monitor and respond to health and protection risks for adolescents, particularly girls.

3. IMPROVE THE QUALITY AND AVAILABILITY OF SERVICES AT LOCAL LEVEL

EXPAND THE AVAILABILITY OF SERVICES

Local-level provision of health and protection services should be improved. Health services should be established at local level and/or transport facilitated to existing health services. Facilities should be equipped with supplies such as delivery kits, family planning kits, MHH and dignity kits. **Additional SRHR and protection staff** including community volunteers should be hired, and adequate training and support provided.

PROMOTE ADOLESCENT-FRIENDLY SERVICES FOR ADOLESCENTS

It is important to work with service providers to deliver **adolescent-friendly services** that meet minimum standards and help reduce barriers for adolescents, including unmarried girls. Health and protection workers should be trained on delivering services including comprehensive case management in a way that protects the safety, confidentiality, respect, non-discrimination of the client or survivor. **Transparency and accountability** of humanitarian aid should be increased and adolescents should be involved in designing, implementing and evaluating assistance.

ENDNOTES

1. Plan International (2021). Adolescent Life Skills and Parenting in Crisis Settings: Consultations for Programme Design in the Lake Chad basin.
2. UNHCR Niger (2022). "Population of Concern as of June 2022". [accessed 8 September 2022]
3. Girls Not Brides (2022). Child Marriage prevalence rate Niger. [accessed 31 October 2022].

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