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I'm Here Approach Implementation in Cox's Bazar: Key Findings and Recommendations for Identifying and Engaging Isolated Adolescents

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The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

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Cover photo

View of Kutupalong camp, Cox's Bazar. © Partners in Health and Development, 2020.

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Executive Summary

From September 2020 to February 2021, Partners in Health and Development (PHD), with support from the Women's Refugee Commission (WRC), implemented the I'm Here Approach in Block E of Camp 14 in Kutupalong camp, Cox's Bazar, Bangladesh, the largest refugee camp in the world. WRC coordinated tool adaptations, virtual training, remote support for field implementation, and virtual co-analysis workshops. PHD was responsible for site selection, tool adaptations, data collection, co-analysis, and integration of findings into programming. From October to November 2020, PHD used I'm Here tools to map over 300 households and nearly 200 service points. In addition, PHD held 12 participatory group activities with different subgroups of adolescents, and subsequently co-analyzed data with WRC from December 2020 to February 2021.

The I'm Here Approach is a set of steps and tools designed to help humanitarian actors identify, engage, and be accountable to the most marginalized adolescents in emergencies. Since 2014, I'm Here has been piloted in more than 30 communities across 10 humanitarian settings. This project was the first time the approach was implemented in Cox's Bazar. Given the unique context of Cox's Bazar and the Rohingya refugee community, and the unique circumstances of the COVID-19 pandemic, several key adaptations were made to the tools, training, and implementation to better understand adolescents' experiences of isolation and how to reach those with critical sexual and reproductive health (SRH) and gender-based violence (GBV) programming. Findings emerged that will inform future implementation of the I'm Here Approach and, more generally, multisectoral programming that reaches the most isolated adolescents.

The goal of this report is to share key lessons learned and recommendations with the wider humanitarian community, especially humanitarian actors in Cox's Bazar. In this way, it may also serve as guidance on implementing holistic, multisectoral adolescent programming that leverages the existing capacities of adolescents and their communities.

Key findings

- Certain areas of Kutupalong refugee camp are underserved due to their location and physical terrain. Limited availability of services and challenges in accessing services in Camp 14 were exacerbated during the COVID-19 pandemic.
- No adolescent girls, and very few adolescent boys, in Block E of Camp 14 were reported to attend adolescent programming, although the majority of heads of households surveyed reported an interest in learning more about available adolescent programming. Adolescents also cited the lack of adolescent programming as a major concern in their lives.
- By age 17, girls rarely leave the house to visit friends. Girls also leave the house less and less frequently as they get older, and increasingly require permission to do so. Meanwhile, adolescent boys' mobility increases as they get older, and they are just as likely to socialize with friends as adolescents and young adults as they are when they are children.
- Adolescents in Block E of Camp 14 reported the distance to the nearest health facility as a major barrier to accessing services. For adolescent girls, the lack of a female doctor was also a major concern.
- Both adolescent boys and girls recognized intimate partner violence and dowry to be harmful and of concern in their lives. Adolescent boys also cited violence from older boys and disrespect from adults in their communities as a concern.

Key recommendations

- Distinctions should be made beyond just age when planning and implementing programming for Rohingya adolescents. Practitioners must consider adolescents' marital status, household composition, and schooling status when deciding how to group program participants.
- Instead of setting up programming where they are already working, organizations need to prioritize remote or hard-to-reach areas of the camp. Organizations should also consider the accessibility of their program sites based on physical terrain and other potential barriers faced by adolescents.
- The adolescent mapping tool may require further adaptations for contexts where there are different household dynamics and understandings of adolescence. Different screening questions may be required for the Girl Roster and Boy Matrix to identify married Rohingya adolescents.
- Future implementation of the I'm Here Approach may benefit from including questions on mobility to identify changes in access to programming and services from childhood to early adulthood.

Project background and rationale

Adolescents face unique risks in emergency settings, yet they are frequently overlooked in humanitarian response. Communities affected by conflict and displacement experience weakened social structure and protection mechanisms, compromising safety and reinforcing gender inequalities that place girls at greatest risk. Despite this heightened risk, adolescent girls possess tremendous capacity to transform communities and drive response and recovery processes forward when their rights and well-being are protected.

PHD is building its capacity to identify and engage the most vulnerable adolescents displaced in Cox's Bazar and integrate their distinct needs into new and existing humanitarian programming. The I'm Here Approach[1] is a set of steps and complementary tools that enables humanitarian actors to visualize the context-specific profile of adolescents within a service-area and engage them in targeted participatory activities around their needs and concerns. With this information, PHD, its partners, and local stakeholders can modify outreach activities, adapt existing programming to be more responsive, and design new programming to account for the specific needs and capacities of adolescents.

1 Women's Refugee Commission (WRC), *I'm Here Approach*, https://www.womensrefugeecommission.org/special-projects/im-here-approach/.

Cox's Bazar

The outbreak of violence in August 2017 in the Rakhine state of Myanmar led to mass forced displacement of Rohingya Muslim populations throughout the region. As of May 2019, there were over 900,000 refugees living in and around Cox's Bazar, Bangladesh.[2] Despite efforts at the international, national, and community level to meet the basic needs and rights of the Rohingya refugees, there remains limited access to clean water, safe shelters, education, and health care.[3]

Adolescent Rohingya girls living in Cox's Bazar are in urgent need of targeted services. Rapid assessments have confirmed that adolescent Rohingya girls are particularly vulnerable to GBV, including physical attacks, sexual violence, child marriage, and human trafficking, with notable consequences for their SRH.[4] Research also suggests that adolescent girls experience severe restrictions on their movement, limiting their access to critical services and resources. For example, out of an estimated 103,000 adolescent girls living in refugee camps in Cox's Bazar, in April 2019, fewer than 4,000 were participating in GBV programming.[5] There remains a limited understanding as to the best means of reaching adolescent girls with appropriate information and services, and how to address barriers at the individual, household, and community level. As programs are being designed and implemented, there is urgent need for more in-depth knowledge of the needs and priorities of adolescent Rohingya girls in Cox's Bazar, as well as the barriers and facilitators of access to information and services.[6]

The COVID-19 pandemic has exacerbated the prevalence of GBV among Rohingya in Cox's Bazar, as barriers to care are becoming increasingly insurmountable. Lockdown measures to address rising COVID-19 cases trap women and girls in domestic settings, resulting in more cases of GBV.[7] Furthermore, even when services are available, social and gender norms impede women's and girls' mobility and access to them.[8]

I'm Here Approach

I'm Here is an operational approach that helps implementing partners reach the most vulnerable adolescents and supports partners in being accountable to adolescents' safety, health, and well-being. I'm Here enables humanitarian actors to engage adolescents in creating their own solutions, ensuring that their rights are protected and programs are effective.

2 United Nations High Commissioner for Refugees (UNHCR), *Population Map: UNHCR, Bangladesh, Cox's Bazar- as of 31 May 2019*, June 2019, https://data2.unhcr.org/en/documents/details/69852.

3 Inter Sector Coordination Group (ISCG), *JRP For Rohingya Humanitarian Crisis: March - December 2018*, March 2018, p. 8, https://reliefweb.int/report/bangladesh/jrp-rohingya-humanitarian-crisis-march-december-2018-0.

4 United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) Bangladesh, *Gender Brief on Rohingya Refugee Crisis Response In Bangladesh*, October 2017, http://asiapacific.unwomen.org/en/digital-library/publications/2017/10/gender-brief-on-rohingya-refugee-crisis.

5 ISCG, *Situation Report: Rohingya Refugee Crisis – Cox's Bazar*, April 2019, www.humanitarianresponse.info/en/operations/bangladesh/document/situation-report-rohingya-crisis-coxs-bazar-april-2019.

6 Plan International, *Adolescent Girls in Crisis: Voices of the Rohingya*, June 2018, https://plan-international.org/publications/adolescent-girls-crisis-rohingya#download-options.

7 International Rescue Committee (IRC), *The Shadow Pandemic: Gender-Based Violence among Rohingya refugees in Cox's Bazar*, May 2020, www.rescue-uk.org/report/shadow-pandemic-gender-based-violence-among-rohingya-refugees-coxs-bazar.

8 AKM Mainuddin et al., "Women Empowerment and Its Relation with Health Seeking Behavior in Bangladesh," *Journal of Family and Reproductive Health, 9*(2) (June 2015): pp. 65–73, www.ncbi.nlm.nih.gov/pmc/articles/PMC4500817/.

The approach urges practitioners to see adolescents as more than just a homogenous group, and to advocate for multisectoral action to meet the needs of different subgroups. Since 2014, I'm Here has been piloted in more than 30 communities across 10 humanitarian settings. I'm Here is adaptable to various on-the-ground situations to ensure inclusion and engagement with adolescents.

I'm Here provides concrete steps and field tools to:

- Pillar 1: "Find them": Identify adolescent girls and boys in a given community.
- Pillar 2: "Listen to them": Assess their needs, risks, capacities, and interests.
- Pillar 3: "Design, implement, and evaluate with them": Monitor adolescents' access to key services, programs, and assets.

I'm Here Approach in Cox's Bazar

The overall aim of this project was to identify and engage with the most isolated Rohingya adolescents, understand their needs and barriers to accessing services, and generate insights that can help to improve programming and service delivery. Isolation, or, social isolation, is the deprivation of social connectedness, defined as "the inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment)."[9] Utilizing the I'm Here Approach, this project aimed to understand factors that contribute to adolescents' isolation, and how interventions can better respond to the needs of isolated adolescents to mitigate the risk of GBV and improve SRH outcomes.

Using innovative tools and methodologies that promote adolescent-driven programming, the main objectives of this project were to:

- operationalize the I'm Here Approach in Cox's Bazar and explore the barriers and enablers of access to SRH and GBV information and services for Rohingya adolescents;
- engage adolescent Rohingya girls and boys to identify and understand their needs and priorities for information and services;
- identify interventions and pathways that may respond to adolescent Rohingya girls' and boys' priority needs and overcome potential access barriers;
- document and share learning and recommendations with the wider humanitarian community, especially for use by PHD staff and other humanitarian actors in Cox's Bazar.

9 Diego Zavaleta, Kim Samuel and China Mills, "Social Isolation: A conceptual and measurement proposal," Oxford Poverty & Human Development Initiative (OPHI) Working Paper, no. 67 (January 2014), https://ophi.org.uk/social-isolation-a-conceptual-and-measurement-proposal/.

PHD's programming in Cox's Bazar

PHD has been operating in Cox's Bazar since 2018. At present, PHD's humanitarian programming focuses on strengthening primary health service delivery, GBV, SRH, adolescent girl programming, and livelihoods. Since 2018, in partnership with the United Nations Population Fund (UNFPA), PHD has implemented the Skilled Girl Force Project, which focuses on delivering comprehensive sexual and reproductive health and rights (SRHR) education programs for adolescent girls in selected camps. The project aims to reduce child marriage and early pregnancy among adolescent girls by improving the skills and capacities of adolescent girls to exercise their SRHR and access SRH facilities autonomously in the targeted areas. To reach this goal, PHD trained 300 girls on comprehensive SRHR and education, gender, protection, and GBV. PHD then partnered with WRC to implement the I'm Here Approach, with a view to expanding programming to more areas of Kutupalong camp and ensuring that adolescent programming is inclusive and responsive to the diverse needs of adolescents.

Implementation process

Between September 2020 and February 2021, WRC provided technical support to PHD to both implement, and use findings from, I'm Here in Cox's Bazar. The first step of the process was to finalize the methodology, which involved adapting the I'm Here tools to the context of Cox's Bazar and identifying service-area sites. WRC and PHD updated the service mapping and adolescent mapping tools, adding a series of questions to assess adolescents' mobility. PHD staff chose to implement I'm Here in Block E of Camp 14, knowing that this area lacked basic health services and humanitarian programming given its challenging terrain and geographical distance from other areas of the camp.

Virtual I'm Here Training Part 1 and adaptation of tools

In October 2020, WRC held the first part of the virtual I'm Here training. The overall objective of the three-day session was to orient PHD staff to the I'm Here Approach and its tools and plan for implementation of service and adolescent mapping. Staff from several other organizations implementing adolescent programming in Cox's Bazar also participated in the first two days of the training. These focused on an introduction to the approach and tools, and Magpi, the online platform used to administer the tools. The final day involved an in-depth review of the adolescent mapping tool, refresher training on research ethics, and logistical planning for enumerator training and mappings.

The service mapping and adolescent mapping tools were adjusted in several ways in line with the context. To better understand potential barriers for adolescents in accessing each service, additional questions were added to the service mapping tool. Together, the following questions help to assess how "adolescent-friendly" certain services are:

1. Is the service located within walking distance of a place where adolescents congregate?
2. Is the service open during hours that are convenient for adolescents, such as in the evenings or on the weekend?
3. Are there specific times or spaces set aside for adolescents?
4. Are drop-in clients welcomed without appointments?
5. Is there a separate, discrete space for adolescents to ensure privacy?

A known issue for adolescent Rohingya girls is their limited mobility and restrictions on leaving the house. To better understand this phenomenon, a short set of mobility-specific questions was added to the questionnaire to assess girls' and boys' experiences around leaving the home. These questions were as follows:

1. In the past 15 days, about how often has he/she left the house? Would you say multiple times a day, once every day, a few times per week, once per week, or never?
2. In the last 15 days, has he/she left the house for any of the following reasons: To fetch water? To use the washroom? To go to school? To collect firewood? To go to the market? To go to a safe space or community center? To go to programming for adolescents? To go to a health clinic? To help earn money? To visit friends? To visit family? To go to mosque? To go to madrasa? Any other reason?
3. In general, is he/she allowed to leave the house to do these activities alone, or only if he/she is with someone else?
4. In general, who decides whether or not he/she is allowed to leave the house?

Adolescent mapping overview

Adolescent mapping includes three complementary tools: the Girl Roster, the Boy Matrix, and Inclusion Now. It allows us to see the demographic characteristics of adolescents living in a program catchment area and gives us an idea of which adolescents in a community are particularly marginalized. Adolescent mapping collects data through a short set of questions, administered to the female in the household who knows the most about the children living there.

The Girl Roster uses a brief household questionnaire and rapid analysis tool to generate a snapshot of how many girls there are in a service-area, sorted by age, schooling, accompaniment, marital and childbearing status. The Boy Matrix and Inclusion Now serve as complementary questionnaires to capture the number of boys, sorted by school, work and accompaniment status, and to identify disability statuses within households and communities. The Inclusion Now questionnaire was adapted from the Washington Group's Short Set on Functioning.

Virtual I'm Here Training Part 2

WRC held its second three-day virtual training session for PHD staff in October 2020, with the aim of discussing results from the mapping activities and identifying subgroups of adolescents to engage for Pillar 2 of the I'm Here Approach. Using information collected from the adolescent mapping tools, WRC generated tables to visualize the total number of girls and boys in the community, segmented by their top-line capacities and vulnerabilities. WRC and PHD discussed where adolescents live and which services and resources are available in their community. They then discussed the implications of these findings, such as possible barriers for adolescents attending their program, and what subgroups of adolescents are being left out of current outreach and recruitment efforts.

Based on initial analysis of the mapping data, PHD selected 12 subgroups of adolescents to target for their programming. WRC provided guidance on Pillar 2 ("Listen to them"), which involves facilitating participatory methodologies with adolescents of similar capacities and vulnerabilities. WRC trained PHD staff on participatory methods, such as Participatory Ranking Methodology (PRM), body mapping, community mapping, and the Asset Exercise, which are aimed at more meaningful engagement with adolescents when designing programs, recognizing that each subgroup has unique needs and priorities that must be addressed through tailored programming. Using results from adolescent mapping, WRC advised PHD's selection of specific methodologies to implement with each subgroup and development of tailored recruitment strategies.

Co-analysis workshop

In November 2020, WRC held its first three-day virtual co-analysis workshop with PHD staff. WRC staff used various facilitation techniques and media during the workshop, including PowerPoint, Mural, group activities, worksheets, and small group discussions. The overall goal of the workshop was to train PHD staff on how to use information generated from the I'm Here methodologies and tools to design, implement, and evaluate inclusive adolescent programming (Pillar 3: "Program With Them"). WRC provided an overview of mixed-methods data analysis techniques and provided a synthesis of the quantitative PRM data. It then facilitated an activity with PHD staff to thematically analyze qualitative data from the PRM activities and in-depth interviews (IDIs) using Mural.

WRC facilitated the Asset Exercise for the selection of programming objectives. In groups, PHD staff completed the exercise for both adolescent girls and boys using a Mural board created by WRC. Next, WRC facilitated an activity in which PHD staff split into small groups to identify key themes and assets, and barriers and enablers related to those assets based on each subgroup. The barriers and enablers were color coded according to the different levels of the socio-ecological model, so participants could identify at which levels to intervene. Finally, using the results from the PRM analyses and the Asset Exercise, PHD staff selected 10 to 15 key assets for different subgroups of adolescents and developed indicators to measure future programming's success in building each asset.

Remote I'm Here training and technical support

Due to COVID-19 restrictions on international travel, WRC staff adapted their in-person I'm Here training and co-analysis workshops, as well as technical support, to be delivered virtually. Remote technical support and training brought opportunities and challenges.

Opportunities included adaptations to I'm Here tools, such as the Asset Exercise, utilizing an interactive online collaboration platform, Mural. WRC staff shared instructions to log in and basic information about how to use Mural via short video links, so that PHD staff could troubleshoot prior to training. WRC also prepared a simple activity for PHD staff to complete to familiarize themselves with Mural. Each session was no longer than three hours, and included frequent breaks. WRC staff developed distinct participatory activities using Mural in advance of each session and facilitated both plenary and small group work. PHD completed follow-up activities using skills and knowledge learned during training in their own time, which was discussed with WRC staff the next day.

Despite these opportunities and successes, the PHD staff shared that upon reflection, in-person training is preferable due to poor internet stability which impedes clear communication. Furthermore, in-person training builds relationships and trust between partners, and facilitates assistance and oversight during training activities, allowing challenges and issues not communicated via camera, and to a lesser extent audio, to be addressed.

Findings

Data were analyzed in several stages. First, top-line findings from the mapping activities were reviewed by WRC and PHD using Magpi; these findings were then discussed and co-analyzed. Qualitative data from the participatory activities were also co-analyzed and used for the Asset Exercise and creation of benchmarks. This section presents the key findings from these data analysis activities.

Service mapping

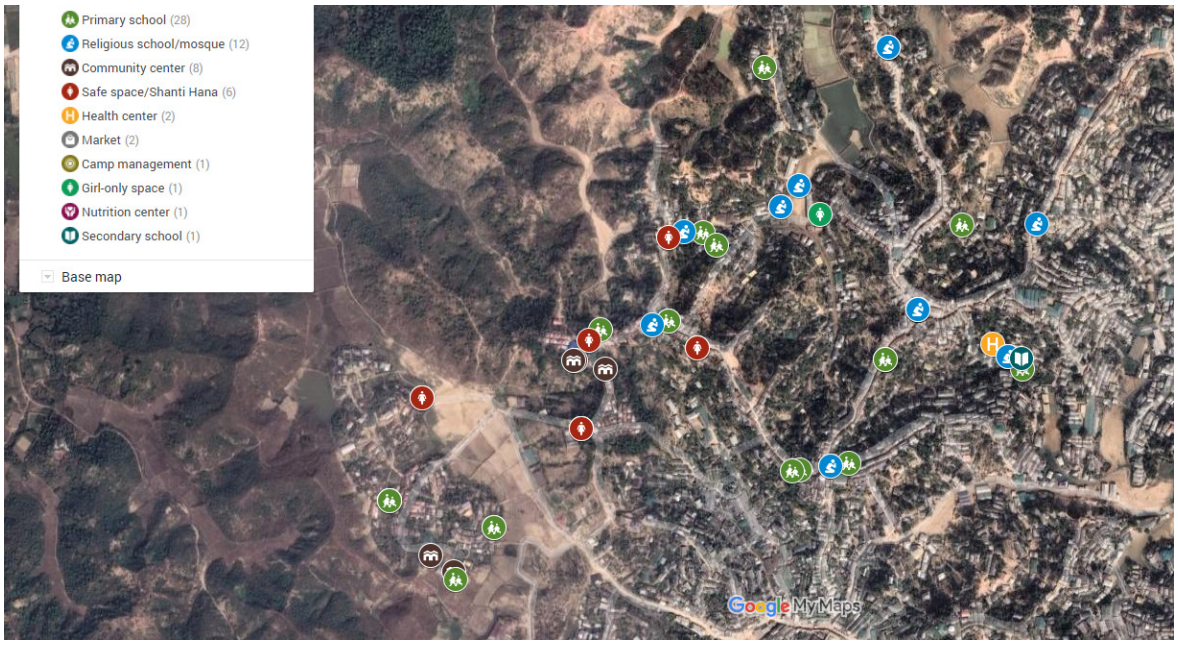
Service mapping was conducted over two days. Using mobile devices equipped with a GPS mapping application, PHD staff defined the perimeters of Block E in Camp 14 and used GPS pushpins to mark key structures, services (e.g., schools and health clinics), and hazards. The walkable community was defined based on girls' mobility and experiences. PHD staff mapped a total of 171 locations in Camp 14, including 71 water, sanitation, and hygiene (WASH) facilities; 30 primary schools or learning centers; 14 religious schools or mosques; eight community centers, and six Safe Spaces for Women and Girls (Shanti Hana). Notably, only one health center, one youth center, one secondary school, and one girl-only space were identified. Moreover, the health center was just outside of the camp entrance, relatively far from most homes, and with challenging terrain (steep hills).

Nearly half of the locations (45.6 percent) were categorized as supportive resources, 22.2 percent were categorized as a risk, and 25.1 percent as both (for example, toilets could be both a resource and a risk, since they are a necessary service but may also be dangerous for adolescent girls to go to alone). Service mapping also revealed that a quarter of locations offered adolescent-friendly services. However, when looking at the different aspects of adolescent-friendly services, only one location—a community center—met all five criteria (within walking distance of a place where adolescents congregate; open during hours convenient for adolescents; specific times set aside for adolescents; drop-in clients/visitors welcome; has a separate, discreet space for adolescents). Only 22.1 percent of locations were considered accessible for people with disabilities.

Asset Exercise overview

An asset is a person's own store of value, which shapes what they can do or be. Assets can include resources, knowledge, and skills. Girls can draw upon assets to shape their lives and contend with emergencies on their own and others' behalf. The Population Council's Building Assets Toolkit supports an interactive exercise to identify program activities that build protective assets. **Asset-building** is an approach rooted in an understanding that girls' chances of making a safe and healthy transition to adulthood improve when they have the support they need to build knowledge, skills, and relationships, and have or can access critical resources to make and act on healthy choices as they get older. Asset-building reflects an inherently multisectoral approach to girls' health and well-being. While stand-alone programs may not build all assets, specific assets can be operationalized into distinct positive, developmentally and socially appropriate age-bound benchmarks for measuring program success. The 90-minute **Asset-building Exercise** ("Asset Exercise") allows multiple stakeholders to use information about girls (e.g., the proportion married by age 15, living separately from parents, out of school) to determine the appropriate content for their specific target population. Assets can serve as either topics to include in content for tailored, community-based girl programming, or indicators of program quality.

Figure 1: Service mapping, Camp 14



While reviewing the service mapping data during training and co-analyses, PHD staff highlighted several additional points about the availability and distribution of services in Camp 14. First, they noted that the camp is extremely hilly, and that this terrain is a barrier to residents' access to services not close to their homes. The terrain also means that service providers and nongovernmental organizations (NGOs) are less likely to operate in Camp 14 than in other camps that are more accessible by vehicle. PHD staff also highlighted that not all services mapped were operating due to the COVID-19 pandemic, including primary schools and learning centers, community centers, and safe spaces. Although it was known prior to service mapping that there was a lack of health services in the camp, PHD staff were still surprised to see just how difficult it was to access the health clinic, especially compared with other camps where PHD works, which often have multiple health clinics.

Adolescent mapping

Adolescent mapping was conducted over four days. Data was collected in Magpi with a short set of questions given to the female in the household who knows the most about the children living there. PHD staff mapped 306 households across one walkable community in Block E of Camp 14 and administered questionnaires to heads of households. Of the 306 households surveyed, there were more men (595) aged under 25 years than women (549), and more adolescent boys aged 10-19 years (319) than adolescent girls aged 10-19 years (228).

Key findings about the children, adolescents, and young people living in surveyed households include:

- Adolescent girls fall "off track" at 13-16 years old. During this time, girls' school attendance declines by about 50 percent, while boys' school attendance only falls slightly.
- By age 17-19, over one-third of adolescent girls are married or engaged, compared with only 15 percent of adolescent boys.
- Almost half (46 percent) of young women aged 20-24 have a child, compared with one-third of their male counterparts.
- Only one adolescent girl was reported to be working for money. In contrast, the percentage of boys who work for money increases sharply, from 16.8 percent among those age 13-16 years, to 40 percent once boys reach 17-19 years old.
- Although no girls and very few boys (4 percent) were reported to attend adolescent programming, approximately three-quarters of heads of households reported interest in learning more about adolescent programming, indicating a great unmet need for adolescent programming in Cox's Bazar.

Of particular interest were findings on adolescent mobility (see Figures 2 and 3). These questions were added to the adolescent mapping tools due to the context of Kutupalong camp and the limited freedom of movement experienced by adolescent girls. As expected, the team found that as adolescent girls age, they leave the home less frequently. As girls get older, they are also less likely to decide for themselves whether to leave the house, and increasingly require permission to leave, while the opposite is true for adolescent boys. Certain findings provided more nuance on the issue of adolescent mobility:

- 91 percent of girls aged 6-9 years leave the home multiple times per day. By age 20-24, only 46 percent of young women leave the home multiple times per day. Fifteen percent of adolescent girls aged 17-19 years and 20 percent of young women aged 20-24 years never leave the home.
- Leaving home to visit friends becomes less and less common as girls age. Over one-third of girls aged 6-9 years leave home to visit friends, but the rate steadily declines to just 5 percent for girls aged 17-19 years. Among women aged 20-24, none ever leave the home to visit friends.
- By contrast, about 40 percent of adolescent boys leave home to visit friends and this remains the case from childhood to young adulthood.
- As girls age, they are less likely to leave home alone, while boys are more likely to do so. Young women aged 20-24 years reported having the least independent mobility. Only 40 percent reported being allowed to leave home by themselves, and 57 percent reported being allowed to leave home only if they are with someone else.

The onset of puberty is a turning point for adolescent Rohingya girls' vulnerability, marking a decrease in frequency of mobility; autonomy over the decision to leave home; and access to education, adolescent programming, and peer networks, which spirals into early marriage and childbearing as they transition into young adulthood. These key social development indicators were fairly equal for adolescent girls and boys at 6-12 years, but at 13-16 years, adolescent girls fall off track. As adolescent girls age, they face increased risks, while for boys, the consequences of aging are less precarious. At 17-24 years, adolescent girls are more likely than adolescent boys to be married and have children. Meanwhile, as boys age, they are more likely than girls to report that they decide for themselves whether to leave the house.

Figure 2: Percentage of girls able to leave the house

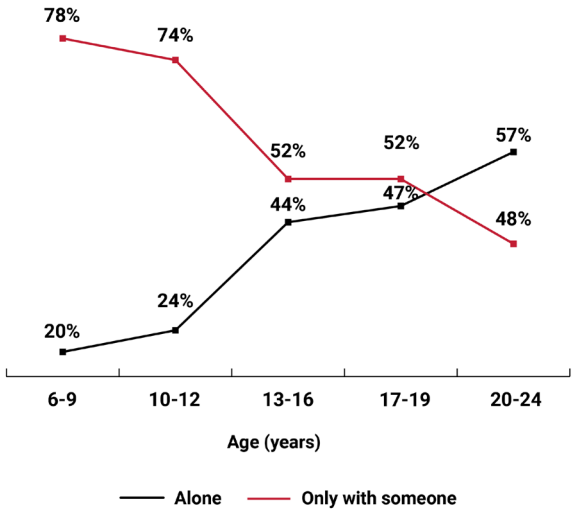
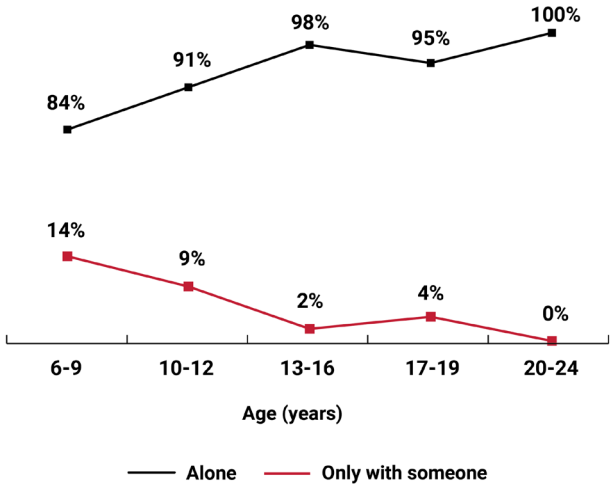


Figure 3: Percentage of boys able to leave the house



The team encountered a few **surprises and** identified **potential limitations of the adolescent mapping** tool:

- Households interviewed contained **fewer girls than boys**, and **fewer married girls were identified than expected**. This may be due to the screening question, which asks heads of households whether there are any girls under the age of 24 living there. If the word for "girl" is understood to mean "unmarried," as is the case in the Rohingya language, respondents may be less likely to report married adolescents or young women.
- Households interviewed contained **fewer people living with disabilities** than reported by other sources. This may be due to response error, either from misunderstanding of the survey questions or hesitancy to report that an individual in the household has a disability.

Participatory group activities

Over the course of five days, PHD implemented nine participatory sessions, including storytelling and PRM, with eight subgroups of adolescents, and conducted two IDIs with adolescent girls living with a disability. PHD staff chose storytelling as the first activity to gently introduce sensitive topics, such as SRH and GBV. PHD staff relayed a fictional story about adolescents living in Cox's Bazar, and then asked a series of probing questions that allowed participants to relate the stories to their own lives. Following the storytelling activity, PHD used PRM to understand the needs and priorities of different subgroups of adolescents. PRM is a mixed-methods approach that provides categories, frequencies, and rankings of needs and priorities raised by participants alongside contextualized notes. In addition to the group activities, PHD staff facilitated IDIs with two adolescent girls living with a physical disability to better understand their unique needs, priorities, and barriers to services.

Adolescents identified 45 unique issues and concerns through the PRM activity. The most critical issues—based on how many groups cited the issue and how highly it was ranked—are presented in Table 1.

Table 1: Priority issues identified by adolescents

Issue	# of groups	Average rank
Health facility is far	7	2
Intimate partner violence	6	5
School is far	3	2
No female doctor	4	3
Dark toilet facilities	4	4
No adolescent center	2	2
Boys teased by girls	3	4
School is closed	2	4
Wet dreams	2	4
Robbery	4	6

Priority concerns differed among subgroups. Unique issues for girls included the lack of female doctors, dark toilet facilities, lack of menstrual hygiene materials, being teased by boys, the poor condition of the toilets, and household violence. Unique issues for boys included the lack of adolescent centers, wet dreams, having to wait in line to fetch water, dowry, corporal punishment in school, and polygamy. Younger adolescents noted robbery and the lack of a playground as unique concerns, whereas older adolescents more commonly cited the distance of school, intimate partner violence, and water scarcity.

Excerpts from participatory group activities were further analyzed to understand key barriers and enablers for adolescents in accessing services. Several key themes emerged and guided PHD staff on potential program content, revealing a need to go beyond provision of information to adolescents themselves. First and foremost, many adolescents expressed feelings of fear in their day-to-day lives: fear of robbery, fear of kidnappings, fear of punishment at home, fear of feeling shame, and fear of changes associated with puberty. These feelings limited adolescents in their ability to access services, socialize with their peers, and carry out day-to-day tasks.

> *"I'm feeling scared to go the market. Some hijackers are roaming there. They will snatch our earrings and necklaces from us and run away. These incidents always make us worried about the market."* – In-school adolescent girl, aged 13-16

> *"I feel scared to go to the toilet as the toilet is far from my household and also doesn't have a light. Boys used to sit around the toilet, so I'm feeling really uneasy to go."* – In-school adolescent girl, aged 13-16

Adolescents were aware of changes that were expected of them as they grew older, and how their age and gender may limit them and their autonomy. For example, boys noted the increasing responsibilities to earn money and carry out household tasks, but often felt disrespected by adults in the community.

> *"When we go to collect water, we need to stand in line. Elders never maintain the [order of the line]. They will go first and if we say something, they beat us."* – In-school adolescent boy, aged 13-16

> *"When we go to school, senior boys fight and beat us. After complaining to the teachers, nothing changed. We used to go to school, but now we can't go."* – Out-of-school adolescent boy, aged 10-12

Girls discussed their inability to make decisions about their movements, including seeking health care. Due to their age and gender, adolescent girls felt especially wary of accessing health services without assurance of a female provider who would understand their health issues.

> *"I am not allowed to go there [to the health facility]. My husband doesn't let me go. When my husband is not in the house, I go to the hospital secretly."* – 16-year-old adolescent girl with a disability

> *"Girls want to solve those problems [health-related issues]. So they go to the hospital to talk with doctors. But if there is a male doctor, they don't say anything about this to him. … They shouldn't talk about their private parts to any man. It is a matter of shame."* – Married adolescent girl, aged 17-19

Both boys and girls noted how certain cultural norms related to marriage negatively affected their lives. Interestingly, adolescent boys were just as likely as girls to mention the issue of dowry as a major challenge.

> *"About dowry, if CIC [camp management] will punish people and will instruct the Majhis [community leaders] to stop the dowry system, then it will be stopped."* – In-school adolescent boy, aged 13-16

Adolescent girls were particularly affected by the issue of intimate partner violence, but boys also expressed concern over how common the practice is in their community.

> *"Apa [sister], husbands always beat their wives. [She gives a sad expression]. And the situation becomes normal after some time."* – Out-of-school adolescent girl, aged 17-19

> *"In anger, they beat their wives. They are not adults, but they get married and have no understanding. At the age 12 or 13 they get married. They are not understanding, and they beat their wives."* – In-school adolescent boy, aged 13-16

Throughout the discussions, adolescents offered numerous solutions to the challenges they faced. Overwhelmingly, adolescents wished for a place where they could go to freely discuss their problems and receive guidance. They also noted the importance of certain decision-makers in their lives, especially Majhis, parents and caregivers, and camp management.

Asset Exercise

WRC recreated the Asset Exercise using the Mural platform (see Annex 1). The asset cards were made using color-coded sticky notes for each asset domain (economic, participation, education, safety, health, and social), and were organized into an "asset bank." Two Mural boards were created—one for adolescent girls and another for adolescent boys. PHD staff split into small groups, then moved the asset cards from the asset bank underneath the age at which girls should possess the asset. When all groups had finished placing the assets, WRC and PHD staff reviewed their placement and added an icon next to assets that sparked questions, leading to discussion and the movement of some assets from older ages to younger ages. PHD staff completed the exercise for adolescent boys independently, and WRC staff facilitated discussion of the results the following day.

Following discussion with WRC staff, PHD staff moved any assets identified for 18 and 20 years to earlier ages, determining that adolescents needed to attain all selected assets between the ages of 6 and 16 years. PHD staff articulated that particular assets may vary based on adolescent characteristics other than age and gender, noting that each subgroup of adolescents faces unique barriers and facilitators to possessing each asset. WRC then facilitated a follow-up activity in which PHD staff selected specific barriers and enablers to possessing assets for different subgroups. The barriers and enablers were color coded based on the socio-ecological model: individual, family/interpersonal, community, organizations/institutions, and environment.

For the married adolescent girl subgroup, lack of knowledge/education was specified as a barrier for possessing specific health and safety assets. Most family and interpersonal entities (e.g., peers, husband or partner, male relatives) were identified as enablers for health-related assets (e.g., knowing the location of emergency health services; knowing signs during pregnancy, and about labor and where to go for help), but female relatives were noted as a barrier. For other SRH-related assets (e.g., understanding the basics of sexuality and reproduction; knowing where and how to get condoms and contraceptives), PHD staff identified family/interpersonal entities as both barriers and enablers, while community-level entities (e.g., social/gender norms, religious leaders and Majhis) and decision-making abilities (individual level) were identified as barriers only.

For certain health and safety assets, NGO services were mostly identified as enablers. Barriers to participation assets (e.g., knowing and being able to describe their rights as outlined by the Convention on the Rights of the Child; knowing what programs the government and NGOs provide for girls their age) varied by asset and comprised the individual, family/interpersonal, and organizations/institution levels. Notably, no enablers were identified for these assets. Social assets (e.g., having a trustworthy adult who can provide accurate, nonjudgmental advice on contraception; having (at least three) non-family friends and one safety asset (having a safe space to meet peers at least once a week) were related to themes of fear, social norms related to age, and social isolation. Barriers identified comprised the individual (household responsibilities); family/interpersonal, community, and environment levels. Female relatives were identified as an enabler, while a husband or partner was identified as both a barrier and an enabler.

Benchmark selection

For each subgroup, PHD staff assigned benchmarks to evaluate changes in adolescents' assets as a result of programming, developing at least one benchmark per asset. A sample of benchmarks is provided in Table 2.

Table 2: Sample benchmark selection

Subgroup	Asset	Benchmark(s)	Main barriers	Main enablers
Married girls	Has a safe space to meet peers at least once a week	Knows at least one place outside their home where they can be with other girls/ boys and feel safe and supported	1. Social norms 2. Household responsibilities 3. Husband 4. Infrastructure 5. Female relatives	1. Husband 2. Female relatives
Unmarried girls (10-12 years)	Feels like she can say "no" to her friends if they are pressuring her to do something she doesn't think is right	Knows that she can decide what to do and what not to do	1. Family 2. Community 3. Decision-making abilities	1. NGO services 2. Majhis 3. Decision-making abilities
Unmarried girls (13-14 years)	Knows her rights as a girl and that dowry is a form of gender discrimination	Disagrees that families should pay a dowry so that a girl can get a good husband	1. Knowledge / education 2. Social context 3. Family 4. Gender discrimination	1. Decision-making abilities 2. Awareness 3. Religious leader
Unmarried boys (10-12 years)	Is able to describe two strategies that may reduce his exposure to common safety risks	Knows places in the camp where it is unsafe for girls/boys his age Feels safe when walking around the camp with at least one other friend or a family member	1. Social isolation 2. Fear 3. NGO services	1. Family 2. Peers 3. Adolescent learning center
Adolescent boys (13-16 years)	Knows how to manage money: revenue, savings, spending, debt, interest, investment	Has received training/ support on how to manage money (spending and savings)	1. Resources 2. Knowledge/training	1. Family 2. Male relatives 3. Peers
Adolescent boys (17-19 years)	Knows how and when to access food distribution services	Knows the procedure of getting food from a distribution hub	1. Knowledge / information	1. Awareness 2. Majhis 3. CIC

Most of the benchmarks PHD developed are measures of knowledge (e.g., knowing the procedure of getting food from a distribution hub). Other benchmarks measure attitudes (e.g., disagreeing that families should pay a dowry so that a girl can get a good husband) and behavior (e.g., having received training/support on how to manage money [spending and savings]). Some assets were simply rephrased as an outcome with a measurable indicator (e.g., knowing the procedure of getting food from a distribution hub), while other benchmarks were directly related to programming outputs (e.g., having received training/support on how to manage money [spending and savings]).

Key action taken and next steps

Various action was taken concerning adolescent programming in Cox's Bazar as a result of the adaptation and utilization of the I'm Here Approach and its findings. First, findings actively informed PHD's development of an **adolescent program strategy**. Over the course of two months, WRC and PHD worked together to create a strategy for all future adolescent programming. The strategy drew heavily from I'm Here findings and includes the following elements:

1. Vision statement and goal
2. Theory of change
3. Program objectives
4. Target program participants and subgroups
5. Outreach and recruitment
6. Participatory program design methods
7. Suggested program content, differentiated by target subgroups
8. Monitoring and evaluation plan, with indicator framework
9. Coordination and knowledge sharing
10. Advocacy and donor engagement.

Furthermore, the strategy identified physical locations where programming should be implemented, refined outreach and recruitment strategies to ensure that more isolated groups were targeted, and created a monitoring and evaluation framework that includes assets and adolescent benchmarks. Based on findings from participatory group activities with adolescents, the program strategy also provides recommendations for participatory program design activities and priority areas for programming. PHD's program strategy is underpinned by a theory of change, and highlights the need for multisectoral programming that takes into account the diverse needs of different subgroups of adolescents in Cox's Bazar.

Throughout implementation of the I'm Here Approach, PHD and WRC worked to share findings and lessons learned with other humanitarian actors, including national and international organizations. As part of an I'm Here webinar series, PHD and WRC co-hosted a webinar in December 2020 to share initial findings, and the International Rescue Committee (IRC) and UNFPA joined the panel to share challenges and solutions programming for adolescents in Cox's Bazar.

As PHD and WRC continue to share lessons learned with humanitarian actors in Cox's Bazar and beyond, the next steps planned are as follows:

- Work with other humanitarian actors in Cox's Bazar to formulate a policy brief on multisectoral and inclusive programming for adolescents. The policy brief will summarize actionable lessons learned from the I'm Here Approach and experiences of other implementing organizations working with adolescents in Cox's Bazar.

- Use policy brief and PHD program strategy to advocate to humanitarian actors, policymakers, and donor agencies. These efforts will promote a shift to a programming approach that focuses on building Rohingya adolescents' protective assets and responding to the unique and diverse needs of different adolescent subgroups.
- Continue to explore virtual mechanisms for delivery of services and information to reach more isolated adolescents. Given that limited mobility of adolescent girls has been identified as a challenge, PHD will continue to develop a strategy for remote programming through peer mentors and community outreach.

Recommendations

Recommendations for adolescent programming in Cox's Bazar

Building the protective assets of adolescent boys and girls requires holistic programming and service delivery that take into account the unique priorities of different subgroups of adolescents. Programming must take into consideration the following:

- Although the Rohingya community does not have a term for "adolescent," it recognizes distinct stages of adolescence: 10-12 years (pre-puberty); 13-15 years (onset of puberty; pre-marriage); and 16-19 years (considered eligible for marriage). However, **distinctions should be made beyond just age when planning and implementing programming for adolescents**. Practitioners must consider adolescents' marital status, household composition, and schooling status when deciding how to group program participants.
- The influx of Rohingya refugees in 2018 was followed by an influx in programming and services. However, there **remain areas of Kutupalong camp that are underserved and isolated due to their geographical location and terrain**. Instead of setting up programming where they are already working, **organizations need to prioritize hard-to-reach areas of the camp**. Organizations should also consider the accessibility of their program sites based on physical terrain and other potential barriers faced by adolescents. The service mapping tool can be extremely helpful when deciding where to set up adolescent programming in Kutupalong camp.
- There are many **important gatekeepers and decision-makers in the lives of Rohingya adolescents**, especially Rohingya adolescent girls. Failing to engage with these gatekeepers, such as parents, caregivers, siblings, husbands, and community and religious leaders, can result in even more barriers for adolescents in accessing programming or services. **Sharing information with the community and involving them in certain aspects of programming** is essential to avoiding community backlash to programming.
- Adolescent boys and young men can serve as an important asset and advocate in the lives of adolescent girls. In the activities, adolescent boys proved their understanding of the issues faced by their female peers, and their desire to change certain harmful norms and practices, including intimate partner violence and dowry. **Targeted programming for adolescent boys is necessary to build protective assets for both boys and girls**.

Recommendations for I'm Here implementation

This was the first implementation of the I'm Here Approach in Cox's Bazar, and the first implementation during the COVID-19 pandemic. The I'm Here tools proved adaptable and relevant in this setting, and PHD staff were able to make adjustments in line with COVID 19 precautions and safety recommendations. However, certain challenges and limitations should be addressed for future implementation:

- **The adolescent mapping tool may require further adaptations for contexts with different household dynamics**. In Cox's Bazar, married adolescent girls may have been overlooked due to their classification as women as opposed to girls or adolescents. In future, implementing organizations should work with community members, ideally including adolescents, to ensure that questions are understood and relevant for the given context. Different screening questions may be required for the Girl Roster and Boy Matrix to identify married adolescents.
- Adolescent mapping tools are intentionally designed to identify the adolescents who are least likely to access services and programming. The **inclusion of mobility questions in the adolescent mapping tool** allowed program staff to identify changes in access to services from childhood to early adulthood. Future implementation of the I'm Here Approach should consider similar questions that are adapted to the given context and **questions exploring why individuals do not leave the home**.
- **Remote training and support of I'm Here implementation is possible**. While certain activities required more preparation and lateral thinking in terms of training delivery, both the WRC and PHD teams used multiple platforms to ensure that content was understood and that PHD staff were able to engage with the material. **The** I'm Here Playbook **is a useful resource to use for training and implementation**.

Recommendations for policymakers and donor agencies

Meaningfully reaching adolescents in Kutupalong camp requires not only well-designed and well-implemented programming, but also matched support from policymakers and donor agencies. The following recommendations emerged as necessary in order to implement multisectoral and inclusive programming for Rohingya adolescents:

- Funding should be **flexible to account for implementation delays amid challenges in refugee settings**, including changing government policies, restrictions due to violence, and, in the last year, the COVID-19 pandemic.
- Building the protective assets of adolescents requires **higher-level changes in cultural and gender norms. Multi-year funding is necessary** to design, implement, and assess gender-transformative change.
- **Adequate support for robust monitoring and evaluation of programming will expand the evidence base** on holistic, multisectoral adolescent programming in diverse settings and contexts.
- There is a need to **leverage local expertise and capacities** with adequate funding and allow time for meaningful partnership building with local organizations.

Annexes

Annex 1. Asset exercise table

Legend	
Green	Economic assets: relate to earning, or managing, money
Purple	Participation assets: address decision-making and representation in public and within household, exercise of rights and access to entitlements
Orange	Education assets: contribute to concrete skills-building and/or access to school or alternative learning environment
Blue	Safety assets: promote physical security at home, in institutional settings, and in public spaces
Yellow	Health assets: support healthy behaviors, reduction in risks, and/or use of health services
Red	Social assets: relate to features of relationships with self, peers, and adults

Adolescent girls

Age 6	Age 8	Age 10	Age 12	Age 14	Age 16
Know how many years of primary and secondary education to which she is entitled	Know what to say and what not to say to a survivor of a violent crime	Feel like she can say no to her friends if they are pressuring her to do something she doesn't think is right	Be able to respectfully assert preferences for when to marry and who to marry	Be able to assess risks associated with different options for earning money	Have savings that can be accessed in case of personal emergency
Know when, why, and how to wash hands	Be able to complete basic mathematical calculations (add, subtract, multiply, divide)	Have the self-confidence to negotiate her preference for staying in school	Have (at least three) nonfamily friends	Have a skill she can use to earn money	Know how to initiate conversations about traditional norms, including describing personal views and questioning them
Has a data card	Be able to read and write a sentence	Be able to identify and know when to test clean drinking water sources	Know how HIV is transmitted and how to prevent it	Know signs of danger during pregnancy, labor, and where to go for help	Has all applicable identity documents
Know that she has the same rights as her brother	Know basic nutritional needs of adolescent girls	Know the symptoms that should prompt her or a family member to seek medical attention (sustained fever, persistent cough, diarrhea, blood in stool or phlegm, etc.)	Have access to supplies to manage menstruation every month	Know location of emergency health services	

Age 6	Age 8	Age 10	Age 12	Age 14	Age 16
Know and be able to describe rights as outlined by Convention on the Rights of the Child	Know the routes to sources of clean water, and the strategies for mitigating risks along the route to/from water collection	Know specifics of menstruation and how to manage it	Know requirements for accessing SRH services	Know that dowry is a human rights violation	
Be able to describe her residence/home in relation to key landmarks	Know what abuse is and the difference between a "good touch" and a "bad touch"	Know what programs government and NGOs provide for girls their age	Understand the basics of sexuality and reproduction	Know how to ask for a female authority if she feels uncomfortable with a male	
	Know phone number to call when in need of help	Identify a skill she can teach others	Know signs of drug and alcohol dependence	Be able to describe two strategies that may reduce her exposure to common safety risks	
	Know the code of conduct that outlines appropriate and inappropriate behavior for teachers	Know that according to international human rights frameworks, marriage before a girl's 18th birthday is illegal and that girls have a right to determine when to marry and who they marry	Know how to grow a few important foods		
	Be able to describe times of day and specific situations when she feels unsafe	Be aware that most violence against women and girls is perpetrated by someone they know	Know where to get an HIV test and what treatment options are available		
	Know about dangers of trafficking and how to avoid it	Know how to read a map, and where relevant to identify where she lives in relation to other features on the map	Have a safe space to meet peers at least once a week		

Adolescent boys

Age 6	Age 8	Age 10	Age 12	Age 14	Age 16
Know and be able to describe rights as outlined by Convention on the Rights of the Child	Know what programs government and NGOs provide for boys their age	Has all applicable identity documents	Know that according to international human rights frameworks, marriage before a boy's 21st birthday is illegal and that boys have a right to determine when to marry and who they marry	Know how to initiate conversations about traditional norms, including describing personal views and questioning them	Have access to supplies to manage menstruation every month
Has a data card	Know how to play traditional games	Be aware that most violence against women and girls is perpetrated by someone they know	Be able to describe two strategies that may reduce his exposure to common safety risks	Be able to plan for seasonal, weather-related risks that affect him and/or his family's safety and/or economic status	Know how to manage money: revenue, savings, spending, debt, interest, investment
Know that boys and girls have the same rights	Know where to turn for support if he or someone he knows has experienced violence	Have a safe place to spend the night away from home in case of emergency	Have access and control over portable light source	Know how HIV is transmitted and how to prevent it	
Know the code of conduct that outlines appropriate and inappropriate behavior for teachers	Know the location of adolescent-friendly spaces	Know location of emergency health services	Know the symptoms that should prompt him or a family member to seek medical attention (sustained fever, persistent cough, diarrhea, blood in stool, or phlegm, etc.)		
Know phone number to call when in need of help	Be able to describe times of day and specific situations when he feels unsafe	Be able to identify and know when to test clean drinking water sources	Know where and how to get condoms and contraceptives		
Know what abuse is and the difference between a "good touch" and a "bad touch"	Know how to read a map and, where relevant, to identify where he lives in relation to other features on the map	Know signs of drug and alcohol dependence	Understand the basics of sexuality and reproduction		

Age 6	Age 8	Age 10	Age 12	Age 14	Age 16
	Knowledge about dangers of trafficking & how to avoid it	Know how and when to access food distribution services	Know where to get an HIV test and what treatment options are available		
	Be able to read and write a sentence	Have (at least three) non-family friends	Be able to respectively assert preferences for when to marry and who to marry		
	Be able to complete basic mathematical calculations (add, subtract, multiply, divide)	Feel like he can say "no" to his friends if they are pressuring him to do something he doesn't think is right	Have a trustworthy adult who can provide accurate, non-judgmental advice on contraception		
	Know the routes to sources of clean water, and the strategies for mitigating risks along the route to/from water collection	Have the self-confidence to negotiate his preference for staying in school	Know what to say and what not to say to a survivor of a violent crime		
			Have a marketable skill		

Abbreviations

Partners in Health and Development (PHD)

Women's Refugee Commission (WRC)

Sexual and reproductive health (SRH)

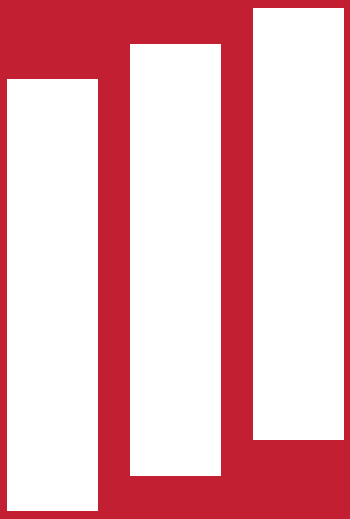
Gender-based violence (GBV)

United Nations Population Fund (UNFPA)

Sexual and reproductive health and rights (SRHR)

In-depth interviews (IDIs)

Nongovernmental organizations (NGOs)



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