PMNCH background paper 12:

The forgotten population? A call to invest in adolescent well-being in humanitarian and fragile settings

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ABSTRACT

Adolescents are disproportionately affected in humanitarian and fragile settings, where they will often find themselves in high-risk situations and may be forced to take on adult roles within their families and communities. They are also more likely to have poor well-being outcomes related to disrupted or no access to optimum nutrition, health services and protection, as well as opportunities for education, training, and employment. Our paper aims to provide an overview of current interventions focusing on adolescent well-being and to provide a set of policy and programmatic recommendations to prevent long-term consequences of crisis and conflict on adolescents' lives. According to the UN H6+ Technical Working Group on Adolescent Health and Well-beings' framework for adolescent well-being, this article analyses adolescents' backgrounds and interventions oriented to them within humanitarian and fragile settings. In this sense, we refer to five domains that include: good health and optimum nutrition; connectedness, positive values and contribution to society; safety and a supportive environment; learning, competence, education, skills and employability; and agency and resilience.

Despite scant evidence on both the implementation and evaluation of interventions to address the diverse needs of adolescents in humanitarian and fragile settings, we call for greater investment in, and prioritisation of, adolescent well-being programming in these settings, linked to careful documentation of programmatic inputs, processes and outcomes and, wherever possible, evaluation of effectiveness and cost-effectiveness. Furthermore, it is critical to include adolescents in the design, implementation and evaluation of interventions and to consider adolescents as full actors with diverse needs, including by prioritising supporting local adolescent-led initiatives and organisations. Sustainable systems must be built for adolescent empowerment and participation in decision-making (especially for girls), and investments made in gender transformative approaches to improve adolescent girls' agency and leadership at community, provincial, and national levels. It is also imperative that links are strengthened between sectors, including protection, education and livelihoods, for a holistic, multisectoral response for adolescents using existing structures in humanitarian and fragile settings. Where adolescent-focused interventions are embedded within broader programmes, implementers

and/or researchers should include adolescent-specific strategies, targeted at all genders where appropriate, and collect data disaggregated by age, gender and disability status to help to meet the diverse needs of this population that is largely forgotten in humanitarian and fragile settings, and even more so during the COVID-19 pandemic.

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INTRODUCTION

In 2019, the United Nations High Commissioner for Refugees (UNHCR) reported that 79.5 million people in the world have been forcibly displaced from their homes because of conflict and persecution, including 26 million refugees, over half of whom are under the age of 18 (2). Adolescents, including unaccompanied minors, were disproportionately affected by displacement due to conflict between 2009 and 2017, compared to women and children under the age of five years, with the number of displaced adolescents increasing from 13 million in 2009 to 19 million in 2017 (3).

Focusing on the well-being of adolescents in humanitarian and fragile settings (HFS) is essential considering the specific physical, social and cognitive changes experienced during this life stage and the effects of humanitarian crises on each of these. Given the protracted nature of recent humanitarian crises, adolescents may spend much or all of this life-stage in such settings. During and after humanitarian crises, vulnerabilities affecting adolescents become more manifest. These vulnerabilities, exacerbated by poverty, gender inequities and human rights violations, intersect and may include long-term mental illness due to sexual exploitation, abuse of drugs and alcohol among other stressors, academic underachievement due to sustained or permanent interruption to schooling, reduced economic prospects, chronic poverty associated with forced migration, poor psychosocial outcomes and increased risk of sexual and gender-based violence (1). Furthermore, the COVID-19 pandemic is exacerbating challenges that adolescents face in HFS; both the disease and its related response measures are having a profound effect on this population's health and well-being, with long lasting and often irreversible impacts (also see Background Paper 13, Adolescent Well-Being in the Time of COVID-19).

This review highlights some of the challenges of maintaining adolescent well-being in HFS, provides an overview of current interventions focusing on adolescent well-being and concludes with policy and programmatic recommendations to prevent long-term consequences of crisis and conflict on the lives of adolescents. The paper is structured around the UN H6+ Technical Working Group on Adolescent Health and Well-being´s (4) framework for adolescent well-being which encompasses five interconnected domains – both subjective and objective- and the

requirements for achieving these (see Annex I). The five domains include: (i) Good health and optimum nutrition; (ii) Connectedness, positive values and contribution to society; (iii) Safety and a supportive environment; (iv) Learning, competence, education, skills and employability; and (v) Agency and resilience.

SCOPE AND METHODS

Though there are many different types of HFS, this paper focuses on armed conflicts and environmental disasters, which align with the mandate of UNHCR.

A literature review was conducted, drawing on databases including PubMed, Google Scholar, BMC Conflict and Health, Plos One, Science Direct and ReliefWeb to identify peer-reviewed and grey literature on adolescent well-being in humanitarian settings from 2000 to December 2020. In addition, websites of organisations working within the humanitarian sector were searched for relevant reports and articles. These included the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG), UNICEF, UNFPA, Population Council, Overseas Development Institute (ODI), International Rescue Committee (IRC), Care International, Women's Refugee Commission (WRC) and ALNAP. Finally, co-authors of the paper provided examples from their first-hand experience working on adolescent well-being in HFS. This review was exploratory and allowed the authors to identify strategic points and reflections about how adolescents' needs are being taking into account within HFS.

The group of authors contributing to this review includes young people and represents a great diversity of regions in the world according to World Health Organisation (WHO) region classification: 1 author from the Americas, 3 authors from the Eastern Mediterranean region, 2 authors from the African region, and 4 from the European region. Nonetheless, this review cannot be considered a comprehensive or a globally representative review on adolescent wellbeing in humanitarian and fragile settings; rather, it is a rapid scoping review based on experiences in varied HFS.

WELL-BEING OF ADOLESCENTS IN HFS CONTEXTS

1. Good health and optimum nutrition

Challenges

Adolescence is a critical stage of human development during which future patterns of adult health are established (5). Health systems in HFS are usually ill-equipped to meet the physical and mental health needs of adolescents and few interventions are implemented to promote adolescent health and well-being. A 10-country case study aiming to assess the provision of women's and children's health services in countries currently experiencing conflict found that adolescent health was largely ignored, with the majority of the examined case studies reporting no evidence of implementation, with some exceptions related to sexual and reproductive health (SRH) programmes led by international humanitarian actors (6). Furthermore, adolescent health and well-being needs are often ignored as more attention is given by governments and donors to maternal and child health and other conditions associated with high mortality in such contexts, such as disease outbreaks, infectious diseases, injury and trauma or neonatal disorders.

Meeting the health and nutrition needs of adolescents remains a challenge in HFS. A systematic review of SRH interventions for young people and adolescents in HFS found no studies on sexual health awareness, prevention of mother-to-child transmission (PMTCT), safe abortion, post-abortion care, urogenital fistulae or female genital mutilation (FGM) (7). The ability of adolescent girls to develop good menstrual hygiene management practices is usually very limited in HFS, with insufficient knowledge about menstruation, and structural constraints such as lack of affordable and culturally acceptable sanitary materials, lack of separate toilet facilities for girls and women, and lack of easily accessible sources of water for washing. For example, in Lebanon, Syrian refugees are accommodated in a second, afternoon shift in Lebanese public schools, but the lack of janitorial services means that adequate bathroom facilities are often not available.

An increase in mental health disorders, including depression and anxiety, is common among war-affected young adolescents as a direct result of exposure to violence, breakdown of family structures and social disintegration (8-10). Comorbid mental health disorders can also have an impact on the use of SRH services by adolescents, resulting in negative health outcomes (11).

The nutritional needs of adolescents in humanitarian settings have received even less attention (12). Specific indicators for measurement of pre-pubertal and post-pubertal malnutrition, evaluation of nutritional interventions and evidence on what constitutes good nutrition for adolescents in HFS are unavailable for further planning and implementation of nutrition programmes. Poor health and food insecurity among adolescents, particularly girls, can increase the likelihood of experiencing interpersonal violence and suicide attempts (13) and exacerbate existing gender inequalities (14, 15) as well as having inter-generational biological effects (16).

Interventions

Overall, the evidence from evaluations of health and nutrition-related interventions in HFS is sparse and largely focused on SRH, mental health and anaemia. A systematic review of rigorously evaluated SRH interventions for young people in humanitarian and low- and middle-income country (LMIC) settings found evidence of significant beneficial effects on SRH outcomes for school-based and group-based interventions (11). Successful components included education/knowledge building on puberty, anatomy, pregnancy, HIV/STI prevention as well as gender equity and skills building on condom use. In total, 50% of the studies that were found to be effective incorporated psychosocial components, including assertiveness training, communication skills and problem solving. Several toolkits have been developed to guide, monitor and evaluate adolescent SRH health in humanitarian settings. These include the Women's Refugee Commission and UNICEF toolkit which provides a standardised mechanism to monitor and evaluate adolescent SRH interventions in safe spaces (17) and IAWG's recently updated toolkit on adolescent SRH in humanitarian settings (18).

A systematic review of reviews of mechanisms of change used in psychosocial interventions to improve the wellbeing, mental health and resilience of conflict-affected children and adolescents found high quality evidence for family and caregiver capacity building, family and caregiver relationship strengthening, active problem-solving and therapeutic rapport/reflective practice (19). However, the review also highlights the low quality of evidence underpinning the use of

many common psychological interventions in the field. Further reviews of interventions for children and adolescents affected by war and natural disasters found promising evidence for the use of KidNET (narrative exposure therapy) (20) and psychosocial or mental health school-based programmes conducted by teachers or local paraprofessionals (21) to reduce post-traumatic stress disorder (PTSD) symptoms in these age groups.

In Afghanistan, a weekly iron folic acid (IFA) supplementation programme is being implemented in all of its 34 provinces for school-going adolescent girls (aged 10-19 years) to improve their school performance and boost pre-pregnancy stores of iron for a healthy reproductive life (22). The programme involves a 'fixed day', once a-week approach for teacher-supervised IFA administration, communication on the benefits of adequate iron intake and relevant dietary advice, counselling on reproductive health and the risks of teenage pregnancy, and a deworming component to increase iron absorption and general health. This programme has been integrated with Afghanistan's National School Health Policy, along with other initiatives such as Menstrual Hygiene Management, which aims to improve school retention and quality of learning for adolescent girls and to provide the continuum of care between adolescent and maternal nutrition. An evaluation of the programme in 2018 with 1600 adolescent girls from 40 schools in four provinces found increased awareness of anaemia and its definition amongst 92% of participants, as well as increased knowledge of symptoms associated with anaemia, such as low energy and shortness of breath, demonstrated by 69% of the participants; however, knowledge of how to prevent anaemia was not widely noted (22). The study also reported higher mean haemoglobin levels among respondents who had been exposed to the WIFS programme, which may have contributed to improved health and nutrition outcomes among these female students.

2. Connectedness, positive values, and contribution to society

Challenges

Living in HFS causes major disruption to adolescents' social relationships, attitudes, activities and interpersonal skills. This is clearly illustrated through recent reports of the lived experiences of Rohingya adolescent girls for whom displacement and family separation have been a major source of stress (23). For refugees, tensions between adolescents and host populations, as well as the concerns of parents about adolescent refugees' safety in unfamiliar environments, may contribute to mobility restrictions, as was observed for Syrian refugee adolescent girls in Lebanon (24). Closure of schools, educational disruption leading to adolescents not being in age-appropriate grade levels, breakdown of supportive family networks, and the relative dynamism of fragile settings - as opportunities for migration/asylum-seeking emerge, and situations in host countries evolve - create an unstable ecosystem for adolescents to form meaningful, emotional connections with others. Adolescents often become the main economic providers in households, and girls, in particular, often take on caretaker roles of their younger siblings. As a consequence, while these situations may increase adolescents' agency and resilience, they may also fail to develop essential social skills and may eventually internalise their emotional and behavioural problems independent of age or gender (25).

During armed conflict, young males are often targeted and recruited by armed groups. In HFS such as Colombia, youth may be viewed as being "problematic" or difficult to work with, preventing them from participating in and contributing to society (26). Fear of being recruited or being marked as problematic creates barriers for the participation of young men and women in responses needed to overcome situations of stigmatisation and exclusion, including political engagement. Conflict also often leads to the exodus of unaccompanied minors as internally displaced persons or refugees suffering from a lack of protection in their host countries.

Interventions

Adolescent Engagement in Programming

The need for adolescent engagement in programming in humanitarian settings is particularly apparent in the wake of COVID-19, where the participation of adolescents has often been relied

upon to mitigate the pandemic. For example, in refugee camps in South Sudan, the establishment of Youth Committees (made up of adolescents and young people) ensures that adolescents are represented in decision-making and are therefore able to contribute positively to their communities through youth-/adolescent-led interventions (27). One such intervention involved the composition of COVID-19-related songs in local languages representing ethnic groups within the camps. The songs drew on WHO-approved COVID-19 messages and were used to disseminate prevention messages to the entire community, while also fostering connection through language and music.

In a separate intervention, refugee students (beneficiaries of UNHCR scholarships) volunteered to disseminate COVID-19 prevention messages within their communities, and to provide referrals to health partners, as needed. Further, in Ugandan refugee settlements, there are examples of adolescent-led WASH initiatives to sensitise adolescents to COVID-19 prevention measures. Other instances from Uganda include an adolescent- and youth-managed initiative which simultaneously addressed the issue of youth idleness in refugee settlements, while responding to mobile phone-charging needs in the community. This intervention entailed the active participation and leadership of young people with regard to awareness-raising about the phone-charging booths/centre, price-setting for phone-charging services, and relationship-building between young people from both refugee and host communities, the sale of mobile phone airtime by young people, and advocacy for (and participation in constructing) a latrine at the centre.

A recent UNHCR compendium of interventions documents these and other interventions that meaningfully involve adolescent refugees in designing and implementing context-appropriate interventions in their communities. Notably, systematic and rigorous evaluations of these efforts are rarely conducted. However, these are important examples of how HFS generate also interactions that promote adolescents' resilience and empowerment.

Parenting programmes

In refugee settings, children and adolescents frequently require some form of foster care, due to parents returning to their country of origin without their children, child abuse in the context of kinship care, or minors who are unaccompanied, for example. This makes parenting programmes particularly important. Though not specific to HFS, a review of parenting programmes in low-and-middle-income countries (LMICs) found promising evidence for the use of group sessions, with space to improve communication skills; the inclusion of joint adolescent and parent sessions, to understand each other's perspectives and improve family dynamics, as well as separate sessions; and the use of video and audio material modelling sensitive and effective communication (28). These interventions increased communication and reduced neglect and violence, improved psychosocial well-being (of parents and adolescents) and reduced problematic behaviour, enhanced communication and understanding of adolescent SRH needs, and changed negative gender attitudes around education, marriage, roles and gender equality.

In Kenyan refugee contexts, one parenting intervention involves mentors who play a foster parent role in the lives of child and adolescent household heads (27). The latter identify adult mentors/supervisors of their choice to provide various forms of support (fetching water while mentees are in school, cooking, accompanying them on hospital visits, etc.). Adult mentors are informed of their selection and participate in sensitisation sessions on parental responsibilities, and the role of mentors/supervisors under the intervention, which includes reporting their mentees' protection concerns. Adolescents making the transition to adulthood are also supported via life and coping skills training in refugee camps. Another Kenya-based intervention involves formal foster parents who are refugees themselves and volunteer to care for and raise abandoned and unaccompanied minors (27).

3. Safety and a supportive environment

Challenges

Exploitative work (29), violence, trafficking (30), and recruitment into the army (military, sub-military, non-state armed groups) are frequently reported in HFS. Adolescents in HFS often face legal constraints in accessing, as well as inadequate knowledge of, legal and social protection services that are not designed with adolescents in mind (29). Constraints to legal birth and marriage registration in some settings – such as among Syrian refugees in neighbouring countries – may affect entitlements to services, with humanitarian institutions acting as key brokers to such systems (31).

In the Occupied Palestinian Territories, adolescents are systematically prosecuted by the Israeli military in the West Bank (32). They are physically and verbally abused, humiliated, and denied access to healthcare and legal advice. This has negatively impacted their lives, causing serious, long-term mental health problems, sleeping disorders, and physical symptoms (42). Advocacy and programmatic interventions in HFS typically focus on women and children as it is assumed that they are most vulnerable. Adolescent males, adolescents with non-binary gender identities and transgender populations risk being ignored, as the great majority of programmes targeting adolescents focus exclusively on girls (7, 33). The centrality of women and girls in these interventions is the result of historical inequalities among women and men that usually are deepened within HSF, furthermore it is important to identify how young males are being also affected by gender-based violence and inequalities as well to find strategic ways to include them in different interventions.

Interventions

Adolescent-friendly spaces

Evidence in humanitarian settings shows that, in places where adolescent-friendly spaces have been successfully implemented, significant reductions in gender-discriminatory practices among adolescents and overall improvement in adolescent girl wellbeing were observed (34). Promoting adolescent-friendly spaces has been proved to effectively address protection risks,

threats to psychosocial wellbeing and support developmental assets amongst younger adolescents (35).

Protection: trafficking, child soldiers, violence, child marriage

Child/adolescent protection is a key priority in refugee settings. The majority of UNHCR country operations have established robust child protection structures, and 'Child Protection and Youth' (with children and adolescents being below the age of 18) is one of UNHCR's thematic areas (27). Case management is a key feature of child and youth protection endeavours in these settings, with a focus on identifying and monitoring individual cases of at-risk children and adolescents. Case management includes home visits, awareness-raising, and monitoring data collection. A wide range of existing community-based structures (e.g, Child Welfare Committees, Child Protection Committees, Community-Owned Resource Persons, Child Protection Volunteers, etc.) are often drawn upon to support child protection activities, particularly in situations when partner organisations are unable to reach refugee communities (e.g. during COVID-19) (27). In such cases, these structures are trained to identify, report, and follow up on adolescent protection issues.

The COMPASS (Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces) programme implemented by IRC in Democratic Republic of Congo (DRC), Ethiopia/Sudan border and NW Pakistan, included the creation of special "safe spaces" for girls, adolescent girls' life-skills sessions, parent/caregiver discussion groups and service provider support. The evaluation showed girls increased their knowledge of professional gender-based violence (GBV) services, felt more positive about themselves and their future, had stronger social networks and were able to utilise safe spaces (36). Parents and service provider attitudes also improved. Although there was an overall reduction in girls' reported exposure to GBV in DRC from the beginning of the programme to the end of it, the evaluation could not demonstrate that this change came as a result of COMPASS. The evaluation of the intervention also did not show a statistically significant improvement in girls' feelings of safety outside the safe space in Ethiopia or DRC (36).

4. Learning, competence, education, skills, and employability

Challenges

Among the most important factors directly affecting the well-being of adolescents in HFS is education which is often disrupted due to fragile education infrastructure, and damage to education facilities and roads, and the lack of education-friendly environments either at home or at school (power cuts, stress and instability) (37). According to most recent data from the World Bank, the secondary school enrolment rate globally is 47% (38), with more adolescent boys enrolled in secondary school (51%) compared to adolescent girls (43%). However, context influences adolescent girls' and boys' access to secondary school education in HFS. For example, in Lebanon, while the most common reasons for Syrian refugee adolescents not being in school are related to them not being the appropriate age due to educational disruptions, or able to afford school supplies, books or transport, (39) adolescent boys are more likely to drop out of school after primary level than girls due to poverty and child labour and as a result of prevailing gender norms requiring them to become the breadwinner (40). In the Lebanese context, adolescent boys also experience higher rates of school-based violence and low school achievement (40). On the other hand, an assessment by CARE International in Mali in 2020 reported that 7% of girls were unlikely to return to school after the COVID-19 pandemic, compared to 1% for boys (41).

Lack of social cohesion due to rising social tensions between refugees and host communities is another challenge faced by crisis-affected adolescents. A review of the well-being of Palestinian adolescents in Lebanon revealed that lack of access to the same rights as host communities, and lack of security and opportunities (including employment, education, and training) was often associated with poorer mental health outcomes (40). Furthermore, it was found that Palestinian adolescent boys often experience tensions within their own families and communities due to negative experiences within wider society in terms of social interaction with Lebanese communities and other refugee communities (40).Sometimes it takes long duration for refuges to take resident permit in the host community; in that period, they are not eligible for basic services, such as education and employment, for example in the case of forcibly displaced Afghan adolescents in Iran (42). Additionally, integration processes with host communities are

slow and create tensions between adolescents' own families and host communities due to fear related to acculturation processes that occur within schools.

Interventions

In a world of rapid digitalisation, leveraging technology to both ensure the continuity of education and improve the quality of education in HFS can be a key intervention. In the Philippines, during the 2019 conflict in Bangsamoro region, the Department of Education teamed up with UNICEF to restore educational facilities in Marawi that had been destroyed in the ensuing violence. The Learning Tracking System was built on an existing mobile data collection platform, Ona Data gathered data on learners and their caregivers through field surveys to track displaced learners so that essential educational services could continue to be provided to them (43).

Alternative methods of learning have been developed to better serve young people in HFS with regards to education. Fab Labs (fabrication laboratories), a physical space with access to several digital manufacturing tools such as 3D printers, were pilot tested in Greece for young refugees who had been stranded following the closure of the Balkans route in 2016. This innovation equipped these young refugees with non-formal educational skills and practical digital training to contribute to their future employment opportunities (44).

It should be noted that some populations in HFS face difficulties accessing digital and technological devices, as well as the internet (45). Despite UNHCR called attention to the importance of digital connectivity to support refugees, including adolescents, digital gaps remain and have disproportional and gendered effects on adolescents' education and integration to society (45).

Additionally, due to the inaccessibility of FM radio in many humanitarian contexts, community radio is increasingly drawn upon as a learning/education intervention in these settings to ensure the continuity of schooling during long holiday periods, or during school closures due to other circumstances, such as the COVID-19 pandemic. In refugee camps in Kenya and Tanzania, for instance, distance learning programmes via community radio have been developed for children and adolescents in partnership with the government (e.g., through the use of government-

approved curricula) to meet adolescent refugees' learning needs (27). Such educational radio programming for adolescents is often coupled with other technologies, such as WhatsApp, to enhance interaction between students and teachers. Limited access to radios in refugee camps has led to further improvisation, including the distribution of solar-powered radios to households.

5. Agency and resilience

Challenges

Adolescents with prolonged exposure to conflict and related trauma, loss, separation and anxiety lose invaluable opportunities for developing self-esteem. Structures intended to help adolescents develop and appreciate themselves, including school clubs, parks for recreation, and sports, are often unavailable (46). Some adolescents in HFS are put in a position to have to head their household and care for family members, thus losing the privilege of being able to make important life choices e.g., marriage and education. This directly or indirectly limits the scope of their perceived life chances and their ability to maximise their potential. Others have no real opportunities for political or civic participation, and are prevented from becoming actively engaged members of society (40).

However, recent research on the effects of the COVID-19 pandemic on youth and adolescents in Colombia showed that even though rapid changes such as the ones produced by a sudden pandemic can have a deep effect on their lives, many adolescents were able to cope with the situation and to demonstrate resilience in order to overcome challenges faced during humanitarian crises (47).

Interventions

Programmes for economic empowerment

In DRC, an animal microfinance/asset transfer programme named Rabbits for Resilience was implemented where rabbits were provided to adolescents (10-15 years old) as a productive asset loan. A study on the effectiveness of this programme measured changes in economic assets, education and health, and found that young adolescents who participated in the programme alongside their parents showed improvements in asset building and prosocial

behaviour, were able to pay for school fees, helped their families meet basic needs and therefore gained respect within their families and communities (48).

Although not specific to HFS, a rapid evidence review of interventions in LMICs (including HFS) promoting adolescent girls' economic capabilities found that those which provided financial education and/or assets, vocational and/or business training, or a combination of support services showed the most potential to improve economic outcomes. Results included increased income, increased financial literacy and savings, investment in further skills training, improved SRH outcomes, better protection against violence, development of social networks, enhanced self-esteem and voice, increased mobility, and more gender equitable views (49).

Cross-cutting themes

Lack of data on adolescent well-being

Despite the high number of HFS, there is only a limited body of research investigating the effects of humanitarian crises on the wellbeing of adolescents (1). This lack of data cuts across all five domains included in adolescent well-being framework (4). Specifically, there is a lack of well-established indicators to measure the physical, mental, and social progress and development of adolescents. Currently available indicators therefore do not portray a full picture of well-being – focusing instead on physical health, education, fertility and employment, rather than more difficult to measure aspects, such as self-esteem, relationships and connectedness, resilience, stress, depression and anxiety (1). The data that does exist is typically cross sectional, typically due to the difficulty of collecting data over time given high mobility, not allowing the assessment of causality (1). Even conducting cross-sectional studies among representative samples is challenging in these contexts, as typically sampling frames do not exist and refugees and displaced populations may be living among local host communities and be very mobile. Often data is lacking on the pre-displacement or pre-disaster situation, making comparisons difficult, and in the case of refugees there are few studies comparing the status of refugees to that of host population adolescents.

A WHO report describes special ethical considerations that exist and pose challenges to such research and data collection when including young people in research on topics such as sexual and reproductive health and rights, which becomes even more challenging in HFS (50). These considerations include legal requirements that require parental consent for participation mainly needed for younger adolescents, which may be a challenge for recruitment in humanitarian settings where young adolescents might be separated from their parents. While ethical guidelines from the Council for International Organizations of Medical Sciences (CIOMS) in collaboration with WHO include an option of waiving parental consent in certain circumstances, this recommendation is not evenly applied or followed globally, including in HFS (51). Ethical challenges when collecting data from adolescents also include difficulties in asking about traumatic events including abuse, power relations between researchers and adolescents and difficulties ensuring privacy and confidentiality (1).

Poor evaluation of interventions to address adolescent well-being

The effectiveness of current interventions that promote adolescent well-being is largely unknown, and in many cases the evidence that does exist is considered to be of low-quality. For example, a review of mechanisms of change for psychosocial interventions for children and adolescents in conflict settings found gaps in the testing of intervention mechanisms; nine out of 13 mechanisms had only moderate or poor quality evidence to support their use (19). Likewise, large evidence gaps exist on the effectiveness of mental health interventions for war-affected children, adolescents and youth (prevention and maintenance, multilevel interventions, comorbidities, differential effects, measurement tools, and mental health service strengthening) (20), and a stronger evidence base is needed to examine how SRH interventions work (or not) for different young people across varying HFS (11).

Necessarily, this limitation applies to many of the interventions described in this paper. Few have been evaluated for effectiveness, let alone cost-effectiveness. However, they are included to provide indications on the types of interventions that have been implemented. It is hoped that programme implementers will increasingly prioritise and allocate resources for

working with evaluators and researchers either within or external to their organisation to include systematic evaluations of their programmes' effectiveness and cost-effectiveness.

Panel 1. Policy and programmatic recommendations to improve adolescent well-being in humanitarian and fragile settings

1. Invest in evidence and age and sex-disaggregated data that are routinely collected and used. This should include: (i) conducting rigorous evaluations of existing programmes to examine both process and short-, medium- and long-term impacts on adolescents, and to establish any causal links between interventions and outcomes; and (ii) adding adolescent-specific modules to routine data collection systems (e.g. HMIS) and ad hoc surveys e.g. Demographic and Health Surveys (DHS) and Living Standards Measurement Surveys (LSMS), similar to an approach being piloted within UNICEF's Multi Indicator Cluster Surveys (MICS) (1).

2. Conduct research to understand how to improve post-conflict adolescent resilience through context-specific interventions in HFS. Implementation research / preparations before interventions are important to avoid developing resistance from the community towards certain interventions, especially those concerning girls and women's rights and the sexual and reproductive health of adolescents.

3. Bridge the humanitarian–development divide to ensure a life span continuum of care for adolescents that addresses the needs of this group in all its diversity. This is particularly important given the protracted and cyclical nature of many conflicts, which makes it all the more imperative that humanitarian and development sectors work together in a joined-up manner.

4. Meaningfully engage with adolescents: Include adolescents in design, implementation and evaluations of interventions and consider adolescents as full actors with diverse needs, including by prioritising supporting local adolescent-led initiatives and organisations. Additionally, build sustainable systems for adolescent participation in decision-making (especially for girls), and invest in gender transformative approaches to improve adolescent girls' agency and leadership at community, provincial, and national levels.

5. Deliver targeted health interventions by appropriately trained health workers, ensuring the implementation strategy and health workers' skills are tailored to adolescents in varying contexts of HFS. Targeted interventions for adolescents should also be costed and integrated into wider packages of health services in HFS.

6. Strengthen links between sectors, including protection, education and livelihoods, for a holistic, multisectoral response for adolescents using existing structures in HFS.

7. Invest in multisectoral interventions to protect adolescents from child marriage and trafficking; and adolescent boys from being forcibly recruited to armed groups or into exploitative working conditions.

8. Invest in education and empowerment for adolescents: (i) Ensure schooling options and formal educational continuity for those whose education was disrupted through targeted support (e.g. safe passage, financial support to families) and vocational training; (ii) prioritise access to life skills and comprehensive sexuality education in and out of schools; (iii) promote alternative ways of learning crossing generations and using technology (e.g. Fablabs).

9. Provide part-time and flexible education opportunities for adolescents who are the head of their households and for female adolescents who married early.

10. Provide alternative educational approaches/mechanisms where schools are not available, ensuring that approaches are tailored to the sociocultural context. This is because there are no, or few schools available for large populations in many HFS, and families do not send adolescents, especially girls, to school if the school is far from their place of residence or if available transport is considered unsafe.

CONCLUSION

It is clear that adolescents continue to be a largely neglected group in HFS. While there is evidence to support that some interventions to improve adolescents' well-being are being implemented in HFS, there are insufficient details of specific intervention components and outcome measurements to adequately map these interventions or understand their effectiveness. Efforts to address this key population's well-being, which is also heavily contingent on their safety and stability, require urgent attention. Specifically, we call for greater investment in and prioritisation of adolescent well-being in HFS and outline 10 key policy and programmatic recommendations in Panel 1. If well-being interventions are embedded within broader programmes, implementers and/or researchers should include adolescent-specific strategies, targeted at all genders where appropriate, and collect and use data disaggregated by age, gender and disability status to help ascertain if this population's diverse needs are being addressed.

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Annex 1. Adolescent health and well-being framework domains (Ross DA et al. 2020)

Domain	Sub-domain
Good health and optimum nutrition	Adolescent-friendly physical and mental health services Nutrition/diet Health information Self-care interventions WASH services Healthy environment Road safety Physical activity
Connectedness, positive values, and contribution to society	Connected to networks Relationship-building Decision-making Influencing Responsibility Interpersonal skills Active participation Contribute to Change
Safety and a supportive environment	Protection from violence Protection from exploitation Access to rights Access to legal services Social norms Non-discrimination Privacy

	Opportunities for leisure/development
Learning, competence, education, skills, and employability	Continual learning Formal education/training Life skills Livelihoods Confidence/empowerment
Agency and resilience	Agency/ability to make choices and influence Self-identity Purpose Resilience/handling adversity Fulfilment/reach potential