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Rapid Assessment of Policies, Programs, and Community Contexts of Out-of-school Very Young Adolescents in Kinshasa

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on behalf of the Passages Project

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LIST OF ACRONYMS AND KEY PHRASES

ASRH	Adolescent Sexual and Reproductive Health
CBO	Community-Based Organization
DHS	Demographic Health Survey
DRC	Democratic Republic of Congo
EA	Enumeration Area
EPSP	Ministère de l'Enseignement Primaire Secondaire et Professionnel (Ministry of Primary, Secondary and Vocational Education)
GEAS	Global Early Adolescent Study
GUG	Growing UP GREAT
IRH	Institute for Reproductive Health, Georgetown University
IS/ISA	In school/In school adolescents
JHU	Johns Hopkins University
KII	Key Informant Interview
KSPH	Kinshasa School of Public Health
MAS	Ministère des Affaires Sociales (Ministry of Social Affairs)
MSP	Ministère de la Santé Publique (Ministry of Health)
NGO	Non-governmental organization
OOS / OOSA	Out of school / out-of-school adolescents
PMA2020	Performance, Monitoring, and Accountability 2020
PNSA	Le Programme National de Santé de l'Adolescent (National Program for Adolescent Health)
RECOPE	Réseaux Communautaires de protection de l'enfant (community child protection)
Save	Save the Children
SRH	Sexual and reproductive health
VYA	Very young adolescent (ages 10-14)

BRIEF OVERVIEW OF PASSAGES PROJECT AND OF THE VYA STUDY IN KINSHASA, DRC

With support from the United States Agency for International Development (USAID) and the Bill & Melinda Gates Foundation, the Passages project brings together researchers and implementation experts to launch and evaluate gender norm transformative interventions for the purpose of scale-up and lasting change. In Kinshasa, Passages oversees the implementation of the adaptation of a hybrid intervention based on others proven effective in similar contexts (Uganda and Rwanda), GREAT, GrowUp SMART, and VOICES creating Growing Up GREAT (GUG). The GUG intervention will be developed and implemented by Save the Children. The Global Early Adolescent Study (GEAS), developed by researchers from the Johns Hopkins Bloomberg School of Public Health in conjunction with partners at the Kinshasa School of Public Health, will be used to evaluate the impact of this intervention. Activities are coordinated by the Passages team at the Institute of Reproductive Health at Georgetown University. The intervention will be carried out and evaluated among in- and out-of-school girls and boys 10-14 years of age living in the Masina and Kimbanseke communes of Kinshasa. This report represents work conducted with the support of the Gates Foundation.

PURPOSE OF THE ASSESSMENT

A rapid assessment of the policies, programs, and community contexts of out-of-school (OOS) very young adolescents (VYAs) in Kinshasa was carried out to aid in intervention development and research study protocol development.

Specifically, it will provide Passages partners with information to:

1. Increase understanding of community situations and cultural sensitivities of urban-poor programs serving out-of-school adolescents (OOSA);

2. Inform the adaptation of an intervention focused on gender norm formation and role choices to OOSA, and the creation of an environment supportive of shifts toward greater gender equity that reinforces structures for adults to support OOS VYAs' health and social needs during puberty and adolescence, positively affecting their transition into adulthood. The rapid assessment is specifically designed to:

    a. Provide information to inform the adaptation of GUG to OOS VYAs and their parents, and

    b. Identify which CBO partners should be selected to test the OOS adolescent approach of the Passages VYA study.

3. Guide development of a research protocol to evaluate the effectiveness of the VYA intervention; specifically, to

a. Provide information for development of a sampling strategy for the research (intervention/control study) for OOS adolescents; and to

b. Provide information for development of indicators to use for intervention evaluation.

4. Guide selection of strategic central and local linkages that should be made with government, NGOs, health/school health services, and youth advisory bodies engaged in adolescent health, social wellbeing and protection, and gender equity.

KEY ASSESSMENT QUESTIONS

This assessment was guided by a set of questions, which are answered using a variety of data and information that has been gathered for the purpose of triangulation. See Table 1.

TABLE 1. KEY QUESTIONS & DATA SOURCES

Key assessment questions	Data sources and lead data collection/provision organization
1. What are characteristics of OOS adolescents in Kinshasa?	♦ Document review – identified, recently-published, and grey literature studies; government-donor analyses; NGO situational analyses (JHU) ♦ Key informant interviews with central-level government, multinational, and NGO experts (JHU) ♦ PMA2020 survey results – additional questions on OOSA added to one data collection round (JHU/KSPH) ♦ Analysis of 10 dyad interviews with OOSA and parents/caregivers in areas where selected CBOs are operating (JHU/KSPH)
2. What are their needs in information and services in areas of health and social wellbeing?	♦ Document review – identified, recently-published, and grey literature studies; government-donor analyses; NGO situational analyses; Passages trip reports (JHU) ♦ Analysis of 10 dyad interviews – OOSA and parents/caregivers in areas where selected CBOs are operating (JHU/KSPH)
3. What policies exist to support OOS adolescents? What policy gaps exist?	♦ Document review – identified, recently published, and grey literature studies; government-donor analyses; NGO situational analyses; Passages trip reports (JHU) ♦ Key informant interviews with central-level government, multinational, and NGO experts (JHU)
4. Which CBOs, NGOs, Ministries are reaching OOS youth with information and services in Save catchment areas?	♦ Results of key informant 'snowball' assessment to identify potential CBOs for intervention outreach to OOSA (Save) ♦ Results of capacity assessments of selected CBOs (Save)

METHODOLOGY

Data collection and analysis occurred between December 2015 and July 2016. A summary of data collection activities can be found in Table 1 above. More detailed explanation of methodologies used is provided below with references to the appendices containing tools, sources, and more information.

Key Informant Interviews

Key informant interviews were conducted with leaders and stakeholders in the VYA health, education, and wellbeing sectors in Kinshasa by 3 JHU researchers (see **Appendix 1**). Interviewees were introduced to the JHU research team through colleagues at KSHP as well as through colleagues from JHU working on other projects in Kinshasa. Interviewees included national government ministers, international development organizations, and child safety and protection volunteers.

Document Review

Reports on the status of OOSA and policies and programs designed to impact them were gathered and reviewed by individuals from JHU and from IRH. See **Appendix 2** for a complete list.

PMA2020 Survey

The PMA2020 project in Kinshasa uses a two-stage cluster design to draw a representative sample of 58 enumeration areas (EA) in Kinshasa, using selection probabilities proportional to size of the population living in EAs. Within each EA, a random sample of 30 households is selected for each round of data collection, based on the list of all households in the EA. At each round of data collection, resident enumerators collect information on members of the selected household to identify women who are eligible to participate in PMA2020 female surveys. During PMA2020 round 4 in Kinshasa (November and December 2015), KSPH researchers agreed to also collect information to aid in determining the proportion of VYAs who were out of school and reasons for not attending school. Relevant items added to the survey can be found under **Appendix 3**.

OOSA-parent Dyad Interviews

Brief, semi-structured interview guides were created by a qualitative research expert at JHU in conjunction with implementation experts at Save. Ten OOSA (5 girls, 5 boys) between the ages of 10 and 14 and their parents (10 mothers; no fathers were available to participate) were recruited. Participants came from poor neighborhoods in Masina and were purposively sampled from the list created with the help of community health workers for the GEAS pilot survey in Kinshasa. KSPH identified those adolescents who had previously declared that they were out of school and the list was given to trained interviewers who, with the assistance of community health workers, tracked and contacted the parents of those adolescents and invited them to participate and to allow their child to participate. Parents provided informed consent for their own participation and for their child's; adolescents provided informed assent. Mothers and children were interviewed separately: adolescents at a local health center and mothers in their homes. Interviews were transcribed and

analyzed in French using the outline of this report to guide the analysis. See **Appendix 4** for interview guides.

CBO capacity analysis

In March 2016, Save the Children of DRC released an open call for submissions from community-based organizations (CBOs) in Kinshasa to inform the selection of six CBO partners to lead the out-of-school component of GUG. A total of 20 CBOs responded, completing a questionnaire exploring their mission, target populations, domains of intervention, and ASRH-related experience as well as administrative and financial management capacity and infrastructure. See **Appendix 5** for a full list of CBOs that responded.

FINDINGS

OVERVIEW

Context

Kinshasa, DRC, and especially the communes of Masina and Kimbanseke, where the GUG intervention and GEAS evaluation will take place, is a challenging environment for both in- and out-of-school youth to grow up in. Unemployment, disease, and violence are prevalent and poverty is deep and widespread. Adolescent fertility in Kinshasa is 13% among 15-19-year-old girls (EDS-RDC II, 2014, p. 79-80), and is higher among the poorest adolescents, placing girls at high risk of pregnancy-related complications and death, making it difficult for them to finish school, and imposing a heavy economic burden on themselves and their families (C-Change, et al., 2014). According to the FP Task Force in Kinshasa, abortion is prevalent in Kinshasa, affecting an estimated 30% of adolescents living in 3 communes in Kinshasa, including Masina.

While HIV prevalence in the DRC is low among youth aged 15-24 at 2.6% for girls and 1.6% for boys (UNDP, 2013, p. 168), this cannot easily be explained by safe sexual behavior, as the DRC has one of the highest rates in sub-Saharan Africa of girls and women 15-24 years of age who reported having multiple partners (11%), and one of the lowest rates of girls and women in this age range who reported using a condom at last high-risk sex (6%). However, 44% of boys and men of the same age reported using a condom at last high-risk sex, suggesting that Congolese girls and women lack negotiating power (UNFPA, 2013, p. 18-9).

Yet as the second largest city in sub-Saharan Africa, Kinshasa differs from smaller cities and rural areas in DRC and has enjoyed a steady increase in girls' educational attainment since the mid-1970s, whereas the rest of the nation has seen far less change (Shapiro, 2015). This increase in girls' educational attainment in Kinshasa may also help explain sharp declines in early marriage and childbearing; where over 30% of adolescents aged 15-19 were married in 1990, less than 10% were in 2007 (Shapiro, 2015). However, whereas girls with only a primary school education once had the highest fertility rate in Kinshasa, that burden now falls to the small number of girls with no education (Shapiro, 2015), emphasizing the need for girls who have dropped out of school or have received no schooling.

There is very little data to aid in understanding access to health care in the DRC in general and among adolescent populations in particular. The 2011-2015 National Strategic Health Plan report points out the deficiencies of the health care system, which is fragmented between the public and private sectors (mostly religious institutions) and lacking the financial and human resources needed to provide primary care services. The resulting fee-for-service model is a significant barrier to accessing services for the vast majority of the population living in poverty (PNDS, 2010). Along with social stigma and provider bias, cost of services may be a major barrier for adolescents to access reproductive health services, even when such services are available; such is the case in Kinshasa (Kayembe et al., 2015).

Situation of OOSA

Sixteen percent of school-aged youth are reported to be out of school in Kinshasa (UNICEF, 2013, p. 37; EDS-RDC II, 2014), with variations by region and age. Leaders interviewed at the EPSP stated that children and adolescents dropping out of or not enrolling in school is a major problem for the nation. While the situation in Kinshasa appears to have improved drastically between 2007 and 2012—during which time the proportion of OOS children and adolescents saw a relative decrease by nearly 40% (UNICEF, 2013, p. 36), and where, for example, a child's sex is no longer a predictor of school drop-out (Kinshasa being the only province to have achieved this) (UNICEF, 2013, pp. 26-7)—the problem is still strongly felt among government ministers and RECOPE members who work with OOSA. Data regarding prevalence of youth being out of school in Kinshasa gathered in the most recent DHS survey (2013-2014) is similar to that collected in the OOSC-DRC survey conducted one year prior. To our knowledge, no surveys of the situation of OOS children and adolescents have been conducted since 2014, making it difficult to determine the trend in school dropout/non-enrollment since that time.

Out-of-school youth are among the most vulnerable and disadvantaged and are believed by RECOPE volunteer workers interviewed by JHU to face worse health outcomes than their IS peers, especially with respect to SRH and exposure to violence. Research shows that adolescent girls who are OOS initiate sex earlier than their IS peers (C-Change, et al., 2014), and thus have greater need for SRH services and may be more exposed to violence or coercion, supporting the RECOPE volunteers' observations.

Interviews with OOSA and their mothers in Kinshasa indicate that while the importance of education as a pathway to economic opportunity is recognized, social support to help poor children stay in school is reported to be very limited. Out-of-school adolescents report feeling sad, anxious, and inferior to their IS peers. Churches are often the main source of support for vulnerable families with children out of school.

Institutional Support for VYAs

There is a community of government ministers, researchers, and local and international development workers in Kinshasa that has been working to improve the situation of OOSA, but with limited financial resources and little information about the needs of VYAs aged 10-14, most programs are not sustained. For example, while a national plan for "life education"—including sexuality education—in schools exists, it is not well implemented and does not address the needs of OOSA. Similarly, plans to create youth-friendly health centers and to educate health care providers on

ASRH needs have been put into place on a very limited scale. There is no national strategy for reaching OOSA to understand and address their health needs.

KEY FINDINGS ON THE STATUS OF OOSA

What are characteristics of OOS adolescents in Kinshasa?

There are two types of OOSA in Kinshasa, those that have never attended school and those that have dropped out of school. Interviews with OOSA and their mothers indicate that youth who have dropped out will attend again when possible. RECOPE volunteers in Kinshasa explained that OOSA in Kinshasa may live on the street, in group homes for vulnerable youth, or at home with their birth family, other relatives, or a foster family, mirroring findings from the 2012 national survey on out-of-school children and adolescents (OOSC-DRC) organized by the Ministry of Primary, Secondary and Vocational Education (EPSP) and executed by the Higher Institute for Population Sciences (ISSP) of the University of Ouagadougou with support from UNICEF, UNESCO and DFID (UNICEF, 2013). The vast majority of children living on the street in Kinshasa are out of school, with 70% having dropped out in primary school (Kayembe et al., 2009). However, GUG and the associated evaluation will focus on OOSA who are living in a home, anticipating better retention and follow-up, and in accordance with standard ethical guidelines.

The data presented below may be used to paint a picture of the typical OOSA in Kinshasa with a focus on causes of school dropout. Relying primarily on interviews with key stakeholders in Kinshasa, results from the 2012 OOSC-DRC survey, and data collected from PMA2020, we can see that OOSA in Kinshasa are in some ways different from OOSA in DRC as a whole, with additional data on Masina and Kimbanseke communes adding detail and complexity. Analysis of dyad interviews provides insight into how OOSA and their mothers understand their situations, with an emphasis on social situation and needs.

Factors influencing school dropout in Kinshasa

The following correlates or causes of school dropout were identified via key informant interviews conducted in Kinshasa and document review (including results of the 2012 OOSC-DRC survey and the DHS). These correlates or causes of being OOS have been triangulated using data gathered via PMA2020 and interviews with OOSA-parent dyads, which will be expanded upon in the next section.

Poverty

- According to the Secretary General of the MSP in Kinshasa, inability to pay school fees and pressure to work and contribute to the family income are the most common causes of school dropout in Kinshasa.
- On average, parents in urban areas devote 14% of their household income toward their children's education, which is very burdensome when income is low (UNICEF, 2013, p. 10-1). Nearly 50% of youth living in households where total monthly income is less than US$50 are out of school compared with 1.9% of youth living in households with a monthly income of more than US$500 (UNICEF, 2013, p. 10).

Sick or deceased parent(s)

- The correlation between sick or deceased parent(s) and school dropout was explained by RECOPE members working closely with OOSA, and is also highlighted in the 2013 UNICEF report on the situation of OOSA (p. 10).
- The most recent DHS report provides a detailed analysis of the impact of parental death on the academic standing of youth aged 10-14 in DRC generally, finding that the death of both parents increases the likelihood of school dropout for all children, but especially girls, with 78.3% of orphaned boys in school and only 69.9% of orphaned girls in school (EDS-RDC II, 2014, p. 332). In Kinshasa, 22.6% of OOSA have lost at least one parent, usually a father—higher than any other province in DRC (UNICEF, 2013, p. 128).

"Broken homes" and domestic violence

- The 2013 UNICEF report described situations involving sick/deceased parent(s) (above) and those involving "broken homes" (defined as families dealing with marital discord and/or divorce) as having a similar impact on adolescent school dropout.
- RECOPE members highlighted divorce or separation as a cause of youth leaving school, as well as children being accused of witchcraft and cast out of the family.

Foster care

- Children in Kinshasa live in foster homes for a variety of reasons, and fostering is common in DRC and throughout Africa. In cases where the child being fostered is less welcome, being in foster care is correlated with increased incidence of school dropout. Interviews with adults, children, and adolescents in DRC conducted as part of the 2012 OOSC-DRC survey revealed that the mechanism may be foster youth being expected to do more work around the house than biological children, decreasing their opportunity to attend school (UNICEF, 2013, p. 10). However, because there are a variety of reasons for fostering, not all children in foster care are induced to leave school.
- Fostering is a judicial institution in DRC, legally codified in 1987 (N°87/010 du 1er Août 1987). The legal process was designed to protect vulnerable children from exploitation, and is flexible enough to handle cases where parents are alive but cannot be located. However, not all foster situations are legally recognized. There is no clear data regarding the foster system in DRC.
- Children in transition or who cannot be fostered may live in an orphage. In addition to private orphanages, the state runs orphanages under the supervision of the Ministry of Social Affaris (MAS), which has recently suffered budget cuts.
- One way vulnerable children find foster families is with the assistance of UN agencies in partnership with the MAS, social workers, and RECOPE members, who canvass slums and villages for vulnerable children, recruit foster parents, and built shelters. These foster parents receive a small stipend for food and access to free health care through support from UNICEF (Strochlic, 2015).
- Children in urban settings such as Kinshasa are more likely to be orphaned or live with a non-biological family than youth living in rural settings (16.7% compared with 12.2%) (EDS-RDC II, 2014). However, orphaned youth in urban settings are more likely to stay in school compared with their counterparts in the general population (87.6% compared with 66.1%), perhaps indicating the presence of stronger support systems for orphaned youth in urban areas compared with rural areas (EDS-RDC II, 2014).

Female sex

- As identified during conversation with Ms. Kabala of EPSP and the Secretary General of the MSP and highlighted by the 2013 UNICEF report, when girls enter puberty their parents may fear for their safety on the way to and from school.
- While female sex becomes a significant determinant of school dropout in rural areas of DRC beginning in secondary school (typically ages 12-17), sex disparity in school status is much less prominent in urban areas such as Kinshasa, reflecting years of concentrated effort to keep girls in school (UNICEF, 2013, p. 57-8). Explanations for adolescent girls' higher rate of school dropout compared with boys may relate to pubertal development and include early marriage, early pregnancy/childbearing, and increased responsibility at home; however these reasons for leaving school were either not reported or reported infrequently in Kinshasa (UNICEF, 2013, p. 58, 144).

Pregnancy

- RECOPE members noted that while, in their experience, pregnancy is not one of the most common reasons youth leave school, it is a high profile cause of girls' dropout and is very difficult to affect due to the custom of praising very early childbearing. Pregnancy was infrequently reported as a cause for school dropout in Kinshasa, accounting for 2% of reasons (UNICEF, 2013, p. 144).

Uneducated head of household

- Quantitative analysis of the 2012 OOSC-DRC survey revealed that, regardless of residence, parental education level is a key determinant of whether a child is in or out of school with children of less educated parents more likely to be OOS (UNICEF, 2013, p. 9-10).

Timing of school entry

- Attending preschool decreases a child's odds of dropping out of school in Kinshasa (UNICEF, 2013, p. 44).
- Late school-entry (compared with peers) has a similar effect due to the child's falling behind academically (UNICEF, 2013, p. 47-8).

Peer pressure

- The Secretary General of the MSP indicated that youth may feel pressured to drop out of school in order to be like their peers who have already done so, but the frequency of this was not confirmed by other sources.

Repeated absence

- Difficulty getting to school can lead to repeat truancy, which is a common precursor to leaving school permanently. However, this is more common in rural areas where the distance from home to school is greater than in Kinshasa (UNICEF, 2013, p. 10).
- In Kinshasa, boys miss more school than girls (54 absences/1,000 students compared with 31/1,000) with 1 absence defined as being out of school for 4 weeks or more (UNICEF 2013, p. 49).
- Duration of absence typically ranges from 4 to 7 weeks; and absences are longer in urban areas, including Kinshasa, compared with rural areas (UNICEF, 2013, p. 50).

- Incidence of youth who are OOS is decreasing in Kinshasa compared with other major cities in the DRC (UNICEF, 2013, p. 32-3). However, RECOPE members reported a sense that the situation of OOSA in Kinshasa has not improved in the past five years.

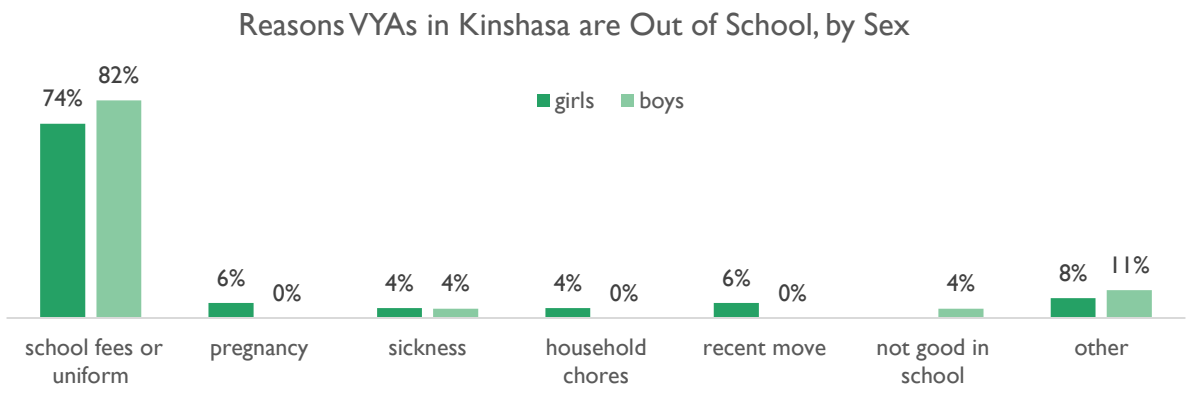
A closer look at Masina and Kimbanseke

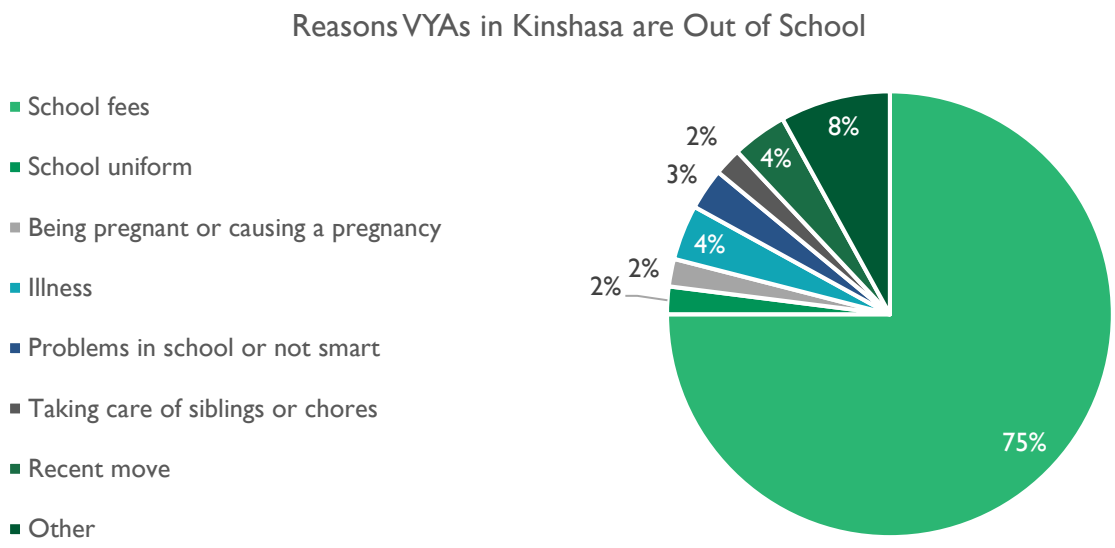
Masina and Kimbanseke are two of the poorest communes in Kinshasa and are where the GUG intervention and GEAS evaluation will take place. Data collected for the present assessment also focused on these areas, providing more detail about the situation and needs of the OOSA with whom the GUG/GEAS will work. These data include quantitative findings garnered from collaboration with PMA2020 researchers and qualitative findings from dyad interviews conducted with OOSA and their mothers.

PMA2020 findings

Data collected during the November-December 2015 wave of data collection for PMA2020 reflects the above reasons that VYAs may be OOS. A total of 1,691 households were surveyed and 1,670 provided complete information about household members including their age. **Altogether, 1,126 adolescents between the ages of 10 and 14 years were identified among whom 131 (7.8%) were out of school**. Some of these youth live in the same household, with 112 households identified as having OOS children. Reasons given for why their child or children were not in school are in **Figure 1**. With only one reason for being OOS per household, the denominator for the following statistics is 112.

Figure 1





Confirming other sources, this data indicates that inability to pay school fees is by far the most common reason for VYAs being out of school, accounting for 82% of reasons for boys and 74% for girls. In addition, 6% of girls were out of school due to pregnancy and an additional 4% were out of school to take care of the household.

While we found no gender difference in the age distribution of OOSA (**Figure 2**), reasons for being out of school varied by age with a significant drop in the proportion of youth who were out of school for financial reasons among 14-year-olds relative to younger adolescents (**Figure 3**). This drop was observed for boys and girls alike.

Figure 2.

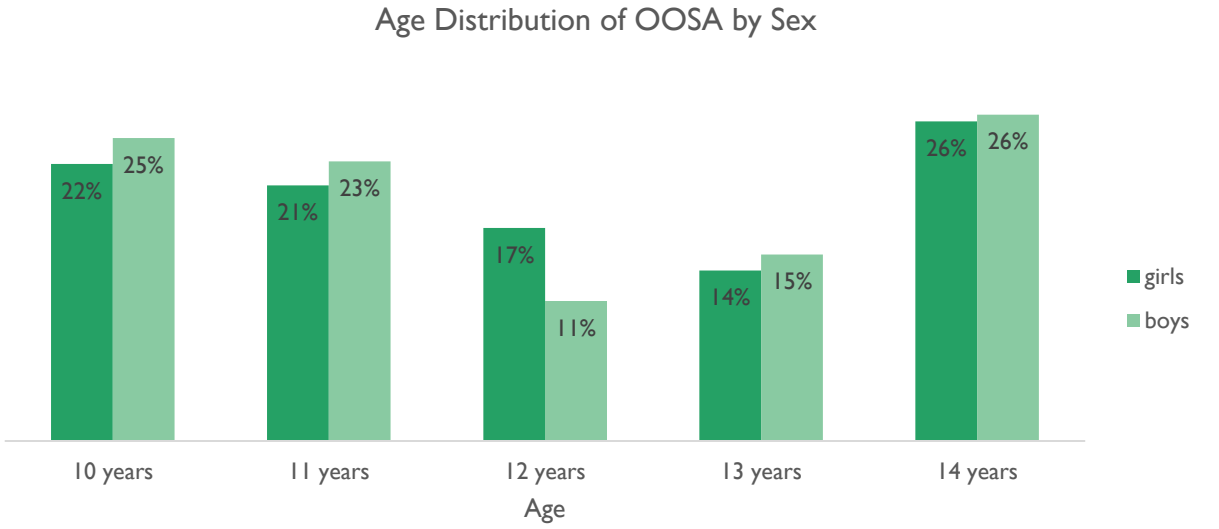
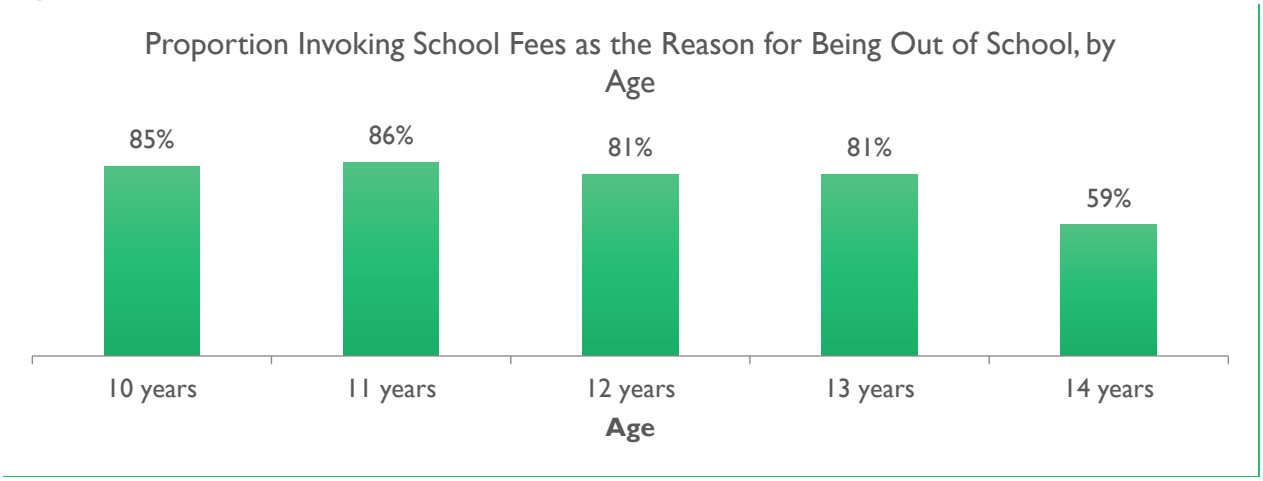


Figure 3.



Subanalysis of households surveyed in the two communes that GUG will target, Masina and Kimbanseke, indicate that the proportion of OOSA in these areas is higher compared to the average in Kinshasa. Among the 28 households that completed the survey in Masina, 9 very young adolescents were identified as being out of school; of the 150 households surveyed in Kimbanseke, 39 very young adolescents were identified as being out of school.

Dyad interview findings

A surface-level analysis of interviews with OOSA and their mothers living in Masina commune fleshes out the numbers above. **The adolescents and their mothers interviewed described lack of money for school fees as being the primary reason for the youth not being in school**, but add that they hope to return to school when they can. It is not uncommon, then, for youth to drop in and out of school depending on whether the family can afford fees, uniforms, and supplies. Lack of money for these things was described as being due to unemployment, competition with other siblings, and financial and social costs related to sickness or death in the family. Of the 10 youth interviewed, 1 girl reported feeling unsafe walking to and from school as her main reason for not attending, and 1 boy reported bad grades and lack of motivation as his main reason for not attending.

Further, OOSA revealed ways in which they feel different from ISA, providing valuable information related to how best to reach and engage them in GUG. Specifically, being OOS is stressful for adolescents, and so delivering an intervention such as GUG will be challenging beyond the fact that OOSA are more difficult to find, as they must deal with stressors that ISA may not experience to the same degree, such as extreme poverty and discouragement due to being OOS. Adolescents who cannot attend school report feeling sad, isolated, bored, and anxious. They feel they are discriminated against due to lacking the social status that being in school grants, and lose self-esteem due to perceived loss in intelligence and life opportunities. They may be bullied due to their lack of education and illiteracy. To compensate, OOSA may show more respect for others than they perceive ISA do (some participants described ISA as obnoxious), find support from friends in similar circumstances, and study on their own.

An intervention targeting OOSA may need to be adapted in terms of literacy level required to engage with the products, and should also account for their other needs. Most OOSA wish they could go back to school and some study on their own, so the opportunity to interact with other youth and also caring adults may be especially welcome.

Participants—both adolescents and their mothers—described feeling that there is not much going on in their lives they are happy about. The youth interviewed named two main things that they like about their lives, studying/going to school and future aspirations, which are of course limited by the fact that they are not in school. Some youth also mentioned going to church and their relationship with God as a source of happiness. Mothers reported liking efforts to improve their community through social support from neighbors and working to reduce youth delinquency.

OOSA reported having busy lives, but perhaps girls more so than boys. Girls handle the majority of the household chores, take care of their siblings, sell things outside their house, go to the market, and shadow their mother or another family role model to learn how to run a household. Boys have responsibilities as well, including sweeping the courtyard and helping their sisters with chores. In their spare time, girls like to visit with friends and family and go to church; boys report that they like to spend their spare time playing football outside with friends in fields and vacant lots. Boys described travelling further than girls to play.

What are their needs in information and services in areas of health and social wellbeing?

Existing Policies

A review of national policy documents produced by the EPSP and PSNA relating to adolescent SRH reveals that while robust policies exist at the national level, implementation has been challenging and many gaps remain. Services that the 2009 PNSA policy aims to provide include a suite of ASRH services at local health centers, which, so far, fewer than 30 centers in 10 of 512 designated health zones have accomplished. The nation is also falling behind on its commitment to open and operate youth health centers with only 4 in the country including two in Kinshasa (in Matonge and Matete communes).

An example of this results of the disconnect between policy and practice can be seen in the results of the 2013-14 DHS in the DRC which showed that while knowledge of contraceptive use was high among girls and women of childbearing age (15-49), unintended and adolescent pregnancy were as well; indeed, the DRC has the second highest adolescent fertility rate in sub-Saharan Africa (UNFPA, 2013, p. 15). While these findings are not unique among low-income countries, it indicates gaps. One reason research and implementation experts living in Kinshasa and abroad provide to explain why national policies are not being implemented is that implementers rely on external funders and receive only a small amount of funding from the government (which lacks resources to contribute), hampering scale-up and sustainability.

Health Concerns of OOSA and their mothers

While the mothers interviewed stressed the importance of monitoring their children, they experience anxiety related to a sense of loss of control after puberty. Additionally, there is an indication that mothers' fear for their children are informed by gender norms. For example, mothers worry that their daughters may not be aware that they are at increased risk of attracting unwanted attention from boys and men as they become adolescents, and they worry that their daughters may become aware of other girls/women who are having sex for "benefits" and start doing so themselves. In addition, mothers worry about their sons being "trapped" by girls who dress "sexy," and being bullied and/or getting into fights with other boys in the neighborhood.

Nearly all mothers and OOSA identified food insecurity and malaria/infectious disease as their most pressing health concerns. To a lesser extent, OOSA reported worrying about gang violence, kidnapping, rape, military harassment, car accidents, and sorcerers.

RECOPE members interviewed stated that OOSA are more vulnerable to early sexual initiation, sexual abuse, and early pregnancy. They also stated that boys who are OOS are more vulnerable to abuse by adults, and girls to rape and transactional sex for basic goods.

In sum, families raising OOSA face significant barriers to health and social wellbeing, and the primary immediate needs of their adolescent children are freedom from food insecurity, infectious disease, and violence. However, healthy relationships and sexuality is also an important aspect of health and wellbeing for OOS girls and boys and a concern of their mothers.

What policies exist to support OOS adolescents? What policy gaps exist?

The education system in the DRC is governed by three ministries: the Ministry of Primary, Secondary and Vocational Education (EPSP), the Ministry of Higher and University Education (not relevant to this assessment), and the Ministry of Social Affairs (MAS). The EPSP focuses primarily on the needs of ISA, while the MAS provides support for OOSA.

While free and compulsory primary education for all Congolese children is enshrined in the 2006 Constitution and was again highlighted in a 2010 policy created by the President, challenges have not yet permitted this to become a reality. Thus, children remain OOS because they cannot afford to attend.

There is no national commitment or unified plan for reducing the number of OOSA in the DRC, but programs have been tested including a EPSP-initiated strategy for the development of primary, secondary and vocational education for the period of 2012-2014 that included programs that aimed to reduce barriers to school attendance by facilitating access to preschool and mitigating the financial burden on households through government payment of school fees (UNICEF, 2013, p. 16). Currently, a cross-ministry strategy is being developed with a goal of completion in 2016. Meanwhile, education programs offered for OOSA by the MAS described by Mr. Mbaya, include literacy classes, a 3-year "catch up" school program, and professional or vocational skills training programs. Additionally, some churches offer clubs for both ISA and OOSA in an attempt to address the general gap in policies and services that address the needs of OOSA. There are also non-religiously affiliated clubs that work to support OOSA, but according to Ms. Kabala of the EPSP, parents perceive them as unsafe for children aged 10-14.

The mothers of OOSA interviewed for this assessment indicated having little to no awareness of the aforementioned government resources for OOSA. However, the current resources do not address what they truly need and want, which is financial support for school fees and associated costs. Currently, parents feel they have little social support to help their children stay in school. Some draw on family (parents or siblings) for social support, and one respondent indicated also receiving social support from her church.

While 60% of OOSA nationwide live in households headed by men (UNICEF, 2013, p. 43), some of the mothers interviewed were single parents with limited resources for raising children, preventing them from sending their children to school. While parents may be hard to reach (some mothers reported feeling that no one can or wants to help them), they would likely welcome any opportunity that would benefit their OOS child/children. Churches are a key area where parents and families get social support; so working with churches may be a way to build trust while implementing an intervention.

Finally, the Education and Family Life Course, which, while comprehensive, is not yet fully implemented, is designed solely for ISA. There are no policies in place to guarantee comprehensive sexuality education for OOSA or to provide them access to youth-friendly health clinics or ASRH services.

Which CBOs, NGOs, Ministries are reaching OOSA with information and services in Save's catchment areas?

A total of 20 CBOs responded to an open call for organizations to partner with Save to implement GUG among a sample of OOSA, completing a questionnaire exploring their mission, target populations, domains of intervention, and ASRH-related experience as well as administrative and financial management capacity and infrastructure. Questions were primarily open-ended and answered in the CBOs' own words. Hand-written responses were entered complied and categorized. As this information came from an open call for partnership submissions rather than a process of methodically assessing all CBOs in the two communes, it is possible that other CBOs whose work engages out-of-school youth in Kimbanseke and Masina do exist. Organizations that indicated SRH as a domain of intervention or indicated having at least 1 staff member trained on ASRH issues are listed in **Table 2**. The full list of CBOs that responded can be found under **Appendix 6**.

Table 2. Cbos With An Intervention Focus In Srh (Green) And/Or Staff Trained In Asrh (White)

Name	Year established	Target population(s)						Stated Mission	Domains of intervention						Number of trainers	Trainers trained in ASRH
		Vulnerable youth	*Young mothers*	*Street children*	*Disabled youth*	*Youth in general*	*Other*		*Child rights/ protection*	*Health (not SRH*	*SRH*	*Education*	*Livelihoods*	*Other*		
Kimbanseke																
Foyer Social Congolais	2016	X	X			X		*Return human dignity to vulnerable individuals through social and professional reintegration for OVCs and young mothers*		X	X				2	0
Associations des Défenseurs des Droits Humains pour le Développement Communautaire	2009					X	X	*Sensitize, train, and orient adolescents and youth on SRH and mainstream child rights*	X		X	X			0	0
Union Féminine du Millénaire	2012		X			X		*Contribute to household development by strengthening women's capacity and independence*				X	X		4	2
Actions Chrétiennes pour la Défense des Droits de l'Enfant Défavorisé et de la Fille	2006	X	X				X	*Support for vulnerable children and the return of human dignity, socio-professional reintegration, literacy, social inclusion of OVC and mothers*	X						4	4

Masina																
Union Des Jeunes Cadet	2001					X	X	*Mobilize, manage, and share aspirations of youth to channel towards defending a just ideal*	X		X			X	6	6
Gouvernance Plus	2011	X					X	*Assistance and rehabilitation for the victims of torture and sexual violence*	X					X	2	1
Centre d'Information de Préparation à l'Accouchement et aux activités de développement	1995					X		*Promote human development and reproductive health among youth (girls and boys) and couples (men and women) in a healthy environment for information, education, and communication*		X		X	X		9	9
Affiliates Of International Organizations Headquartered Elsewhere In Kinshasa																
Association Pour le Bien-Etre Familial-Naissances Désirables	1973	X	X				X	*Facilitate access to quality services for all, particularly the underserved*	X		X			X	15	12
Humana People To People Congo	2006					X		*Contribute directly to socio-economic and cultural development for the population of the DRC, through various solidarity mechanisms and a participatory, active and direct engagement of beneficiaries.*		X		X		X	n/a	7

Key Findings

- All of the 20 responding organizations indicated a focus on youth
    - 5 indicated a focus on youth in general without specifying a particular target group
    - 1 organization focuses exclusively on disabled youth
- ***No organizations indicated a specific focus on OOSA***
- Most frequently, organizations focused on education (11), child rights and protection issues (9), or health issues not specific to SRH (6)
    - Only 4 organizations indicated SRH as a domain of intervention
    - However, total 7 organizations indicated that they had at least 1 trainer trained in ASRH-related issues
- 3 organizations have an explicitly faith-based orientation
- 2 organizations were affiliates of international organizations with offices in Kinshasa and activities in Kimbanseke and/or Masina
- With the exception of the Association Pour le Bien-Être Familial/Naissances Désirables, the IPPF affiliate established in 1973, all organizations were established after 1995

CONCLUDING REMARKS

Out-of-school adolescents in Kinshasa struggle with the realities of extreme poverty including illness, food insecurity, and inability to pay school fees. Most OOSA express deep dissatisfaction with being out of school and study on their own and/or wish to re-enter school. Mothers expressed anxiety relating to their OOS children's sexual maturation and fear for the wellbeing of both their daughters and their sons. These fears are well founded as national policies intended to provide sexuality education and ASRH resources are not well funded or implemented, and in many respects exclude OOSA. While some opportunities for OOSA to gain skills or education exist, they are not well known to adolescents or their parents.

The situation of OOSA in Kinshasa, as the capitol of the DRC and the second largest city in sub-Saharan Africa, is very different than that of OOSA in other cities and rural areas of the DRC. As stated previously, this assessment is focused on OOSA living at home with a family and does not describe the experience and needs of OOSA living in shelters or on the street, whose situation is dire. Thus, the OOSA described in this assessment may have the immeasurable benefit of at least some family support and relatively stable housing. (Of note, also, is that the reviewed literature tended to be deficit-focused rather than strengths/asset-focused, pointing to a need for more research on assets of OOSA to inform programming approaches.)

The information provided herein serves to guide intervention and survey work with OOSA living at home in Kinshasa, particularly the GUG intervention and the GEAS evaluation. Relevant key takeaways include:

1. Intervention implementers and researchers should be prepared to provide more social and emotional support for OOSA compared with their ISA peers;

2. Intervention materials and survey methods may need to be adjusted to account for the limited literacy of some OOSA compared with their ISA peers;
3. Intervention implementers should be aware that OOSA are more likely to have SRH and family planning needs than their ISA peers and adjust accordingly;
4. Though it will not solve the problem of chronic food insecurity, provision of healthy food may be a strong incentive for OOSA and parent participation in intervention and research activities;
5. Churches are a center of social support for some OOSA and their families and may provide a venue for establishing relationships.

Finally, maintaining contact with government officials, especially in EPSP, MAS, and MSP, as well as with relevant CBOs, NGOs, international aid agencies, and donors may help these agencies advocate for programs aimed at improving the health and wellbeing of OOSA by providing new information about their situation and effective implementation strategies.

APPENDICES

APPENDIX 1: Professional and Contact Details of Key Informants Interviewed

Professional And Contact Details Of Key Informants Interviewed				
Conducted by/date	**Location**	**Name**	**Organization & position**	**Contact information**
Jocelyn Kelly December 2015	Kimbanseke	Gerard Kimwanga	RECOPE member	*Via Pierrot Mbela (Save)*
		Donatien Tshinianga	RECOPE member	*Via Pierrot Mbela (Save)*
	Gombe	Dr. Mbadu	MSP, Director of PNSA	mbadu_m@hotmail.com +243-898-940-247
	Gombe	Mr. Mbaya	Ministry of Social Affairs	+243-972-616-600
Bob Blum & Caroline Moreau March 2016	Tulane International & PNSA offices	Arsene Binanga	FP Task Force, Director Tulane International in Kinshasa	abinanga@tulane.edu
		Hannah Mills	CCP, Program Officer	hmills@jhu.edu
		Dr. Mbadu	MSP, Director of PNSA	mbadu_m@hotmail.com +243-898-940-247
	EPSP	Christine Nepa Nepa Kabala	EPSP; Direction de l'EVF/Emp	nepanepakabala@yahoo.fr
		Unknown	MSP, Secretary General	*Via Christine Nepa Nepa Kabala*
		Maker Mwangu	EPSP	*Via Christine Nepa Nepa Kabala*
	WHO	Dr. Yokovide	WHO country representative	*Unknown*
		Dr. Brigitte Kini	WHO technical consultant for youth	*Unknown*
	UNICEF	Dr. Suzie Villeneuve	UNICEF, Director of child survival	*Unknown*
		Dr. Mbadu	MSP, Director of PNSA	mbadu_m@hotmail.com +243-898-940-247

APPENDIX 2: List of documents and literature reviewed for this assessment

1. EDS-RDC II (2014). Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP) et ICF International, 2014. *Enquête Démographique et de Santé en République Démocratique du Congo 2013-2014.* Rockville, Maryland, USA: MPSMRM, MSP et ICF International.

2. Plan National de Developpement Sanitaire (PNDS) 2011-2015 (2010). Republique Democratique Du Congo Ministere de la Sante Publique Secretariat General.

3. Kayembe, P., Babazadeh, S., Dikamba, N., Akilimali, P., Hernandez, J., Binanga, A., & Bertrand, J. T. (2015). Family Planning Supply Environment in Kinshasa, DRC: Survey Findings and Their Value in Advancing Family Planning Programming. Global Health: Science and Practice, 3(4), 630-645.

4. C-Change, PNSA, & USAID (2014). *Communication pour le changement social et de comportement: Manuel de formation sur la prevention de violences sexuelles basées sur le genre associées au VIH destine au adolescents et jeunes en milieu scolaire en RDC – Tranche d'Âges : 10-14 ans*. Report provided by Dr. Chalet of ASF/PSI.

5. UNICEF (2013). National survey on the situation of out-of-school children and adolescents (OOSC-DRC).

6. Strochlic, N. (2015, August 3). The Foster Angels Caring for Congo's Child Soldiers. *The Daily Beast*. Retrieved from http://www.thedailybeast.com/

7. Kayembe, P.K., Mapatano, M.A., Fatuma, A.B., Nyandwe, J.K., Mayala, G.M., Kokolomami, J.I., & Kibungu, J.P. (2009). Knowledge of HIV, sexual behaviour and correlates of risky sex among street children in Kinshasa, Democratic Republic of Congo. *East African Journal of Public Health*, *5*(3), 186-192.

8. Shapiro, D. (2015). Enduring economic hardship, women's education, marriage and fertility transition in Kinshasa. *Journal of biosocial science*,*47*(02), 258-274.

9. UNDP (2013). *Human Development Report*.

10. UNFPA (2013). *Status Report: Youth Sub-Saharan Africa*.

APPENDIX 3: Items about OOSA inserted into the November-December 2015 PMA2020 survey

1. Sex
2. Age
3. Reason for non-attendance
    a. Lack of school fees
    b. Lack of uniform or standard school supplies
    c. Became pregnant
    d. Caused a pregnancy
    e. Work
    f. Illness
    g. Not smart
    h. Married
    i. Other *(write in)*

APPENDIX 4: Guide for OOSA-parent dyad interviews

Interview guide for OOSA rapid assessment interviews – PARENT VERSION
[Consent script]
Introductory questions addressing daily activities

- Let's first talk about what it's like to raise children in this {community}… What do you like best about living here? What do you like least?

Can you tell me a bit about how your son/ daughter spends their day?
What are the chores and responsibilities your [OOS] child has at home? How often and how much time does it take him or her to do these things?
How much time does your [OOS] child spend outside the house?
Where does he or she go?
What does he or she usually do?
Do you know the places your [OOS] child likes to go in your neighborhood?
Can you describe these places?
What you does he or she like doing there?
Let's talk about your experience with your son/daughters schooling

- Were they ever in school and for how long?
- Why did they leave school?
- Did you encourage them to leave or try to stop them?
- Did you ever go to school and for how long?
- How do you think your life might be different now if you'd stayed in school longer [if left early]/left school early [if they graduated]?

Let's talk about your [OOS] child's experiences.

- Can you tell me about some of the problems that your child faces now that might be different from those children in school?
    - Is there any person or organization that has helped you and your child address these problems? How did they help?
    - If not, what kinds of help would you like you and your child to have?
- If given the opportunity, would you like for your child to go back to school?
    - Can you explain your reasons?

Now I'd like to talk about health issues of children your child's age.

- Can you tell me about what it means for a boy your child's age to be healthy in this community?
- What about an adolescent girl?
- What are the key things that every adolescent needs to know or do to be healthy?
    - Probe about why they believe they are needed
- What are the things you worry about most when you think about your [OOS] child's life?
    - Is there anyone, or any organization, who helps address these worries?
        - Can probe about specific types of organizations or services
    - What about worries related to your child's health?
        - Can probe about specific types of organizations or services (if different from above)

Interview guide for OOSA rapid assessment interviews – ADOLESCENT VERSION
[Consent script]
Introductory questions addressing daily activities

- Let's first talk about what it's like to grow up in this {community}… What do you like best about your life? What do you like least?

Can you tell me a bit about how you spend your day? You can describe a typical day from the time you get up to the time you go to sleep?
What are your responsibilities at home? How often and how much time does it take you to do these things
How much time do you spend outside the house?
Where do you go?
What do you usually do?
Where are the places that you like going to in your neighborhood?
Can you describe these places?
What you like doing there?
Let's talk about your experience with school

- Can you tell me a bit about how long you've been out of school?
- How do you think your life might be different from your peers who are in school?
- Can you tell me about some of the problems that you face that might also be different from those in school?
    - Is there any person or organization that has helped you address these problems? How did they help?
    - If not, what kinds of help would you like to have?
- If given the opportunity, would you like to go back to school?
    - Can you explain your response?

Now I'd like to talk about health issues of people your age

- Can you tell me about what it means for a boy your age to be healthy here?
- What about an adolescent girl?
- What are the key things that every boy your age needs to be healthy? What about a girl?
    - Probe about why they believe they are needed
- What are the things you worry about most in your life?
    - Is there anyone, or any organization, who helps address these worries?
        - Can probe about specific types of organizations or services
    - What about worries related to your health?
        - Can probe about specific types of organizations or services (if different from above)

APPENDIX 5: Methods and results of CBO capacity analysis

Results of CBO Identification Exercise																
Name	**Year established**	**Target population(s)**						**Stated Mission**	**Domains of intervention**						**Number of trainers**	**Trainers trained in ASRH**
		Vulnerable youth	***Young mothers***	***Street children***	***Disabled youth***	***Youth in general***	***Other[1]***		***Child rights/ protection***	***Health (not SRH***	***SRH***	***Education***	***Livelihoods***	***Other[2]***		
KIMBANSEKE																
Ministère Emmaus pour l'Amour du Prochain	1995	X	X		X			*Psychosocial, nutritional, medical, educational, legal, economic and spiritual support for OVCs, mothers, idle youths*	X						4	0
Associations des Défenseurs des Droits Humains pour le Développement Communautaire	2009					X	X	*Sensitize, train, and orient adolescents and youth on SRH and mainstream child rights*	X		X	X			0	0
Union Féminine du Millénaire	2012		X			X		*Contribute to household development by strengthening women's capacity and independence*				X	X		4	2
Centre Social Jésus Bon Berger	2014	X				X		*Support for vulnerable youth*	X			X			0	0
Actions Chrétiennes pour la Défense des Droits de l'Enfant Défavorisé et de la Fille	2006	X	X				X	*Support for vulnerable children and the return of human dignity, socio-professional reintegration, literacy, social inclusion of OVC and mothers*	X						4	4
Foyer Social Congolais	2016	X	X			X		*Return human dignity to vulnerable individuals through social and professional reintegration for OVCs and young mothers*		X	X				2	0

[1] "Other" target populations included survivors of torture and sexual violence, parents, community leaders, widows, men and women in uniform, prisoners, street vendors, gays and lesbians, and drug users.

[2] "Other" intervention domains included environment, governance, agriculture, and advocacy.