MODULE 7
YOUNG PEOPLE IN HUMANITARIAN SETTINGS

MY WORLD

MODULE 7

YOUNG PEOPLE IN HUMANITARIAN SETTINGS

UNFPA

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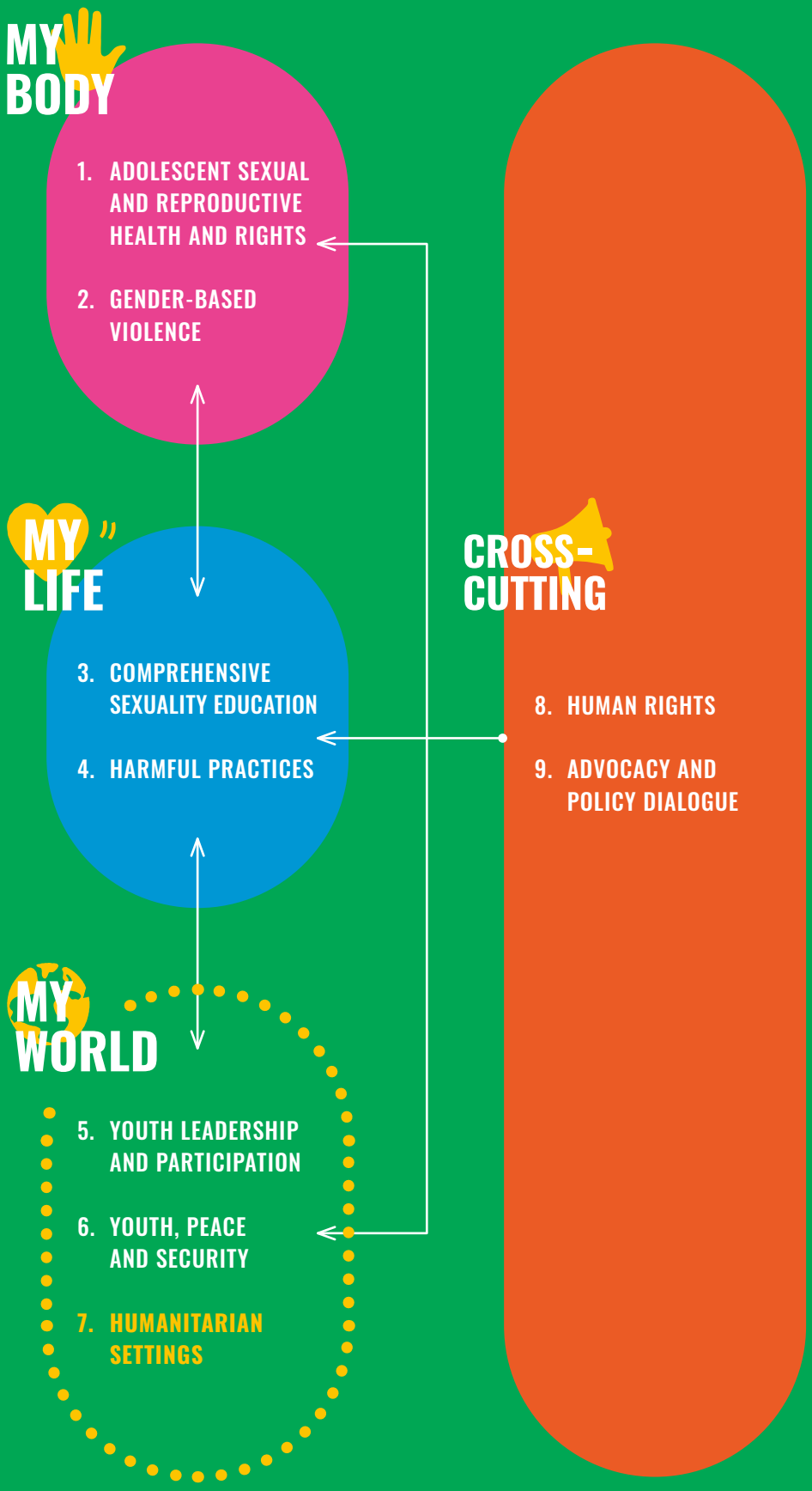
ABBREVIATIONS

AoR	Area of Responsibility
ASRH	adolescent sexual and reproductive health
ASRHR	adolescent sexual and reproductive health and rights
CSE	comprehensive sexuality education
FAO	Food and Agriculture Organization
GBV	gender-based violence
HPC	humanitarian programme cycle
HQ	Headquarters
IAFM	*Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group
IFRC	International Federation of the Red Cross
IOM	International Organization for Migration
IP	implementing partner
LGBTQ+	lesbian, gay, bisexual, transgender, and queer/non-cisgender identities (such as gender non-binary/non-conforming and agender)
MHM	menstrual hygiene management
MHPSS	mental health and psychosocial support
MISP	Minimum Initial Service Package
MPAs	Minimum Preparedness Actions
MPRs	Minimum Preparedness Requirements
NGO	non-governmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
SDG	Sustainable Development Goal
SOP	standard operating procedure
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WFP	World Food Programme
WGSS	Women and Girls Safe Spaces
WHO	World Health Organization

MY WORLD



UNFPA

INTRODUCTION

YOUNG PEOPLE IN HUMANITARIAN SETTINGS

9.7M

youth aged 15-24 displaced because of conflicts, violence or disasters

3.1M

under the age of 18

Young people comprise a substantial proportion of the global population, and they are among the most vulnerable in both fragile and conflict settings. In 2019, approximately 9.7 million youth aged 15-24 were internally displaced because of conflicts, violence or disasters, and of these, 3.1 million were under the age of 18. (1)

Young people are a diverse group, with specific risks and needs that vary depending on factors such as age, sex, gender identity and sexual orientation, developmental stage, health status, marital status, socioeconomic conditions, and environmental and contextual factors. In a humanitarian crisis, they may be forced to take on the burdens of adult responsibilities such as earning an income, becoming a caregiver or managing dangerous or challenging situations, often when they do not yet have all the necessary skills or physical and cognitive capacities. They can also become isolated from opportunities, as social support structures they may have previously accessed, including education, become weaker.

An example of this is the COVID-19 pandemic, which exacerbated the existing vulnerabilities and inequalities of young people, especially among very young adolescents, due to limited institutional capacity and social services including schools and education systems, and decreased access to health, education, livelihoods and protection services. (2) (3) The impact of crises such as this on young people, their families and their communities can create an intergenerational cycle of poverty and inequality.

This module focuses on work with young people in humanitarian settings as part of *My Body, My Life, My World*, UNFPA's global strategy for adolescents and youth. The strategy emphasizes that humanitarian crises are one of the factors that can prevent young people from exercising their rights to make informed choices for a healthy life and successful transition into adulthood. The strategy says:

All adolescents and youth must have opportunities to learn and practice evolving decision-making skills in their families, communities and beyond. This is also true in humanitarian and peacebuilding contexts, where adolescents and youth are critical agents of positive change.

Young people should be seen as a vital resource throughout the humanitarian programme cycle (HPC), from the emergency preparedness phase, through the response phase and in the transition to recovery. They have wide-ranging capacities and unique needs, but they often get lost between programming for children and programming for older adults. Young people can contribute to community resilience and serve their societies when disaster strikes or conflict erupts. They deserve to be recognized as partners in humanitarian response who can support gender equality efforts, [4] provide technologically and socially innovative approaches to ameliorating the effects of humanitarian crises no matter the cause, and help create solutions and insights into humanitarian crises and build societies that are more resilient, peaceful and inclusive. [3]

Young people should be seen as a vital resource throughout the humanitarian programme cycle.

The aim of this module is to provide UNFPA country office humanitarian staff, including Sexual and Reproductive Health (SRH), Gender-based Violence (GBV) and Youth advisors/focal points and UNFPA's implementing partners (IPs) with guidance, recommended actions and resources on how to design and implement interventions to address the SRH and GBV response needs of young people affected by crises. The module also provides suggestions on how to include and engage young people during the preparedness and response phase, throughout the HPC.

WHY DO WE PRIORITIZE SEXUAL AND REPRODUCTIVE HEALTH AND GENDER-BASED VIOLENCE INTERVENTIONS FOR YOUNG PEOPLE IN HUMANITARIAN SETTINGS?

Adolescent girls are among the most vulnerable segments of any population in humanitarian contexts because of factors such as gender inequality, discrimination and poverty.
The barriers to SRH information and services that adolescents face during "normal" times are heightened during crises, when populations may be displaced or forced into camps or other overcrowded areas, and social, health, protection and communication structures are disrupted, legal systems are weakened, and inequalities are exacerbated. These factors put adolescent girls at increased risk of unplanned pregnancies, sexually transmitted infections (STIs) including HIV, and unsafe abortions, as well as various types of GBV and harmful practices, such as female genital mutilation or cutting, human trafficking, engagement in transactional sex, and early and/or forced marriage. (5) (6) The menstrual hygiene needs of adolescent girls and young women are further complicated in these contexts, due to crowding, inadequate water, sanitation and hygiene (WASH) facilities, lack of access to menstrual hygiene supplies, and social stigma.

Adolescent boys also face particular vulnerabilities during crises, including child labour, recruitment into armed forces, human trafficking and sexual violence. They are also more prone to develop high-risk behaviours, such as alcohol and drug use, as well as engaging in unprotected sex. (5) Recent data indicate increasing suicide rates among boys in humanitarian contexts. (7) Violent experiences may impact adolescent boys' attitudes towards gender and masculinity, and social taboos negatively affect their sexual behaviour and health-care-seeking behaviour. One example of this is that boys are less likely to report experiencing sexual exploitation, even though under-reporting is a critical issue for them, as it is for girls.

PARTICULARLY VULNERABLE GROUPS IN HUMANITARIAN SETTINGS

Many young people have overlapping vulnerabilities that can profoundly impact their health and security. When designing and implementing humanitarian SRH and GBV programmes and actions for young people, it is crucial that UNFPA and IPs account for particularly vulnerable groups, such as very young adolescents, married adolescents, pregnant adolescents, LGBTQ+ young people, young people living with HIV, young Indigenous people, young migrant people, young heads of households, widowed young people, young people engaged in sex work, and former child soldiers.
Not only do these groups have specific health and protection needs, they also experience additional discrimination, stigma, abuse, exploitation and violence and thus face even greater difficulties and barriers accessing care and protection services. In UNFPA's programmes addressing young people, it is important to address intersecting forms of structural oppression among young women and girls that exacerbate the risk of GBV and create barriers to accessing SRH and GBV response services, and meaningful and safe inclusion and participation.

Click here for an overview of adolescent sexual and reproductive health (ASRH) needs during crises.

When designing and implementing humanitarian SRH and GBV programmes and actions for young people, it is crucial that UNFPA and IPs account for particularly vulnerable groups, such as very young adolescents, married adolescents, pregnant adolescents, LGBTQ+ young people, young people living with HIV, young Indigenous people, young migrant people, young heads of households, widowed young people, young people engaged in sex work, and former child soldiers.

MECHANISMS FOR WORKING WITH YOUNG PEOPLE IN HUMANITARIAN SETTINGS

THE COMPACT FOR YOUNG PEOPLE IN HUMANITARIAN ACTION

At the World Humanitarian Summit (Istanbul, 2016), building on the 2015 Doha Youth Declaration on Reshaping the Humanitarian Agenda and Security Council Resolution 2250 on youth, peace and security, UNFPA and the International Federation of Red Cross and Red Crescent Societies (IFRC) established and started co-leading the Compact for Young People in Humanitarian Action. The Compact consists of key global stakeholders who are committed to work with and for young people to ensure that the priorities, needs and rights of young people affected by disaster, conflict, forced displacement and other humanitarian crises are addressed, and that young people are informed, consulted and meaningfully engaged throughout all stages of humanitarian action.[1] As of 2021, the Compact has 62 members.

YOUTH TASK FORCE IN THE ZAATARI REFUGEE CAMP IN JORDAN: IMPLEMENTING THE COMPACT'S FIVE ACTIONS

Thousands of young Syrian people currently live in refugee camps in Jordan. The majority have not completed high school or university, most have no access to paid employment, their movements outside the camps are restricted to only a few hours a day, and they are affected by feelings of powerlessness, hopelessness, high stress and interpersonal tension. In an effort to promote meaningful participation of young people throughout the programme cycle, a Youth Task Force (YTF) was formed, co-led by the Norwegian Refugee Council and UNFPA. The YTF aims to advance the adolescent and youth agenda in humanitarian settings, in line with the five key actions of the Compact for Young People in Humanitarian Action.

Click on the hyperlinks below for videos showing how the YTF in the Zaatari Camp in Jordan operationalized the Compact's five actions: SERVICES, PARTICIPATION, CAPACITY, RESOURCES and DATA.

Source: *Youth Task Force (IASC Guidelines)*

1 During the 2016 World Humanitarian Summit, United Nations agencies committed to a "New Way of Working," aimed at reducing risk and vulnerability over time and contributing to the achievement of the Sustainable Development Goals (SDGs). In 2017, a third pillar, peace, was added, creating a triple nexus where development and humanitarian work should align. For more information, see p. 47.

THE FIVE KEY ACTIONS OF THE COMPACT

Action 1 – SERVICES: Promote and increase age-responsive, gender-responsive and inclusive programmes that contribute to the protection, health and development of young women, young men, girls and boys within humanitarian settings.

Action 2 – PARTICIPATION: Support systematic inclusion of, and engagement and partnership with, young people in all phases of humanitarian action, through sharing of information and involvement in decision-making at all levels, including budget allocations.

Action 3 – CAPACITY: Recognize and strengthen young people's capacities and capabilities to be effective humanitarian actors in prevention, preparedness, response and recovery, and empower and support local youth-led initiatives and organizations in humanitarian response, such as those addressing affected young people, including young refugees and internally displaced persons living in informal urban settlements and slums.

Action 4 – RESOURCES: Increase resources intended to address the needs and priorities of young people affected by humanitarian crises, including disasters, conflict and displacement, and identify ways to more accurately track and report on the resources allocated to young people in humanitarian contexts.

Action 5 – DATA: Ensure the generation and use of age- and sex-disaggregated data pertaining to young people in humanitarian settings.

KEY DOCUMENTS AND GUIDANCE ON SRH AND GBV PROGRAMMING FOR YOUNG PEOPLE IN HUMANITARIAN SETTINGS

The *Adolescent Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings* (2020), referred to in this module as the **ASRH Toolkit**, was developed by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG). It provides SRH implementing organizations with practical guidance and tools on the meaningful participation of adolescents, youth and communities; how to prioritize and deliver high-quality young people-friendly SRH interventions; and how to use data for decision-making. The toolkit also provides suggestions on how tools such as the Minimum Initial Service Package (MISP) can be adapted with a young people's lens, to ensure that their particular SRH needs are addressed in humanitarian responses and programme implementation. Finally, the toolkit

provides users with clear justification for prioritizing young people's SRH in humanitarian settings, as well as links to relevant documents that can be used by IPs not only as a reference, but also for advocacy purposes.

IASC, With Us & For Us: Working with and for Young People in Humanitarian and Protracted Crises (UNICEF and NRC for the Compact, 2020), referred to in this module as the **IASC Guidelines**, provides a concrete and actionable framework throughout the HPC, complete with tips, examples and case studies, many of them showcasing UNFPA's interventions. The IASC Guidelines also provide humanitarian actors with a set of core principles for young people's humanitarian programming that are adaptable to different contexts. The guidelines' endorsement by the Inter-Agency Standing Committee (IASC), the highest-level humanitarian coordination forum, highlights the importance of engaging young people in humanitarian and protracted crises. To learn more about the guidelines and for support in rolling them out, visit the Compact website.

The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming (GBV AoR, 2019) introduces the 16 minimum standards for prevention of and response to GBV in emergencies, and defines what agencies working on specialized GBV programming need to achieve in order to prevent and respond to GBV and to deliver multisectoral services. The Minimum Standards aim to establish a common understanding of what constitutes minimum prevention and response programming in emergencies. The standards are universal and relevant for all emergency contexts, although they may need to be adapted to the contextual situation of a particular emergency.

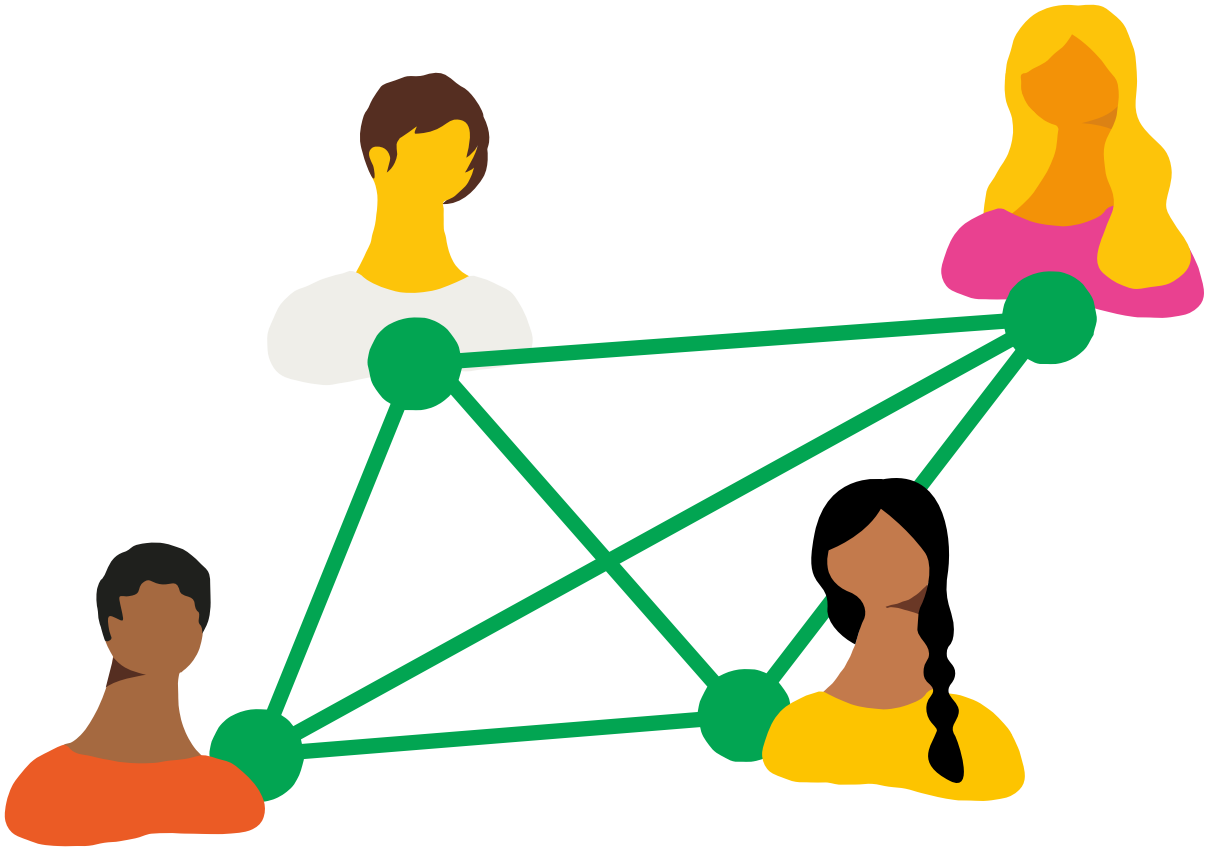
There is a set of key actions for each standard to be implemented during the preparedness, response and/or recovery phases. Of particular interest is Standard 2, on Women's and Girls' Participation and Empowerment, with a list of interventions to ensure women and girls are engaged as active partners and leaders in influencing the humanitarian sector to prevent GBV and support survivors' access to quality services.

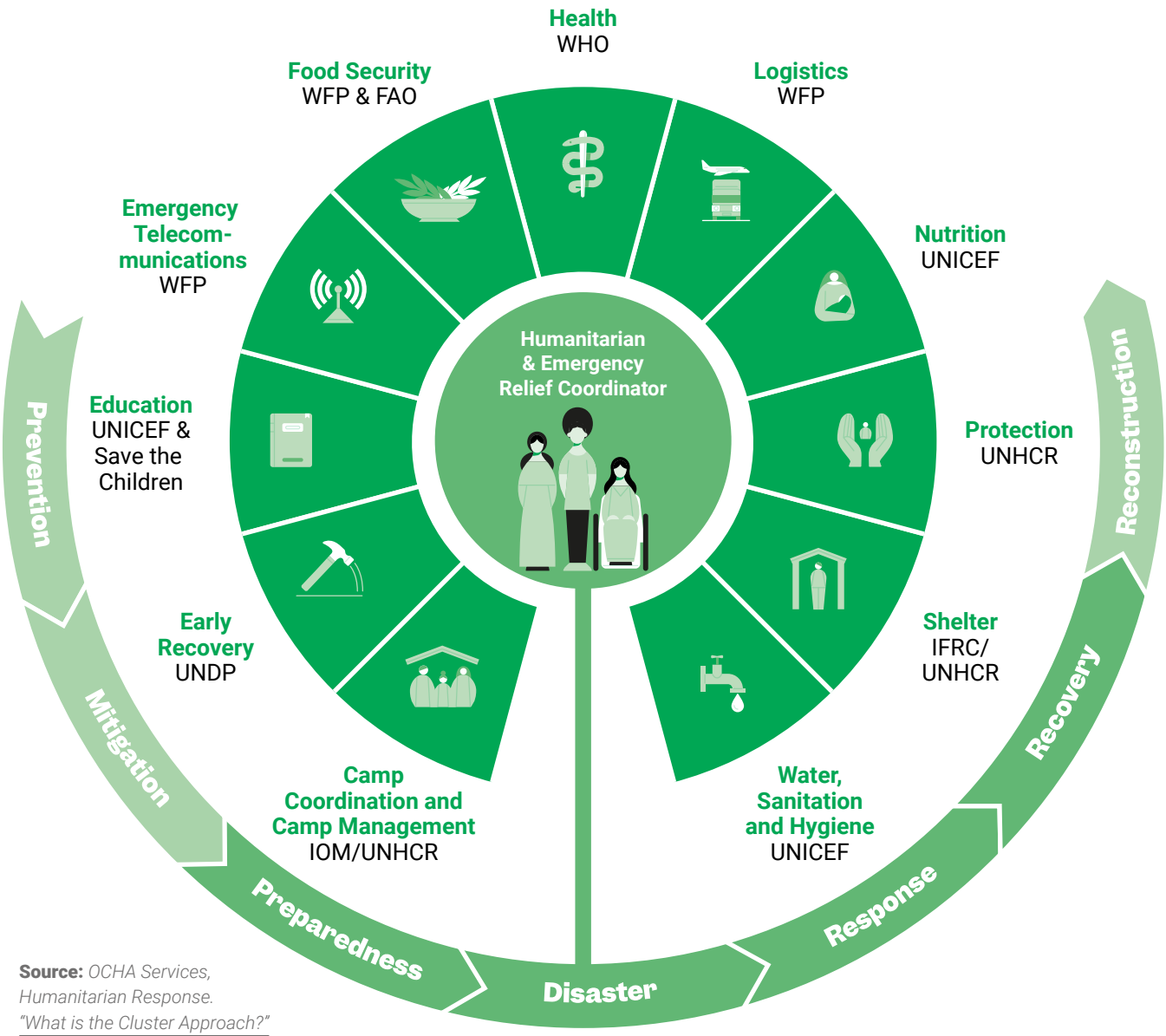
UNFPA'S ROLE IN KEY INTER-AGENCY CLUSTERS AND SECTORS

In humanitarian emergencies, a "cluster approach" is generally adopted at country level to "strengthen partnerships, and the predictability and accountability of international humanitarian action, by improving prioritization and clearly defining the roles and responsibilities of humanitarian organizations". [8] Clusters and sub-cluster coordination mechanisms vary between countries and contexts, and depend on specific emergency contexts, capacities and needs. [4] In the cluster approach:

- SRH is located under the Health cluster, led by the World Health Organization (WHO)
- GBV is a sub-cluster under the Protection cluster, led by the United Nations High Commissioner for Refugees (UNHCR).

In refugee settings, however, UNHCR is mandated to lead and coordinate the refugee response, based on the Refugee Coordination Model. Depending on the capacity of agencies and the context, partners including UNFPA may co-lead the GBV sub-working group in coordination with UNHCR. [4]





Source: *OCHA Services, Humanitarian Response. "What is the Cluster Approach?"*

THE SRH SUB-WORKING GROUP

WHO is the Global Health cluster lead agency, (9) and UNFPA tends to lead the SRH sub-working group at the national level. (10) The terms of reference of the SRH sub-working group may vary depending on the context, but generally UNFPA's main role is to advocate for inclusion of SRH across the Health cluster's humanitarian response and to support the coordination and implementation of the MISP. (11)

THE GBV AREA OF RESPONSIBILITY AND GBV COORDINATION MECHANISMS

UNFPA is the IASC-mandated global lead of the GBV Area of Responsibility (AoR). The mandate bestows a special responsibility on UNFPA for scaling up humanitarian response and the provision of life-saving GBV services, including mental health and psychosocial support (MHPSS) services. (12)
At the country level, UNFPA co-chairs and manages, with a non-governmental organization (NGO) or government co-lead, an interagency forum (GBV sub-cluster or working group) that supports information-sharing and joint action to address GBV risks and programming gaps.
The GBV sub-cluster also facilitates timely and effective implementation of GBV programming, liaising and coordinating with other clusters, supporting training and sensitization, strategic planning, and monitoring and evaluation. (13)
In non-clustered and refugee contexts, UNFPA's coordination role may vary depending on the particular emergency context, presence of other UN agencies and existing local capacity.

All humanitarian actors are called upon to prioritize GBV prevention and risk mitigation across sectors. GBV mainstreaming, or integration, is the process of ensuring that across all sectors, humanitarian interventions:

- do not cause or increase the likelihood of GBV
- proactively seek to identify and take action to mitigate GBV risks in the environment and in programme design and implementation
- proactively facilitate and monitor vulnerable groups' safe access to services.

See pp. 23-30 of this module for specific actions to address the SRH and GBV needs of young people during the emergency preparedness and acute response phases.

INTEGRATING SRH AND GBV INTERVENTIONS FOR YOUNG PEOPLE ACROSS THE HUMANITARIAN RESPONSE

To effectively and comprehensively respond to the specific SRH and GBV needs of young people in humanitarian settings, it is beneficial to strengthen coordination and find avenues to integrate or coordinate SRH and GBV information, mitigation or services with other clusters and sectors of the humanitarian response. Some examples of entry points and opportunities to strengthen SRH and GBV response for young people in the Education, WASH, and Nutrition clusters are included below. Please note that this list is not exhaustive; there are many entry points for coordination and integration across other sectors/clusters.

EXAMPLES OF STRENGTHENING SRH AND GBV INTERVENTIONS FOR YOUNG PEOPLE THROUGH INTER-CLUSTER/SECTOR COORDINATION

EDUCATION

In emergencies, educational programmes often address younger children, with little investment in the developmental and protection rights and needs of adolescents or youth. Entry points to strengthen SRH and GBV coordination with Education include:

- Identify entry points to integrate life skills and comprehensive sexuality education (CSE) into school curriculums.
- Build relationships between SRH, GBV and Education staff to ensure SRH and GBV information for young people is available in schools, including information about how to access services.
- Support messaging for young mothers to continue education, even after marriage and/or childbearing.

WASH

In humanitarian contexts, young women and adolescent girls may have to walk through unsafe areas to access toilet or wash facilities, putting them at risk of sexual violence. Sanitary supplies are often lacking in these contexts, causing young women and adolescent girls isolation and shame, discomfort, and pain while they are menstruating. This may lead to decreased school attendance, missed opportunities and the inability to carry out daily tasks.

Examples of entry points to strengthen SRH and GBV coordination with WASH include:

- Identify entry points where WASH, SRH, and GBV mitigation efforts can be aligned (e.g. design, location, gender segregation of sanitary facilities).
- Coordinate with WASH to ensure that menstrual hygiene management (MHM) equipment and supplies are available in sanitary facilities.
- Engage young people, particularly adolescent girls, in the design and assessment of WASH facilities.

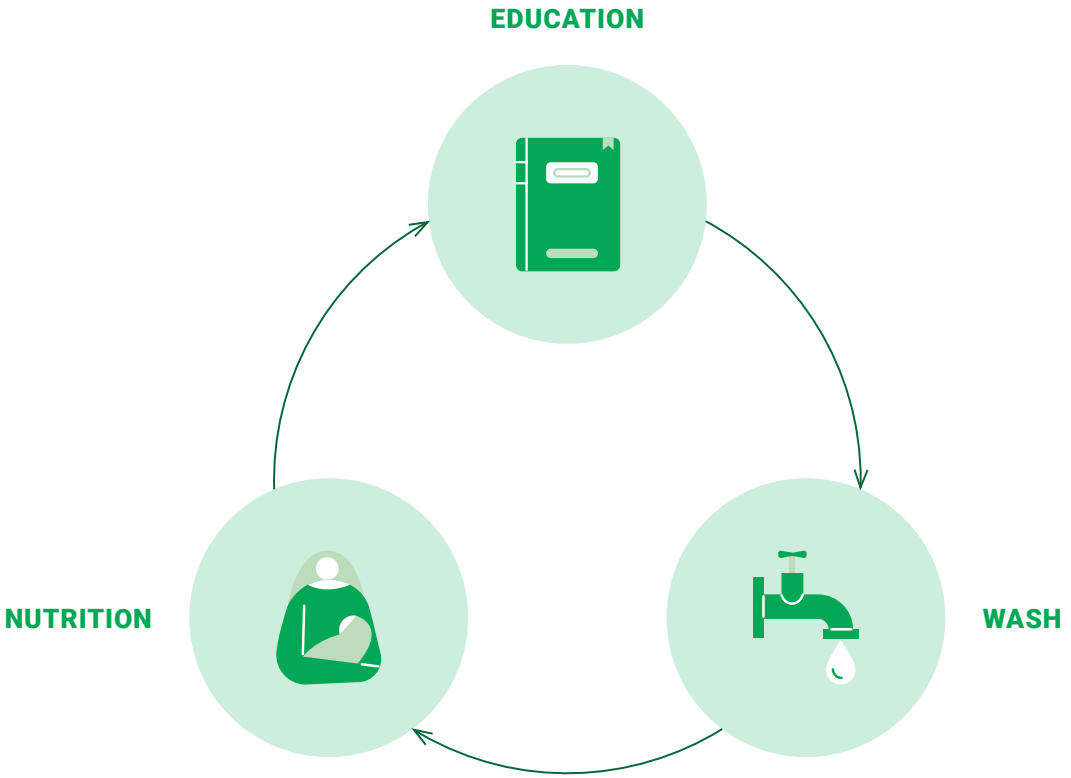
NUTRITION

It is essential for young people to have access to nutritious food, for their physical and sexual maturation and brain development. Nutrition is especially important for pregnant and lactating women and for girls and adolescents who have started menstruating, who are particularly vulnerable to malnutrition. Food and nutritional insecurity can also put young people at a higher risk of GBV and harmful practices, including child marriage and engagement in transactional sex.

Examples of entry points to strengthen SRH and GBV coordination with Nutrition include:

- Use food/supplement distribution as an entry point to link young people, especially young women and adolescent girls, to SRH and GBV information and services.
- Establish a referral system for pregnant and lactating young women and adolescent girls who may require SRH or GBV services.
- Raise awareness among pregnant adolescents and young mothers on the health benefits of breastfeeding and integrate breastfeeding support into existing SRH and GBV services.

Refer also to the IASC Guidelines and *Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery* (IASC, 2015) for additional information on intersectoral coordination.



WHAT WORKS IN PROGRAMMING FOR YOUNG PEOPLE IN HUMANITARIAN SETTINGS?

ADOLESCENT-FRIENDLY SRH AND GBV SERVICES

One of the most important ways of increasing uptake of SRH and GBV services for young people is to train service providers in adolescent-friendly SRH and GBV services. Due to stigma and cultural factors related to SRH and GBV, young people may feel hesitant to seek care, and this may be heightened during crises. UNFPA, other SRH sub-working group and GBV sub-cluster partners, and SRH/GBV IPs should train service providers on adolescent-friendly service provision, particularly for the MISP and GBV services. It is important that UNFPA share and support the implementation of the GBV Guiding Principles (see Standard 1 of the GBV Minimum Standards, p. 2) with other actors, such as child protection, education, and health services, to inform their support of young and adolescent girls.

PROVIDING SRH AND GBV INFORMATION AND PROGRAMMES

The approach to providing information and programmes for young people in humanitarian settings is different to that in development contexts, as the "normal" social structures and modes of communication are often disrupted. When providing information on SRH and GBV to young people, it is important to take several factors into consideration.

- **Be aware that young people in humanitarian settings are often highly mobile.** Shorter sessions given in a concentrated time frame may be more effective, since young people may not remain in one place for an extended period and their lives do not meet a set schedule. Similarly, each lesson should cover a topic completely, rather than carrying over to another session.

- **Disseminate up-to-date information on GBV referral pathways and available SRH services** as part of initiatives for risk communication and community engagement.

- **Take an integrated approach to SRH and GBV information and service delivery whenever possible.** Whenever possible, involve host and/or local communities in SRH and GBV programmes.

- **Remember that sexuality education and GBV information can be addressed in a conservative culture**. This is particularly important for programme developers from outside the culture. Investigate what is available in the context already, or in similar places. In refugee settings, populations often come into contact with a more diverse range of people, which can expose them to new experiences, ideas, messages and programming.

- **Take participants' level of literacy into consideration to ensure that everyone can participate equally.** Young people in humanitarian contexts, especially in recurring or protracted crises, are likely to have missed a lot of school and may have large gaps in their education. Use methods that are appropriate to the literacy level of the learner, rather than their age.

- **Use multiple channels to deliver SRH and GBV information, depending on the humanitarian setting.** These can include direct government services, NGOs or the UN; at fixed locations, such as youth centres, women and girls safe spaces (WGSS), youth clinics or other health services; in mobile classrooms, where the facilitators are brought to the population; or remotely, using technology. Identify existing young people's groups and link them with programmes that provide SRH and GBV information. GBV safe spaces and health clinics are good places to reach young people. Flashcards and leaflets for young people can be distributed together with dignity kits, and social-media platforms and radio programmes can address them with SRH and GBV information.

- **Use creative and flexible outreach strategies to reach young people, particularly most-vulnerable groups, in insecure environments and hard-to-reach areas.** When developing SRH and GBV materials for humanitarian contexts, consider vulnerable groups such as young LGBTQ+ people, married girls, young people living with HIV, young people with disabilities and young people engaged in sex work, since they may have other, different needs. Increase participation by offering flexible access to the programme, and run programmes at times and locations when participants are most available. Programmes may need to budget for transport. Ensure that a gender analysis informs programming so that young women and adolescent girls are able to participate and access services; traditional barriers to participation may have changed in the crisis, and security concerns may have shifted in ways that facilitate or preclude women and girls' engagement.

- **Provide young people with opportunities to socialize, network and organize among themselves.** Support girls' protection and empowerment by giving them the time and space to build friendships and find mutual support among peers and adults in their communities.

INTEGRATING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT INTO SRH AND GBV SERVICES

In humanitarian settings, the well-being of young people can be severely compromised, leaving many unable to access MHPSS services. [5] MHPSS aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders, with a focus on healing, empowerment and recovery. [14] Young people who are exposed to GBV, displacement and other consequences of humanitarian situations may develop negative coping mechanisms which can impact their overall health and well-being, including their SRH. [5] It is therefore important to integrate MHPSS approaches and interventions into SRH and GBV interventions for young people, and that they are age-appropriate and tailored to their specific needs. [14] [15]

See the Annex for comprehensive guidance and tools on integrating MHPSS components into SRH and GBV response services for young people, including suggested actions for UNFPA country offices and IPs, as well as for service providers on how to deal with young people when providing integrated MHPSS interventions.

MEDICO-LEGAL CONSIDERATIONS

When providing SRH and GBV services, UNFPA and IPs must understand the local medico-legal system, be informed about mandatory reporting requirements (and the obligation to inform young people of these), and be aware of local laws and policies related to sexual violence. [5] For instance, it is important to be aware of the age of young people when providing services, and that assent from the minor and consent from parents or guardians are provided, if required. Young people aged 15 years and above are generally considered mature enough to make decisions related to their care and treatment, including their SRH. [13] For more information on ages of consent and the evolving capacities of the child, see Module 1.

HOW TO PLAN AND IMPLEMENT SRH AND GBV SERVICES FOR YOUNG PEOPLE IN HUMANITARIAN SETTINGS

HUMANITARIAN PREPAREDNESS FOR YOUNG PEOPLE

Preparedness refers to the ability of governments, professional response organizations, communities and individuals to anticipate and respond effectively to the impact of likely, imminent or current hazards, events or conditions. (3) UNFPA country offices are required to mainstream preparedness into their country programmes, so that they can respond to humanitarian crises quickly and effectively and contribute to inter-agency and national responses. Young people, including those most often left behind, should be involved from the outset in preparedness planning, as this will allow them to play a meaningful role in future emergency responses and will ensure that humanitarian interventions address their particular needs.

Meaningful adolescent and youth engagement is an inclusive, intentional, mutually respectful partnership between adolescents, youth and adults whereby power is shared, respective contributions are valued, and young people's ideas, perspectives, skills and strengths are integrated into the design and delivery of programmes, strategies, policies, funding mechanisms and organizations that affect their lives and their communities, countries and world. (16)

SRH and GBV preparedness actions should be based on risk-informed analysis and planning as well as the capacities and systems of national and local authorities and implementing partners. They must be aligned with the direction agreed by the UN Resident Coordinator and/or Humanitarian Coordinator and supported by UNFPA subregional and regional offices, and/or headquarters (HQ), when required.

The **Minimum Preparedness Requirements (MPRs)** are globally defined standards established by UNFPA that, as a set, define the minimum level of emergency preparedness that must be met by country offices, regional offices, and HQ. **Minimum Preparedness Actions (MPAs)** are broad actions that UNFPA must implement to meet the MPRs. The UNFPA-specific MPRs and MPAs (*UNFPA Guidance Note on Minimum Preparedness*) are aligned with the IASC MPAs, which can be consulted in the IASC Emergency Response Preparedness Guideline.

The MPRs and MPAs are minimum requirements for all UNFPA country offices, regardless of country risk exposure, country office size or capacity. All country offices should strive to exceed the minimum levels of preparedness, especially in countries at high risk for natural or human-made crises.

The MPRs and MPAs relevant to SRH and GBV are listed in the table below, with additional guidance in selected areas on steps that can be taken by country offices to make them more inclusive of young people, and links to supporting documents.

UNFPA MINIMUM LEVEL OF EMERGENCY PREPAREDNESS

Minimum Preparedness Requirements (MPRs)

COUNTRY OFFICE THEMATIC AREA 1: Risk Monitoring and Contingency Planning

MPA 1
Carry out or support the inter-agency team in risk analysis and monitoring, and in contingency planning

- Consider the SRH and GBV needs of young people, including most vulnerable groups (unaccompanied young people, young people with disabilities, married or pregnant adolescents, young people engaged in sex work, LGBTQ+ young people) during risk analysis, monitoring and contingency planning.
- Involve young people in risk analysis, monitoring, and contingency planning processes whenever possible.

↪ *see suggestions on young people and preparedness in IASC Guidelines, p. 91*

COUNTRY OFFICE THEMATIC AREA 2: Coordination, Advocacy and Management Arrangements

COUNTRY OFFICE THEMATIC AREA 2.1: Management

MPA 2
Develop and implement an Annual Preparedness Action Plan

- Include youth-specific data in country office reporting on Preparedness Action Plan implementation.
- Within contingency and preparedness planning, advocate that GBV services are designated as "essential"; this should not be limited to a health-sector response but be inclusive of basic psychosocial support and case management, including referrals for young people.

↪ *see ASRH Toolkit Chapter 7, "Data for Action", p. 138*

COUNTRY OFFICE THEMATIC AREA 2: Coordination, Advocacy and Management Arrangements

COUNTRY OFFICE THEMATIC AREA 2.2: Cluster/Sector Coordination

MPA 3
Ensure that humanitarian coordination mechanisms in SRH and GBV are in place

- Advocate for the inclusion of youth-led organizations in national coordination mechanisms for SRH and GBV.
- Establish mechanisms for coordinating young people's issues, when relevant.

↪ *see ASRH Toolkit Chapter 3, "Meaningful Participation", p. 39*

COUNTRY OFFICE THEMATIC AREA 2.3: Advocacy

MPA 4
Advocate for SRH and GBV in emergencies

- Advocate for inclusion of ASRH (including the MISP) and GBV in emergency response.
- Advocate for GBV services regardless of the presence or absence of GBV data.
- Advocate for GBV risk mitigation and GBV and gender considerations across humanitarian sectors.

↪ *see ASRH Toolkit Introduction, "Why Should We Prioritize ASRH during Emergencies?", p. 26*

COUNTRY OFFICE THEMATIC AREA 3: Needs Assessment/Information Management/Response Monitoring

MPA 5
Develop tools and make arrangements for needs assessment, information management and response monitoring

- To the extent possible, involve young people in development of tools, needs assessments, information management and response monitoring.
- Find innovative ways to safely use participatory assessments and community-based feedback mechanisms that are accessible to young people to guide strategic decision-making.

↪ *see ASRH Toolkit Chapter 3, "Meaningful Participation", p. 39*

COUNTRY OFFICE THEMATIC AREA 4: Operational Capacity and Arrangements to Deliver Relief and Protection

COUNTRY OFFICE THEMATIC AREA 4.1: Partners

MPA 6
Strengthen humanitarian partnerships

- Map potential partners (e.g. IPs, members of the SRH sub-working group and GBV cluster, youth groups) to support humanitarian interventions addressing young people, including geographic areas of interventions, and IP capacity. These interventions should be updated annually.
- Train IPs and partners on young people-friendly SRH (including the MISP), and GBV services as feasible.

↪ *see ASRH Toolkit Chapter 6, "Training and Capacity-Building of Staff ", p. 82*

COUNTRY OFFICE THEMATIC AREA 4: Operational Capacity and Arrangements to Deliver Relief and Protection

COUNTRY OFFICE THEMATIC AREA 4.2: Supply Chain

MPA 7
Enhance the ability to quickly provide the affected population with critical relief supplies

- Consider the particular needs of young people (including the most vulnerable groups) when developing procurement and distribution plans, and communication messaging and tools.
  ↪ *see IASC Guidelines, "Key actions for Health programming at each stage of the humanitarian programme cycle (HPC)", p. 133*

COUNTRY OFFICE THEMATIC AREA 4.3: Human Resources

MPA 8
Ensure the availability of human resources able to perform critical functions in emergency

- Ensure that personnel (both clinical and non-clinical) are aware of particular SRH and GBV needs of young people during crises.
- Train personnel on adolescent-friendly service provision, including for MISP and GBV.
  ↪ *see ASRH Toolkit Chapter 6, "ASRH Services and Interventions", p. 72*

COUNTRY OFFICE THEMATIC AREA 4.4: Media and Communications

MPA 9
Strengthen UNFPA's ability to perform media and communication activities in emergency

- Develop a country profile, fact sheet and key messages on ASRH and GBV issues related to young people, including vulnerable groups.
- When possible, involve young people in the development of key messages.
- Ensure that youth-led groups are included in communication distribution lists.
- If possible, provide advocacy training for youth groups.
  ↪ *see ASRH Toolkit Chapter 3, "Opportunities to engage adolescents in humanitarian settings", p. 42-45*

COUNTRY OFFICE THEMATIC AREA 4.5: Resource Mobilization and Planning

MPA 10
Ensure the availability of financial resources for preparedness and response

- Advocate for inclusion of ASRH preparedness interventions in country office Emergency Preparedness funding allocation.
  ↪ *see ASRH Toolkit Introduction, "Why Should We Prioritize ASRH during Emergencies?" p. 26*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PREPAREDNESS CHECKLISTS

While the MPAs above describe the minimum steps that country offices can take to support young people's inclusion and participation in humanitarian preparedness, the checklist below is a tool that can be used by country office Adolescent and Youth, SRH, GBV and Humanitarian focal points to encourage more comprehensive and meaningful engagement and participation of young people in humanitarian preparedness, planning and future response interventions. The checklist can be used as a template and adapted to specific contexts. It may be useful to integrate target dates for each intervention into work planning.

CHECKLIST FOR ADOLESCENT AND YOUTH ENGAGEMENT IN HUMANITARIAN PREPAREDNESS

CATEGORY	ACTION *Refer to the IASC Guidelines and ASRH Toolkit for additional guidance on specific actions*
MEANINGFUL PARTICIPATION ***(CUTS ACROSS ALL CATEGORIES)***	↘ Support meaningful representation and participation of young people in SRH working group and GBV sub-cluster/working group (this could require reimbursement of transport costs, adjusting meeting schedules etc.) ↘ Secure space for young people's voices in decision-making bodies and accountability structures at the national, provincial and local/community levels, including technical working groups, camp committees and health development committees. Ensure representation of most-vulnerable groups. ↘ Directly involve young people in identifying and prioritizing their SRH- and GBV-related needs, planning prevention and response interventions, engaging their peers and linking them to programmes, and monitoring and evaluating programmes. ↘ Work directly with young people, including adolescent girls and vulnerable groups, in development of ASRH advocacy campaigns and key messaging.

CATEGORY	ACTION *Refer to the IASC Guidelines and ASRH Toolkit for additional guidance on specific actions*
COORDINATION, NEEDS ASSESSMENT AND PARTNERSHIPS	↘ Map young people-led groups for potential partnerships in humanitarian preparedness, planning and response. Include detail on geographic scope, areas of interest, SRH/GBV experience and capacity to play leadership roles in emergency response. ↘ Identify and establish partnerships with key youth-led groups to support humanitarian preparedness and response efforts. ↘ Conduct age- and sex-disaggregated focus group discussions with young people, respecting international participation standards and including adolescents from subgroups at increased risk, to understand their unique needs, barriers accessing SRH and GBV services and how these may be affected in a crisis. ↘ Advocate with country office leadership, other humanitarian partners and policymakers for young people's engagement in humanitarian preparedness and disaster and emergency planning. ↘ Review disaster-related information, preparedness and emergency plans with adolescent and youth counterparts to ensure that they are inclusive of young people, including most-vulnerable groups.
AWARENESS-RAISING AND EDUCATION	↘ Raise community awareness (community leaders, religious leaders, young people, parents) on the particular SRH and GBV vulnerabilities and needs of young people during emergencies, including of most-vulnerable adolescents. ↘ Identify vulnerable adolescents in the community and engage them in awareness-raising on SRH information and GBV response, in line with the services available. ↘ Engage community leadership and sensitize them to specific adolescent SRH and GBV vulnerabilities and needs, including as components of emergency preparedness.

CATEGORY	ACTION *Refer to the IASC Guidelines and ASRH Toolkit for additional guidance on specific actions*
CAPACITY-BUILDING	↘ Engage young people, and young women in particular, in community leadership structures, and support the capacity development of youth female leaders. ↘ Build capacity of young people on SRH, GBV, gender and human rights, and leadership and advocacy skills. ↘ Build capacity of young people to identify risks and to advocate for young people's priorities within their households, communities and wider environments. ↘ Engage and build capacity of youth networks on SRH emergency preparedness, disaster risk reduction, climate change adaptation and resilience, so that they are empowered to play a meaningful role in future emergency responses. ↘ Train national, local and community-based health workers in the MISP, GBV guiding principles and survivor-centred approach, and GBV case management and psychosocial support for young people, and on provision of youth-friendly services, addressing potential negative attitudes and misconceptions on the part of health providers. ↘ Deliver sensitization and clarification sessions with health providers and IPs regarding the local legal framework, possible barriers to service provision to young people and how to overcome them (provision of family planning/contraception, safe abortion services to the full extent of the law and post-abortion care, and clinical management of rape (CMR) etc.).

YOUNG PEOPLE CHAMPION ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN EMERGENCIES IN THE PHILIPPINES

At the onset of Severe Tropical Storm Washi in the Philippines in 2011, peer educators from the Y-PEER network and International Planned Parenthood Foundation mobilized to conduct rapid assessments, distribute dignity kits and lead health education sessions, including on menstrual hygiene. The youth volunteers quickly mobilized through text and online messaging, and several rounds of real-time training of new volunteers took place, resulting in a large pool of human resources on the ground throughout the response cycle. Learnings from their discussions with fellow young people on ASRH needs, risks and vulnerabilities helped to strengthen ASRH programme design. In the transition to long-term preparedness programming, UNFPA, Save the Children and the Department of Health prioritized training on ASRH to create a pool of master trainers and staff for future emergency responses.

Source: *ASRH Toolkit*

PREPAREDNESS AND RESPONSE FOR YOUNG SYRIAN REFUGEES

The conflict in Syria has resulted in a mass refugee influx into Turkey, making Turkey the largest refugee-hosting country in the world, with more than 4 million refugees (mainly from Syria and other nationalities), 30 per cent of whom are young people aged 10-24 years.

In order to understand the specific SRH and GBV needs among young Syrian refugees, UNFPA Turkey Country Office conducted a needs assessment, which revealed that they faced barriers accessing information and services related to language, violation of rights, limited self-efficacy and feelings of exclusion and discrimination. In response, the country office established four youth centres in four refugee-dense provinces, which provide young people-friendly SRH and GBV services, empowerment and social cohesion activities to young women and girls between the ages of 15 and 24, in their local languages. The services are available for both the host and refugee communities. Young people are systematically integrated throughout the design and implementation of these services, and their meaningful participation is shaping the services of the youth centres.

Prior to the onset of this crisis, UNFPA Turkey Country Office had built the capacity of an IP on SRHR and GBV. This proved advantageous when there was a need to quickly adapt the ongoing programme to respond to the specific SRH and GBV needs of the young refugees, including access to SRH and GBV services and information.

HUMANITARIAN RESPONSE FOR YOUNG PEOPLE

UNFPA's Humanitarian Standard Operating Procedures (SOPs) prioritize implementation of the **Minimum Initial Service Package (MISP)** for SRH. This is a set of life-saving interventions that should be implemented within the first 48 hours of any emergency. In addition to the SOPs, UNFPA's Standard Interventions[2] should be used as a guide during humanitarian response. Although the Standard Interventions are not specific to young people, they can easily be tailored to meet their needs. A young people-inclusive version of the MISP has been developed and is outlined on pp. 35-37.

THE SIX OBJECTIVES OF THE MISP

1. Ensure that the Health sector/cluster identifies an organization to lead implementation of the MISP.
2. Prevent sexual violence and respond to needs of survivors.
3. Prevent transmission and reduce morbidity and mortality due to HIV and other STIs.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
   a. (Other priority: Provide safe abortion services to the full extent of the law)
6. Plan for comprehensive SRH services, integrated into primary health care as soon as possible.

MISP implementation should never be delayed in order to conduct a needs assessment. The focus in an acute crisis must be on saving lives: conducting needs assessments costs valuable time and resources (both human and financial) that are needed to ensure that adolescents have access to life-saving SRH and GBV services, and it could lead to delays in delivering those services.

Needs assessments already conducted during the preparedness phase, however, *should* be consulted when rolling out MISP services for young people; and the SRH and GBV needs of young people, including most-vulnerable groups, should be assessed (or re-assessed) *after* the acute phase has ended, when plans are made to transition to comprehensive SRH services. Other assessments, such as the Multi-Cluster/Sector Initial Rapid Assessment, may be carried out during the initial phase of a crisis, but should not interfere with the delivery of life-saving services, including the MISP.

2 The Standard Interventions are being developed. Please contact country office Humanitarian staff for the link to the final document.

INTEGRATING SRH AND GBV INTERVENTIONS IN ACUTE HUMANITARIAN RESPONSE

UNFPA is mandated to lead the establishment of GBV referral mechanisms, such as a multisectoral referral network for young people who are survivors of GBV, as well as adolescent-friendly complaints mechanisms for sexual exploitation and abuse, through the GBV sub-cluster, the SRH working group and IPs. (5) Health systems should be supported to tailor protocols for service provision to adolescent girls and boys that are age-appropriate, accessible, non-judgmental and non-discriminatory. (4) (14)

WGSS can be one avenue to reach GBV survivors and/or those in need of SRH services or MHPSS. Adolescent-friendly centres should be located close to SRH services, to facilitate access to both GBV and SRH services. Trained GBV counsellors should be placed in health facilities to provide counselling to young people who are survivors of GBV. It is important to ensure that female health service providers are available for girls, and male service providers for boys.

MHPSS should be integrated into WGSS and also, whenever possible, into health services. MHPSS should be accessible especially for vulnerable young people, including survivors of GBV. It may also be beneficial for GBV actors to connect with child-protection actors offering case management services, in order to map response services, understand what MHPSS activities are available for young people, and explore possible referral mechanisms. (13)

Examples of integration of young people's SRH and GBV interventions with the Education, WASH, Nutrition sectors are given on pp. 17-18. Further information on intersectoral coordination can be found in the IASC Guidelines; *Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery* (IASC, 2015); and the *Toolkit for Integration of Menstrual Hygiene Management (MHM) into Humanitarian Response*.

AGE-APPROPRIATE SRH AND GBV RESPONSE

In a humanitarian response, the needs of adolescents (10-19 years old) are prioritized, because individuals over the age of 18 are generally considered "adults" under the law and are therefore legally permitted to make their own health-care decisions without the consent of a parent or guardian.

When considering adolescent SRH and GBV responses in humanitarian emergencies, it is also important to recognize that the 10-18-year age range represents a very diverse group. The SRH, GBV, health and protection needs of very young adolescents (10-14 years) are quite different from the needs of older adolescents. Staff and implementing partners should take this into account when developing communications, assessing needs and providing services. It may be necessary to train providers on how to provide SRH/GBV services for adolescents from different age groups within the framework of the law.

It is always critical to support adolescent girl survivors and place girls' best interests, safety and well-being at the centre of all decisions. Based on an accurate assessment of a girl's development, age and capacity to understand and make decisions about her safety and access to services, GBV-specialized actors must evaluate with the adolescent girl survivor the positive and negative consequences of safety planning and referral for services, choosing the least harmful option and engaging her caregiver when appropriate.

It is always critical to support adolescent girl survivors and place girls' best interests, safety and well-being at the centre of all decisions.

RESOURCES

- The **MISP** is detailed in Chapter 3 of the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAWG, 2018, referred to in this module as the IAFM) and is also available in five languages through the MISP Distance Learning Module. All SRH staff are strongly encouraged to become familiar with the MISP and to complete the Distance Learning Module.
- The **Adolescent-Inclusive MISP** and its implementation are addressed in Chapter 4 of the ASRH Toolkit, which is an excellent reference for adapting the MISP to ensure that the SRH needs of adolescents are met during acute crises.
- **ASRH:** Chapter 6 of the IAFM provides comprehensive guidance to humanitarian actors on the principles of ASRH service delivery in humanitarian contexts, adolescent engagement, and safe and effective adolescent-friendly programming.

The following checklist, based on the Adolescent-Inclusive MISP (ASRH Toolkit), UNFPA's Humanitarian SOPs and UNFPA's Standard Interventions, should be used to complement these tools to help ensure that the SRH and GBV needs of adolescents are being addressed during MISP implementation.

CHECKLIST FOR ADOLESCENT AND YOUTH INCLUSION IN ACUTE HUMANITARIAN RESPONSE (MISP IMPLEMENTATION)

MISP OBJECTIVE	ACTION
COORDINATION ↪ *see ASRH Toolkit, p. 58*	↘ Orient SRH Coordinator on adolescent and youth SRH needs and services. ↘ Advocate for adolescents' inclusion in coordination meetings and decision-making processes.[3] ↘ Advocate with Health cluster and GBV sub-cluster to ensure SRH and GBV information and services for adolescents are available and linked/coordinated during MISP implementation. ↘ Coordinate with other organizations to identify adolescents at increased risk and ensure that they have access to adolescent-friendly SRH and GBV services. ↘ Map ASRH stakeholders and services and share information among SRH partners to avoid duplication of services and ensure SRH coverage for all adolescent populations. ↘ Strategize with community members and/or youth organizations and networks on communication channels to reach adolescents at onset of emergencies. ↘ Ensure that age- and sex- disaggregated data are safely and ethically collected on SRH and GBV so that ASRH service uptake and gaps can be tracked.[4]
OBJECTIVE 2: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS ↪ *see ASRH Toolkit, p. 59*	↘ Coordinate linkages between ASRH and GBV (including through WGSS) to ensure that adolescent survivors are recognized and their SRH, health, MHPSS and protection needs are met. ↘ Ensure that the risks of sexual violence/abuse of young boys are recognized and their SRH, MHPSS and protection needs are met. ↘ Develop and disseminate adolescent-specific advocacy messages on GBV response and risk mitigation in humanitarian crises. ↘ Ensure that dignity kit distribution reaches the most vulnerable adolescent girls as an entry point to raising awareness about GBV and SRH issues, risks and service availability. ↘ Ensure adolescent-friendly care at health facilities for survivors of sexual violence, including clinical management of rape and safe abortion services to the full extent of the law and post-abortion care.

For footnotes 3 and 4, see p. 37.

MISP OBJECTIVE	ACTION
OBJECTIVE 3: PREVENT TRANSMISSION AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIS ↪ *see ASRH Toolkit, p. 60*	↘ Ensure adolescent-friendly services are available for adolescents presenting to facilities with STI symptoms. ↘ Provide adolescents with information about STIs and the locations of adolescent-friendly services. ↘ Promote dual-protection methods (prevention of pregnancy and prevention of STIs, including HIV) for adolescents. ↘ Ensure that adolescents have continued access to antiretroviral therapy (ART) and provide post-exposure prophylaxis (PEP) for HIV to survivors of sexual assault as appropriate. ↘ Ensure that ART adherence support activities are inclusive of adolescents.
OBJECTIVE 4: PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY ↪ *see ASRH Toolkit, p. 60*	↘ Ensure that visibly pregnant adolescents receive clean delivery kits. ↘ Provide pregnant adolescents with information about where adolescent-friendly SRH services, including antenatal care, delivery care and postnatal care are available. ↘ Inform communities, including adolescents, on the availability of safe delivery and emergency obstetric and newborn care services, the danger signs in pregnancy, and the importance of seeking care at health facilities. ↘ Ensure that basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC) services provided at referral hospitals are adolescent-friendly, and, to the extent possible, respect the confidentiality and privacy of the adolescent mother. ↘ Ensure that referral systems consider the needs of adolescents (including consent).
OBJECTIVE 5: PREVENT UNINTENDED PREGNANCIES ↪ *see ASRH Toolkit, p. 61*	↘ Ensure that health providers, communities and adolescents are aware of adolescents' right to contraceptive choice and that all methods, including long-acting reversible contraception (LARC), are safe and effective for adolescents. ↘ Ensure service providers are fully aware of local laws and policies and offer adolescents the full range of contraceptive methods, regardless of age or marital status, to the full extent allowed under the law. ↘ Promote dual-protection methods (prevention of pregnancy and prevention of STIs, including HIV) for adolescents.

MISP OBJECTIVE	ACTION
OTHER PRIORITY: ENSURE THAT SAFE ABORTION CARE IS AVAILABLE TO THE FULL EXTENT OF THE LAW ↪ *see ASRH Toolkit, p. 61*	↘ Raise community awareness on national laws and policies related to safe abortion care for adolescents. ↘ To the full extent of the law, ensure that facilities have at least one provider trained to provide adolescents with counselling on safe abortion and post-abortion care, including counselling and provision of post-abortion contraception. ↘ Establish linkages from the community for adolescents seeking abortion services (through Traditional Birth Attendants (TBAs), midwives, community health workers and peers). ↘ Raise awareness among community leaders and adolescents on the availability of safe abortion care.
OBJECTIVE 6: PLAN FOR COMPREHENSIVE SRH SERVICES ↪ *see ASRH Toolkit, p. 62*	↘ Identify and assess SRH needs of adolescents in the community, including needs of groups at increased risk. ↘ Identify suitable IPs and service delivery sites to expand adolescent-friendly SRH services. ↘ Assess staff capacity to deliver adolescent-friendly counselling and services (including contraception, safe abortion care to the full extent of the law, clinical management of rape (CMR)). ↘ Ensure that the SRH commodity needs of adolescents (contraception methods, antiretroviral therapy (ART), clean delivery kits, safe abortion commodities) are taken into consideration when planning for expansion to comprehensive services. ↘ Engage young people in planning for comprehensive ASRH and GBV services, including MHPSS and MHM. ↘ Engage adolescent/youth organizations in the community to understand adolescents' barriers (financial, bias, other) to accessing SRH services.

3 One way to improve young people's participation in SRH/GBV humanitarian programme design and in humanitarian coordination mechanisms is to identify and nominate young people to participate in meetings of the SRH working group and GBV sub-cluster, where they will be able to share first-hand information on their GBV and SRH needs and ideas on how interventions can best reach them.

4 When collecting data on GBV, it is important to avoid seeking the numbers of GBV survivors and instead focus on service coverage, service points equipped with UNFPA supplies to provide life-saving care, or the estimated number of displaced women and girls.

Other SRH and GBV interventions that should be considered at different stages of the HPC are described in the table below.

SRH AND GBV INTERVENTIONS IN THE HUMANITARIAN PROGRAMME CYCLE

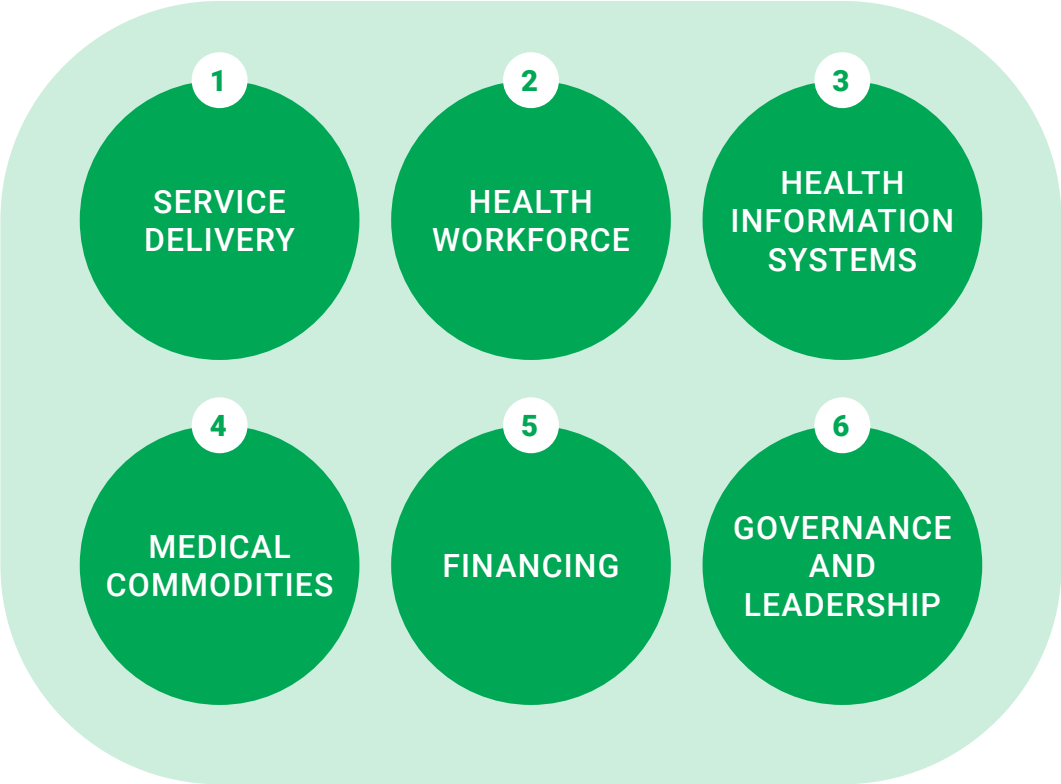
HUMANITARIAN PROGRAMME CYCLE	INTERVENTION
NEEDS ASSESSMENT AND ANALYSIS	↘ Ensure that identified SRH and GBV gaps for young people are included in multi-cluster/sector initial rapid assessment and/or health/protection assessments. ↘ Engage young women in community-based interventions to identify SRH and GBV needs, map available services, and strengthen referral pathways for SRH and GBV.
STRATEGIC PLANNING	↘ Ensure that the response plan addresses the needs of young people, particularly girls and young women. ↘ Include age- and gender-specific results and indicators in the programme, including indicators on their participation. ↘ Ensure young people, particularly young women and girls, are included in the design, implementation and monitoring of interventions, and engage them in advocacy efforts. ↪ see case study (p. 42) on the Whole of Syria Adolescent Girls Strategy.
RESOURCE MOBILIZATION	↘ Ensure that adolescent SRH and GBV are included in funding proposals, For more information on these funding mechanisms, see the UNFPA SRHiE Toolkit, pp. 6, 10-11.
IMPLEMENTATION AND MONITORING	↘ Involve young people in MISP implementation and monitoring. ↘ Engage adolescents and youth in developing key advocacy messages pertaining to their SRH and GBV needs, including MHPSS and MHM. ↘ Build capacities of young people to support basic SRH and GBV services (including MHPSS and MHM). Support them to disseminate information, mobilize and engage communities, facilitate referrals and link other adolescents to SRH and GBV information and services.
OPERATIONAL PEER REVIEW AND EVALUATION	↘ Establish a system for collection, monitoring and reporting of age- and sex-disaggregated data for SRH and GBV services. ↘ Facilitate the participation of young people in monitoring and evaluation processes, project reviews, and policy reviews.

TRANSITIONING TO COMPREHENSIVE SRH AND GBV SERVICES FOR YOUNG PEOPLE

As soon as the situation permits, interventions should be transitioned away from the MISP and to the provision of comprehensive SRH services, working with the SRH working group, Health and GBV sector/cluster, and other stakeholders including IPs to address the six health-systems building blocks: service delivery, health workforce, health information systems, medical commodities, financing, and governance and leadership. Considerations for young people, including groups most at risk, should be made at each of these levels. To the extent possible, adolescents should be engaged in the process from the planning stage through implementation, monitoring and evaluation.

To read more about how to plan for comprehensive SRH services, read MISP Objective 6 in the IAFM and *Monitoring the Building Blocks of Health Systems* (WHO, 2010).

THE SIX HEALTH-SYSTEMS BUILDING BLOCKS



MOZAMBIQUE: INVOLVING YOUNG PEOPLE IN THE EMERGENCY RESPONSE

Since 2019, Mozambique has experienced a deteriorating humanitarian situation due to consecutive cyclones that affected the central and northern regions, as well as insecurity and violence perpetrated by non-state armed groups in the northern region. Both natural disasters and armed conflict have led to massive displacement of populations across affected areas and neighbouring provinces, including young people. The crises have disrupted their livelihood opportunities and limited their educational, social and emotional development.

Young people are also experiencing heightened protection risks including GBV, sexual exploitation and abuse, child marriage, unwanted pregnancies, and early motherhood, as well as SRH-related complications such as STI/HIV infections, maternal morbidity and maternal deaths.

UNFPA Mozambique Country Office and its partners are providing ASRH support in the most crisis-affected areas. The following interventions have been implemented to respond to the SRH and GBV needs of young people, reaching more than 10,000 vulnerable young people since 2019:

- **One-stop mobile clinics:** informed by several needs assessments conducted with young people and tailored to their needs, delivering SRH, GBV, maternal and child health, and family planning services at the resettlement sites and host communities, with a focus on girls of reproductive age.
- **Women and girls safe space (WGSS):** providing protection to internally displaced adolescent girls, through tailored vocational training, training on soft skills (e.g. empowerment and leadership, teamwork, confidence and initiative, communication and literacy skills), information on SRH services and referral to MHPSS services and counselling for GBV. The WGSS also distributes dignity kits.
- **Engagement of young people through capacity-building efforts:** UNFPA Mozambique engages young people as agents of change and has trained almost 200 youth volunteers who support SRH, GBV response and COVID-19 interpersonal communication services through door-to-door, community-based awareness-raising campaigns, information dissemination, data collection and distribution of essential commodities such as dignity kits.
- **Sexuality and MHM education:** sessions on MHM and adolescent SRHR addressing adolescent boys and girls are provided, including distribution of a Smart Cycle and reusable period panties.
- **The DIKA digital platform:** developed with support of young people in Maputo during the pandemic, the DIKA app disseminates information about SRH, GBV and COVID-19 in Portuguese and in local languages.

WHOLE OF SYRIA ADOLESCENT GIRLS STRATEGY: STRATEGIC GBV AND SRH PLANNING WITH AND FOR ADOLESCENT GIRLS

The 2017 Syria Humanitarian Needs Overview identified adolescent girls as a particularly vulnerable group to sexual violence and to child marriage leading to early pregnancy. Based on these findings, consultations held by the GBV AoR and the Reproductive Health working groups of the Whole of Syria identified the need for a strategic framework that would address the specific needs of adolescent girls in Syria focusing on RH and GBV.

The Whole of Syria Adolescent Girls Strategy, developed by UNFPA and closely informed by an adolescent girl technical steering committee, is based upon the findings of a literature review on adolescent girls in emergencies, consultations with humanitarian actors working on existing programming in Protection, GBV and Reproductive Health, and several focus group discussions with adolescent girls. It presents four primary objectives to better respond to the needs of adolescent girls inside Syria and empower them through the provision of humanitarian assistance to allow them to achieve equal rights and control over their lives, to make the choices that they want and to lead meaningful and happy lives. Access the strategy here.

SYRIA: THE ADOLESCENT MOTHERS AGAINST ALL ODDS (AMAL) INITIATIVE

The crisis in Syria has led to an increase in early marriage and adolescent pregnancy, which has highlighted a critical gap in pregnant adolescents' access to life-saving SRH information and services. The AMAL Initiative was designed to meet the needs of pregnant adolescents and first-time mothers in areas affected by crisis, while simultaneously addressing the communities' understandings of gender, power and social norms.

Funded by UNFPA and implemented by CARE and other local partners, the AMAL Initiative includes a peer-based discussion group for pregnant adolescents and first-time mothers called the Young Mothers' Club, centred around improving SRH knowledge and strengthening life skills; community dialogue groups with influential individuals such as religious leaders, teachers and community health workers as well as mothers, mothers-in-law, and husbands of adolescent girls; and participatory exercises with health-care providers focused on rights-based approaches to family planning counselling, communication skills and ensuring adolescent-friendly health services.

The AMAL Initiative also includes Adolescent Advisory Committees, which train adolescent girls in self-efficacy and leadership so that they can liaise with stakeholders to share recommendations and feedback, and identify hard-to-reach and marginalized adolescents in their communities to refer them to AMAL programming, health facilities and other support systems.

With the face of fragile contexts becoming increasingly young, the AMAL Initiative seeks to inform the global evidence base and dialogue around nexus approaches to adolescent-responsive and -inclusive SRH and GBV programming.

GENERATING AND USING DATA

Collecting data from young people must be done in a safe way that ensures their confidentiality, using informed consent and assent procedures. Prior to conducting data collection, staff should be assessed on their capacity to meet these criteria, and offered training where necessary.

CONSIDERATIONS FOR DATA DISAGGREGATION

AGE DISAGGREGATION

Collecting age-disaggregated data is necessary to reflect developmental stages and to recognize needs, including SRH and GBV risks and needs among adolescents and youth. Age-disaggregated data are also important from a legal perspective. The international distinction between children (0-17 years) and adults (18+) should always be considered when providing treatment and care. However, the nationally recognized distinction between children and adults should also be considered, both when collecting data on age, and when providing treatment and other services.

Although using one-year increments to collect data on age can be very useful, it may not be possible in all settings. In cases where one-year increments cannot be collected, using a two-year to three-year range is recommended (i.e. 10-11, 12-14, 15-17, 18-19, 20-24).

The UN defines “youth” as being aged 15-24 years of age. UNFPA defines “adolescents” as 10-19 years and “young people” as 10-24 years. These age brackets can be used when there is a need to arrange data categories for comparability and streamlining.

The table shows the UN definition of age categories relevant for work on young people. These definitions, especially the subgroups within the adolescent and youth categories, are important from a policy and programme perspective, and for the data collection process.

CATEGORY	AGES	COMMENT
CHILDREN	0-17	Definition from Convention on the Rights of the Child (CRC)
ADOLESCENTS	10-19	Adolescence is the transition from childhood to adulthood and comes with different social and cultural expectations. The time category captures psychological and physical developmental changes, and although individuals have different developmental curves, the age categories indicate when the majority of changes take place in a population.
YOUNGER ADOLESCENTS/ VERY YOUNG ADOLESCENTS	10-14	Onset of puberty, self-consciousness increases, social restrictions may be introduced with menarche etc.
OLDER ADOLESCENTS	15-19	Relationships and peers become more important, furthering consequential thinking, need for independence.
YOUTH	15-24	Regional adaptations and age brackets are also recognized, such as the African Charter definition of youth as 15-35, and resolution 2250 on Youth, Peace and Security defining youth to be 18-29 years.
YOUNG PEOPLE	10-24	The umbrella term for adolescents and youth, recognizing that this term does not translate into all languages, including Spanish.

SEX- AND DISABILITY-DISAGGREGATED DATA

Data should always be sex-disggregated, and whenever possible, data on disabilities should be collected too, since this information provides a better understanding of the demographics of the affected adolescents and youth, which should guide programme design and implementation.

CONSIDERATIONS FOR DATA COLLECTION

The specificity of the date of birth data that are collected should always depend on the purpose of the data collection. For example, if the data are to be used for identification or protection purposes (such as intake for GBV case management), the full date of birth (dd/mm/yyyy) should be collected. In other cases, month/year data can provide the flexibility to aggregate data into various age ranges, while avoiding the undue risk of identifying respondents.

If the exact date of birth is unknown, an estimated birth date should be based on available information (defaulting to July 1, together with the estimated year of birth). It is important to mention clearly in the data reporting form that this is an estimated birth date.

KEY DATA GUIDELINES AND TOOLS

The table below provides an overview of key guidelines and tools for generating and using data on young people, as well as links to specific SRH and GBV thematic tip sheets which can be used throughout the HPC.

RISK ASSESSMENT	IASC Guidelines	↘ Table 1: Risk assessment tool for safe adolescent participation, p. 193
DATA ASSESSMENTS	ASRH Toolkit	↘ What should we know before conducting assessments with adolescents?, p. 141 ↘ Checklist for Conducting Assessments with Adolescents, p. 143 ↘ Table 6: ASRH Assessments, Timing and Tools (incl. how programmers can use the assessments to consult adolescents and youth on these topics throughout the HPC and humanitarian continuum), p. 147
INFORMED CONSENT AND ASSENT	IASC Guidelines	↘ Box 15: Informed consent and assent, p. 74
DATA DISAGGREGATION	IASC Guidelines	↘ Box 4: Suggested age groups for data disaggregation for young people in humanitarian action, p. 21
INFORMATION MANAGEMENT	IASC Guidelines	↘ Young people in information management, p. 90 ↘ Checklist: Information management process (incl. at the assessment, analysis and planning stages, during implementation, and during evaluation and post-programme), p. 199
DATA ON HEALTH (INCLUDING SRH)	IASC Guidelines	↘ Tip sheet: Key actions for Health programming at each stage of the HPC, p. 133
DATA ON GBV	IASC Guidelines	↘ Tip sheet: Key actions for GBV programming at each stage of the HPC, p. 164

YOUTH WORKING GROUP, COX'S BAZAR, BANGLADESH

In Bangladesh, children and adolescents comprise 55 per cent of the Rohingya refugee population. The Youth Working Group (YWG) is a coordination structure built by the Education and Child Protection sectors to gather data on, advocate for and support programmes for young people in the Rohingya and host communities. In 2020, YWG co-chairs UNFPA and Save the Children International developed a skills development framework for displaced Rohingya aged 10-18 years in Cox's Bazar. The purpose of this framework is to empower young people through foundational, transferable and job-specific skills. The YWG also led development of advocacy messages for the Government of Bangladesh to allow Rohingya young people to take part in an income-generating programme. The YWG mapped existing initiatives for young people and is collating existing life-skills materials to complement the effort and training partners in adolescent girl-centred programme design.

Source: *YWG, Cox's Bazar (IASC Guidelines)*

YOUTH PARTICIPATION IN INDONESIA

After the 2018 earthquake in Lombok, Indonesia, the International Planned Parenthood Federation (IPPF), Indonesia Planned Parenthood Association (IPPA) and UNFPA Indonesia collaborated to establish a model for youth participation and accountability. It was originally difficult to ensure that youth voices were included in the coordination mechanisms, and it came to light that young people did not always feel comfortable sharing their experiences within coordination due to instances of stigma and lack of acceptance.

Subsequently, IPPF youth volunteers formed a youth forum – managed and led by youth themselves – that enabled the group to come together and identify specific needs, barriers and strategies for meeting their SRH needs during the response. The youth forum discussed action items, strategies and recommendations to raise at SRH cluster meetings via IPPA staff. While it remains important to include youth in existing coordination mechanisms, IPPA found it was best to establish forums where youth felt comfortable and had a platform to share their opinions free from stigma. It is important that these forums are led and managed by youth themselves as a key driver of success.

Source: *ASRH Toolkit*

THE HUMANITARIAN–DEVELOPMENT–PEACE NEXUS

Just as it is valuable to include young people in the preparedness and acute-response phases of humanitarian crises, both as recipients and as implementers, they can also play a vital role in social cohesion and peacebuilding efforts. Peacebuilding activities can take place prior to the outbreak of violence, during conflict or once hostilities have ended and reconstruction has begun. [3]

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The term "humanitarian–development–peace nexus" focuses on the work needed to coherently address people's vulnerability before, during and after crises. It implies a New Way of Working (NWoW) that simultaneously meets the immediate needs of populations and ensures longer-term investment to address the systemic causes of conflict and vulnerability, such as poverty, inequality and the lack of functioning accountability systems. [17] [18]

UNFPA has committed to this NWoW and consistently works across this nexus by engaging partners at the individual, community and national levels, including by strengthening the capacities of local women and youth groups and government authorities to enhance basic services and address inequalities. UNFPA's programming – such as young people's participation and leadership, access to SRH, population data, women's empowerment and participation, GBV prevention and response – makes critical contributions to peace by addressing long-term drivers of conflict caused by inequitable access to services, gender-inequality, GBV and youth marginalization. [19] [20]

Strengthening linkages across this nexus thus helps attain long-term development gains and build resilient and peaceful societies. In large-scale emergencies, the nexus approach allows governments and humanitarian actors to respond appropriately, while also anticipating additional follow-on shocks by building the skills of young people. Young people involved in peacebuilding processes are more active citizens for peace. Their participation increases peaceful coexistence, supports those living in vulnerable situations, and reduces discrimination and violence, thus contributing to more resilient communities and societies.

This recognition of young people as a positive force in preventing and resolving conflict and building sustainable peace has gained significant momentum since the adoption of the Security Council resolution 2250 on youth, peace and security (YPS) in 2015, which recognized for the first time "the important and positive contribution of youth in efforts for the maintenance and promotion of peace and security". (21) The resolution identifies five pillars for action and calls for mechanisms that allow the meaningful participation of young women and men in peace processes and dispute resolution and that address the underlying causes of the rise in violent extremism and conflict.

To read more about how to operationalize readiness to implement the YPS agenda for UNFPA and other UN agencies for country, regional and global teams, see *Youth, Peace and Security: A Programming Handbook* (United Nations and Folke Bernadotte Academy, 2021) and Module 6 of this Operational Guidance.

ANNEX: GUIDANCE ON INTEGRATING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT INTERVENTIONS INTO SRH AND GBV PROGRAMMING FOR YOUNG PEOPLE

MHPSS integration or strengthening should always aim to serve the best interests of people who seek care and be guided by a patient- and survivor-centred approach and the principles of confidentiality, safety and security, respect and non-discrimination. (22) When MHPSS approaches and interventions are provided to young people, it is important to tailor them to address their special psychosocial needs.

Many young people report that they have poor access to adolescent-friendly services, including MHPSS. These services do not always need to be provided by specialized MHPSS providers, but may be provided by trained health-care workers or GBV protection staff. The most important factor is that whoever provides integrated MHPSS approaches and interventions to young people has the knowledge and skills to tailor their communication methods to fit the age of young people, is able to understand their particular needs, is aware of their own attitudes and prejudices towards young people, and realizes what challenges young people may face related to their SRH, GBV experience and psychosocial well-being.

The "do no harm" principle should guide all MHPSS integration work. While young people's access to MHPSS should be included in initial humanitarian assessments, MHPSS services do not always need to be specialized services, but can also be community-focused interventions. Community mobilization activities can be supported to facilitate community self-help and social networks, which should include support to young people. In families and communities, steps should be taken at the earliest opportunity to activate and strengthen local support systems and to encourage a spirit of community self-help. To read more about the different levels (person-focused and community-focused) of MHPSS interventions for survivors of conflict-related sexual violence, please see *Mental Health and Psychosocial Support for Conflict-related Sexual Violence: Principles and Interventions* (WHO, 2012; p. 4).

MHPSS integration should be tailored to address the potential long- and medium-term psychosocial and well-being impacts for young people who are seeking SRH and GBV services. Service providers with experience of providing MHPSS to young people should be identified to train SRH and GBV service providers on how to identify and assess young people's MHPSS needs. GBV programmes that have integrated psychosocial activities should consider incorporating MHPSS referrals into their programme activities. At the national level, MHPSS cross-linkages, referrals and integration can be established with other clusters/sectors, such as Education and Child Protection. See the *Inter-Agency Referral Form and Guidance Note* (IASC, 2017; pp. 6-8) to find MHPSS referring forms, as well as a table with output and outcome level indicators for inter-agency referrals (p. 11).

To read more about MHPSS referrals for young people, see the ASRH Toolkit (p. 137), where links are provided to the following documents:

- 3/4/5 W's templates (p. 302)
- Referral Form for Referring Agency Copy (p. 233)
- Referral Form for Client Copy (p. 235)
- Referral Form for Receiving Agency Copy (p. 237)

If the decision is made to expand MHPSS services to risk management of psychosocial distress to cover, for example, suicidality or treatment of psychosocial distress, UNFPA country offices together with their IPs should assess their capacity to adequately provide such technical services. Before expanding services, it is important that SRH and GBV providers have been trained and referral mechanisms are in place, and it is recommended that a dedicated MHPSS specialist be assigned to support the implementation of such services.

The table below provides suggested actions for UNFPA country offices and IPs, as well as for service providers on how to deal with young people when providing integrated MHPSS interventions.

MAKING A PSYCHOSOCIAL ASSESSMENT OF YOUNG PEOPLE SEEKING CARE

Some initial questions to understand the needs and problems of the young people who are seeking care can be framed around following areas:

Ask the young person what their question or problem is.
Home: With whom do you live? Can you describe your living situation?
Education/employment: Are you studying? How is school/work? Are you working outside your home?
Eating: What do you think and feel about your body? Are you happy with how you are/look, or would you like it to be different in any way? On a normal day, how many meals do you have and what do you normally eat?
Activity: What do you do in your free time? Whom do you spend time with?

Once the initial questions have been asked, and a relationship with the young person has been established where they feel safe and comfortable to open up more, let them know that you'd like to learn a little more about their life to be able to help. Questions can then include:

- **Drugs:** Have you ever used tobacco/alcohol/other substances? If yes, are you currently using them?
- **Sexuality:** Have you ever had sex? If yes, what were the circumstances in which you had sex: did you want to or were you forced to have it? Are you sexually active now?
- **Safety:** Do you feel safe at home/in your place of study/in your neighbourhood? If not, what makes you feel unsafe?
- **Suicide:** Do you feel able to cope with your situation? Have you ever thought about ending your life?

ALGORITHMS FOR MANAGEMENT OF ANXIETY AND DEPRESSION, AND INFORMATION FOR YOUNG PEOPLE (AND ACCOMPANYING ADULTS/GUARDIANS)*

- If it is believed that the young person is suffering from anxiety or depression based on the initial assessment, please see the decision-making trees in the *WHO Adolescent Job Aid: A Handy Desk Reference for Primary Level Health Care Workers* (p. 16 for anxiety and p. 20 for depression)

INFORMATION TO BE GIVEN TO YOUNG PEOPLE (AND THEIR PARENTS/GUARDIANS)

- **Mental health:** *WHO Adolescent Job Aid: A Handy Desk Reference for Primary Level Health Care Workers* (p. 83)
- **Sexual activity:** *WHO Adolescent Job Aid: A Handy Desk Reference for Primary Level Health Care Workers* (p. 82)
- **Violence (including sexual violence):** *WHO Adolescent Job Aid: A Handy Desk Reference for Primary Level Health Care Workers (p. 81)*

* Note that if it is decided that parents/guardians need to be involved, the service provider should be supervised and/or receive support from a person with MHPSS experience.

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