MISP: Adolescents and Sexual Violence Fact Sheet

Why is sexual violence important to consider for adolescents in emergency settings?

During an acute emergency, incidents of sexual violence, including rape, sexual abuse and sexual exploitation, are likely to increase. Adolescents who are faced with poverty or separation from their families or communities as a result of an emergency situation are at risk of sexual violence. They may be coerced to provide sex in exchange for food, clothing, security, or other necessities, or they may sell sex to earn money for what they or their families need. Adolescent girls, especially if they are unaccompanied or have the responsibility of caring for younger siblings, are at risk of rape and SEA because of their dependence on others for survival, because of their limited decision-making power, and because of their limited ability to protect themselves.[14] In addition, young girls may be subject to forced early marriage or trafficking by their families because of economic hardship. Existing sex- and age-related power disparities may become more prominent in an emergency setting. Despite the social upheaval that occurs during a crisis, adolescent girls may be expected to sustain cultural norms, such as modesty and virginity; if they fail to do so, they are at risk of violence from men within their homes or the community.

Adolescent girls are particularly vulnerable to sexual violence:

- during conflict, when rape may used as a method of war;
- during conflict, when adolescent girls may be forced to become child soldiers or sex slaves;
- during displacement from their homes of origin;
- while collecting water or firewood;
- in unsecured or unprotected sanitation or bathing facilities;
- at the hands of military, peacekeepers, humanitarian workers or community members (this includes both sexual assault and sexual exploitation).

Although the majority of GBV survivors are women and girls, men and boys can also be subjected to sexual violence. Marginalized adolescents, such as those with disabilities, migrants, and indigenous adolescents among others are also at risk of SEA.

What are the consequences of GBV among adolescents?

Adolescent survivors of sexual violence are at risk of physical injury, STIs including HIV, unwanted pregnancy and unsafe abortion. In addition to physical injuries, young survivors of sexual violence may suffer severe mental health and psychological problems. It is common for survivors to be blamed for the violence they experience and, as a result, they may experience social stigmatization, be deemed unmarriageable, and be rejected by their own families. In certain cultures, survivors of sexual violence may be seen as having dishonored their families and communities and, therefore, may be at risk of "honor killings" at the hands of their own family members.

What program interventions should be implemented to address adolescent GBV in emergency settings?

It is very important that adolescents be considered and specifically targeted for program interventions as the MISP is implemented. Programs should make efforts to reach out to those sub-groups who are at increased risk of sexual violence in emergencies: orphans, separated adolescents, adolescent heads of household, marginalized adolescents, and children associated with armed forces and armed groups (CAAFAG).

During implementation of the MISP, ASRH program interventions to support the prevention and clinical management of sexual assault in adolescents include:

- *Basic prevention activities:* Firewood and water patrols, well-lit paths to latrines and bathing facilities, and secure and sex-segregated latrine and bathing facilities should be introduced. Safe sleeping arrangements should be ensured, especially for orphans and separated adolescents. Temporary collective centers must be segregated by sex and age.

- *Multi-sector coordination with adolescent participation:* Efforts to prevent and address sexual violence should be coordinated among the health, protection, camp management, community services and security sectors. Examples of multi-sector coordination include:
  - A GBV prevention task force, with representation from the various sectors, community members and adolescents, can identify entry points to reach adolescents and develop prevention messages and strategies that specifically address adolescent vulnerabilities;
  - An inter-sectoral referral system should be developed, so that survivors of sexual violence who present to any sector are referred for health, protection or counseling services, as required;
  - Inter-sectoral meetings should be held on a regular basis to review the numbers, sex and ages of new clients seen by each service and to identify gaps or weaknesses in the referral network.
  - Inter-sectoral efforts should be undertaken to ensure that complaint mechanisms for SEA are in place and are adolescent-friendly.

Adolescent-friendly services: Clinical care for sexual assault survivors should be based on WHO/UNHCR 2004 *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* and should include treatment of physical injuries (or referral, if injuries are severe), post-exposure prophylaxis for HIV (PEP), emergency contraception (EC), presumptive treatment for STIs, hepatitis B and tetanus immunizations, either provision of or referral to mental health and psychosocial support, and voluntary referral to protection and legal services if available. The security of the survivor must always be a priority, and the health or protection sector may need to provide a

CHARACTERISTICS OF ADOLESCENT-FRIENDLY SERVICES FOR SURVIVORS OF SEXUAL VIOLENCE:

- Clinical services for sexual assault survivors should be available 24 hours per day, seven days per week, to avoid delays in treatment; services should be offered free of charge;
- Survivors of sexual violence should be triaged directly to treatment areas to protect their privacy. Alternatively, a separate, discreet entrance to the clinic can be made available, which allows survivors to access the treatment area directly, without passing through registration or the waiting area;
- If possible, the clinical examination of a sexual assault survivor should be conducted by a provider of the same sex. If this is not possible, a person of the same sex should accompany the survivor during the physical examination;
- Vaginal speculum examination may be very traumatic for the immature adolescent and should never be used in pre-pubertal girls. If a speculum examination is indicated (for example, suspicion of a vaginal injury or foreign body), the girl should be referred for specialist care.
- All staff, including registration clerks, guards, and cleaners should be non-judgmental and should be aware of the need to ensure the privacy and respect the dignity of young survivors;
- Services for adolescent survivors of sexual violence should be confidential; parental consent should not be required;
- Health workers should understand that sexual violence may also happen to boys and that male clients should receive the same level of clinical care and respect that female survivors receive.

safe place for the survivor to stay if there is risk of retaliation by the perpetrator and/or re-victimization by the family or community.

- Awareness-raising: All stakeholders, including community members, adolescents, health staff, staff from other sectors, humanitarian agents and security personnel, should be made aware of the problem of sexual violence and the risks faced by women, girls and other high-risk adolescents. Sexual violence prevention strategies should be communicated and information about where help is available and how to access it should be made available. Adolescents should know that confidential services are available for all survivors, regardless of age or marital status.
    - During MISP implementation, this information can be provided through MISP orientation sessions, which should include sessions for adolescents, as well as through IEC materials distributed in the community. Community health workers (CHWs) and traditional birth attendants (TBAs) should also be informed, so that they can link young survivors to services. As the emergency stabilizes, health information and education campaigns can convey these messages with the involvement of adolescents.
    - It is important to raise awareness about SEA among humanitarian personnel, including personnel from UN agencies, peacekeeping forces, and NGOs. **For all humanitarian workers, a zero-tolerance policy for SEA must be enforced.**
    - Other uniformed services (police, military) should be sensitized about GBV and its consequences. The health cluster and the RH Officer should advocate with officials to ensure that zero-tolerance policies are in place for SEA among uniformed personnel.
- Community linkages: ASRH programs should try to link with any networks already existing in the community to reach adolescent survivors and to disseminate prevention messages. For example, CHWs and TBAs can provide information to the community on prevention measures and clinical services available. They may be aware of young survivors of sexual violence in the community and should know how to refer these clients for clinical services as well as legal and psychosocial support. Religious or other community leaders may also be good resources for identifying problems within the community and for disseminating information.

GBV is a broader term that encompasses a wide range of issues, including sexual violence, trafficking, domestic violence, and harmful traditional practices such as female genital cutting (FGC) and forced early marriage. As crisis situations stabilize, other forms of GBV are reported more frequently, although sexual violence continues to be an important problem for adolescents. Once the emergency has stabilized and comprehensive RH services are introduced, multi-sectoral collaboration is important to ensure that:

- GBV awareness-raising and prevention activities are carried out at the community level, with adolescents, with military and peacekeepers, and with humanitarian workers;
- the community and adolescents are involved in developing GBV prevention strategies and improving the mechanisms for handling complaints about SEA;
- staff are trained (or re-trained) in screening for GBV and in sexual violence prevention and response systems;
- appropriate, confidential, ethically-sound data collection, storage, analysis, and dissemination systems have been established;
- the systems to prevent and address GBV that were established during the acute phase are continued and strengthened; and
- the community is involved in referring GBV survivors to health facilities and other support services.

SUGGESTED READING:

1. WHO, UNFPA, UNHCR, *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.*, 2009.
2. WHO/UNHCR, *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* (revised edition), 2004.
3. IASC. *Guidelines for Gender-Based Violence Interventions in Emergency Settings, 2005.*
4. IASC Sub-working Group on Gender and Humanitarian Action *Establishing Gender-Based Standard Operating Procedures (SOPs) for Multi-sectoral and Inter-organisational Prevention and Response to Gender-based Violence in Humanitarian Settings*, 2008.
5. UNFPA. *Sexual Exploitation and Abuse (SEA) Information Sheet*. http://www.humanitarianreform.org/humanitarianreform/Default.aspx?tabid=521
6. Women's Refugee Commission: *"Don't Forget Us": The Education and Gender-Based Violence Protection Needs of Adolescent Girls from Darfur in Chad*, 2005.
7. Women's Refugee Commission. *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations*, 2006. www.misp.rhrc.org
8. UNHCR. *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response*, 2003.