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Gender Based Violence in

Learning Brief: Increasing Attention to Young Girls in Gender-Based Violence Programming

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Introduction

The purpose of this paper is to explore how gender-based violence (GBV) programs in emergency contexts can better address the GBV-related experiences, needs and risks facing girls aged 0-11 years.[1] It first sets out why increasing attention to girls in early and middle childhood within GBV programming is important, then briefly overviews the ways in which this group of girls is impacted by GBV, before looking at potential opportunities for GBV programs to be more responsive to the safety, needs and well-being of this group in emergency contexts. This paper does not seek to reflect or duplicate the work or mandate of child protection actors. Rather, it aims to promote reflection and discussion among GBV specialists on how GBV programs in emergencies might better tailor their services and interventions so that they are more appropriate, relevant and responsive to the needs of girls in early and middle.

Why GBV programs should increase attention to young girls

GBV policy frameworks, standards and guidelines consistently refer to 'women and girls', recognizing that the gender-based discrimination and violence experienced by females occurs throughout the lifespan, from before birth through to old age. In addition to gender, age is recognized as a critical determinant of GBV risks and experience, along with factors such as race, ethnicity, disability, poverty, sexual orientation and gender identity. Yet, the category 'girl' spans a significant period of human development, from infancy through to early adulthood. The social, emotional, cognitive and physical developmental changes that occur at different stages of girlhood between birth to 18 years are profound. The types of GBV that girls are exposed to, their capacity and agency, and the resources available to them also vary significantly across developmental stages of girlhood, during early and middle childhood, as well as during early, middle and late adolescence.

While there has recently been much needed attention given to the vulnerabilities, capacities, needs and rights of adolescent girls in humanitarian emergencies, and to their heightened risk for sexual violence, child marriage, and intimate partner violence,[2] less attention has been paid to the GBV

[1] The focus of this paper is girls aged 0-11. This paper refers to 'girls in early and middle childhood.' Early childhood is defined as birth to 6 years, and middle childhood as 7 years to 11 years. The paper also refers to 'young girls' to refer to this cohort of girls.

[2] See for example Women' Refugee Commission (2016) *A Girl No More: The Changing Norms of Child Marriage in Conflict*; Women' Refugee Commission (2016) *I'm Here: Steps and Tools to Reach Adolescent Girls in Crisis;*

risks and experiences facing younger girls in early and middle childhood, or to the opportunities that exist for GBV programs to better respond to the GBV-related needs, experiences and risks facing girls in this group.

It is important to recognize over the past decade there have been notable efforts by humanitarian actors to improve responses to sexual violence against children in emergency contexts. The *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings* guidance and materials developed by IRC and UNICEF, and the joint GBV Area of Responsibility (AoR) and Child Protection AoR *Child and Adolescent Survivors Initiative* (CASI) are examples of advances in practice within inter-agency humanitarian response aimed at bringing attention to and ensuring child survivors of sexual abuse more consistently and predictably receive compassionate and age-appropriate clinical and psychosocial care.

Despite these and other efforts, and despite the high levels of GBV that girls in this age group are exposed to, anecdotal information indicates there is limited GBV service demand or uptake by younger girl survivors and their families in emergency contexts. Further, there is limited readily available information regarding the extent and ways in which GBV programs are inclusive of strategies to cater to the needs of girls age 0-11. There is also limited research or practice evidence on which to base guidance for addressing safety, needs, risks and rights of younger girls within GBV prevention, mitigation and response as a standard element of programming. This paper therefore focuses on this cohort of girls in an effort to generate reflection and discussion regarding how the GBV community might better center the experiences and needs of girls in early and middle childhood within GBV programming. It seeks to identify opportunities for ensuring that GBV frameworks, programming and services more routinely and adequately integrate a developmental perspective responsive to the distinctive needs and experiences of younger girls.

What is known about GBV and young girls?

Understanding the nature, dynamics and magnitude of GBV against girls up to the age of 11 in emergency contexts, as elsewhere, is hampered by a lack of quantitative and qualitative data. Ethical, safety, methodological and practical issues inhibit research on GBV prevalence, risks and characteristics among girls in early and middle childhood within and across emergencies. Even outside emergency contexts there are significant gaps in data about prevalence of all forms of violence against children of different ages, with "a severe lack of self-report data on any form of violence against children under about 11 years of age and on sexual violence across a range of ages"(Devries et al, 2017, p.11).

Compounding the lack of prevalence data is the lack of reliable data about girls use of and inclusion in GBV services across emergency contexts, making it difficult to ascertain the extent to which girls are currently accessing and benefitting from GBV services. While there is evidence to indicate GBV service uptake by younger girls in some contexts,[3] anecdotal information suggests there is variability

Women' Refugee Commission (2015) *Including Adolescent Girls with Disabilities in Humanitarian Programs*; Women' Refugee Commission (2015) *Empowered and Safe*; CARE International (2015) *"To protect her honour": child marriage in emergencies - the fatal confusion between protecting girls and sexual violence*; Girls Not Brides (2020) *Child marriage within the global humanitarian system*; Population Council's *Girls in Emergencies Collaborative*; UNFPA (2016) *Girls in Disaster and Conflict;* Plan International (2018) *Adolescent Girls in Crisis: Experiences of Risk and Resilience Across Three Humanitarian Settings*; Plan International (2020) *Guidance and tools for adolescent programming and girls' empowerment in crisis settings*; Women Deliver (2018) *Addressing the needs of adolescent girls in humanitarian settings*.

[3] For instance, an IRC report from 2011 indicated in the Central African Republic, nearly half of GBV survivors receiving support from the IRC were girls under the age of 18 and in Sierra Leone, 73% of female survivors supported by the IRC were under 18, with 23% under the age of 11.

across emergency settings; it appears to be the exception rather than the norm for girls in early and middle childhood to be brought to GBV service providers for care and support.

Most publicly available GBV service data and reports from emergency contexts do not disaggregate beyond the category 'child', nor do they provide data on different forms of GBV disaggregated by age, making it difficult to easily undertake analysis across settings regarding the proportion of GBV survivors accessing services who are aged between 0-6 and 7-11 years. The lack of age-disaggregated data regarding the characteristics of GBV and of GBV help-seeking for this age group helps contribute to girls' invisibility within GBV programming. The following section provides an overview of what available data tells us about the extent and dynamics of GBV perpetrated against girls and highlights some issues pertinent to help-seeking for this group.

Extent and dynamics of different forms of GBV against girls in early and middle childhood

Sexual violence

The extent of sexual violence against girls in early and middle childhood in emergency settings is unknown. As with GBV against adolescent girls and adult women, girls may be more likely to experience sexual violence at higher rates than pre-emergency due to magnified risk factors present in emergency contexts. While there is limited reliable data on rates of sexual violence against girls in early and middle childhood in general, available data from different countries suggests that sexual violence is common in the lives of girls globally. Until recently, much of the evidence regarding sexual violence against children came from high-income countries. However, research undertaken in low and middle-income countries indicate that the prevalence and characteristics of sexual violence against girls vary across settings. The landmark WHO multi-country study on women's health and domestic violence found prevalence of sexual violence before the age of 15 years reported by adult women varied from 1% to 21%, with this violence usually perpetrated by a male family member other than a father or step-father (WHO, 2005).

Another study based on meta-analyses of global studies across hundreds of different age-cohort samples reported that 18-20% of girls are estimated to experience sexual violence (Collin-Vezina et al, 2013). Recent data generated by violence against children (VAC) surveys administered by the Centers for Disease Control and Together for Girls in seven countries, found the prevalence of sexual violence in childhood ranged from 4.4% among females in Cambodia to 37.6% among females in Swaziland, with prevalence in most countries surveyed greater than 25% (Sumner et al, 2015).

While much survey data on child sexual violence, including the above, is not disaggregated by age cohorts, some research does help illuminate the extent of girls' sexual violence victimization prior to adolescence. In one review, about a quarter of child sexual violence survivors reported they were first abused before the age of six (Putnam, 2003). According to findings from recent VAC surveys, between 8.5% and 55% of girls who experienced child sexual abuse, experienced the

Box 1. Proportion of sexually abused girls who experienced first incident age 13 or younger

Moldova	8.5%[4]
Lesotho	13.1%[5]
Kenya	18.4%[6]
Zambia	28.4%[7]
Colombia	37.2%[8]
Honduras	54.9%[9]

[4] See https://www.togetherforgirls.org/wp-content/uploads/Moldova-VACS-report_English.pdf
[5] See https://www.togetherforgirls.org/wp-content/uploads/2020/09/Lesotho-VACS-2019_Final-Report-1.pdf
[6] See https://www.togetherforgirls.org/wp-content/uploads/2020-7-16-TfG-Kenya-VACS-report.pdf
[7] See https://www.unicef.org/zambia/sites/unicef.org.zambia/files/2018-11/Binder%20EMAIL%20thursday%20NEW.pdf
[8] See https://www.togetherforgirls.org/wp-content/uploads/2020-3-17_Colombia-VACS-Final-Report-English.pdf
[9] See https://www.togetherforgirls.org/wp-content/uploads/2019-Honduras-VACS-Report-English.pdf

first incident before 13 years of age (see Box 1 for country-specific data generated through these VAC surveys).

It is likely that the true extent of sexual violence against girls in early and middle childhood is not accurately reflected in surveys due to the fact it is a highly sensitive issue that is difficult to explore in survey research (WHO, 2005), and underreported due to stigma, shame, trauma and sampling bias. For example, surveys are unlikely to reflect the distinct experiences of particularly vulnerable girls, such as those with disabilities; those who are homeless, living in institutions or in conflict-affected settings; or those who have been trafficked for domestic servitude or sexual exploitation. In addition, surveys may not capture the dynamics and typologies of different forms of sexual violence to which girls are subjected, such as harmful traditional practices that include sexual relations between relatives (Maternowska et al, 2018), other forms of sexual violence within the family and community, or commercial sexual exploitation.

Child marriage

An estimated 12 million girls are married each year, with emergencies compounding existing drivers of gender inequality, social norms, and lack of opportunities for girls while also creating new risks related to protection concerns and extreme poverty (Girls Not Brides, 2018). Although child marriage is generally less common during middle childhood than adolescence, evidence suggests emergencies can increase the risk of girls being married at a younger age, with girls married as young as 11 years reported in some settings (UNFPA, 2012; Guglielmi et al, 2020). In some settings, conflict, disasters and displacement not only increase risk of child marriage (Girls Not Brides, 2018), but also alter the "social process of marriage, resulting in shorter engagement periods, lower bride prices, changes in cousin-marriage practices and a reduced age at first marriage" (UNFPA, 2020). The changes put younger girls at elevated risk of marriage in some emergency contexts.

Intimate partner violence

Almost a third of all women who have been in a relationship have experienced physical and/or sexual violence by an intimate partner (WHO, 2013). Available evidence indicates that intimate partner violence (IPV) is the most common form of GBV in many humanitarian settings (Murray, 2018). Girls in early and middle childhood are directly harmed by IPV in a number of ways. Firstly, all married girls are at high risk of IPV, with research showing women who married as children are more likely to report past year physical and/or sexual intimate partner violence compared with those who married as adult. This research found the younger the girl is at the time of marriage, the more likely she is to report experiencing sexual intimate partner violence (Kidman, 2017). Secondly, girls – as with boys – are harmed by violence perpetrated against their mothers in the household. This harm occurs not only when girls' witness and/or are targeted at the same time as violence is perpetrated against their mothers, but also due to the effects of the violence on their and their mother's health and well-being. In some settings, there is a gendered dimension to infant mortality linked to intimate partner violence, with research from one context finding that not only is infant mortality greater among infants whose mothers experienced IPV, but that this effect was significant only for girls (Silverman et al, 2011).

Other forms of GBV impacting young girls in emergencies

Emergencies exacerbate existing risks and create new risks for other forms of GBV which directly and/or indirectly impact girls' survival, safety and development. A range of harmful practices in early and middle girlhood are part of the continuum of GBV across the life course of females and that constitute a "silent and endemic crisis" (UNFPA, 2020). It is estimated more than 200 million girls and women alive today have undergone female genital mutilation/cutting (FGM/C), with an estimated 3 million girls at risk globally of undergoing FGM every year (WHO, 2020). The majority of girls are cut before they turn 15 years old, with FGM commonly carried out during infancy (as early as a

couple of days after birth) and during early and middle childhood (WHO, 2020).

Less well researched than other forms of GBV, harmful behaviors linked to 'son preference' may have even more acute impacts on girls in emergencies, threatening their health and development, and even their survival. In contexts where families are facing economic hardship, sex-selection may occur before and at birth, or infant and young girls may be denied food and adequate nutrition, medical care and treatment, or access to education. Research shows that in some contexts where sons are favored over daughters, girls are breastfed for shorter periods of time than boys (UNFPA, 2020), with evidence from sub-Saharan Africa suggesting a substantial gender difference in infant mortality (affecting more girls) following droughts (Flato and Kotsadam, 2015).

Trafficking in emergencies is not well-documented; however, there is evidence that girls under the age of 12 are trafficked for commercial sex work in different countries (ECPAT, 2018), and this is likely to continue as a consequence of displacement, with traffickers taking advantage of the challenge facing families in the aftermath of conflict and disasters. Moreover, evidence from some conflict settings suggests that even very young girls are trafficked for forced marriage to armed fighters, sexual enslavement and assault by military groups (ECPAT, 2020).

Dynamics of GBV against young girls

The vast majority of GBV against girls in early and middle childhood takes place within the family, and to a lesser extent the wider community. It is overwhelmingly perpetrated by someone known to the girl and in familiar locations; the child's home is the most frequently mentioned location for sexual assaults and rape. The neighborhood and schools are also places where young girls experience GBV (Devries et al, 2017). Some girls are at greater risk of exposure to GBV than others. For example, orphanhood and maternal absence have been identified as risk factors for sexual abuse (Maternowska et al, 2018), while poverty, conflict and displacement are risk factors for early marriage (Girls Not Brides, 2018), sex trafficking and sexual exploitation (McAlpine et al, 2016) and intimate partner violence (Murray, 2019).

As with GBV against adult women, GBV experienced by young girls is not about isolated incidents of violence; it "is a fundamental enforcer of male control over young females" (UNFPA, 2020). GBV against girls is structural and underpinned and perpetuated by gender and social norms that afford young girls the least voice, agency or status in the family and community. Social norms surrounding gender, sex, sexuality and violence are compounded by beliefs and attitudes surrounding children and childhood, and serve to keep GBV against girls in early and middle childhood hidden, tolerated or, in the case of harmful practices, even expected. Further, social norms act as barriers to disclosure, help-seeking and perpetrator accountability.

Sexual violence in particular is surrounded by silence, stigma and shame, and it is well established that because of this, many survivors never disclose their experiences, let alone formally report the abuse or seek help from services (IRC, 2011; Nguyen and Kress, 2018). Disclosing sexual abuse in childhood is a sensitive process influenced by several factors, including pressure for secrecy, feelings of responsibility or blame, feelings of shame or embarrassment, or fear of negative consequences (see Box 2). It is important, however, to recognize that context, including cultural and religious factors, influence disclosure rates and patterns, and act as either facilitators or barriers to a child telling someone about sexual abuse (Collin-Vezina et al, 2013).

Box 2. Differences in girls sexual abuse disclosure rates and patterns

Research examining the prevalence of sexual violence, help-seeking behaviors, and factors associated with disclosure among girls in Nigeria and Malawi found while self-reported prevalence

of sexual violence was similar in both countries (Nigeria (26%) and Malawi (27%)), disclosure rates and reasons for disclosure were not similar. Over one third (37%) in Nigeria and over half the girls (55%) in Malawi disclosed their experience of sexual violence. Those in Nigeria were significantly more likely to disclose to their parents (31.8%) than females in Malawi (9.5%). The most common reason for nondisclosure in Nigeria was not feeling a need or desire to tell anyone (34.9%) and in Malawi was embarrassment (29.3%). Very close relationships with one or both parents were significantly associated with disclosure among Nigerian females but were inversely associated with disclosure among Malawian females (Nguyen et al, 2019, p. 1).

Accessing help after GBV

GBV has potentially devastating acute and life-long impacts on girls' health, development and well-being. In addition to detrimental physical and reproductive health outcomes, sexual violence in childhood is a risk factor for future alcohol and other substance misuse, as well as development of mental health problems and disorders including post-traumatic stress disorder, self-harm and suicide (Singh et al, 2014). IPV experience or exposure has well-documented significant short and long-term impacts, including increasing risk of future victimization--girls who witness violence against their mothers, or experience sexual abuse in childhood, are more likely to be victimized by their partners as adults (Abramsky et al, 2011). The physical, mental and reproductive impacts of FGM/C and early marriage are also well established, with the risk of girls dying as a result of early pregnancy and childbirth twice as high for girls aged 15-19 and five times as high for girls aged 10-14 compared to women in their twenties (UNFPA, 2016). Young married girls not only experience physical and reproductive harm, they experience high levels of psychological distress, as findings from research described in Box 3 illustrate.

Box 3. Psychological well-being of married girls

In Niger, a survey of 2,463 women found significantly decreased psychological well-being among girls who married before the age of 15 and dramatically lower well-being among those who married aged 12 or younger. The research found that even in settings where child marriage is normative, marrying very early is associated with negative outcomes and for very young girls forced into marriage the burden of marital responsibilities, including the partner's sexual demands, childbearing and childrearing, led to significant emotional distress and depression (John et al, 2019).

Due to their dependent status, children often have no capacity to act without their parents or other adults, and therefore access to services depends on the knowledge, willingness, resources and capacity of adults to act. Younger girls do not typically have the agency or resources to independently report GBV, or seek help from services. Unless they disclose to someone who is able to seek assistance on their behalf to address the serious harms associated with GBV, younger girls rely on adults around them to identify that GBV has, or is likely to occur, and to act to obtain care, support and protection. Because GBV is commonly perpetrated against girls by members of the family or by someone else known to them, it can be even more challenging for girls to disclose violence. When GBV is committed by those in positions of care or authority, the ability for a child to seek help is significantly impacted, more so for younger girls who lack contact with people outside the household from whom they might seek help.

How an adult responds to a GBV disclosure or concern related to a girl's safety or well-being determines what happens next in terms of care, support and protection provided to the child. When a young girl does disclose GBV, or when GBV is suspected, an adult will usually make the decision about whether and to whom to report the violence and whether and how to seek help. Yet, parents, caregivers and other significant adults in the lives of girls in early and middle childhood may not be

aware of the harms associated with GBV, or familiar with indicators that violence has been perpetrated against a young girl. If they are aware that a girl has experienced, or is at risk of GBV, they may not know what to do, where to turn, or how to best support the child.

As well as adult capacity to act, community norms and practices are critical determinants of responses to GBV perpetrated against girls in early and middle childhood. GBV is often considered a fact of life for girls rather than a rights violation. Customary justice systems that center on compensation and/or restitution for families after a child has been raped, rather than on the safety and well-being of the survivor, exist in some settings, and may influence responses to GBV, including whether the child is protected from further violence. For example, in settings where customary justice dictates a perpetrator of rape should marry a child victim, the girl will be exposed to, rather than protected from, further sexual violence girl who has been raped should marry the is forced to marry the perpetrator. There are other challenges to girl survivors and those at risk of GBV being able to obtain care, support and protection in emergencies. This includes the lack of child-sensitive and child-friendly GBV-related health, psychosocial and safety services.

Opportunities for increasing attention to girls within GBV programming

Given that emergencies are likely to increase the already significant risk of GBV for younger girls, and that there is limited use of GBV services by girls aged 0-6 and 7-11 in emergency contexts, this section explores potential opportunities for optimizing GBV programming in emergency contexts to better address the safety, needs and protection of girls in early and middle childhood impacted by GBV. The opportunities and strategies are not exhaustive, but rather seek to lay the foundation for further discussion and strategizing on how to increase attention to younger girls within GBV programming. Opportunities are explored in four areas:

1. Generating knowledge and sharing information about girls and GBV in emergencies.
2. Providing services for young GBV survivors.
3. Reducing GBV risks in an emergency.
4. Reaching girls experiencing or at risk of GBV.

Generating knowledge and sharing information about girls and GBV in emergencies

Age plays a critical role in defining risk and protective factors for GBV; therefore, prevention and response interventions and strategies must be framed with an understanding of the specific set of experiences and vulnerabilities experienced by girls at different points in their development (Ligiero et al, 2019). Yet, as noted earlier, there is a lack of information within and across emergency settings regarding how girls in early and middle childhood are impacted by GBV and how GBV programs can best respond to the needs of young girl survivors and those at risk. Despite evidence indicating young girls may experience high levels of GBV before and during emergencies there remains limited evidence regarding how to best address the GBV-related needs of young girls in emergencies. Beyond the Caring for Child Survivors of Sexual Abuse guidance, there is little information on promising or effective approaches to responding to the GBV-related experiences and needs of this group. While the Caring for Child Survivors materials provide an evidence-based framework for responding to children who have experienced sexual violence, there remains a lack of evidence-based guidance for frontline response to young girls who have experienced or at risk of other forms of GBV, including early marriage, FGM/C and other harmful practices, such as son preference.

Further, there is little evidence regarding what kinds of interventions and services offered in humanitarian contexts might best promote the safety and well-being of young girls and protect them from GBV. Evidence is lacking for how to best reach and address the GBV needs and risks of the most vulnerable girls - those not able to speak for themselves due their young age, marginalization and invisibility due to disability or other factors heightening their vulnerability. It is

therefore critical that GBV specialists at global and field levels document and share what kinds of service adaptations and interventions work, under what conditions and for which girls in order to build the evidence base and advance practice in GBV prevention, mitigation and response targeting the safety, rights and needs of young girls in emergencies.

While ethical, safety, methodological and practical issues inhibit research on GBV prevalence and risks among girls within and across emergencies, it is vital that knowledge about the extent and nature of GBV against girls in emergencies, and evidence-based approaches to addressing it, are generated and shared in order that this violence does not remain hidden and inadequately addressed. More and better information within and across settings will help build awareness about GBV-related violations of girls' rights, mobilize commitment and resources to address it, and contribute to development of evidence-informed responses to it. Some potential opportunities and strategies for safely and ethically learning more about different forms of GBV against younger girls within and across emergency contexts are set out below.

Global level

Convene a global taskforce on girls and GBV in early and middle childhood in emergencies. A taskforce bringing together GBV, child protection, nutrition, health, child survival, education, adolescent and early childhood specialists could be responsible for identifying knowledge gaps and information priorities, opportunities for joint research and advocacy, and piloting evidence-informed programming.

Document the state of evidence regarding girls and GBV in early and middle childhood in emergencies. Undertake research on girls in early and middle childhood, GBV and emergencies, synthesizing available literature and practice evidence, disaggregated GBV service data and programmatic experience to document what is known about the nature and scope of GBV against girls in early and middle childhood in emergencies, where and how GBV and other sectoral programs are addressing drivers, risks and outcomes of GBV against young girls in emergencies, and what good practices exist.

Explore opportunities for creative use or adaptation of technology for safely learning more about girls' risk and protective factors in emergencies. Explore how existing tools and technology, such as Population Council's Girls' Roster[10] that helps to identify girls at risk and their needs, or Girl Effect's Technology-Enabled Girls Ambassadors TEGA platform,[11] might be adapted for use with younger cohorts. The guidance should look at how to safely incorporate girls into rapid and comprehensive GBV assessments, including safety audits, as well as how to undertake girl-centered formative research to inform intervention design.

Develop practical guidance to support girl-centered information gathering and knowledge generation at the field level. Develop and pilot simple, practical guidance to support field-level GBV actors to safely and ethically collect information about younger girls and their GBV needs and experiences. The guidance should bring together best practice in GBV information gathering in emergencies with best practice in information gathering with and about young children.

Field level

Partner with local women's organizations to plan and implement all GBV assessment and research activities. Women are experts in their own lives and communities and have lived experienced of GBV in girlhood. Partnering with women's organizations at the local level has the benefit of building knowledge among humanitarian GBV actors of women and girls' lived experiences, community

[10] https://www.popcouncil.org/research/girl-roster

[11] https://global.girleffect.org/what-we-do/mobile-platforms/tega/

dynamics and responses to GBV against girls, and building knowledge of women's organizations in humanitarian systems and processes.

Put girls age 0-6 and 7-11 at the center of GBV assessments and research for program design. In stable settings where GBV programs are already established, design formative research for GBV interventions so that research questions and age-sensitive data collection put girls in early and middle childhood equally at the center of knowledge generation and program design. This will require GBV programs to partner with those with expertise in applying different approaches and methods to researching the needs of children at different development stages. Make sure that assessments to learn about availability, accessibility and quality of GBV services, about GBV risk and protective factors, or about social norms that influence GBV help-seeking or perpetration, reflect the specific experiences and needs of girls of different developmental stages.

Collaborate with other sectors to build awareness and optimize girls' visibility within sectoral assessments. GBV specialists can increase awareness and provide technical support to leverage sectoral or multi-sector humanitarian assessments looking at food security and nutrition, health and child survival to collect information about the GBV-related safety, well-being and needs of girls in early and middle childhood in emergencies. Assessments collecting household-level data can offer particularly critical information and proxy measure for GBV related to nutritional and health status of infant girls, in turn indicating gender-based risks facing these girls in emergencies.

Providing services for young GBV survivors

The first step in encouraging GBV service uptake by younger girls is to ensure the services are girl friendly and tailored to provide age- and developmentally-appropriate care, support and protection for girls aged between 0-6 and 7-11. Opportunities for creating girl-friendly GBV services so they are better equipped to address the specific and particular needs of girl survivors aged 0-6 and 7-11 include the following:

Global level

Develop and pilot a girl-friendly GBV service self-audit tool for the field. Such a tool would help frontline services become aware of key elements of a girl-friendly GBV service, assess their services and identify key gaps and strategies for addressing them to build services more inclusive of the developmental needs and stages of younger girls. The tool could be revised and adapted over time as good practices evolve.

Field level

Create girl-friendly facilities/service points. Girl-friendly facilities/service points are those that are provided in a location or manner that is safe, welcoming and comfortable for young girls. Locating GBV caseworkers in places that are accessible to girls or to the adults who regularly interacting with girls, such as early childhood health workers and educators is one strategy for increasing accessibility of GBV services to younger girls. Simple things -- such as putting age-appropriate pictures on the walls, having soft toys to hold for comfort during an examination or interview, supplying paper and pencils for drawing and toys to play with while waiting -- are relatively easy and cost-effective ways of making a GBV service more friendly to a child survivor.

Modify interagency procedures, protocols and referral pathways to reflect age-sensitive principles, guidance and practices for coordinated response to survivors of GBV aged 0-6 and 7-11.

Interagency working groups should review and address girl survivor-related gaps in interagency protocols, including GBV and CP SOPs. The protocols should reflect GBV experiences and risks facing girls in early and middle childhood, and provide guidance to workers who regularly interact with families and younger girls, such as those from the health, education and child protection sectors, on

how to safety refer girls who appear to be at risk of GBV or who disclose GBV.

Adapt GBV service procedures and protocols to be inclusive of girls aged 0-6 and 7-11. GBV service providers need clear guidance when working with girls aged 0-11 and their families. Service and casework protocols should set out:

- practice for responding to different forms of GBV against young girls occurring in the setting, application of legal frameworks and GBV principles including confidentiality, mandatory reporting and best interest of the child when working with clients aged 0-6 and 7-11;
- how to work with families, including protocols for working with family members who are not protective;
- tools specific to working with child survivors, including tools for engaging and communicating with child survivors of different ages about their safety; intake, case planning and referral forms;
- supervision and decision-making in complex cases and case review processes and responsibilities.

Build capability of GBV service providers to engage with girls and their families. Working with children of different ages requires particular attributes, knowledge and specialist skills. Not only does it require expertise in communicating with, interviewing and assessing children of different ages and stages of development, it requires attributes and skills for working with parents/carers and families. GBV programs need to identify and develop capabilities of specialists to engage with girl survivors of different forms of GBV and to work with their families. To be girl-friendly, GBV programs need staff with knowledge and capabilities in:

- early and middle childhood development, including understanding in how children of different stages process information and respond to traumatic events;
- communicating and undertaking assessments with children of different ages, including skills in using age-appropriate language and concepts and in managing conflict and difficult conversations with parents/carers;
- trauma-informed and culturally competent engagement with girls aged 0-6 and 7-11 ages;
- working with marginalized girls, including those with disabilities, which may require particular communication skills;
- working with parents, including when the perpetrator is a family member and when parents are not protective;
- referral protocols and safe and ethical information-sharing between service providers, and informed consent and best interest of the child.

Develop and offer interventions for children of women attending GBV services. In adult-focused services, the needs of children can be less visible. Viewing children of GBV survivors as service clients in their own right offers opportunities for identifying concerns regarding well-being, needs and risks facing younger girls, and opportunities for therapeutic and gender-specific early intervention for young boys and young girls exposed to violence against their mothers in the household. Providing childcare and other services to children could potentially also increase accessibility of GBV or related services to particularly vulnerable young women, such as young mothers, by enabling their attendance at safe spaces and participation in educational, therapeutic or skill-building programming. GBV programs could:

- Collaborate with health and early childhood programs to deliver health and developmental screening of infant girls and provide information to mothers in settings where there are concerns regarding discriminatory or harmful practices against infant and young girls such as withholding of nutrition or health care or FGM.

- Deliver therapeutic interventions tailored to girls who have witnessed or been otherwise harmed by IPV or other forms of GBV. These could include structured or play-based interventions and serve to identify risks and initiate follow-up where there concerns about or indicators of harm.
- Ensure trained GBV workers engage with, assess and provide information to young girls whose mothers or sisters are receiving GBV services.
- Deliver educational and life-skills programs tailored to primary-age girls to build their confidence, knowledge and skills about their health, bodies, safety and rights, and to connect them with safe, trusted adults in GBV services with whom they can ask questions and communicate concerns.

Reducing GBV risks

Opportunities exist in emergencies for reducing factors that increase exposure to GBV, as well as for identifying and increasing factors that protect against GBV. Strategies for identifying and addressing risk and promoting factors linked to younger girls' safety and well-being in humanitarian contexts include:

Advocate for and support age-sensitive GBV mitigation across sectors. The GBV Guidelines provide comprehensive guidance on sectoral risk mitigation; however, the guidance does not specifically focus on risks facing younger girls. Opportunities exist for GBV workers to do advocacy across the humanitarian system and provide technical support to other sectors to support age-sensitive approaches and strategies for GBV risk mitigation reflective of and responsive to the specific experiences and needs of girls between the ages of 0-6 and 7-11 which may otherwise remain invisible.

Adapt safety audit and community safety planning tools and methods to be inclusive of girls ages 0-11. GBV programs could convene multi-disciplinary teams incorporating practitioners and community experts in in GBV, child protection, child health, survival and development, and education to adapt tools and methodologies for implementing culturally safe and age-appropriate risk and safety assessments and designing and implementing community safety plans, ensuring an appropriate level of participation by girls aged 7-11 in community safety assessments and plans.

Partner with other sectors to design targeted interventions to reduce risks for prevalent forms of GBV experienced by girls 0-6 and 7-11. Families, parents and other carers are primarily responsible for the safety, protection and well-being of young girls aged under 11, and GBV programming in emergencies should work with community members and other sectors to put younger girls at the center of design, targeting and implementation of programming, including social protection programming, to reduce GBV risks facing young girls. For example in settings where son preference may mean infant girls receive less access to nutrition or healthcare, partner with food or social protection services to ensure targeting to and monitoring of vulnerable families to provide supplementary feeding or other safety net interventions appropriate to the context, such as cash transfer. In settings where child protection or other actors are developing parenting programs, GBV programs can partner with them to ensure they are designed and delivered in manner that is sensitive and responsive to GBV concerns in families, including intimate partner violence, son preference and other discrimination against girls.

GBV programs should look for opportunities to partner with those providing direct services to girls, such as formal and informal early and primary education programs, child-friendly spaces, community centers, or other services that work with children to ensure that these services not only prioritize and protect girls' safety, but that their services, including education and life-skills programming, are

tailored to the experiences, needs, risks and circumstances of girls aged 7-11.

Reaching girls experiencing or at risk of GBV

As noted earlier, young girls have limited capacity to independently seek support if they have experienced or are at-risk of GBV. This capacity may be even more constrained in emergency contexts where girls' mobility or engagement with others outside the household may be further limited. Ensuring adults who regularly interact with girls during early and middle childhood have the knowledge and capacity to appropriately respond to GBV disclosure or concerns is therefore vital to helping girls' access GBV services and supports. Strategies GBV programs could adopt to help better identify and reach girls who have experienced or are at-risk of GBV include:

Increase capabilities of community members and others regularly interacting with girls to identify and respond appropriately to those who may be at risk or have already experienced GBV. This would include mapping who young girls 0-6 and 7-11 do have contact with--such as parents, carers, extended family, community members and workers the household, such as neighbors, community groups and networks, maternal and child health workers, community health workers, clinic and hospital workers, child-friendly space workers, child helpline workers, teachers, early childhood workers, teachers, etc.--and ensuring those adults are informed about:

- prevalent forms of GBV impacting girls aged 0-6 and 7-11 in the community;
- indicators that a girl may be experiencing or is at-risk of a particular form of GBV;
- how to seek help when GBV is disclosed or suspected in relation to a young girl.

Identify opportunities for co-locating GBV workers within other services engaging with girls and their families. Put GBV workers in services where they can engage with and build relationships with younger girls, including schools and child-friendly spaces. Have GBV workers build relationships with and do outreach work at places where GBV against young girls may be reported such as police stations.

Build girls' knowledge and ability to seek help. While it may be challenging to reduce all the barriers girls face in disclosing GBV and seeking help, it is possible to make sure that primary school-aged girls have age-appropriate information about what to do if they feel unsafe or need help. Providing appropriate information to girls attending school may be done through teachers, school focal points, girls clubs, child friendly spaces, or within other programs engaging primary school-aged girls.

Target at-risk and vulnerable girls. Some groups of girls are likely to be at higher risk of GBV and it is important that efforts are made to reach these girls with information, and to facilitate their access to a safe adult to whom they may disclose and receive help. Find ways for GBV workers to partner with other services to do outreach to particularly vulnerable families and women, by working with community health, maternal and family health workers providing services to very young married girls; disability service workers; workers supporting women engaging in sex work and their children; services for unaccompanied or separated girls and other groups of marginalized young women and girls.

Conclusion

Despite their vulnerability, there is currently very limited information regarding the GBV-related experiences, risks and needs of girls aged 0-11 in emergency contexts or how GBV services in humanitarian settings can best serve, support and promote the interest and rights of this group of girls. This paper has provided a high-level overview of issues relevant to the GBV-related experiences, needs and risks facing young girls in emergencies, and highlighted some potential opportunities for GBV programs to better serve the needs and interests of this cohort.

In particular, the paper calls for the generation and sharing of more and better information within and across settings to help build awareness about GBV-related violations of girls' rights, mobilize commitment and resources to address it, and contribute to development of evidence-informed approaches to prevention and response. The paper also identifies the need to tailor GBV services so they can deliver age- and developmentally-appropriate care, support and protection for girls aged between 0-6 and 7-11 who have experienced or are at-risk of GBV. Two further areas explored include opportunities for better integration of young girls' vulnerabilities and experiences within GBV risk mitigation, and the importance of implementing strategies for reaching those girls who may be most vulnerable yet least visible.

While some key issues have been surfaced in the paper, there remains a need for further reflection and discussion among GBV specialists on how GBV programs in emergencies may become more appropriate, relevant and responsive to the needs of girls in early and middle childhood. Advancing efforts to better serve young girls in GBV programs will require development of guidance and support for facilitating ethical and safe participation of girls aged 7-11 in GBV assessments, and fostering of specialist expertise within GBV programs to work with young girls. In developing guidance and capacity, there is scope to learn from and adapt good practices from non-emergency settings in relation to effective prevention and response to GBV against girls, including harmful traditional practices. There is also scope for GBV specialists to explore new and innovative partnerships, including with local women's organizations, other humanitarian sectors, and non-traditional partners in efforts to draw attention to and learn about the GBV-related needs and rights of young girls in humanitarian contexts, and to trial evidence-informed strategies to promote their care, support and protection.

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The GBV AoR Helpdesk

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