unicef
for every child

Girls in the First Decade

A SCOPING STUDY ON MHPSS-GBV INTERVENTIONS FOR GIRLS 0-11

OCTOBER 2023

ACKNOWLEDGEMENTS

UNICEF would like to thank the participants who took part in the key informant interviews, who offered their time generously, and who made this study possible. This project was funded by the German Federal Ministry for Economic Cooperation and Development (BMZ) and supported by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. The scoping study and report were led by Meghan O'Connor with support from Gretchen Emick.

Supported by the

TABLE OF CONTENTS

I. BACKGROUND

There is a dearth of data on the nature, dynamics and magnitude of GBV against girls in the first decade (age 0-11) in humanitarian settings.[1] Even outside humanitarian contexts there are significant gaps in data about the prevalence of all forms of violence against children under the age of 11; data that does exist is often not disaggregated according to age and gender.[2] What we do know from existing data is that GBV against girls in the first decade is largely perpetrated by someone known to the girl and in familiar locations.[3] Furthermore, there is limited information about the extent to which younger girl survivors access GBV services in humanitarian contexts and limited readily available information regarding the extent and ways in which GBV programs are inclusive of girls 0-11 or if their needs are addressed through programming provided by other sectors that reach children in this age range.[4] What we do know about violence against girls globally suggests that girls in this age range are experiencing and are at risk of sexual violence- including child sexual abuse and sexual exploitation, early and forced marriage and intimate partner violence.[5, 6, 7]

In the past 10 years there has been a significant focus on adolescent girls and their exposure to GBV, tailoring services to meet their needs, and creating programming that seeks to prevent and reduce their risk of GBV. At the same time, there is also increased awareness of the importance of addressing the mental health and psychosocial support (MHPSS) needs of GBV survivors.[8] However, such interventions and program models are generally for girls starting from age 10. A systematic review for MHPSS interventions for survivors of GBV in conflict-affected settings 2013 found no studies with young people under 14 years old.[9] More recent humanitarian initiatives are bringing more attention to the needs of child sexual abuse survivors, including the Child and Adolescent Survivor Initiative (CASI) and the revision and update of the Caring for Child Survivors (CCS) resource package.[10] The recent desk review Mental health and psychosocial support for survivors of gender-based violence in humanitarian settings[11] includes a learning brief on addressing the MHPSS needs of child and adolescent survivors, in which it highlights significant gaps in practice and coordination amongst GBV, Child Protection (CP) and MHPSS actors in providing MHPSS services to child and adolescent survivors.

---

1 GBV AoR Helpdesk (2020). Learning Brief: Increasing Attention to Young Girls in Gender-Based Violence Programming.

2 Devries et al (2017). Who perpetrates violence against children? A systematic analysis of age-specific and sex-specific data', BMJ Paediatrics Open, 2(1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5842994/

3 GBV AoR Helpdesk (2020). Learning Brief: Increasing Attention to Young Girls in Gender-Based Violence Programming.

4 Ibid.

5 Devries, K., Knight, L., Perzonld, M., Merrill, K., Maxwell, L., Williams, A., Cappa, C., Chan, KL., Garcia-Moreno, C., Hollis, N., Kress, H. Peterman, A., Walsh, S., Kishor, S., Guedes, A., Bott, S., Butron Riveros, B., Watts, C. and Abrahams, N. (2017) 'Who perpetrates violence against children? A systematic analysis of age-specific and sex-specific data', BMJ Paediatrics Open, 2(1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5842994/

6 Girls Not Brides (2018) Child Marriage in Humanitarian Settings Thematic Brief, Girls Not Brides, https://www.girlsnotbrides.org/wp-content/uploads/2016/05/Child-marriage-in-humanitarian-settings.pdf

7 Ligiero, D., Hart, C., Fulu, E., Thomas, A., and Radford, L. (2019) What works to prevent sexual violence against children: Evidence Review, Together for Girls, togetherforgirls.org/svsolutions

8 The 2022 Interagency Standing Committee MHPSS Minimum Services Package outlines the key MHPSS services that should be provided to GBV survivors.

9 Devries et al (2017). Who perpetrates violence against children? A systematic analysis of age-specific and sex-specific data', BMJ Paediatrics Open, 2(1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5842994/

10 IRC & UNICEF (2023). Caring for Child Survivors of Sexual Abuse. UNICEF https://www.unicef.org/documents/caring-child-survivors-sexual-abuse (Revisions on-going at the time of publication of this

11 Global Women's Institute and Trocaire (2022). The Mental health and psychosocial support for survivors of gender-based violence in humanitarian settings: A Desk Review.

II. PURPOSE OF SCOPING STUDY

To address some of these gaps in knowledge and practice, UNICEF's GBV in Emergencies and MHPSS teams carried out a joint scoping study to document existing gaps and best practices in how GBV and MHPSS programs are addressing the needs of girl survivors of GBV in early and middle childhood. Through a literature review and key informant interviews, the scoping study sought to answer the following questions:

- What are the elements of interventions and best practices that have effectively provided GBV+MHPSS services to girls ages 0-11 who have experienced GBV?
- What are the current gaps in both GBV and MHPSS programming to address the needs of girl survivors ages 0-11?
- What are potential opportunities for GBV and MHPSS programming to address the needs of girl survivors ages 0-11?
- How might these opportunities and best-practices extend to address sexual violence in boys in the same age group, building stronger linkages between GBV, MHPSS and CP programming?

For the purposes of the study, GBV for girls 0-11 was defined as sexual violence, intimate partner violence, forced and early marriage; boys 0-11 sexual violence only. Mental health was defined as emotional, psychological, and social well-being.[12]

III. LITERATURE REVIEW

The literature review sought to identify elements of interventions and best practices that have effectively provided GBV+MHPSS services to girls ages 0-11 who have experienced GBV. It also sought to consider how these practices can extend to address sexual violence against boys of the same age.

A. Methodology

Data collection

Sources for the literature review included the following: academic journals with primary research, academic reviews with secondary research (e.g. evidence reviews, metanalyses); non-academic published reports, briefs, and reviews of both primary and secondary research.

The PICO framework (Population, Intervention, Comparison, Outcomes)[13] was used to outline inclusion and exclusion criteria (see Table 1 below). Source material from high income countries was selected only: 1) if it included conflict-affected/refugee populations; and/ different combinations of criteria across these categories were used to maximize transferable evidence and learning. A total of 80 articles were screened of which 33 met the criteria for inclusion. The majority of the included articles were published academic literature, primarily meta-analyses. Non-academic literature included were published reports by organizations that included both primary and secondary research. Annex 1 provides a summary of the articles included.

[12] https://www.unicef.org/media/73726/file/UNICEF-MH-and-PS-Technical-Note-2019.pdf.

[13] https://academy.pubrica.com/research-publication/systematic-review/what-are-the-pico-elements-in-systematic-review/

Table 1: PICO Framework for Literature Review

POPULATION	Included	Excluded
	• Girl survivors ages 0-11 • Girl survivors where intervention includes portion of age range 0-11 and may include ages above 11 up to age 15 • Interventions that target girls more broadly in age ranges 0-11, including prevention programs • Interventions that target girls more broadly and may include girls up to age 15, including prevention programs • Interventions that target children ages 0-11 and may include children up to age 15 where there is an equal or greater proportion of girls, including prevention programs. • Interventions that target caregivers in which children 0-11 can also be present • Interventions that target boy survivors of sexual violence ages 0-11	• Interventions in which target population is only boys and is outside target scope: no history of experiencing sexual violence and above age group 0-11
INTERVENTION	**Included**	**Excluded**
	• Intended outcome or purpose of the program articulates mental health and/ or well-being • Intended outcome or purpose articulates safety, but strategies to promote mental health and wellbeing are included	• Interventions that do not reference mental health/ well-being/ safety (as it relates to mental health and well-being as intended outcomes
COMPARISON GROUP (Types of evaluation)	**Included**	**Excluded**
	• Studies or research that have quantitative measures and or qualitative measures. • Studies that use comparison groups • Studies that use pre and post intervention measures. • Studies that measure post-intervention • Reviews of studies meeting the above criteria	• Studies or reports that do not have an evaluation component.
OUTCOMES	**Included**	**Excluded**
	• Measures outcome related to mental health and/ or well-being and/or safety	• Outcomes measured are outside scope of mental health, well-being and/or safety • No outcomes measured

Data Analysis

The literature was analyzed according to elements of interventions in order to identify common themes, best practices and gaps of the reviewed interventions:

- **Location:** In what type of setting was the program/ intervention provided (e.g., clinic, safe space, community center)
- **Access/ entry point**: How did the program/ intervention access girls 0-11 survivors? Directly? Indirectly?
- **Criteria for participation:** Were there specific criteria for participation in the program intervention?
- **Type of service received:** What service/intervention did girls 0-11 receive? Did it facilitate disclosure of GBV and/ or respond to GBV and its mental health impacts?
- **Ingredients of the program:** What were the general topics/ strategies used?
- **Delivery agent:** What was the background of the person delivering it - professional background, training provided, supervision provided?
- **Length/intensity:** How many sessions did the program entail, and over what period of time?
- **Caregiver engagement:** To what extent and how were caregivers engaged?
- **Outcomes:** What were the expected outcomes? How were they measured? To what extent were outcomes achieved?

The analysis also included identifying relevant challenges /gaps as well as recommendations or best practices the source material highlighted for consideration.

Limitations of the literature

Documentation of and evidence for interventions targeting girl GBV survivors 0-11 is sparse for low and middle-income contexts, and in particular for humanitarian contexts. This is also the case for boy survivors of sexual violence in this age range. Due to this significant gap in the literature, the review also included broader interventions inclusive of but not limited to girls ages 0-11, interventions with this age group but not specific to GBV survivors, as well as interventions targeting caregivers of children in this age range. Below is a summary table of the main categories of interventions reviewed in the literature as well as their limitations with respect to the scope of the review.

Table 2: Summary of literature and its limitations

CATEGORY OF INTERVENTION AND DESCRIPTION	Number of articles	Limitations
GBV interventions: Interventions with an identified focus on GBV prevention, risk mitigation or response targeting girls survivors and at risk of GBV, inclusive of but not specific to ages 0-11. The primary entry point is GBV programming / service providers.	**6** Includes: • 4 development settings • 2 humanitarian settings • 5 target GBV survivors • 1 prevention focused on early marriage • 2 systematic reviews	Participation age of girls was usually 10 or higher. Even when girls lower than age 10 were included, the age range was quite varied, for example from ages 4-18.
Child-focused interventions: Interventions targeting children ages 0-11 or older with an identified focus on mental health and/or child protection. These were not gender specific and the age range for participation was mostly middle childhood ages 5-11. The entry points for these programs were child protection programs (in humanitarian settings) or education programs/schools (in development settings).	**18** Includes: • 9 humanitarian settings (Five included analysis of specific interventions in a defined setting), • 8 from development settings • 1 High income context • 6 articles included specific evaluation studies • 12 systematic reviews	Outcomes not reported on by age or gender. Not clear extent to which participants may have experienced GBV or whether GBV was disclosed during the program.
Caregiver interventions: Interventions targeting female and male caregivers with an identified focus on parenting skills. Girls / children ages 5-11 were secondary beneficiaries. These were mostly accessed through child protection or education programming. Interventions targeting mothers or caregivers with infants and young children who may be at risk of malnutrition. Infant Young Child Feeding (ICYF) and Maternal Child Health (MCH) interventions include focus on mother's mental health which translates to child's healthy 62development. The entry point for this programming was health and more specifically nutrition programming.	**9** Includes: • 1 development settings • 8 humanitarian settings • 6 parenting interventions • 3 mother-child interventions • 1 systematic review	Outcomes for children not reported on by age or gender. Not clear extent to which children of participants may have experienced GBV.

Systematic reviews and meta-analysis

Of the 15 systematic reviews and meta-analyses included, one was a child focused intervention focusing on high income countries while the rest focused on humanitarian and development settings. A total of six reviews were included from the UNICEF Review "Mental Health and Psychosocial Support for Children in Humanitarian settings: An updated Review of Evidence and Practice." The systematic reviews included a total of 292 articles. Some articles across the systematic reviews concerned the same studies, therefore, the actual studies reviewed is likely slightly less than 292. An additional four systematic reviews from High Income Countries were not included in the literature review but could provide further considerations for practices and approaches that may be translatable to humanitarian and development contexts.

B. Findings from the Literature Review

The findings related to the elements of interventions are presented in the table below. The three main categories of interventions found in the literature—interventions with a GBV focus targeting girls, interventions targeting children and interventions targeting caregivers—are used to organize the findings and highlight differences as well as commonalities across these interventions.

Element of intervention	GBV Intervention	Child-focused intervention	Caregiver Intervention	Common themes
Location	WGSS Separate spaces in schools	Child friendly spaces Community centers	Community centers Health clinics for interventions targeting mothers with infants/ toddlers	Privacy Safety Confidentiality
Access/ entry point	GBV organizations/ service providers	Child protection programs MHPSS programs Education programs	Health systems and services, school systems, and protection programming offered in the community	Effective entry points for youngest survivors. Gaps in access

Element of intervention	GBV Intervention	Child-focused intervention	Caregiver Intervention	Common themes
Criteria for participation	Must be a girl Age range – mostly adolescence 10-19. Assumption is that girls in all age ranges face risk of GBV, so qualify for the program.	Age 5 and above Some interventions assume a level of risk for violence, and a level of need with respect to MHPSS because of contextual factors. Manualized mental health interventions had set criteria including known or disclosed experiences of trauma or violence, or emotional or behavioral symptoms that met the pre-set criteria.	Must have children in the age range of 0-11 Other criteria which varied across programs: known or disclosed use of verbal or physical violence with their children; experience of displacement; their own experiences of violence; an interest in participating in the program. Mothers with children ages 0-2 at risk of malnutrition or with concerns related to attachment.	Criteria not specific to girls with histories or experiences of GBV.
Type of service received	Group-based interventions related to risk mitigation and prevention of GBV. No articulated intention to facilitate disclosure of GBV.	Individual interventions to address behavioral or emotional difficulties. Group interventions to build resilience, facilitate safety.	Group interventions focused on reduction and prevention of parents use of physical and emotional abuse as well as building skills of parents to support the well-being of their children. Group interventions focused on providing psychosocial support to mothers and health and nutrition support to their children.	Not focused on responding to GBV. No articulated intention to facilitate disclosure of GBV.

Element of intervention	GBV Intervention	Child-focused intervention	Caregiver Intervention	Common themes
Ingredients of the program	Curriculum-based or use of semi-structured group sessions focused on life-skills, empowerment and GBV awareness raising.	Curriculum-based or use of semi-structure group sessions to provide education related to trauma and violence; education and skills-building on emotions and feelings; education on body safety and healthy relationships. Manualized individual sessions with children drawing from Cognitive Behavioral Therapy modalities largely focused on education and skills-building related to emotions / feelings and their connection to behavior.	Curriculum based group sessions focused on positive parenting skills. Curriculum-based or semi-structured group sessions targeting mothers of infants and toddlers with content on health, nutrition, early childhood brain development and mental health for themselves and their children. Individual support provided as needed.	Mostly content not specific to GBV. Content not differentiated based on individual experiences of trauma or violence. Content not differentiated for gender of children. Caregiver content not differentiated for gender of children.

Element of intervention	GBV Intervention	Child-focused intervention	Caregiver Intervention	Common themes
Delivery agent Non-specialist – defined as someone who may have an educational background or experience in GBV, child protection or mental health programming but without formal specialist mental health training Or could be community staff or facil-itators who have received training Specialist – defined as someone with advanced education and training in mental health	Delivered by non-specialists Staff received training in the specific intervention they were expected to deliver.	Individual and group delivered by non-specialists Manualized mental health interventions delivered by non-specialist staff with remote supervision and support from specialized mental health professionals.	Caregiver inter-ventions delivered by non-specialists. Specialized mental health support available for individual support in mother-child intervention.	Delivery mostly through non-specialists. With the exception of the manualized mental health interventions, supervision protocols were not explained.
Length/ intensity	Semi-structured groups 4-8 weeks. Curricula with 12-16 sessions (1 session per week)	Child friendly space groups – no set length Manualized mental health interventions for children ranged between 12 and 20 sessions	Curriculum-based parenting inter-ventions also ranged between 12-24 sessions depending on the context.	Varied widely depending on design

Element of intervention	GBV Intervention	Child-focused intervention	Caregiver Intervention	Common themes
Caregiver engagement	Consent / permission from caregiver	Consent / permission from caregiver Parallel programming for caregivers to support their child's well-being.	N/A	Programs did not indicate whether a participating caregiver was assessed or identified to be an "offending" or "non-offending" caregiver prior to engagement and participation.
Outcomes	Primary outcomes related to safety and empowerment. Secondary – well-being	Manualized mental health interventions had the most clearly articulated outcomes focused on presence and absence of emotional and behavioural difficulties, skill development in managing emotions and stress; and behavioral changes.	For parenting programs outcomes related to decreasing caregivers' use of violence as a form of discipline and increase in uses of positive parenting techniques which were inclusive of mental health outcomes for children. For mother-child nutrition programs outcomes related to mother's psychosocial status and child's nutrition and development status.	Varied based on the target and design of the program. Outcomes were measured varied as well. Some impact evaluations of curriculum based interventions

Major challenges and gaps cited across the literature included (not specific to reaching girls 0-11):

- No programs with specific methods to create access for the youngest girl and boy survivors or their caregivers in need of interventions, rather programs focused on psychoeducation, recognition of symptoms, prevention and risk mitigation.
- Inconsistent participation of children and caregivers due to contexts of displacement, livelihoods needs, social norms and stigma.

- Training staff to facilitate interventions and the supervision required for the delivery of interventions.
- Carrying out ethical research on interventions with children, particularly in a younger age range.
- Resource limitations as described in Table 2 above.

Recommendations for consideration included the need for more research in order to better evaluate impact and replicate evidence-based programming; investment in multi-level and multi-modal interventions; and the need for greater and more sustainable funding for these types of interventions.

C. Discussion of Literature Review Findings

The literature review highlighted **several key gaps** in GBV/MHPSS programming for girls in the first decade:

- **Programming entry points do not facilitate access for young girls.** The youngest girls are unlikely or unable to directly disclose or access programming that addresses GBV. GBV services do not have tailored, developmentally appropriate programming for girls in this age range and Child Protection programs, caregiver interventions through schools, health and nutrition centers lack the training and expertise on GBV and gendered responses to violence. This likely results in the youngest girl survivors falling through the cracks of these various areas of programming. In turn, this results in gaps in existing literature because there are not interventions specifically targeting this age range of girl or boy survivors.
- **Lack of programming specifically targeting girls ages 0-11.** Because of the importance of GBV survivor safety and confidentiality, it is not surprising that there is little documentation of interventions specifically targeting girl GBV survivors 0-11. The articles that were reviewed were inclusive of girls at the older end of this range and more geared to adolescent girls. However, more surprising is the lack of literature on programming and interventions that are specifically designed to target girls more generally in this age range—interventions which are likely inclusive of GBV survivors but do not target them explicitly.
- **Lack of programming with developmentally tailored content for GBV.** Despite the availability of programming that speaks to the experiences of adolescent girls and their experiences of GBV, only one program targeted toward younger girls articulated age appropriate content or interventions for the youngest survivors of GBV in Humanitarian settings. This intervention was specific to girl survivors of sexual exploitation living in a residential center.
- **Lack of intervention data on girls 0-11.** The lack of data surfaced in several ways. First, there is an overall lack of data on interventions that specifically target girl survivors in the first decade. For example, GBV and child protection case management services are likely reaching girls ages 0-11 but there is little documentation of these interventions perhaps because they are hard to measure and to research. Additionally, because services are typically inclusive of GBV survivors but do not solely target them, there are no evaluations of interventions addressing GBV survivors in this age range.

  Second, existing program evaluations have not documented or evaluated the elements of their interventions and outcomes according to age and gender. For GBV interventions, more attention should be paid to the different stages of childhood and adolescence and collecting data according to these categories. Interventions targeting children should disaggregate intervention data based on smaller age groups and gender. Caregiver

interventions should also document the age and gender of the children who are secondary beneficiaries.

- **A lack of intervention content based on a gender analysis.** In interventions targeting children 0-11 and caregivers of children in this age range, the content delivered lacked differentiation based on a gender. A gender analysis should inform whether and how the content and approach of material needs to be different based on the intersection of age and gender.
- **A lack of content based on development stages.** Few interventions provided differentiated content based on age, which is likely to be important given the wide range of developmental stages captured in the age range 0-11. Few child-focused interventions targeted children in the age range 0-5. Mother-child interventions that focus on infant and young child nutrition and development generally targeted children ages 0-24 months. The age range of 3-5 was not included in either of these categories of interventions.
- **No clear articulation of protocols for handling disclosures of GBV or sexual violence.** Few of the articles identified clear protocols for responding to disclosures of GBV or sexual violence in the case of boys. Given the likelihood of girls being at risk of and having experienced GBV, interventions should have clear protocols for responding to such disclosures and ensure that staff are trained to do so. This is particularly important for interventions that are designed to address experiences of trauma and violence as well as those aimed at addressing behavioral and emotional difficulties that may be symptomatic of experiences of trauma and violence. While the lack of documentation of protocols does not mean they did not exist a part of the interventions reviewed, it perhaps signals it was not considered essential or important.
- **No clear procedures handling disclosures involving caregivers as perpetrators who are already involved in interventions or programs with their child.** Interventions reviewed that targeted girls and/or boys more broadly, caregivers of girls and boys and caregivers and children together do not have a process for identifying if they have offending caregivers engaged in their interventions. There is also no articulated process or best practice for how to respond if a disclosure happens once the caregiver is already engaged in the interventions with their child. Given the importance of caregiver engagement in this developmental period, but also the reality that violence experienced by girls in this age range is most commonly perpetrated by someone known to the girl and her family, it is critical to further understand and provide guidance on appropriate methods of caregiver engagement.

Despite the significant gaps in evidence and the clear need for continued work to build the evidence base for providing on MHPSS services to girl survivors GBV and boy sexual violence survivors 0-11 years, some promising findings did emerge. Common trends in practice across the literature are:

- Interventions are delivered in spaces that offer privacy and confidentiality (if an individual intervention).
- **Interventions can be done by non-specialists.** Interventions across type were delivered by those who are not-MHPSS specialists, including teachers, paraprofessionals, and GBV staff. Even individual manualized mental health interventions based on Cognitive Behavior Therapy modalities were implemented by staff and volunteers in humanitarian and development settings with paraprofessional training, rather than formal degrees. Staff may have had relevant education background or experience and were trained in the intervention they delivered.
- **Interventions are sequenced and carried out over a specific timeframe.** While the content being delivered varied, the structure of the interventions was largely similar -

individual sessions or group sessions in which content is sequenced and carried out over a specific time frame. Session delivery ranged between 4-24 weeks depending on the focus of intervention. Consistent participation was a requirement of the intervention and group interventions were closed once they began- meaning membership stayed the same throughout the intervention.

- **Thoughtful caregiver engagement facilitates access to girls and has the potential to support the well-being of girls in this age range.** Across interventions, caregiver engagement was important for accessing girls in this age range allowing them to participate in interventions. Interventions specific to GBV survivors that were reviewed did not discuss the role that caregivers played beyond informed consent processes- which may suggest that caregivers were not involved beyond informed consent.

  On the other hand, most child-focused interventions specifically worked with caregivers in parallel with children. Individual interventions engaged caregivers in parallel processes of learning and skill development. Group interventions with children engaged parents to varying degrees but also focused on parallel processes of learning and skills development in order to support the safety and well-being of their children. Evaluations of these interventions showed positive outcomes for children's mental health.

  Evaluated interventions directed at caregivers also showed positive mental health outcomes for caregivers and their children who were secondary beneficiaries. These interventions target female and male caregivers with parenting and family relationship skills and are largely framed as interventions to prevent and reduce children's risk of violence. There are also examples of evaluated interventions that targeted pregnant women and mothers of infants and young children (ages 0-2 years) with health and mental health support. These interventions facilitated better early childhood development outcomes across physical, cognitive and social aspects of children's development as well as positive mental health outcomes for the women participating. Building in awareness and psychoeducation on child sexual abuse could increase access to these critically under accessed children. The potential for embedding targeted programs for the youngest survivors in these settings could be further explored as could targeted programming for parents with concerns, leading to a smoother referral process and greater access for these children and their parents.

  Despite this positive evidence, more analysis and research is required to better understand how to safely engage caregivers in interventions that are likely to include girls who have experienced GBV, and in how to best manage situations in which caregivers engaged in programming disclose perpetration of GBV. While best practice guidance for GBV programming is that only non-offending and supportive caregivers should be engaged in services for GBV survivors,[14] this is not a practice that other sectors have adopted. For example, parenting programs largely target all parents without procedures to address disclosure or identification of GBV during the intervention.

There are two additional themes from the literature that require further query and research:

- **It is not clear what the best entry points are for girls and boy survivors in the first decade, particularly those in early childhood.** From the literature reviewed, young child survivors are falling through the cracks in both GBV programming and child-focused programming. Given that younger girls and boys are unable and/or unlikely to directly disclose abuse, more consideration should be given to the potential of accessing such children through programming that targets their caregivers and that accounts for the

[14] IASC (2017) Gender-Based Violence Case Management Guidelines. IRC. http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf

likelihood of co-occurring violence in families. For example, GBV programming has yet to systematically adopt an approach to its response, risk mitigation and prevention work that acknowledges co-occurring violence within the family and how women can both receive support for their own experiences of GBV as well as receive support to recognize and respond to experiences of GBV their children may be facing. Likewise, child protection programming that targets caregivers lacks gender analysis, and more specifically, dedicated GBV components that can be delivered by staff trained in gender awareness.

- **There is little to no content adaptation based on a child's specific circumstances** (experiences of trauma, types/ forms of violence or GBV, etc.). The literature review revealed that manualized or curriculum-based interventions have little to no content adaptation based on a child's specific circumstances of trauma, violence, etc. even when a history of such experiences is part of the criteria for participation. For many of the manualized MHPSS interventions included in the review this was an intentional aspect of the design—the idea being that the intervention addresses symptoms rather than experiences but also can reach a larger number of children with the same intervention. For other interventions included in the review – including those with caregivers—the lack of specification seems less intentional. Given the gendered and systemic nature of violence against women and girls, it is important to understand how this impacts whether the interventions appropriately address the complex safety risks for girls, the extent to which the content aligns with the framing of GBV interventions and to what extent this impacts girls' experience of the intervention. Further, the lack of evidence and best practice extends to adaptations of interventions like CBT, CETA, etc. such that there is little understanding of how best to support young girls to understand and cope with their experiences both now and as they age.

While the literature and current evidence base does not provide sufficient evidence from which recommendations on best practices on interventions that target girl GBV survivors in this age group, it does help identify critical gaps in knowledge. Recommendations based on the findings of the literature review are integrated with recommendations from the key informant interviews in section V.

IV. KEY INFORMANT INTERVIEWS

To complement the literature review, key informant interviews (KIIs) were carried out with targeted GBV and MHPSS service providers working with women and children to identify current gaps, best approaches and recommendations for providing MHPSS services to girl GBV survivors and boys that have experienced sexual violence ages 0-11.

A. Methodology

Data collection

The criteria for selecting and including key informants were as follows:

- Must be either a GBV/ women's rights, MHPSS, child protection, protection, health or education actor working in humanitarian settings
- Must be a representative or member of a relevant UN agency, INGO, NGO or community-based organization (CBO)
- Must have first-hand knowledge of topic and population

- Must be proportional representation across UN, INGO, NGO, and CBO representatives to ensure meaningful participation of women-led and local organizations.
- Must be proportional representation across GBV/women's rights, MHPSS and child protection actors.
- For global organizations, regional representation was preferred

Sources for identifying key informants included the UNICEF project team; GBV and MHPSS communities of practice; and recommendations from key informants. A total of 24 interviews were conducted with representatives as follows (see Annex 2 for a list of the key informants):

- **10 representatives of NGOs and CBOs**
  - 6 GBV programming
  - 2 CP programming
  - 2 GBV/CP programming
- **11 representatives of INGOs (this included a mix of global and context-specific programming)**
  - 2 GBV programming
  - 2 CP programming
  - 4 MHPSS programming
  - 1 Early Childhood Development programming
  - 2 GBV/ CP
- **3 representatives of UN entities:**
  - 1 global GBV/ CP programming
  - 1 regional gender unit programming
  - 1 global GBV programming

Interviews were carried out via an online platform using the key informant interview guide (see Annex 3). Interviews ranged between 45-60 minutes.

Data analysis

Data from key informant interviews was analyzed by the lead author using inductive approaches—allowing for themes to emerge from the data and subsequent coding. Data was also synthesized to identify the most common themes that emerged throughout the interviews; the most common themes that emerged for each interview question; and differences in responses based on demographics (e.g., type of actor, institution, geographic location).

B. Findings from the Key Informant Interviews

Findings are presented according to key questions asked during the KIIs.

1. How are girl survivors of GBV in the first decade and girls in the first decade more generally being reached directly with MHPSS interventions and activities?

Depending on the focus of their services / programming the organizations interviewed are reaching girls in the first decade, inclusive but not limited to GBV survivors, through several different entry points described below. The majority of the interventions are Level 2 of the MHPSS pyramid with the exception of individual higher level mental health care (Level 3).

GBV programming/service providers

In general organizations with GBV programming targeting women and girls identified that the primary way in which they are reaching girl survivors in the first decade is through their case

management services. The extent to which their caseloads are inclusive of girls in the first decade varied depending on the context, however most organizations identified that they expect the actual number of cases to be higher than what they are receiving, attributing stigma and cultural norms as barriers to accessing girl survivors in this age range With the exception of one organization working in Latin America, across contexts, participants identified early marriage as the primary form of GBV impacting young girls in the higher end range of 0-11 (age 8 and above).

Beyond case management, individual psychosocial support, or in some cases higher-level mental health services provide to GBV survivors, most organizations did not have specific programming designed for girls in the first decade more generally. Their programming with girls is with adolescents (inclusive of ages 10-11) and focuses on risk mitigation and prevention of GBV, empowerment and life skills programming. Two local organizations implement semi-structured group MHPSS activities (art, sports, dance) with girls in general ages 5 and above, however they indicated that the majority of the girls participating are older.

Lastly, three GBV organizations - a mix of INGO and local organizations - indicated that they have set up day care services in their women's centers/ Women and Girls Safe Spaces (WGSS) for the infants and young children of women accessing their services. Such services are intended primarily to facilitate women's access to services so are not necessarily designed with the intention of targeting the children themselves with programming or identifying GBV survivors amongst the children. One local organization indicated that their day care program for children below the age of 6 is overseen by specialists in early childhood development that bring expertise and knowledge on early childhood development to their services.

Child protection programming

Organizations that identified working on the intersection of child protection and MHPSS similarly did not have specific programming intended to target girl survivors or girls 0-11 more generally. These organizations are providing case management and individual psychosocial support to children for a range of protection issues- inclusive of GBV. Other MHPSS programming primarily targets girls and boys of school-age (not specific to GBV survivors) and includes structured, semi-structured and unstructured MHPSS interventions and activities provided in child-friendly or community spaces. For example, both international and local organizations mentioned implementing structured curricula with a focus on social and emotional learning (see Annex 4 for a list of resources commonly mentioned in the KIIs).

School-based programming

Two local GBV organizations are implementing programming in schools—both programming that specifically targets girls ages 6 that is a combination of awareness raising on GBV, life skills and semi-structured MHPSS activities and MHPSS activities with girls and boys together up to age 10.

Mental health service providers

Two organizations interviewed provide individual mental health services to adults and children. While there were no tailored services for girl survivors in this age range, their services are inclusive of all children who have experienced various forms of violence and trauma and/or are experiencing emotional and behavioral difficulties. The individualized support is provided by trained psychologists and included forms of art and play therapy depending on the age.

Early childhood development (ECD) programming

One INGO with education programming also has specific interventions for early childhood development that focus on building social and emotional skills with toddlers and working with

caregivers to support their child's development. These services are primarily implemented through home-visits following the Reach Up and Learn model in which community facilitators work with caregivers and their children together. There is no content differentiation for girls, however facilitators are trained on how to handle disclosures of GBV and to make referrals.

The extent of gendered-approaches to programming for girls in the first decade

All participants were asked the extent to which girls 0-11 required specific, separate programming. Common themes that emerged are:

- Girls in the first decade who are GBV survivors need individualized services such as case management and individual psychosocial support in order to support their healing and recovery.
- The 'first decade' is a large age range made up of early and middle childhood in which the entry points for accessing girls are quite different. Most child protection organizations identified reaching girls in middle childhood through implementing mixed gender programming for children (age 5/6 and above). Most GBV organizations identified that other than case management services, they do not have programming for girls below age 10 and identified it as a gap.
- Participants from GBV and CP organizations felt that up to age 8/9 (dependent on cultural norms) group programming with MHPSS outcomes could largely be delivered in a mixed gender setting and that the content could mostly be the same for girls and boys. Several participants identified there being advantages in keeping girls and boys together at this age, stating that for early childhood in particular, keeping girls and boys together provides opportunities for gender transformative programming. If designed intentionally, girls and boys can be exposed to activities, play, books and role models that push beyond traditional gender norms and can to contribute longer term norms change.
- Across participants, there was agreement that once girls start to enter into adolescence (age 10/11 or younger if they have already entered puberty), they require their own space and tailored content. Common reasons participants stated were: cultural norms related to gender that may dictate that girls and boys of a certain age cannot be together; the ways in which girls at this age may feel that they cannot speak freely or behave as they want to in front of boys; the need for girls to be able to have information specific to their sexual and reproductive health; the likely increase in risk for various forms of GBV as they enter adolescence, (e.g. early marriage); and the likelihood of school dropout.
- Two participants representing GBV programming, identified the importance of all programming being gendered—which they indicated did not necessarily mean that the programming had to be delivered separately, but that the content and the methodology needed to designed and implemented with a gender analysis, understanding and approach. For example, even with girls and boys in early childhood very light touch exercises related to power and gender can be used. Novel approaches to parenting/family-based programs identified through KIIs.

2. How are organizations working with non-offending caregivers?

A common element across organizations and types of programming was the importance of working with caregivers of girls in the first decade. Organizations are doing this to varying degrees in the following ways:

- Engaging caregivers in order to get their consent/permission to work with girls.
- Providing interventions in parallel to caregivers of girls engaged in their programming.
- Implementing interventions that target caregivers in order to support their children's development, safety and well-being. In this case, girls are the secondary beneficiaries.

These three strategies as implemented by organizations are described further below.

Engaging caregivers in order to get their consent/ permission to work with girls. This type of caregiver engagement was identified as a requirement to working with girls in the first decade—whether that be for the purpose of providing individual case management (which may be for GBV) or psychosocial support services or for the purpose of engaging them in a group intervention. For organizations providing case management and individual psychosocial support, caregiver engagement is mainly carried out through the informed consent process prior to service engagement and through decision making throughout case management services. For organizations providing group interventions inclusive of girls in middle childhood, this was primarily done by holding information sessions for caregivers in the community or in the school in order to explain the program and its benefits and recruit children for the program.

Providing interventions to caregivers in parallel with girls engaged in programming. This type of caregiver engagement was carried out in two ways: 1) caregiver interventions for girls engaged in case management or individual psychosocial support (which may be for GBV) the purpose of which is to facilitate the non-offending caregiver's ability to support the girl's healing and care as well as to provide psychosocial support to the caregiver; 2) group interventions for caregivers of girls engaged in the organization's programming that are carried out in a similar timeframe. For example, one GBV organization implementing a curriculum-based intervention with girls in middle childhood explained that they bring the mothers of girl participants together prior to the first session in order to go over the content that girls will learn and how caregivers can best support their child's learning. Throughout the curriculum the girls and their mothers are brought together for recreational activities that focus on building and maintaining a positive relationship. This group of mothers is re-engaged at the end of the intervention in order to discuss changes that the mothers observed in their child and how their mothers can continue to support their daughter's growth and development. Several participants of CP organizations also identified implementing Safe Healing and Learning Spaces or adaptations of it in which the caregivers of children attending the SHLS are also asked to participate in caregiver sessions. The caregivers learn the same social and emotional skills their children are being taught and are supported to build their child's acquisition of these skills at home. This type of programming can be implemented for caregivers of children ages 0-11 and depending on the model, there is often differentiated content for caregivers of children ages 0-5 and 6-11. **However, there is no content differentiation for girls and no content specific to children being survivors of GBV.** Several participants also noted that it is largely female caregivers who attend these sessions citing gender roles and livelihoods needs as barriers to male caregivers' participation.

Implementing interventions targeting caregivers that are intended to support their children's development and/or facilitate safety.

Parenting or family-based programs. Participants also provided several examples of caregiver engagement in which caregivers are the primary target. In this programming, MHPSS outcomes for caregivers and their children are articulated but the program is often framed in terms of safety and violence reduction. Often referred to as "parenting" or "family-based" programs/ interventions, parents learn about their child's development, the impact of violence and trauma on their children, positive parenting techniques, cognitive, social emotional skills and how to facilitate a supportive and empathic relationship with their children. These interventions largely align with models such as Families Make A Difference in which there is specific content for parents of children ages 0-5 and for children ages 6-11. However, again there no content differentiation for the caregivers of girls and no content that would help a parent respond to a disclosure of GBV from their child. In addition, similar to the SHLS -style of programming referenced above, organizations identified that it is largely female caregivers who attend these sessions.

Novel approaches to parenting/family-based programs identified through KIIs

Safe at Home aims to improve family wellbeing by addressing violence within the home, mainly co-occurring intimate partner violence (IPV) and child maltreatment. This intervention targets couples with children ages 6-12 and both parents must participate regularly. It is a curriculum-based intervention delivered through gender transformative group processes that unpack unequal power relations in the family and build knowledge and skills of parenting, safety and emotional well-being. It is carried out in gender-segregated male and female discussion groups and periodic family sessions, where participants come together as a couple or a family to build and practice key family relationship skills. While the content is not differentiated for caregivers of girls versus boys, the content for parents is deeply embedded in a gender lens. An evaluation of Safe at Home demonstrated correlation between family functioning and mental health of children and adults, as well as positive parenting, power sharing, and non-violent relationships between family members.

The *Be There* intervention seeks to lower stress and improve wellbeing among parents and other caregivers with the assumption that this will also improve the mental well-being of the children. It works directly with caregivers to not only address their own mental health needs but also to strengthen their abilities of caregivers - supporting them to make the best use of the parenting knowledge and skills they already possess. It is unique in that most other parenting programs do not have such as significant focus on the mental health of the caregiver. A limitation of the intervention is that it does not address gender and power dynamics between parents or within the family.

Mother-child interventions. A few participants also shared examples of programming focused on early childhood development in which caregivers, and more specifically mothers, are the target. These programs are for mothers of infants or young children (0-2 years) and

are focused on supporting the mother to provide their children with what they need physically and emotionally for healthy brain development. While the prevention of malnutrition is often the entry point for this type of programming, there are clear articulated MHPSS outcomes for both the mother and the child. One participant shared the Baby Friendly Space model which delivers evidence-based care practices for infant and young children (e.g. breastfeeding and nutrition counseling, child play and stimulation, parenting skills) to strengthen mothers' skills; and psychosocial support (e.g. group discussions, stress management skills, psychoeducation) to enhance mothers' well-being and internal resources to care for their children. Again there is not content specific to parenting girls or to GBV. However, staff are trained on how to handle disclosures of violence that a mother or a child may be experiencing and to make referrals as needed.

3. Who is delivering programming for girls in the first decade and how are they trained and supervised?

Common themes identified from participants across organizations were as follows:

Profile of providers. Individual level case management and focused psychosocial support for GBV survivors (Level 2 or 3 of the MHPSS pyramid) is mostly being provided by trained case-workers who either have backgrounds in social work or psychology. Higher level mental health (Level 4 of the MHPSS pyramid) care is provided by trained and certified psychologists. Group interventions (Level 2) are most commonly provided by people from the community who have been trained on the intervention and are supervised.

Training. In addition to education certifications that social workers and psychologists may have received, the most common type of training identified by participants was: GBV or CP case management training (for those implementing case management services), training on GBV and how to handle disclosures; training on communication and helping skills, training on PSS and Psychological First Aid; and secondary trauma and self-care.

Supervision. Notably, supervision was identified as an important practice implemented in a regular and consistent way through individual and/or groups. Supervisors have higher level training and more technical experience than the staff they supervise.

4. To what extent are organizations carrying out monitoring and evaluation?

Monitoring and evaluation practices varied across organizations with no particular patterns. Many organizations identified the need for more guidance, support and resources for monitoring and evaluation in general. The most common forms of monitoring and evaluation identified were:

- Outcomes related to case management or individual psychosocial support – such as scales that measure well-being and functioning: coping skills, self-esteem, reduced symptoms of mental illness, resilience.
- Outcomes part of curriculum-based interventions usually measuring safety and aspects of well-being. This includes organizations who are using their own curricula implementing pre/post intervention assessments to measure changes in knowledge, attitude and behavior as well as resource packages of program models that offer tools for monitoring implementation and measuring pre-identified outcomes.
- Some of the participants also shared program models their organizations had developed which have undergone evaluation in humanitarian settings or are currently part of research agendas in which MHPSS outcomes are measured.

5. Challenges

The common challenges participants identified in reaching girls 0-11 have been categorized as follows:

- Conceptual/ design challenges
- Access to girls in this age
- Provision of services/ programming

Conceptual / design challenges

Several KII participants from GBV programs identified that one of the most significant barriers to reaching girls in the first decade is that there is a lack of intentionality in engaging this group. The focus to date has been on adolescent girls. While programming for adolescent girls continues to be important and needs to be prioritized, there is a recognition that the specific needs of girls in early and middle childhood are being ignored. Another participant identified that there are important differences in conceptual frameworks for working with adult women versus children. GBV programming with adult women and to a large extent adolescent girls is focused on their safety and empowerment, centering their right to decision making. Decision making for girls 0-11 will primarily be mediated by their caregivers. In this sense, non-offending caregivers become the 'frontline workers' who can facilitate the safety and well-being of girls in this age range. This is a considerable shift for GBV practitioners and likely a barrier.

Accessing girls in the first decade

The most common challenges participants identified related to accessing girls 0-11 were:

- Stigma and cultural norms related to GBV and MHPSS.
- A lack of awareness of the MHPSS needs of girls in this age range as well as where to access services in a confidential, safe way.
- The need to engage parents in order to provide services or to receive permission for girls to attend programming. Without their support and buy-in, the value of MHPSS programming may be overlooked or there may be competing demands on time and resources.
- The likelihood of girls dropping out of school. Organizations accessing girls through school-based programming identified that as girls start to reach the end range of middle childhood, it is more likely they will drop out due to early marriage and gender norms.
- Organizations working with highly mobile populations or populations in which security is an issue identified that such movement and instability is problem for both initially accessing girls in this age range as well as for continuity of care and/or participation in programming.
- Lack of Integration. Participants identified the considerable missed opportunities for accessing girls 0-11 with MHPSS services due to a lack of integration of MHPSS into other sectors such as education, health, and protection / social welfare.

Provision of services

The most common challenges participants identified related to providing MHPSS services to girls 0-11 were:

- **Lack of skills, training and expertise.** This theme surfaced in a few different ways. For example, participants from both GBV and CP organizations identified the complexity of working with girls in this age range and children more broadly. First, participants identified the tremendous variation of needs across developmental stages of children and how differently they will be impacted by trauma based on developmental stage. There was a recognition that MHPSS programming for this

age range needs to be steeped in a developmental lens and requires specific training and expertise.

Participants from GBV organizations also identified that GBV staff often lack the skills required for communication with children, the experience to navigate mandatory reporting, and the confidence to work with younger girls.

Of note, a child protection actor also identified that the main tools their organization is using and training its staff on to address child sexual abuse are not designed for the reality that most perpetrators are someone in or known to the family. The result is that staff are ill-prepared to work with the family system in such cases.

Lastly, local organizations identified a lack of trained mental health professionals in general, but also more specifically those who have experience working with young girls who can provide higher level individualized services with fluency of language, culture and context (Level 3).

- **Limited resources.** Organizations identified that they struggle with limited funding and funding that lacks the continuity required to establish and maintain specific MHPSS programming for young girls. This includes infrastructure for separate spaces and resources for staffing such programs.
- **Limited intersectoral collaboration:** Participants identified siloed programming and limited collaboration between GBV, CP and MHPSS sectors as a significant barrier to providing comprehensive services. It is often not clear who is "responsible" for addressing the MHPSS needs of girls in this age range, who is doing it, and in some cases there is competition rather than collaboration to reach these girls.

6. Best practices

Participants were asked to identify successful strategies they have used or know of to reach girls 0-11 with MHPSS services. The following best practices emerged which were also identified as applicable or adaptable to interventions for boys who have experienced sexual violence.

- **Provide individual and group MHPSS.** Participants identified the importance of having individual and group MHPSS services available to all girls and boys in the first decade. The availability of individual support for girls even if they are not GBV survivors was identified as important given their likely risk for GBV throughout childhood and adolescence.
- **Use play, art and game-based methodologies.** For all types of MHPSS interventions, participants identified the importance of using play, art, dance and games with girls in this age range and that this should be the foundation of programming for all children ages 0-11.
- **Engage non-offending parents and caregivers in services.** It was identified by all participants that it is critical to engage non-offending parents and caregivers in services--not just as the gatekeepers of girls—but also to receive their own services that support their mental health and well-being. This should include interventions that seek to build the knowledge and skills of parents to be able to support the well-being of their children but not be limited to this. There was agreement across participants that parents need their own individual and/or group MHPSS support in parallel with their children. As discussed in the findings of the literature review the engagement of caregivers in interventions with children requires further unpacking and further guidance in cases where GBV is being perpetrated by a caregiver already engaged in services for the child.
- **Design and deliver multi-disciplinary/ multi-sectoral interventions.** Across sectors and types of organizations, participants identified the importance of bringing together specialists from GBV, CP, MHPSS, and Education and Early Childhood Development to design and implement services for girls 0-11 together. This was deemed important

because of the entry points that other sectors provide for girls in early and middle childhood as well as the diverse skill sets these sectors bring to meet the needs of girls in a holistic way.

- **Implement school-based programming:** Participants identified that for settings in which there are stable schools in the community, there is an opportunity to embed MHPSS programming and better reach school-aged girls and their caregivers. Schools can provide consistent access to individual mental health services that are provided by trained professionals who also understand and can respond to GBV. There is also an opportunity to integrate MHPSS education into school curricula.
- **Engage communities in a sustained manner.** Participants also identified that the successes they have had in reaching girls in this age range have been because of the investments they have made in community relationships. Providing consistent information to the community at-large about mental health and GBV, normalizing the mental health needs that children and parents may have, and providing information about accessing services are strategies identified as critical to facilitating girls (and boys) access to individual and group MHPSS interventions.

7. Recommendations from interviews

In addition to identifying best practices, participants were asked what recommendations they have for next steps of this initiative. Common themes identified include:

- Break down this age group further into middle aged /school-aged girls and early childhood (infants + toddlers) to fully recognize the large developmental span and diverse needs of girls 0-11.
- Carry out small-scale research to better understand needs of girls in these age groups and how best to reach them.
- Support the design of an intervention that brings specialists from different sectors together – in particular GBV, child protection, education and MHPSS.
- Development practical guidance for organizations to:
    - Engage caregivers of girls in parallel interventions in a way that is safe and meets the needs of caregivers.
    - Increase their knowledge and skills for working with this age range of girls and the complexities of working with girls who have experienced GBV.
    - Re-consider the design of existing GBV programming to allow for entry points for girls in this age group.
- Ensure that guidance created is adaptable, contextualizable and outcome-based not sector specific.
- Develop recommendations that are concise and specify 2-3 concrete next steps.

V. CONCLUSIONS AND RECOMMENDATIONS

The conclusions and recommendations outlined below reflect the findings related to key gaps in knowledge and practice from the literature review and key informant interviews and best practices and recommendations from the key informant interviews.

A. Conclusions

1. **The most appropriate and effective access points need to be determined.** Girls and boys 0-11 are primarily reached through parenting programs or school interventions. School interventions fail to reach the youngest in this age range and also fail to reach and create entry points for boys and girls out of school in this age range. As girls age up into 10-11, the likelihood of being out of school increases in many settings, further exacerbating challenges of access related to gender. Further, parenting programs may target parents of the youngest children, but with considerable gaps as they do not acknowledge the likelihood of girls experiencing GBV and how non-offending parents can support and respond. Further exploration is needed of entry points that enable access of most parents of young children, those that can be targeted and narrow, and those that are most effective in reaching the youngest child survivors.

2. **The needs of girls in the first decade require more attention.** The literature and the key informant interviews demonstrate a lack of interventions intentionally designed to meet the needs of girls and boys 0-11. With the exception of GBV and CP case management services, GBV interventions with MHPSS outcomes for girls tend to be geared towards adolescent girls starting at ages 10-11, but do not reach younger girls in middle childhood or early childhood with systematic programming or tailored services. Child protection programming with MHPSS outcomes is primarily for children ages 5-11 and does not have content differentiated by gender or experiences of GBV, so little evidence exists on how to tailor services to girl survivors of GBV, or boy survivors of sexual violence.

3. **More evidence on what works to meet the needs of girl survivors in the first decade is required.** The literature review confirmed that MHPSS for children and adolescents in humanitarian and development settings is typically neglected. There is less evidence generally of what works to support the mental health of children, especially younger children.[15] Through the literature review and key informant interviews it is clear there is even less evidence about what works for girl GBV survivors and boy sexual violence survivors in this age range, and how to address their safety, needs, risks and rights, and the unique considerations needed based on gender.

4. **The age range 0-11 represents a vast developmental span too broad for understanding, designing and researching programming for girls and boys in childhood.** The age range 0-11 represents a vast developmental span and the needs of girl and boy survivors in this range are diverse. This age range also includes 10-11 which overlaps with early adolescence and makes it difficult to accurately target programming. The entry points for MHPSS programming are also different — girls and boys in early childhood are primarily reached through their caregivers, whereas girls and boys ages 5-11 may access programming in schools, child friendly spaces or other spaces without their parents present.

5. **Programming must be conceptualized, designed, delivered and evaluated with a gender lens.** GBV practitioners identified the importance of all programming being gendered—which did not necessarily mean that the programming had to be delivered separately for girls, but that the content and the methodology must be designed and implemented with a gender analysis, understanding and approach that is also informed by age. Programming should be designed and delivered to be gender transformative.

[15] UNICEF Review funded by GIZ.

6. **Caregiver engagement is critical and caregiver interventions have value, but a better understanding of how best to work with caregivers of this population is required.** From the literature review and the key informant interviews we find that the engagement of non-offending caregivers is a basic requirement for girls (and boys) of this age range in order to participate in services and interventions, however there may also be value in working with caregivers in parallel with girls in this age range, as well as value in targeting caregivers with girls in this age range. There are promising programs such as Safe at Home and BeThere that are looking at the impact of their programming on MHPSS outcomes of caregivers and children participating in their programming. There are also promising outcomes from the Baby Friendly Spaces model which can reach younger girls and boys.

   More discussion is required across relevant sectoral entry points on how to safely work with caregivers. In particular there are known differences in how GBV and child protection actors work with parents who are considered "offending" parents and it is likely that other sectors do not have an articulated approach. Among the issues requiring more discussion and cross-sector guidance are: how to handle child or parent indirect disclosures, confidentiality and mandatory reporting practices, how offending caregivers participating in caregiver programs are handled should it be identified or disclosed that they have perpetrated GBV against their children; risk mitigation measures for girls and boys and female caregivers when male caregivers are included.

7. **Provide multi-modal and multi-layered MHPSS programming.** Multi-modal and multi-layered programming was identified as important not just for girls who are GBV survivors but for boys and girls in general in this age range. The key informant interviews emphasized the importance of individual and group MHPSS services being available for children and their caregivers - group interventions that are provided at Level 2 of the MHPSS pyramid and individual interventions primarily provided at Level 3 of the pyramid but also Level 4 in situations where this is needed. These modalities were also identified in the literature review. Furthermore, the key informant interviews emphasized the importance of community engagement in order to reduce stigma associated with mental health and GBV as well as facilitate safer and more consistent access to girls.

8. **There is a need and opportunity for multi-disciplinary design and provision of programming and services.** Through the key informant interviews, the importance of cross-sectoral, multi-disciplinary programming was identified and in particular, GBV, CP, MHPSS, Education and Early Childhood Development. These sectors provide important entry points to girls in early childhood and middle childhood. Furthermore, the diverse skill sets these sectors bring provide the opportunity to design programming that is holistic.

9. **The conclusions and best practices identified through this study can benefit the design and delivery of programming for boys who have experienced sexual violence.** The best practices identified through the literature review and the key informant interviews have relevance for programming for boys who have experienced sexual violence in this same age-range. However, given that the drivers of sexual violence against boys are different than girls, gender specific interventions (in addition to age) should be considered if the intervention targets boys who have experienced sexual violence or will target a population of boys at high risk of sexual violence.

B. Recommendations

1. Moving forward, any work carried out to understand the needs of girls in the first decade must recognize the diverse development stages in this age range and further break this age range down into smaller cohorts. Doing so will benefit both research and practice.

2. Support local action research that seeks to better understand the needs of girls in early and middle childhood, how to best access them, what are the most effective entry points and what adaptations are required to existing programming.

3. Further investigate and explore the possibility of collaboration with existing promising interventions that offer important entry points to accessing girls in this age range and that may be open to addressing some of the gaps identified through this study—for example, WGSS programming that maybe inclined to experiment with reaching younger girls and/or more actively addressing co-occurring violence in the lives of the women and girls that come to the WGSS. In addition, caregiver/ family-based interventions that may be open to a more gendered approach that more systematically address co-occuring violence against women and children and have clearer mechanisms in place to respond to such violence.

4. Further understand and invest in models of working with caregivers of girls engaged in MHPSS programming that also address the MHPSS needs of caregivers, consider risk mitigation required for the safety of girls and female caregivers and that are designed to be gender transformative in content and delivery.

5. Invest in the development of guidance that can be incorporated into existing programming with caregivers and families across sectors that outlines strategies for responding to disclosures of GBV across multiple scenarios: women that disclose their own experiences of intimate partner violence; caregivers who disclose that they are perpetrators of IPV, GBV against girls and sexual violence against boys; as well as caregivers who disclose that their partners are perpetrators of GBV against a daughter and sexual violence against a son. Such programs need clear protocols for how to respond in such a way that non-offending caregivers and children are not put at further risk.

6. Invest in multi-disciplinary, inter-sectoral collaboration. Support a series of multi-sectoral workshops in order to discuss how the needs of girl survivors and children in general in early childhood and middle childhood can be better reached. Explore the following:

    - How can referral pathways between and within MHPSS, CP, ECD, and GBV providers reflect the complexities and sensitivities of GBV cases?
    - What are the existing opportunities for collaboration that can allow us to better reach girl survivors and children more generally in these age ranges?
    - What could multi-disciplinary interventions look like? How can they draw on the perspectives and expertise of multiple sectors and in particular MHPSS, CP, ECD, and GBV providers?
    - How could collaboration between sectors be encouraged and/or incentivized to ensure holistic programming that meets all needs of families and can effectively support girl survivors of GBV and boy survivors of sexual violence in a way that is responsive to their gender and age?
    - What training and resources are required to support staff working in GBV and CP programs to be able to work with children in diverse developmental stages? What is required of ECD and Education staff to bring a greater gender lens to their work?

ANNEX

ANNEX 1: SUMMARY TABLE OF ARTICLES INCLUDED IN THE LITERATURE REVIEW

Article Name	Author(s)	Population	Intervention	Setting/location	Type of evaluation
Music therapy programming at an aftercare center in Cambodia for survivors of Child Sexual Exploitation and their Caregivers.	Schraeder, E.. Wendland, J.	Girl survivors 0-11 and up to age 15+	GBV	Development settings	Pre and post intervention measures
Effectiveness of Trama-focused CBT among trauma-affected children in Lusaka, Zambia	Murray, et al.	Children 0-11 and up to age 15+	MH and/or well-being outcome	Development settings	Pre and post intervention measures
Preventing Child Sexual Abuse: A systematic review of interventions and their efficacy	Mayeya,et al.	Children 0-11 and up to age 15+	GBV/MHPSS within Multi-sectoral	Development settings	Comparison Groups
Samata intervention to increase secondary school completion and reduce child marriage among adolescents from marginilised communities in northern Karnataka	Mwiya Imasiku, PhD, Paul A. Bolton, MBBS	Girls 0-11 and up to age 15+	GBV	Development settings	Pre and post intervention measures
Gender differences in Sexually Abused Children and Adolescents: A Multicenter Study in Turkey	Soylu, et al.	Children 0-11 and up to age 15+	MH and/or well-being outcome	Development settings	Quantitative and/ or Qualitative measures
A review of the literature on good practice considerations for initial health system response to child and adolescent sexual abuse	Elena T Broad-dus-Shea, Kerry Scott, Megin Reijnders, Avni Amin	Children 0-11 and up to age 15+	MH and/or well-being outcome	Development settings	Comparison Groups
The role of communiites in mental health care in low- and middle-income countries: A meta-review of components and competencies	Kohrt,et al.	Multi-layer/ cross-sectoral interventions	MH and/or well-being outcome	Development settings	Comparison Groups

Article Name	Author(s)	Population	Intervention	Setting/location	Type of evaluation
Moderators of treatment response to trauma-focused cognitive behavioral therapy among youth in Zambia	Kane,et al.	Children 0-11 and up to age 15+	MH and/or well-being outcome	Development settings	Comparison Groups
A systematic review of evidence-based interventions for child and adolescent mental health problems in low- and middle-income countries	Wagner, et al.	Children 0-11 and up to age 15+	MH and/or well-being outcome	Development settings	Quantitative and/or Qualitative meas-ures
Sexual Abuse prevention education for preschool-aged children: Parents' attitudes, knowledge and practices in Beijing, China	Wenjing Zhang, Ping Ren, Guijin Yin, Haiyan Li, Yichen Jin	Children 0-11 and up to age 15+	Prevention	Development settings	Quantitative and/or Qualitative meas-ures
Identification, modification, and implementation of an evidence-based psychotherapy for children in a low-in-come country: the use of TF-CBT in Zambia	Murray, et al.	Children 0-11 and up to age 15+	MH and/or well-being outcome	Development settings	Comparison Groups
Interventions to Prevent Child Marriage Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature	Amanda M Kalamar, Susan Lee-Rife, Michelle J Hindin	Girl survivors 0-11 and up to age 15+	Prevention	Development settings	Comparison Groups
Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice	Unicef	Children 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	No evaluation component

Article Name	Author(s)	Population	Intervention	Setting/location	Type of evaluation
Improving Mental Health Outcomes of Burmese Migrant and Displaced Children in Thailand: a Community-Based Randomized Controlled Trial of a Parenting and Family Skills Intervention.	Annan, J. Sim, A., Puffer, E.S., Salhi, C., Betancourt, T.S.	Children 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	Comparison Groups
No place is safe: Sexual abuse of children in rural Bangladesh	Kazi Nazrul Fattah & Zarina Nahar Kabir	Girl survivors 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	Quantitative and/or Qualitative measures
Healing the invisible wounds of war: A roadmap for addressing the mental health needs of children and young people affected by conflict	Save the Children	Children 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	Quantitative and/or Qualitative measures
Child-centered, cross-sectoral mental health and psychosocial support interventions in the Rohingya response: A field report by Save the Children	Aladin Borja Jr., Ruma Khondaker, Jessica Durant, Beatriz Ochoa	Children 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	Comparison Groups
Interventions for children affected by war: An ecological perspective on psychosocial support and mental health care	Aladin Borja Jr., Ruma Khondaker, Jessica Durant, Beatriz Ochoa	Children 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	Comparison Groups
What are the barriers to, and facilitators of implementing and receiving MHPSS programmes delivered to populations affected by humanitarian emergencies? A qualitative evidence synthesis	Kelly Dickson & Mukdarut Bangpan	Children 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	Quantitative and/or Qualitative measures

Article Name	Author(s)	Population	Intervention	Setting/location	Type of evaluation
Cognitive behavioral therapy for post-traumatic stress disorder, depression, or anxiety disorders in women and girls living with female genital mutilation: A systematic review	Adegoke Adelufosi, Bassey Edet, Dachi Arikpo,Ememobong Aquaisua, Martin M Meremikwu	Girl survivors 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	Comparison Groups
Mental health and psychosocial support for conflict-related sexual violence: principles and interventions	WHO	Children 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	No evaluation component
An evaluation of a common elements treatment approach for youth in Somali refugee camps	Murray, et al.	Children 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	Pre and post intervention measures
Approaches to providing psychosocial support for children, teachers, and other school staff, and social and emotional learning for children in protracted conflict situations.	Jacqui Mattingly	Children 0-11 and up to age 15+	MH and/or well-being outcome	Humanitarian Settings	Quantitative and/ or Qualitative measures
Co-occuring Intimate Partner Violence and Child Abuse in the Democrartic Republic of Congo: The Influence of Early Life Experiences of Abuse	Falb, et. Al	Caregivers of children 0-11	GBV	Humanitarian Settings	Quantitative and/ or Qualitative measures
Preventing Co-occurring Intimate Partner Violence and Child Abuse in Eastern Democratic Republic of Congo: The Role of Family Functioning and Programmatic Reflections	Falb, et al	Caregivers of children 0-11	GBV	Humanitarian Settings	Pre and post intervention measures

Article Name	Author(s)	Population	Intervention	Setting/location	Type of evaluation
Family Functioning in Humanitarian Contexts: Correlates of the Feminist-Grounded Family Functioning Scale among Men and Women in the Eastern Democratic Republic of Congo	Blackwell, et al.	Caregivers of children 0-11	GBV	Humanitarian Settings	Pre and post intervention measures
Supporting parenting among Syrian refugees in Lebanon: a randomized controlled trial of the caregiver support intervention	Miller,et al.	Caregivers of children 0-11	MH and/or well-being outcome	Humanitarian Settings	Comparison Groups
Supporting maternal mental health of Rohingya refugee women during the perinatal period to promote child health and wellbeing: a field study in Cox's Bazar	Francesca Corna, Fahmida Tofail, Mita Rani Roy Chowdhury & Cécile Bizouerne	Caregivers of children 0-11	MH and/or well-being outcome	Humanitarian Settings	Pre and post intervention measures
The neglected 'm' in MCH programmes – why mental health of mothers is important for child nutrition.	Atif Rahman, Vikram Patel, Joanna Maselko, Betty Kirkwood	Caregivers of children 0-11	MH and/or well-being outcome	Development settings	No evaluation component
Lessons learned evaluating the baby friendly spaces program for south Sudanese refugees in Gambella, Ethiopia: strengthening research and programmatic partnerships to address maternal and child health and psychosocial needs in humanitarian emergencies.	Lasater, M.E., Woldeyes, G.M., Le Roch, K. et al.	Caregivers of children 0-11	MH and/or well-being outcome	Humanitarian Settings	Quantitative and/or Qualitative measures

Article Name	Author(s)	Population	Intervention	Setting/location	Type of evaluation
Interventions that Foster Healing Among Sexually Exploited Children and Adolescents: A Systematic Review	Melissa Moynihan, Claire Pitcher & Elizabeth Saewyc	Girl survivors 0-11 and up to age 15+	MH and/or well-being outcome	HIC	Comparison Groups
Re-designing community mental health services for urban children: Supporting schooling to promote mental heatlth	Atkins, et al.	Children 0-11 and up to age 15+	MH and/or well-being outcome	HIC	Pre and post intervention measures

ANNEX 2: LIST OF KEY INFORMANTS

Name	Organization	Geographic Scope	Sector/Focus
Amel Amirali	UNHCR	Global	GBV/ CP
Julieta Sevene	UNICEF ESARO	Regional	Gender Unit
Sophie Reade-Hamilton	GBViE Helpdesk	Global	GBV
Jacqueline Uwimana	IMC	National (Mali)	GBV
Stephanie Bou Gebrayel	IMC	National (Lebanon)	MHPSS
Elisabetta Dozo	ACF	Global	MHPSS
Danielle Roth	IRC	Global	GBV/CP
Mehreen Jaswal	IRC	Global	GBV/CP
Serene Ghazal	IRC	National (Lebanon)	CP
Katie Murphy	IRC	Global	ECD
Alessandra Sachetti	HIAS	National (Ukraine)	MHPSS
Annie Bonz	HIAS	Global	MHPSS
Robyn Yaker	HIAS	Global	GBV
Anne Filorizzo Pla	Save the Children	Global	MHPSS
Nidal Mortada	Sawa for Aid and Development	National (Lebanon)	GBV/MHPSS
Yusra Ali	Active in Development Aid	National (Somalia/Kenya)	MHPSS
Mariam Hussein	Hawa Young Feminist Collective	National (Somalia)	GBV
Maria Seeman	KAFA	National (Lebanon)	GBV/CP
Michael Stavneak and Sulava Shdo	Women's Rehabilitation Organization	National (Iraq)	GBV
Walaa Ahmed	Better World Organization	National (Iraq)	GBV / CP
Pascalia Ogutu	Horn of Africa Institute	National (Kenya)	GBV
Suad Ahmed	Deem	National (Yemen)	GBV
Rose Habchi Daher	Himaya	National (Lebanon)	CP
Yusuf Abba Tijjani	Grow Strong Foundation	National (Nigeria)	CP

ANNEX 3: KEY INFORMANT INTERVIEW GUIDE

Elements of program design and delivery

- In what ways is your sector/ program/ organization working with girls 0-11 survivors? What about girls 0-11 more broadly?
- What are the most pressing MHPSS needs for this population? Both girls and caregivers?
- To what extent do you engage non-offending caregivers of this population? In your experience, what supports do you find most important for these caregivers to support their children as survivors?
- How is your programming for this population (and/or more broadly girls of this age range) delivered?
- What kind of training, supervision, and support is needed for the staff in order to provide MHPSS support?
- What outcomes do you target, and how do you measure these?

Challenges and barriers

- What are the most pressing/common barriers your org/ program has had in accessing and providing services to this population? Are barriers different for accessing vs providing services?
- What are the key barriers across sectors in accessing and providing services to this population? What kinds of linkages are needed to other sectors?
- What challenges have you experienced more broadly working with girls 0-11?

Successes

- What have you done to access this population?
- What approaches have you found helpful for MHPSS support?
- What multi-pronged, embedded, or other joint programming has been explored? And are there specific examples that have worked well?
- What of the successful strategies you have seen or implemented so far do you think could also be useful for working with boys who have experienced sexual violence?

Other

- What resources have you found helpful in designing services for this population?
- What program models, approaches, or adaptations have you found helpful in accessing and providing services to this population?
- If funding was no issue, what would your ideal programming for this population look like?
- What recommendations do you have for this project and potential next steps? What would you like to see happen?

ANNEX 4: RELEVANT RESOURCES

The following are resources or program models that participants of key informants identified as informing their work with girls and caregivers.

MHPSS Minimum Services Package The minimum services package includes menu of MHPSS activities that should be implemented in all emergency responses and includes activities specifically for GBV survivors:

Girl Shine Girl Shine has been designed to help contribute to the improved prevention of and response to violence against adolescent girls in humanitarian settings, by providing them with skills and knowledge to identify types of GBV and seek support services if they experience or are at risk of GBV. Additionally, Girl Shine aims to build the social assets of girls to ensure they have someone they can turn to if they experience or are threatened by GBV. Girl Shine supports adolescent girls as they navigate a safe and healthy transition into adulthood, protected from GBV, supported by their caregivers and peers and able to claim their full rights. Girl Shine also provides adolescent girls with life skills that strengthen their social and emotional learning skills and provides them with information related to adolescent sexual and reproductive health, critical to making healthy decisions. Includes age 10 and up. There is also a caregiver curriculum for both female and male caregivers It provides complementary support to the Girl Shine Life Skills Curriculum and is a critical component of the overall Girl Shine program. The Girl Shine Caregiver Curriculum is not a parenting curriculum, in the sense that it does not aim to equip parents and caregivers with positive parenting skills. Rather, it has instead been designed to address broader issues around gender equality, especially in relation to the experience of adolescent girls and the root causes of the violence against them.

Now I'm Stronger Curriculum This is an adolescent MHPSS curriculum focused on children' emotions developed by IRC's Child Protection program in Lebanon. It targets adolescents that have been through a lot of difficulties and potentially traumatic events and who might exhibit a range of behaviors and emotions that impact their life and their way to connect and interact with others.

SAFE (Supporting Adolescents and their Families in Emergencies) SAFE is a protection and psychosocial support program model for adolescent girls and boys (ages 10-19) so that they are safer, more supported, and equipped with positive coping strategies in acute emergencies. It is designed for the first phase of an emergency response and framed as an 'on-ramp' to more comprehensive programming for adolescent girls and boys. SAFE also includes a caregiver curriculum intended to be used with caregivers of adolescents. There are separate curricula for girls and boys with tailored content for ages 10-14. and ages 15-19.

Safe Healing and Learning Spaces For children ages 0-5 and 6-11 and their caregivers. An SHLS program seeks to achieve multiple outcomes for children, including improvements in social and emotional skills and reading and math outcomes; and reductions in emotional distress and violence in the home. Achieving these outcomes requires strengthening the knowledge and skills of SHLS staff and parents to create a home and learning environment conducive to children's healthy development and well-being.

Caregiver / Parenting Interventions

Families Make a Difference Targets caregivers from ages 0-11. Also separate curricula for children 0-5 and 6-11.

Safe at Home aims to improve family wellbeing by addressing violence within the home, mainly co-occurring intimate partner violence (IPV) and child maltreatment. This intervention targets

couples with children ages 6-12 and both parents must participate regularly. It is a curriculum-based intervention delivered through gender transformative group processes that unpack unequal power relations in the family and build knowledge and skills of parenting, safety and emotional well-being. It is carried out in gender-segregated male and female discussion groups and periodic family sessions, where participants come together as a couple or a family to build and practice key family relationship skills.

Be There This intervention seeks to lower stress and improve wellbeing among parents and other caregivers with the assumption that this will also improve the mental well-being of the children. It works directly with caregivers to not only address their own mental health needs but also to strengthen their abilities of caregivers - supporting them to make the best use of the parenting knowledge and skills they already possess. It is unique in that most other parenting programs do not focus on the mental health of the caregiver.

Caregivers Matter Caregivers Matter presents an evidence informed program focused on the following: A strengths-based approach to address feelings of guilt, inadequacy, and to promote feelings of self-worth and caregiver agency in caring for a child; Psychoeducation on effects of stress and distress, secure attachment, adversity and empathy, caregiver wellbeing, routines, and enriched appropriate play; Cognitive Behavioral Therapy (CBT) and Trauma-Focused CBT influences to directly address negative self-talk and drivers of low function; Group therapy techniques to facilitate peer-to-peer support and relationship building; Problem solving strategies to acknowledge and tackle the extreme challenges facing caregivers, families, and children in the country context.

Baby Friendly Spaces Baby Friendly Space's main objective and line is to take care of the mother/caregiver in order to support her/him to take care of the child/infant. Baby Friendly Spaces do not only focus on breastfeeding and the child. The goal of the BFS is a holistic psychosocial program that aims at providing comprehensive support to children and their caregivers who are facing emergency situations. Infants and young children belong to the most vulnerable groups. They depend on other people to care for them, they are vulnerable to diseases and malnutrition and what children experience during the early years sets a critical foundation for their entire life course – as research confirmed a strong relation between child survival and child development. The child's well-being is the result of different components: health, food and economical resources, as well as the type and quality of the caregiver-child relationship.

Reach Up and Learn Based on the Jamaican Home Visit program Reach Up and Learn

works through parents by building a positive relationship to support them in strengthening skills to promote child development.

- Aims to build mothers' skills, self-esteem and enjoyment in helping her child play and learn.
- Home visitor is trained to listen to the mother, seek her opinions and ask about things she already does with her child and to acknowledge these and give encouragement and praise.
- Uses a structured curriculum of developmentally appropriate activities
- Uses an interactive approach of demonstration and modelling and practice of activities to build skills.
- Emphasizes praise for parent and child.