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Together BLTG coalition members engage in a global, multi-agency initiative that aims to promote women’s transformative leadership in GBV emergency preparedness and response. The coalition is composed of feminists, women’s rights advocates, grassroots organizations, activists, and national, regional, and network organizations working in emergencies and fragile contexts and committed to the protection and empowerment of women and girls. More information on the BLTG initiative can be found here.¹

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Women and girls are key actors in their own protection, and it is critical that they are active partners in the process of identifying protection risks and solutions in GBV programming in emergencies. The Building Local, Thinking Global (BLTG) coalition provides support to GBV actors to ensure women’s and girls’ access and participation from the onset of an emergency in order to achieve better GBV programming outcomes. This Guidance Note aims to address the heightened risks and barriers to service access for women and girls from diverse backgrounds. Our goal is for all women and girls to have safer access to services and to be able to participate meaningfully in inclusive GBV programming.

When GBV actors address the barriers and discrimination that diverse women and girls face in humanitarian settings, this ensures that ALL women and girls benefit from the programming, are protected from harm, and are supported to recover and thrive. This means recognizing and understanding how “intersecting inequalities” affect diverse women and girls and shape their identity and power. Based on requests from local service providers in the BLTG coalition, this resource has focused on the following intersecting inequalities that affect diverse women and girls: discrimination based on older age, adolescence, disability, sexual orientation, gender identity, race, and ethnic or religious affiliation. This guide is therefore not exhaustive; in every location there will be women and girls facing increased discrimination based on intersecting inequalities that are not adequately covered in this resource. These women and girls may include those who are HIV+ or engaged in commercial sexual exploitation, and migrant and stateless women and girls. Although not exhaustive, this resource outlines principles and practices that can be thoughtfully applied to adapt GBV programming.

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to reach diverse women and girls in different humanitarian contexts. Additional interagency guidance resources are signposted throughout the Guidance Note for ongoing learning by GBV actors on particular topics.

WHY IS INCLUSION OF DIVERSE WOMEN AND GIRLS IN GBV EMERGENCY RESPONSE PROGRAMMING IMPORTANT?

Diverse women and girls are present in every humanitarian context. GBV actors should always seek to understand women and girls in all of their diversity, and take action to ensure that GBV programming is inclusive and addresses the needs, barriers, and risks that diverse women and girls face. Diverse women and girls face multiple forms of oppression, which further reduce their power, choice, and protection from GBV, and increase barriers to accessing services. Some displaced and host community women will also be advantaged and protected by their social status, and GBV actors need to ensure they are not only serving privileged adult women in the community who come from higher class/socioeconomic status; are educated, heterosexual, able-bodied, cisgender, or HIV-; or are affiliated with the majority ethnicities or religions.

The GBV Guiding Principles, as well as broader humanitarian values and principles, require targeted action to support the inclusion of all women and girls in GBV programming. The humanitarian principle of impartiality – providing assistance on the basis of need and without discrimination – requires donors and aid agencies to reduce barriers so that all members of a population can access relief on an equal and equitable basis.\(^1\) In the Sphere Standards, sex, age, and disability disaggregation is a core requirement for responding to the needs of people at risk.\(^2\) The exclusion of diverse women and girls from emergency response increases casualty rates, psychosocial impact, and health issues. The resulting discrimination is a form of violence that limits women’s and girls’ ability to meet their basic needs and increases their risk of additional violence. Inclusion does not need specialist skills but is about addressing barriers to support all women’s and girls’ equal protection and empowerment in humanitarian action.

REMEMBER! Women and girls are most at risk of experiencing GBV in every context. This is because of their subordinate status in the gender hierarchy, the resulting systemic gender inequality, and the power and privilege experienced by men and boys globally.

WHO SHOULD USE THIS RESOURCE?

GBV actors who are using the IRC’s GBV Emergency Preparedness and Response Program model, assessment tools, and training package can use this Guidance Note to ensure diverse women and girls are supported through emergency GBV preparedness and response programming. This Guidance Note targets GBV-specialized actors and agencies who are already trained and have skills in GBV response. It was developed with and primarily for members of the BLTG initiative, to support local GBV actors and women’s rights organizations to respond with inclusive GBV programming when humanitarian crisis affects local populations.

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This Guidance Note is designed to support GBV actors to reflect, learn, and take action to implement inclusive GBV programming for diverse women and girls. When using this resource, we encourage you to:

**ACKNOWLEDGE THIS IS ABOUT US AND AVOID “OTHERING”**

Women staff and volunteers responding to GBV will have experienced privilege and discrimination themselves, based on their gender, race, class, disability, sexual orientation, gender identity, ethnicity, or religion. Avoid framing inclusion as if these identities and experience belong to other women only. “Othering” these issues is a form of discrimination and exclusion. Instead, provide opportunities for women to share their own knowledge and personal experiences of privilege, discrimination, and diversity.

**BE SELF-AWARE**

Be mindful of your attitudes and biases. Reflect on your own intersectional experiences of oppression and privilege. Know your limitations and reach out for support to learn more about the barriers and risks experienced by diverse women and girls and maintain openness to learning more about diverse women’s and girls’ experiences as their needs and gender identities evolve.

**FOCUS ON THE PERSON AND THE ENVIRONMENT / SYSTEMIC BARRIERS**

Explore how diverse women and girls experience increased discrimination and systemic inequality, all of which increase their risk of GBV and the barriers they face in accessing GBV services.

**CELEBRATE DIVERSITY**

A key message in this resource is to take a strengths-based approach to the diversity of women and girls, as with all GBV programming. This approach acknowledges the diverse lived experiences of women and girls and acknowledges the solidarity and mutual support that women and girls experience in groups formed around their diverse identities. A strengths-based approach promotes the benefits of creating GBV programming that is inclusive of all women and girls.

**COMMIT TO LEARNING**

GBV actors are still learning how diverse forms of inequality and discrimination affect women and girls, and un-learning biases and internalized prejudice. We encourage you to be open to learning and listening to each other and to commit to upholding professional values that support all women’s and girls’ rights to safe access to services, dismantle barriers, and work together to end discrimination against all women and girls. Local experts on older age, disability, LGBTQI, ethnicity, and religion are partners in our learning. Make connections with other social justice movements and actors to learn more.
DEFINITIONS AND TERMS

Accessible: When GBV response services are accessible, they can be reached and utilized in a timely, safe way by diverse women and girls according to their needs. In the Convention on the Rights of Persons with Disabilities (CRPD), accessibility is defined as “appropriate measures to ensure persons with disabilities access (services) on an equal basis with others.”

Bias: A prejudice against something or someone. Biases are often based on stereotypes and result in harmful attitudes and discriminatory practices, either direct or indirect. Many people may be unaware of their biases formed from lifelong social norms, which discriminate against certain groups of people.

Cisgender: A woman or girl whose gender identity matches the female sex that she was assigned at birth.

Discrimination: Direct discrimination occurs when, in a similar situation, certain persons are treated less favorably than other persons because of a different personal status for a reason related to a prohibited ground. Indirect discrimination means that laws, policies, or practices appear neutral at face but have a disproportionate negative impact on certain persons.

Empowerment: Empowerment is a process where women and adolescent girls have increased control over their lives and bodies: They set their own agendas, gain skills, solve problems, and develop self-reliance. Empowerment enables women to influence the policies, processes, and institutions that affect their lives, including the structures and institutions that reinforce and perpetuate gender-based violence, discrimination, and inequality. The concept has a long history in social change work, which emphasizes the importance of gaining the ability to make meaningful choices.

Exclusion: Exclusion is the consequence that discrimination and violence may have in the lives of women and girls. There may be conscious and subconscious ways in which we relegate excluded groups to subordinate positions, making them feel as if they are less important than those who hold more power or privilege in the community.

Heteronormative: Attitudes, behavior, and systems based on the assumption that everyone is straight or heterosexual.

Identity: Different aspects of one’s experience based on the characteristics (e.g., age, class, ethnicity, etc.) and roles (e.g., mother, athlete, student, leader, etc.) that connect individuals to specific groups in society and make each person uniquely who she is. One’s identity influences how she sees the world, chooses to act, and is treated by others. While some parts of identity (e.g., skin color) are quite public, other aspects (e.g., sexual orientation) may be kept hidden, due to fear for one’s safety or fear of stigma, rejection, or judgement. It is important to note that identity is both chosen and imposed. For example, women and girls with disabilities may not see themselves as having a disability and it is hurtful to view disability as a key aspect of one’s identity when this may not be her lived experience.

Inclusion: Inclusion is the process of improving the way people participate in the community and how they access services and resources. Inclusion is particularly important for diverse women and girls who face discrimination, increased risk, and additional barriers to
participation and access to services. Inclusion involves proactively addressing barriers and risk to ensure everyone can meaningfully participate and benefit from services. Inclusion involves enhancing opportunities, access to resources, voice, and respect for rights.10

**Intersectionality:** This feminist framework created by Kimberlé Crenshaw11 explains how interlocking systems of oppression mean that women and girls experience violence and discrimination differently based on their race, class, age, disability, sexual orientation, gender identity, ethnicity, and religion. An intersectional approach requires that action to achieve social justice be informed by an understanding of the multiple experiences of inequality faced by women and girls, rather than prioritizing the experience or needs of one group of women over another.

**Minority / Minorities:** No internationally agreed definition determines which groups constitute minorities. In general, minorities are defined as “groups differing … in race, religion or ethnic background, from the majority of a population.” The UN Minorities Declaration adopted in 1992 refers to minorities as groups based on national, ethnic, cultural, religious, or linguistic identity, and asserts that states should protect their existence. The characteristics that define minorities vary widely from one context to another.12 Importantly, social groups are uncomfortable with the “minorities” label because it may be linked to “vulnerability,” weakness, or less value than the majority, shaping power relations and undermining a language of equality. Because of this negative connotation, this Guidance Note uses the term “ethnic and religious affiliation.”

**USE OF THE TERM MINORITY**

In Iraq and Syria, social groups are uncomfortable with the term, “minorities”. Objections to using the term include:

- It is a source of vulnerability, indicating weakness or less value than the majority.
- It shapes power relations and undermines a language of unity around citizenship.
- For some groups, the concept overshadows their historical roots as indigenous peoples or descendants from ancient Mesopotamian peoples.

“The Protection of Minorities in Iraq and Syria,” Norwegian Church Aid (2016)

**Participation:** Meaningfully involving women and girls in decision-making and action both in their communities and within the wider humanitarian system. Women and girls’ participation promotes community resilience by building on the existing capacities and resources of diverse women and girls. Participation of diverse women and girls from the affected community, individually and through local women’s movements and groups, can enhance local capacity, foster ownership, build resilience and improve sustainability.13 Participation is a key aspect of empowerment and results in better humanitarian outcomes.

Pronouns: A pronoun is a word that refers to either the person talking (I or you) or someone or something being talked about (she, he, it, them, or this). Transgender women and girls face difficulty when the pronoun they identify with does not match the sex they were assigned at birth or others’ perception of their gender identity. For example, a transgender woman may be called “he” by people who are unaware that she identifies as female and prefers the pronoun “she,” by people who are confused by her gender identity, or by people who are deliberately trying to hurt her. Respecting a person’s pronoun(s) is a simple act of inclusion.

Reasonable accommodation means necessary and appropriate modifications and adjustments where needed in a particular case and that do not impose a disproportionate or undue burden, to ensure women and girls with disabilities are comfortable or exercise on an equal basis with others of all human rights and fundamental freedoms.¹⁴

Universal design/access is a way of ensuring accessibility through the design of products, environments, programs, and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.

<table>
<thead>
<tr>
<th>Term to use</th>
<th>Term to avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women and girls with disabilities</td>
<td>Disabled women, PWDs (i.e., using acronyms to refer to people)</td>
</tr>
<tr>
<td>Women who are older</td>
<td>Elderly women, OAPs, old women</td>
</tr>
<tr>
<td>Women and girls with diverse sexual orientations and gender identities (SOGI)</td>
<td>Tomboy, lesbian woman, queer women</td>
</tr>
<tr>
<td>Diverse women and girls</td>
<td>Marginalized women and girls</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>Sodomy, defilement</td>
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To be effective GBV actors, we must understand how oppression based on age, race, disability, class, sexual orientation, gender identity, ethnicity, and religion, compounds the risks and discrimination faced by diverse women and girls in emergencies. **Women and girls who face multiple forms of oppression are at increased risk of GBV and face increased barriers to accessing support and to recovering.**

When GBV actors are aware of the risks and barriers diverse women and girls face, they can take action to remove those barriers, ensure GBV services are accessible to all women and girls, increase GBV programming capacity to include the full diversity of women and girls in the community. GBV actors who **proactively include diverse women within their response teams** will have an advantage in understanding and connecting with diverse women and girls in the affected community. All GBV actors can commit to learning more about diversity and intersectionality and taking action to include all women and girls.

> **Today our challenge to ourselves and the women’s movement must be to render the complexities of intersecting discriminations plain enough to see and intervene in so that marginalized women are included not only in how we talk about effecting change but are also involved as participants in the actions to which we commit ourselves in future directions of the women’s movement.**

Marsha Darling, AWID Forum “Reinventing Globalization” Guadalajara, Mexico, October 2002

Understanding how intersecting inequalities can undermine diverse women’s and girls’ power and decision-making and increase their risk of GBV will help GBV actors to adapt their response. Considerations include:

- **Loss of familial and community support mechanisms:** During displacement, families and communities often become separated and traditional community support structures become weaker. This weakening of community protections affects diverse women and girls particularly harshly as they already have fewer...
protections or people they trust and could turn to for support if they experience GBV. In an emergency context, women and girls with disabilities, adolescent girls, and women who are older, may not have well-known family or community members they can depend on, which can often add to their risk of violence. Women and girls with diverse sexual orientations and gender identities, particularly in contexts where same sex relationships are criminalized, may have carefully built up support networks and strategies to navigate their home context more safely before the crisis. Displacement disrupts these networks and strategies, thereby increasing their risk of experiencing GBV and reducing the number of people from whom they can seek support. Women and girls from diverse ethnic and religious groups may be at increased risk of GBV as they may also be targeted on the basis of their ethnicity or religion, particularly where those factors drive local conflict.

Dependence and control: Issues of power and control may be more complex in relationships in which a woman or girl is reliant on her parent or partner as a caregiver. Dynamics and tactics of power and control that may be used against diverse women and girls with increased dependence on caregivers include situations in which abusive caregivers:

- Threaten to or withhold basic care and support (food, money, hygiene) or leave her unattended.
- Threaten to or withhold, misuse, or delay specific support that helps the woman or girl function (e.g., medication, equipment).
- Use the woman’s or girl’s money for themselves and/or make financial decisions for her without her consent.
- Isolate the woman or girl from social networks.
- Ridicule and embarrass the woman or girl because of her age or disability.
- Blame the woman or girl for their own stress (e.g., as a result of having to care for them).

Barrier Analysis

The following barrier analysis framework, adapted from a disability barrier analysis, can support GBV actors to identify and target barriers that can be removed to support the access and participation of diverse women and girls.

Physical

Physical barriers impact diverse women’s and girls’ access to services and can be natural or be created by humanitarian actors or others.

Information

Information barriers occur when information is not made available and accessible for all women and girls.

Attitudes

Harmful attitudes remain one of the major barriers to full and equal participation of diverse women and girls in GBV response programming.

Institution

Institutional barriers are the procedures and policies that discriminate against diverse women and girls.

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Physical: Physical barriers impact diverse women’s and girls’ access to services and can be natural or be created by humanitarian actors or others. Physical barriers are compounded by gender norms that limit women’s and girls’ mobility and increase isolation of GBV survivors, which make distance to services a critical factor. Narrow doors, stairs, steep slopes, or other physical difficulty elements also limit access for women and girls with physical disabilities who may need wheelchair access. Diverse women and girls may be hidden or isolated by their families on the basis of adolescence, older age, or disability. They may also hide their identities when their ethnicity, religion, sexual orientation, or gender identity puts them at risk of discrimination and violence. Physical isolation further increases risk of GBV, particularly inside the home, and limits women’s and girls’ options to seek help. Isolation can lead to depression and other mental health issues, as it is a barrier to accessing response services and reintegrating into educational and economic opportunities, and increases dependence and limits choice.

Information: Information barriers occur when information is not made available and accessible for all women and girls. Women and girls with visual disabilities, who speak diverse languages, or who do not read confidently or at all, all face significant challenges to accessing written information on GBV response services. In addition, information that excludes diverse women by visually portraying only some types of women accessing services presents a barrier to service uptake by making some women and girls feel unwelcome or unsure about whether services are applicable to them. Women with audio disabilities may struggle to participate in safe space activities and GBV response services where sign language is not available to help them communicate.

Attitudes: Harmful attitudes remain one of the major barriers to full and equal participation of diverse women and girls in GBV response programming. Unconscious bias or directly discriminative action excludes diverse women and girls from accessing services and participating in GBV programming. Patriarchal or sexist attitudes are exacerbated for diverse women and girls who also experience ageism, homophobia, transphobia, racism, and prejudice based on disability, class, HIV status, religion, and ethnicity from GBV service providers, other humanitarian actors, and women’s and girl’s family and community members. If GBV actors do not proactively make it clear to diverse women and girls that they are welcome in women and girls safe spaces and GBV response programs, then women and girls may fear they will find the same harmful attitudes present in the wider community and may not seek help.

Institutional: Institutional barriers are the procedures and policies that discriminate against diverse women and girls. For example, when a male partner’s consent is required to provide health care for GBV survivors, this not only discriminates against women’s bodily autonomy and choice, but poses a significant barrier for women in same sex relationships. Diverse women and girls with higher levels of dependency on others, such as some adolescent girls, women and girls with disabilities, or women who are older, may need to disclose their situations to others in order to access services, and responders or community members may take action on behalf of the survivor without her consent or assent. Other examples that could lead to the exclusion of diverse women in GBV response teams include recruitment practices that are not flexible or adapted for women with disabilities, that do not facilitate diverse religious practices, or that do not support child care or allow for parental leave.

BARRIERS FACING DIFFERENT CATEGORIES OF WOMEN AND GIRLS

The following section focuses on different groups of women and girls. Recognizing these specific groups of women and girls is helpful as an organizing tool. However, it is important to recognize that women and girls rarely inhabit a single group. For this reason, it is important to think of the diversity of experience within each group and the intersections among the groups. Viewing women and girls in groups based on one aspect of their identity may obscure each of their specific situations, including their strengths.
Adolescent girls account for an increasing proportion of displaced persons and are at higher risk of rape, sexual exploitation and abuse, early marriage, and abduction compared with other population groups. Evidence reveals that adolescent girls not only face a multiplicity of risks during a crisis, but also remain invisible, unprotected, and unengaged, particularly in the crucial first 45 days of a crisis. When humanitarian actors do not consciously account for adolescent girls in emergency responses, girls’ abilities to safely access life-saving information, services, and resources are constricted.

Younger adolescent girls (aged 10-14) and older adolescent girls (aged 15-19) are among the most vulnerable segments of any population in humanitarian contexts; they face the highest protection risks, yet are one of the most invisible populations. As they enter adolescence, younger adolescent girls begin taking on adult roles and responsibilities, even though they do not yet have all the skills or physical and cognitive capacities they may need.

Adolescent girls face increased risks of GBV and additional barriers to accessing services due to the following factors:

- Social and cultural norms are manipulated to exert power and dominance over adolescent girls.
- Weakened institutions, poverty, and financial hardship leave adolescent girls vulnerable to abuse, exploitation, and violence (including risky livelihoods).
- Restricted mobility and visibility increase adolescent girls’ isolation, by breaking bonds with peers and with other survival networks.
- Restricted access to adolescent-friendly information and services compromises adolescent girls’ survival.
- Limited attention by the humanitarian community to adolescent girls’ unique roles, needs, and risks.

Inclusive GBV programming differentiates between the needs of younger and older adolescent girls who face distinct developmental challenges, risks, and discrimination. GBV actors must recognize that adolescent girls are not a heterogeneous group and commit to seeing the full “universe” of girls, with differences, including age (younger vs. older adolescents), marital status, accompanied or orphan status, HIV status, ethnicity, educational or employment status, economic status, whether they are time-poor, pregnant, or lactating, disability, mother or primary caregiver, sexual orientation, gender

**RESOURCE FOR WORKING WITH ADOLESCENT GIRLS: GIRL SHINE**

Girl Shine is a program model and resource package that seeks to support, protect, and empower adolescent girls in humanitarian settings, and contains specific guidance on engaging younger and adolescent girls in the design, implementation, and monitoring of GBV programming activities for adolescent girls. [https://bit.ly/2izF4QS](https://bit.ly/2izF4QS)
identity, and experience of sexual exploitation. GBV-specialized programming actors should commit to providing compassionate care and services that are accessible, acceptable, and appropriate to diverse younger and older adolescent girls.

Many adolescent girls – particularly the poorest girls in the poorest communities – already live in an “emergency.” Humanitarian crises only amplify the call on their coping and caring capacities, while exacerbating their vulnerabilities to violence:

**Collaborative for Girls in Emergencies, Statement**

Women who are older can be subject to GBV throughout their lives, although some types of violence are even more likely to occur in older age. Discriminatory laws and practices against women who are older in all spheres of their political, economic, social, and family lives fuel violence and abuse. Worldwide, almost half of women who are older live alone due to being widowed, divorced, or never married. Women who are older and who are isolated from friends, family, and community have a threefold risk of exploitation and limited or no access to services or support in the event they experience violence or abuse.

GBV against women who are older is widespread yet mostly hidden. The World Health Organization’s Global and Regional Estimates of Violence against Women Report (2013) found lifetime prevalence of intimate partner violence among women over 50 years old to be 20.6%. This is likely to be under-reported as less is known about patterns of violence against women who are older than those between the ages of 15 and 49. GBV against women who are older occurs in multiple, often intersecting forms by perpetrators who may include intimate partners, family members (including female and male adult children), caregivers, or members of the wider community. Many women who are older experience one or more types of physical, sexual, financial, and psychological violence, abuse, and neglect. For women who are older and survivors of sexual assault, the health consequences and resulting injuries are often more severe. There is significant evidence that older age impacts women’s health-seeking behavior and access to services, which in turn means that the harmful

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28 Ibid.
31 Ibid.
health consequences for GBV can go untreated and may worsen while GBV continues and increases in frequency and severity. In part based on the focus on women of reproductive age, the sexual health of women who are older is often ignored, marginalized, and stigmatized, impeding access to preventive services and care for interpersonal violence and sexually transmitted infections, including HIV. While many primary care providers avoid talking to their patients about sexual health (due to a range of reasons such as time constraints, lack of resources, training, or perceived ability), they are even less likely to inquire about the sexual activity of older patients.36

The majority of women who are older with dementia experience some form of abuse and their dementia may prevent them from seeking help.37 Disability can be an added risk factor for women who are older, who may acquire an age-related disability. Worldwide, more than 46% of people aged 60 and over have disabilities, many of them associated with sight or hearing loss.38 Women with a lifelong disability can become more vulnerable to violence as they become older, particularly if they are dependent on another person for daily care.39

Women who are older may be at increased risk of GBV due to decreased power and status after a lifetime of diminished opportunities for economic security and education on account of their gender.40 Age and gender discrimination combined can lead to a greater likelihood of poverty, limited access to protective resources, and heightened risk of GBV and abuse.

Women who are older experience discrimination that jointly stems from patriarchal attitudes and norms that place a premium on youth and on women’s roles as child bearers. This discrimination may lead to prejudice that women who are older are “useless” or become invisible or perceived as being less valuable once they are past reproductive age. This creates a specific type of vulnerability to violence driven by ageism as well as sexism.41 The current humanitarian focus on women of “reproductive age” is a manifestation of the intersection of ageism and sexism that sees women reduced to their reproductive function and only counted as “women” depending on their childbearing ability. According to HelpAge International, if left unchallenged, this focus risks promoting a harmful stereotype that violence only happens in younger age, rendering invisible the experiences of women who are older.42

Similar to adolescent girls, humanitarian crises can further increase risks of GBV for women who are older, as ordinary social controls are eroded. In the Democratic Republic of the Congo, for example, 15.5% of women seeking care for sexual violence in a South Kivu hospital between 2004 and 2008 were aged 55 and above. Reports from Iraq highlighted a mass grave of older Yezidi women murdered by the Islamic State of Iraq and Syria (ISIS). According to humanitarian actors working to support the younger surviving women, the

**“OLD” AND AGEISM**

There is no global consensus on when “old age” begins, mainly because the perception of aging varies by individual, community, and societal contexts.

**Ageism** is the systemic stereotyping of, and discrimination against, people because they are considered old. The social construction of old age is reinforced by ageism, which can further inhibit the realization of equality for older women.

*“Brief on Violence Against Older Women,” Violence against Women and Girls (2016)*

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36 Ibid, p.5.
40 Ibid, p.4.
41 Ibid, p.3.
Women and girls with disabilities experience increased risks and barriers in humanitarian contexts due to separation from family, loss of assistive and mobility devices, and difficulties with accessing information. They are more susceptible to exploitation and abuse and are among the most socially isolated groups in any crisis-affected community. They may have difficulty accessing humanitarian assistance programs due to a variety of societal, environmental, and communication barriers.

**DISABILITY, PERCEPTION, AND POWER**

Women and girls with disabilities are not more vulnerable to violence because of their disability, but because they are perceived as being different, have less power and status, are marginalized, and are even directly targeted for violence due to these factors.

For women and girls with disabilities, the intersection of gender inequality and disability makes them especially vulnerable to GBV. A 2015 report on disability inclusion in Burundi, Ethiopia, Jordan, and the Northern Caucasus, states that sexual violence was the most common type of GBV reported by focus group participants in the project settings, with some women and girls with disabilities reporting being subjected to sexual violence, including rape, on a repeated and regular basis and by multiple perpetrators. Family and service providers may only become aware of sexual violence against women and girls with disabilities when they become pregnant. There are reported cases of child marriage among girls with disabilities, who may be pressured to an early marriage before they are perceived as “less desirable” due to both their age and disability. Survivors with disabilities may wait over one year to seek help.

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48 Ibid.
49 Ibid.
month to report violence, due to the additional barriers they face to disclosure.\footnote{Ibid.}

Women and girls with disabilities may face unique barriers to accessing GBV response services and participating in GBV response programming. These may include the following barriers:

- **Physical**: Physical barriers can be natural or people-made. Common barriers include narrow doors and passageways, staircases, level changes, uneven and steep slopes, inaccessible public toilets, waste and debris, heavy food distributions, and services, water, and firewood located at far distances. These physical barriers prevent women and girls from participating fully in community life or accessing needed services. GBV prevention and response services may be physically inaccessible due to long distances, lack of accessible transportation, or high costs of reaching facilities. Furthermore, health clinics and women’s centers may not be accessible for wheelchair users or those with other mobility challenges, which may also convey a message that services are not welcoming to women and girls with disabilities.

- **Communication**: Information about GBV response services may not be presented in formats that are accessible for women and girls with disabilities, including those with visual, hearing, and intellectual or psychosocial disabilities. As a result, women and girls with disabilities, especially those with intellectual disabilities, may not recognize abuse when it occurs or may not know where to access support. Additionally, GBV actors need to recognize different personalized communication styles and forms and cater to the specific communication style of the woman or girl with a disability. Paying time and attention to accurately interpreting and understanding what the woman or girl is expressing or saying may require support from a non-abusive family member or friend.

- **Relationship with caregivers**: Women and girls with disabilities may rely on other family or community members to access services and assistance, which makes it difficult for them to do so in a confidential way. If the caregiver is the perpetrator, it will be extremely difficult for the survivor to access help because she is dependent on the caregiver for communication, transportation, and daily needs.

- **Fear of not being believed**: As with all GBV survivors, a common barrier to care is the survivor’s fear that she will not be believed. This is even more exaggerated for survivors with disabilities, particularly those with intellectual disabilities, whose comprehension and decision-making capacity may be questioned inappropriately. These survivors may fear that she will not be believed if she tells someone, which may put her at added risk of further harm.

- **Perceptions about the capacity of women and girls with disabilities**: People may not listen to women and girls with disabilities or believe them when they disclose violence, especially if the survivor has intellectual or psychosocial disabilities. Furthermore, women and girls with disabilities may be excluded from opportunities to learn about violence, sex, and healthy relationships, and to develop new skills and strengthen peer networks. As such, they may be targeted for rape, abuse, and exploitation, or have less capacity to negotiate power in intimate relationships.
Women and girls with diverse sexual orientations and gender identities are at high risk for multiple forms of interpersonal violence committed against them by colleagues, family members, neighbors, or intimate partners. At the family level, discrimination and violence against girls and women with diverse sexual orientations and gender identities are likely to derive from three inter-related sources: 1) an intense pressure to marry and lead a heterosexual life, 2) abusive family members trying to coerce heteronormative behavior according to rigid gender norms, and 3) social isolation and disconnection from family and community resources. The so-called “corrective rape” of women is a practice that seeks to “cure” a lesbian or bisexual woman of her sexuality by forcing her to have sex with a man or many men. GBV against women and girls of diverse sexual orientations and gender identities aims to uphold the dominant social position of heterosexual men.

Pronouns: A pronoun is a word that refers to either the person talking (I or you) or someone or something being talked about (she, he, it, them, or this). Transgender people face difficulty when the pronoun they identify with does not match the sex they were assigned at birth or others’ perception of their gender identity. For example, a transgender woman may be called “he” by people who are unaware she identifies as female and prefers the pronoun “she,” by people who are confused by her gender identity, or by people who are deliberately trying to hurt her.

Remember: Respecting a person’s pronoun(s) is a simple act of inclusion.

Discriminatory laws often criminalize same-sex and gender non-conforming behavior. The impact of these laws may involve criminal prosecution for same-sex relationships and increase the risk of women and girls being targeted for police extortion and violence or coercion by community members threatening to report women and girls to the police for same-sex relationships.

Discriminatory family and civil laws can also impact the wellbeing of women and girls with diverse sexual orientations and gender identities. This includes the state’s definition of family and marriage, as well as the ability to change one’s sex assigned at birth on official state documents.53

Women and girls with diverse sexual orientations and gender identities may face significant barriers to living openly or “coming out” to their friends, families, and communities and fear hostile reactions, rejection, or violence if they share their identity. Unless GBV service providers are openly welcoming and inclusive, they will face similar barriers when accessing response services and may fear they are not welcome in women and girls safe spaces or GBV programming activities. When GBV response services are heteronormative and assume women and girls are heterosexual or cisgender, they put in place barriers that lesbian, bisexual, and transgender women, and girls have to overcome. Lesbian, bisexual, and transgender women and girls face increased risks of GBV, high levels of rejection by their family and community, and reduced social support networks and educational and economic opportunities. Their heightened need for GBV services and lack of alternative social supports and reduced individual assets, makes it critical that GBV response programming is inclusive and welcoming of lesbian, bisexual, and transgender women and girls.

Challenges that women and girls with diverse sexual orientations and gender identities may experience include:

- A mistrust of authority due to police and other official targeting.
- Fear that their family will find out if they share their status with humanitarian organizations.
- Fear that humanitarian aid workers will discriminate against or make assumptions about them.
- A belief that sharing their identity could bar them from resettlement or delay their case.
- Lack of access to local resources or information about activities or rights if they have not shared their status with NGOs or international organizations.54

“Around the world, lesbians, bisexuals, transgender people and others with diverse sexual orientation and gender identities are targets of brutal physical and psychological violence. We are subject to harassment, assault and other violence; often under the guise of so-called ‘honor’, ‘tradition’, ‘nations and families’.”


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53 Ibid.
Women and girls with diverse ethnic and religious affiliations are often overlooked in emergency response. If the violence that caused displacement targeted specific communities, women and girls from those ethnic or religious communities may be at greater risk of continuing violence and discrimination. Some ethnicities are excluded from economic opportunities and at increased risk of trafficking, including sexual exploitation. This risk multiplies in a situation of displacement and is particularly acute for women and girls with diverse ethnic and religious affiliations. Women and girls with diverse ethnic and religious affiliations may be more socially isolated and may lack community protection compared with more dominant social groups. Women and girls from diverse ethnic and religious affiliations may lose important elements of their cultural identity or have elements of their cultural identity misinterpreted or interpreted negatively. They may also lose their support networks when separated during or after displacement, which can be particularly harmful to women and girls who have experienced GBV. Women and girls may not be able to speak openly if interpreters are from a different community in the country of origin or country of refugee or asylum.

There are nuanced differences between the humanitarian needs of certain groups and how best to meet those needs, in terms of the nature, targeting, and delivery of assistance. Those differences depend on whether a minority group has been directly targeted during the conflict, its past experience of persecution and discrimination, its level of political power or influence, and its beliefs and cultural norms.

Many humanitarian organizations do not currently consider ethnic and religious affiliation in programming, and the significance of people’s ethnic and religious background is overlooked in the way information is gathered. Humanitarian responses need to take this diversity into account in order to meet the critical needs of women and girls affected by conflict and support them in a sustainable way. They must also address aid prioritization and beneficiary criteria that may fuel resentment, discrimination, and tensions by excluding some conflict-affected groups.

In a GBV rapid assessment conducted for a 2016 regional study, 25% of women indicated that their religious affiliation (and nationalities) negatively affected their access to services. When listening sessions and assessments are not carried out with women and girls from diverse ethnicities and religious groups, GBV programming may not be informed by an understanding of their particular needs and priorities. Information on how to access GBV response services may not be provided to the community in diverse languages. GBV service providers may not speak all local languages or hire community volunteers and interpreters who speak diverse languages. Women and girls safe space activities may not be implemented in diverse languages, and when one ethnicity or religious group dominates these safe spaces, other ethnic or religious groups may not feel welcome. Some safe space or GBV programming activities that incorporate religious or ethnic cultural activities or music may also exclude wider participation by diverse women and girls.

UNDERSTANDING “DISABILITY”

Article 1 of the UN Convention on the Rights of Persons with Disabilities defines persons with disabilities as follows: “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which
in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.\textsuperscript{61}

Women and girls with disabilities are often considered to be objects of charity or, from a medical viewpoint, persons needing medical treatment, rehabilitation, and care. These perceptions are described as the charity and medical models. They are perspectives based on disability being an individual problem that must be managed, cared for, or fixed. This approach suggests that a woman is prevented from functioning in society by her body or brain – and that this is her problem.

The rights-based model views women and girls with disabilities as rights-holders, promoting full and equal enjoyment of all human rights to women and girls with disabilities, and respect for their inherent dignity. This approach focuses on equal opportunities, non-discrimination based on disability, and participation in society. The rights-based approach requires authorities to ensure rights and not restrict them; enforce laws to ensure full inclusion in all social aspects (school, family, community, work, etc.); apply policies to raise awareness; and respect equal recognition before the law.

The key principles of a human rights approach to disability include inclusion, participation, accessibility, non-discrimination, respect for difference and diversity, equality of opportunity, and respect for human dignity. This approach is applicable to all women and girls.

The social model developed as a reaction against the individualistic approaches of the charitable and medical models. With the social model, disability is not a “mistake” of society, but an element of its diversity. The social model focuses on society and considers that the problem lies with society, that women and girls with disabilities and women who are older are excluded due to various barriers, whether social, institutional, economic, or political.\textsuperscript{62} In other words, according to the social model\textsuperscript{63} of disability, people with disabilities are disabled not because of their individual differences, but because of the systemic barriers they face in society. Therefore, it is possible to understand the word “disabled” not as “less able” but rather as “prevented from functioning.”

Moreover, the social model distinguishes between “impairment” – the things one cannot do because of her body and/or brain – and “disability,” which are the social barriers that disable someone because she has an illness or impairment. In other words, impairment is only one component of disability and refers to the body function (e.g., a cataract that prevents the passage of light in the eye, the loss of one limb, or a mental function that is affected); the other components of disability are activity limitation and participation restrictions, which are factors of the environment.

The shift toward the social model has meant promoting the inclusion of people with disabilities by removing barriers and obstacles, rather than addressing individual impairments through specialized interventions. This includes making accessibility adaptations of the built environment, ensuring accessible information and communication, and ensuring access to basic services, providing technical and assistive devices, changing attitudes and reducing stigma, as well as empowering people with disabilities and their families.

Disability = Impairment (of the person) + barriers (in/by the environment)

“Disability” is not inherent to a woman or girl; it results from the environment’s failure to meet her needs.
Assessments must be approached with the understanding that every community includes adolescent girls, women who are older, women and girls with disabilities, women and girls with diverse sexual orientations and gender identities, and women and girls from diverse ethnic and religious affiliations. This includes understanding that women and girls likely hold multiple intersecting identities. As with the presence of GBV, it is not necessary to verify the number of women and girls with disabilities or the presence of women and girls with diverse sexual orientations and gender identities to design programming that is inclusive and responsive to all.

Based on these facts, any assessment should seek to address diverse women’s and girls’ needs. GBV assessments are not about determining whether GBV is occurring, but rather better understanding the context, the dynamics of violence, and the existing services to inform what kind of services and activities are appropriate and feasible for women and girls to recover and thrive. Moreover, a strong contextual understanding of intersectional inequalities women and girls face is vital to ensuring that response services and risk mitigation activities are inclusive and accessible to all women and girls and do not inadvertently expose survivors or individuals to further harm. It is important to note, however, that some women and girls may fear being identified openly as part of a certain identity group (e.g., a religious affiliation, diverse sexual orientation, or gender identity), either in general or among women and girls who are in the majority population.

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It can be useful to mobilize separate groups of diverse women and girls to meet the language needs of diverse ethnic groups, to ensure adolescent girls and women who are older feel comfortable sharing their priorities, and to create space for the participation of women and girls with disabilities. However, it is NOT recommended to form separate groups for women and girls with diverse sexual orientations and gender identities due to safety risks and stigma. There are also benefits to forming mixed groups of diverse women and supporting dialogue with translation, sign language, or visuals, to allow for interactive discussion and to promote an inclusive understanding of priorities among diverse women.

It is, however, NOT recommended to ask women and girls to disclose their sexual orientation or gender identity. GBV actors can take the approach already used to discuss GBV by using intersectional case stories and general questions about GBV risks to discuss sensitive issues with women and girls safely, without facilitating personal disclosure of violence.

**The key information points to discuss with women and girls include:**

- Women and girls who are at particular risk of discrimination and violence.
- Specific barriers related to their access to services.
- Factors that increase vulnerability to risk and violence.
- Mechanisms and approaches that may support specific groups of women and girls to access services and information safely.

**Design the assessment with the following questions:**

- Which groups of women and girls are most at risk in this community? What are the expressed needs, gaps, and priorities of these groups?
- Which groups of women and girls have access to services? Which groups are not accessing services? Why? How can we increase their participation?

**WHEN DESIGNING THE ASSESSMENT CONSIDER:**

**Adolescent girls:** Engaging adolescent girls and particularly younger adolescent girls (aged 10-14) in information-gathering exercises may raise more risks than benefits. All risks should be carefully considered prior to engaging adolescent girls. If benefits to participating are outweighed by efforts that can sufficiently reduce risks of participation, assessment teams should move forward with engaging these women and girls. However, if the risks continue to outweigh the benefits from participation, women’s and girls’ safety should be prioritized over their engagement in assessment activities. Adolescent girls have different needs and interests from adult women and often report they are not interested in participating in activities (including information-gathering activities) alongside their mothers. Adolescent girls who attend school are likely to have different needs and interests from those who are out of school and available to participate in assessment activities at different times.

**Women who are older** are often assigned childcare and household responsibilities that restrict their participation in assessment activities. The voices and priorities of women who are older may be ignored by community leaders when mobilizing women to participate in assessment activities. Women who are older may have mobility issues compared with younger women or may find it challenging to participate in information-gathering activities alongside younger women due to hearing impairments.

**Women and girls with disabilities** (physical, mental, intellectual, vision, or hearing) will require a variety of ways to communicate information and assistance to reach and engage in assessment-related discussions. For example, considerations should include additional time to discuss and ask questions, picture formats, sign language interpreters, and visual demonstrations. In addition, assessments can include interviews with disability actors to guide GBV program design. As with any community group, disability groups may be male-dominated. Try to identify local

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women-led disability groups or ask to speak with women with disabilities within disability groups to understand the specific risks and barriers facing women in this community.

**Women and girls with diverse sexual orientation and gender identities** should not be mobilized in separate groups in the community. To safely inform your assessment, make sure to connect with local LGBTQI actors who understand the local context and legal frameworks. Make sure to ask to speak with women within the LGBTQI community as this community may also be male dominated. Engage women-led LGBTQI groups where they exist.

**Pronouns (e.g., she/her)**

When speaking to women and girls with diverse sexual orientation and gender identity, remember to refer to the person by the name and pronoun they share with you. If you are not sure what that is, ask. Respect women’s and girls’ identities. Do not make assumptions.

**Women and girls with diverse ethnic and religious affiliations** will require different locations and languages to participate in assessments. Ensure that conditions are sufficiently secure for women and girls to feel comfortable about identifying themselves as members of an ethnic or religious group. This also requires being aware of and configuring the assessment team composition to maximize comfort levels for women and girls. Make sure that women and girls not wishing to self-identify are not forced to do so, especially in situations where they may be at risk. When organizing a meeting with an individual or a group from an ethnic or religious minority, make sure that measures to ensure their security and privacy are in place.66

**Key Actions:**

- Safely engage women and girls from diverse groups – do not make assumptions about how diverse women and girls want to be engaged. Always ask about participants’ preferences to ensure diverse women and girls are comfortable and can safely participate.

- In group discussions, create as safe a space as possible by reinforcing confidentiality and reassuring participants it is not necessary to share personal disclosures of GBV or discrimination. Use case studies and general examples as models to explore how different identities may increase risks and barriers for diverse women and girls. If an individual disclose, remind the group about confidentiality.

- Do not identify diverse women and girl participants by pointing out or identifying her age, disability, sexual orientation, gender identity, religion, ethnicity, or other characteristic, as this can be harmful and stigmatizing.

- If women and girls self-identify and share personal experiences that are sensitive, then – in the same way you would respond to a disclosure of GBV – thank the participant for sharing her valuable personal experience, remind the group of confidentiality, and explain that if the participant would feel more comfortable, you are happy to speak with her one-on-one, after the general group discussion. If, however, the participant is comfortable sharing within the group, then support her to share and respect her agency to talk about her experience of discrimination and her identity. Sharing in a safe space discussion can be empowering for diverse women girls and their agency should be respected.

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Use and adapt GBV assessment tools that are inclusive for all women and girls.

Disaggregate data collection by sex, age, disability, and other relevant local inequalities.

Document qualitative findings that illustrate the lived experiences of diverse women and girls to inform GBV program design.

Engage service providers to uncover norms and attitudes toward diverse women and girls.

Translate GBV assessment tools to the diverse languages used by women and girls as much as possible.

Extend the assessment planning, staff training, and tool review with existing local inclusion expert groups, such as LGBTQI, older age, and disability actors.

**PROGRAM DESIGN**

Directly engaging diverse women and girls in program design activities at the onset of an emergency and throughout the response is critical to implementing inclusive GBV programming. This includes engagement through monitoring and feedback mechanisms. By using an intersectional approach from the start of an emergency to design GBV programming, GBV actors can address the radical roots of intersectionality, power oppression, and privilege that women and girls uniquely experience, thus planning to ensure the diverse group of women and girls participate and benefit from the program. By engaging diverse women and girls in leadership roles in the design of GBV emergency response programming, GBV actors provide an opportunity for diverse women and girls to act as agents and leaders of change in reconstruction and rehabilitation efforts, including making decisions for their safety, wellbeing, and rights. This is seen as the most effective way to challenge the root causes of discrimination and exclusion.

**KEY ACTIONS:**

Design GBV programming with groups of diverse women and girls from the start of an emergency to make sure GBV programming is adapted to the local context and accountable to women and girls.

Disaggregate monitoring data by sex, age, disability, and other locally relevant identities.

Proactively engage diverse representation of women and girls in groups who are regularly engaged in accountability and feedback mechanisms.

Ensure the locations of emergency safe spaces are safe for diverse women and girls.

Ensure safe space activities are designed to be accessible to diverse women and girls.

Consider different entry points for diverse women and girls to GBV response services and work with other actors to facilitate their access, including health, child protection, disability, older age, and LGBTQI actors.

Recruit GBV response teams to be responsive to local diversities and proactively recruit a range of people who speak different languages, younger and older women, and women with disabilities. And when advertising positions, promote diversity.

Train GBV response teams to apply an intersectional approach from the start of the emergency to ensure teams adopt helpful attitudes and are sensitive to local intersecting inequalities.

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GBV CASE MANAGEMENT

Diverse women and girls need access to quality GBV case management services and coordinated care in a safe and timely manner. These services and care should be responsive to their sex, age, disability, sexual orientation, gender identity, ethnicity, and religion. Survivor-centered GBV case management is delivered to meet the individual needs of each survivor and therefore can responsively meet the needs of diverse women and girls by ensuring informed consent and confidentiality, respecting the survivor’s wishes, and providing accessible information on services without discrimination. A survivor-centered GBV case management approach is built on the foundation that the survivor understands her own situation more than the case worker ever can. By utilizing a survivor-centered approach, the survivor is the decision maker and the case worker provides unconditional positive regard and a healing relationship to support the survivor’s recovery. This approach is therefore effective in supporting the recovery of survivors with diverse identities and experiences.

In emergencies, it is often difficult to provide the full range of case management services. Survivors’ immediate needs and choices should be prioritized, including their safety, security, and access to healthcare and psychosocial support (PSS). GBV case management and response services must be inclusive and responsive to the needs of diverse women and girls. GBV service providers have a professional obligation to equally serve every woman and girl with dignity and respect. When training GBV case workers, it is important to provide opportunities for response teams to identify and explore internalized discrimination and prejudice to ensure an unbiased, compassionate, and non-judgmental response to survivors.

KEY ACTIONS:

- Conduct service mapping to identify existing response services and gaps, taking into consideration the diverse needs of women and girls, and develop a plan to address critical service availability or capacity gaps with GBV key stakeholders and organization.
- Ensure multiple entry points beyond GBV case management and link women and girls to psychosocial support services.
- Recruit and hire staff/volunteers who are representative of the different diversities of women and girls in the community.
- Support GBV services providers with survivor-centered case management training that is tailored and specific to adolescent girls, women who are older, women and girls with disabilities, women and girls with diverse sexual orientations, gender identities, and ethnic and religious affiliations.
- Monitor service access and quality of care that is responsive to the diverse needs of all women and girl survivors of GBV through confidential client feedback surveys, ongoing supervision of case workers, and regular feedback listening sessions group and discussions with diverse women and girls.
- Strengthen inclusion of diverse women and girls in referral pathways by ensuring disability, older age, and LGBTQI actors and diverse ethnic community and religious leaders are part of the referral pathway.
- Provide inclusion and diversity sensitization training to case workers, response staff, and GBV service providers.
- Leverage experiences, best practices, support, and services from local actors working with diverse women and girls (e.g., disability, older age, and LGBTQI actors).

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ANNEX TO GBV CASE MANAGEMENT: CONSIDERATIONS ON PROVIDING CARE & SUPPORT TO SURVIVORS WITH DISABILITIES

COMMUNICATION

In most cases, survivors with disabilities can communicate directly with helpers or service providers with no, or relatively small, adaptations, such as identifying someone who can interpret their form of sign language or by using simplified language in discussions. In other cases, the best way to communicate with a survivor may be less clear, and additional steps may be required to determine this. When working with women and girls with disabilities who find it difficult to communicate you should:

- Take time, watch, and listen. If you are in a context where you will be able to see a survivor more than once, remember that case management is a process, not a one-time event. Each time you meet the survivor you will learn something new about them and understand better how they communicate and what they mean.

- Always talk directly to the individual, even when a caregiver is present. If you are still establishing communication methods with the survivor and need to ask for advice from the caregiver, make sure that you have these conversations in front of the survivor, so they can hear what is being said and participate in any way possible. Remember that women and girls who cannot speak or move may still understand what is happening around them and what people are saying about them.

- Pay attention to any way in which women and girls wish to communicate, which could be through gestures and sometimes their emotions. Some women and girls with intellectual and psychosocial disabilities can exhibit a wide range of behaviors. This is sometimes the way they communicate with others. If you observe or sense a survivor is trying to communicate with you, but you do not understand, it is okay to say, “I don’t understand.”

- Do not put pressure on a survivor. Often times survivors with intellectual and developmental disabilities regress to a lower level of understanding or functioning when under stress. Always respect the individual’s readiness to speak about incidents. As with any survivor, beware of unconsciously replicating dynamics of power and control by pressuring the survivor to disclose information she is not yet ready to talk about.

INFORMED CONSENT AND DECISION-MAKING

The Convention on the Rights of Persons with Disabilities highlights that persons with disabilities have the same rights as everyone else to make their own decisions, and that appropriate measures must be taken to support them in exercising their legal capacity. An individual cannot lose her legal capacity to make decisions simply because she has a disability. You should initially assume that all adult survivors with a disability have the capacity to provide informed consent independently. Always ask the individual whether she would like to access support to make an informed decision.

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28 Ibid.
If you are working with a person with whom you are having difficulty communicating, ask yourself the following key questions:

- Did you try more than one method of communicating the information? Have you given her time to process this information and ask questions?
- Are you able to determine whether the survivor understands the information provided and the consequences of decisions she may make? How did you determine this (i.e., through questions, discussions, gestures, or other means)?
- Have you been able to ensure that the survivor’s decisions are voluntary and not forced or coerced by others? How did you determine this?
- Is a caregiver or family member already involved? If so, how? Are they answering the questions you ask without consulting the survivor?

If, after reflecting on these questions, you are still unsure of a survivor’s capacity to consent independently, you should involve a supervisor to help you determine whether there is a need to provide additional support for informed consent. You can discuss taking the following next steps with your supervisor:

Consider involving a trusted support person. Family members, caregivers, and peers of persons with disabilities can be a valuable resource in facilitating understanding and communication with the person. If you determine that it is safe to do so, ask the survivor’s permission to include someone she trusts in your discussion as a way of supporting communication and enhancing the survivor’s ability to provide informed consent. Let the survivor identify whom they would like to involve and watch for any signs that she agrees or disagrees with the suggestions being made by the support person. You will need to carefully check that the support person does not take over the decision-making process.

Evaluate the best interests of the survivor. Ultimately, if you are still unsure of the survivor’s capacity to consent at any point in the case management process, you can use the following guiding principles to identify decisions that are in her best interest.

- **Safety**: Does the decision or action protect the survivor from potential abuse (physical, emotional, psychological, and sexual, etc.)?
- **Empowerment**: Does the decision or action align with the best interpretation of the will and preferences of the survivor?
- **Cost-benefit analysis**: Do the potential benefits of the decision or action outweigh the potential risks?
- **Healing**: Does the decision or action promote the survivor’s overall healing, growth, and recovery?

To the extent possible, you should still obtain informed assent from the survivor (i.e., their communicated willingness to participate in proposed decisions, services, and/or activities).

**WORKING WITH CAREGIVERS OR FAMILY MEMBERS**

As discussed in the previous sections, it can be very useful, and in some cases necessary, to work with the survivor’s caregiver(s) and/or family members. However, doing so can also complicate efforts to promote the safety, confidentiality, and interests of the survivor. Persons with disabilities should always be consulted on the involvement of caregivers and family members, as would be the case with all survivors. You will need to routinely assess the risks and benefits of involving a caregiver in a survivor’s care and continually ask if it is necessary, safe, and ultimately empowering for the survivor to do so. Some important things to remember when working with caregivers and family members:

**Assess safety.** Routinely carry out a thorough safety assessment to rule out potential abuse from the assisting person, as most often the perpetrator is someone the survivor knows and it may be the person providing them care and assistance on a daily basis.
Focus on the survivor. The survivor is the individual seeking services and all actions should be guided by her will and preferences. The interests of family members and caregivers may or may not be linked to the will and preferences of the survivor. Maintain primary communication and participation with the survivor and ask for her permission to communicate with the caregiver or family member.

Maintain confidentiality. If the survivor discloses information she does not wish to be shared with her caregiver or family members, you must respect and maintain the survivor’s confidentiality. Do not share any of the survivor’s information, even with the caregiver, without explicit permission from the survivor. When sharing information, always think about why the caregiver needs that information and only share what is necessary to facilitate care. For example, you may do a joint session with a survivor and her caregiver to review a case action plan because it requires the caregiver’s or family member’s action. In that case, they only need to know what is relevant for facilitating care. Finally, if a caregiver or family member is involved in any aspects of the case management process, they also need to maintain confidentiality. Be sure you have made this clear to the person from the beginning.

Support the caregiver or family member. If you determine that the caregiver or family member involved is safe, you should provide support to the caregiver as well. Providing them with accurate information about the risks and impacts of GBV and trauma can help them understand what the survivor may be experiencing and how to best support her. Caregivers may be inclined to blame the survivor, so be sure to communicate that what happened was not the survivor’s fault. Caregivers may also blame themselves for not being able to protect the survivor from violence. Providing messages to the caregiver that are supportive, non-blaming, and non-judgmental may be important for them to hear. By supporting them, you are also enhancing their ability to support the survivor. Caregivers may also be struggling to accept or cope with the girls’ disability and be contemplating forced or early marriage of the girl to a man or boy so that they no longer have to support her. GBV response staff should be aware that girls with disabilities may be at increased risk of forced or early marriage in some contexts and seek to mitigate these risks with the survivor through the case management process.

Safety

Safety plans for survivors with disabilities must be highly individualized and should take into account the following:

The individual’s specific disability and living situation and ways in which a perpetrator may try to exploit the survivor’s disability to isolate her, prevent her from leaving, or further harm her.

How the survivor’s disability may impact the execution of her safety plan. Adjust the plan as necessary.

What disability-specific items the survivor may need if she implements her safety plan, such as medication, assistive devices or equipment, or relevant documentation for health or legal support.75

29 Ibid, p146.
75 Ibid.
PSYCHOSOCIAL SUPPORT

Support the provision of cultural-, age-, and gender-sensitive psychosocial support services to ensure that survivors of traumatic events receive sufficient protection and rehabilitation to reintegrate into society. Ensure that appropriate and effective referral mechanisms are accessible for all women and girls. The discriminatory exclusion of women and girls from the diverse groups from psychosocial support and response services increases casualty rates, negative psychosocial impact, and health issues.

Modes of expressing distress – how women and girls explain and make sense of their health symptoms and how they seek help – are culture-specific and rooted in religion and social norms. Women’s and girls’ religious and ethnic backgrounds are therefore critical factors in understanding and meeting the needs of GBV survivors. For example, trust in service providers is necessary for them to come forward, and in some instances, women feel more comfortable receiving support from case workers from the same faith. Sensitivity to women’s family and community culture is important in supporting survivors of GBV as issues around privacy, domestic habits, and tradition sometimes differ. Failing to take these into account could prevent women from accessing the support they need. Use existing civil society structures trusted by local populations, including those of diverse ethnicity and religious groups, to provide information on GBV response services.

KEY ACTIONS:

- Train and support GBV first responders to provide a safe, calm environment; to listen supportively; to demonstrate compassion and non-judgment; to provide reassurance without bias; and to promote access to diverse women and girls.

- Provide psychosocial support that is responsive to diverse women’s and girls’ age, disability, culture, and religion.

- Ensure information about psychosocial support services is shared with and reaches all diverse women and girls through targeted outreach.

- Identify and remove barriers to diverse women’s and girls’ access to psychosocial support services, including: location, mobility and accessibility, cost, privacy, language, culture (e.g., need for permission or accompaniment of a male relative), child care, timing of activities, etc.

BEST PRACTICE: REINTEGRATING ENSLAVED YEZIDI WOMEN INTO SOCIETY

Norwegian Church Aid’s partner organization, Yazda, in cooperation with the Yezidi religious leadership in Lalish (a Yezidi holy place outside Dohuk), has developed an integration process for women survivors of captivity under ISIS. At the beginning of the reintegration program, these women visit Lalish for a few days, receive counselling, and undergo cleansing rituals, before being publicly welcomed back to the Yezidi community by the clergy in Lalish. Clergy members also publicly state that the women are in no way responsible for what happened to them, and that they should be received back into their families and communities without any resentment or prejudice.

Protection of Minorities in Iraq and Syria, p. 13

BUILDING LOCAL THINKING GLOBAL
Identify and promote inclusive community-based support group, self-help, and resilience strategies (such as working with communities), existing local actors/activists to establish/adapt routines and practices that may facilitate community support that promotes inclusion, safety, respect, care, and recovery.

Integrate inclusive psychosocial support services in the referral pathway; ensure safe and confidential referrals to clinical care, mental health, and other protection services; and implement livelihood and empowerment activities for all diverse women and girls.

WOMEN & GIRLS SAFE SPACES (WGSS)

A women and girls safe space is a place where women and girls are respected and welcomed in all their diversity. Staff and volunteers should be aware of and consult with women and girls on how to adapt WGSS structures and recreational activities to be inclusive of women and girls of all ages, disabilities, sexual orientations, gender identities, ethnicities, and religions. Diverse women and girls should feel physically and emotionally safe to access the WGSS to report protection concerns, express their needs, receive services, engage in empowerment and livelihood activities, and support and connect with other women and girls. A WGSS should actively amplify the voice, agency, and leadership of diverse women and girls and take action to maximize their meaningful participation in WGSS services and activities.

Segregated spaces for diverse women and girls are rarely the answer to specialized needs. A WGSS should aim to house a range of activities that can meet diverse women’s and girls’ needs and build a diverse women’s movement, connecting displaced women and girls in a new community. In general, GBV actors should aim to adapt safe space activities to be widely accessible, rather than organizing specialized activities for segregated groups. When in doubt, consult diverse women and girls and build collective understanding of diverse needs. If conflict or competition among diverse women and girls occurs, organize listening sessions and dialogue to facilitate a process for WGSS participants to build empathy and understanding for each other’s experiences. For example, celebrations of religious events can be valuable to bring multi-faith communities together and promote interfaith tolerance. Separate spaces for adolescent girls within a WGSS are recommended to provide a space with specialized age-appropriate activities. However, sharing learning from the adolescent girls safe space (AGSS) with the wider women’s and girls’ community builds understanding and community support for the needs of adolescent girls. Similarly, celebrating or holding awareness-raising events on international days focused on disability, older age, or LGBTQI rights, can build awareness and promote tolerance within the wider community of women and girls.

ENSURING DIVERSITY IN THE WGSS

1. Empower and celebrate diversities in the WGSS.
2. Respect and accept women and girls as they are.
3. Consult with women and girls how they prefer to participate in WGSS activities.
4. Promote the use of positive inclusion terminology among staff and in WGSS activities.

KEY ACTIONS:

- Proactively engage diverse women and girls in the design of the WGSS.
- Organize a WGSS committee to run safe space activities that includes representation of diverse women and girls.
- Recruit staff and community volunteers to run WGSS activities who represent diverse women and girls in the community.
Use an appropriate range of local languages and alternative communication methods to reach diverse women and girls in the community.

Provide inclusion and diversity sensitization training to WGSS staff and volunteers, and engage them in continuous reflection and self-awareness of implicit biases, power dynamics, and privilege that affects diverse women and girls.

Engage women and girls actively through informed outreach strategies to mitigate identified access barriers that hinder diverse women’s and girls’ equal and meaningful participation.

Disaggregate WGSS participants’ feedback on programming by age, disability, and other locally relevant inequalities and address gaps and barriers to participation.

**HEALTH RESPONSE**

Access to quality, confidential, age-appropriate, and compassionate healthcare services is a critical and life-saving component of a multi-sectoral response to GBV in emergencies. Healthcare providers are often the first and sometimes only point of contact for GBV survivors. They offer a general entry point that diverse women and girls can usually safely access for health reasons, without specifying that they are in need of clinical care for GBV until they are in a private setting with the healthcare provider. Healthcare providers are at the front lines of GBV response in emergencies and play a central role in identifying protection concerns affecting diverse women and girls, immediately addressing physical and emotional/psychological needs, and providing an entry point to ongoing GBV response and WGSS services. However, as with all GBV responders, healthcare providers may benefit from opportunities to identify and explore their internalized bias and harmful attitudes to ensure ethical and non-discriminatory provision of care.

Interacting with survivors with disabilities is a matter of persons, not of disabilities. **IRC.**

**KEY ACTIONS:**

- Ensure all diverse women and girls have immediate access to priority reproductive health services, as outlined in the Minimum Initial Service Package (MISP) at the onset of an emergency (no needs assessment is necessary).81
- Ensure all diverse women and girl survivors of GBV have access to high-quality, life-saving health care, including timely clinical management of rape and post-rape treatments.
- Consult with diverse women and girls in the design and delivery of GBV and health programming.
- Develop women’s support groups, including providing training or specific support for inclusion of diverse groups in the community, according to their age, disabilities, and other identities.
- With health coordination mechanisms, support a mapping exercise or analysis of existing sexual and reproductive health (SRH) services, including specialized local groups or service providers that are already working with diverse women and girls. Identify SRH program needs, capacities, and gaps, and conduct a planning exercise in coordination with all relevant stakeholders for effective and efficient health service delivery. Ensure that access to health services is not undermined by staff attitudes or power dynamics based on the intersectional inequalities faced by diverse women and girls.

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Comprehensively include community-led outreach; community health worker, traditional birth attendances, hygiene promotor, women’s group and other community outreach workers to exhaustively encompass diverse women and girls to inform affected health and reproductive health related consequences of GBV and services available.

Identify, collect, and analyze disaggregated health information system by sex, age, disability, and other identities to monitor GBV risk-reduction activities and access and barriers to health services.

Health staff must be trained to deliver age-appropriate and disability-friendly services. Training on diverse populations, non-discrimination, stigma reduction, power dynamics, and the right to access services, must be integrated into clinical capacity-building for all staff.

In providing health services, work with local actors, gender specialists, diversity specialists, inclusion specialists, or specialized networks based on age, disabilities, LGBTQI, or ethnic or religious affiliation.

Healthcare and psychosocial support. A functional referral system is survivor-centered and inclusive of diverse women and girl survivors. Diverse women and girls can learn about GBV response services through their participation in other social change movements. Equipping humanitarian actors focused on disability, older age, and LGBTQI rights with an understanding of the GBV response referral pathway will help staff to refer women and girls who disclose GBV for care. Engaging these groups can also help GBV actors learn about different services available to meet the needs of diverse women and girls.

**KEY ACTIONS:**

- When conducting GBV service mapping, include criteria that assesses inclusive access to services by diverse women and girls.

- Engage social change and inclusion actors, such as disability, LGBTQI, older age, youth, and child rights groups, to ensure their familiarity with GBV response referral pathways and support women and girls from these groups to access services.

- Ensure referral pathways are accessible to diverse women and girls through multiple mediums: multi-language radio, posters with braille, sign language at community events, etc.

- Pay specific attention to how adolescent girls can have entry points to GBV response through both GBV and child protection programming.

- Hold service providers accountable to the diverse needs and inclusion of diverse women and girls through existing coordination mechanisms and standard operating procedures.

**REFERRAL SYSTEMS**

Survivors of GBV have multiple needs, and coordination among service providers is crucial to support women and girls to meet those needs. Context-specific referral systems coordinate service delivery and facilitate survivors’ access to services. In emergency settings, GBV survivors from diverse backgrounds need access to life-saving services quickly and safely. At a minimum, diverse women and girls need (1) a network of qualified service providers, and (2) an established referral pathway detailing where and how survivors can access services.

A referral pathway is a flexible mechanism that safely links diverse women and girl survivors of GBV to supportive services. In emergency contexts, referral pathways prioritize safe access to

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COMMUNITY OUTREACH

In an emergency, community outreach facilitates GBV actors to share information with community members, which can support diverse women and girls to access GBV response services and reduce the risks that diverse women and girls face. Community outreach includes information on the benefits of GBV response services, as well as how, where, and when to access them. Community outreach is an opportunity to demonstrate inclusive GBV response programming in the images, languages, and materials used to promote understanding and access to GBV response services. Engaging a diverse range of women as staff and community volunteers can role model inclusivity and make services more attractive and accessible to diverse women and girls in the community. Posters, radio shows, and mass campaigns can represent diverse women and girls in positive ways, promote recognition of equal rights and dignity, and show diverse women and girls supporting each other and working together to prevent GBV.

KEY ACTIONS:

- Ensure GBV outreach teams are as diverse as possible and include community volunteers and staff from diverse groups of women with particular attention to age, language groups, and disability.

- Ensure that information, education, and communications (IEC) materials on promoting uptake of GBV response services and breaking the silence on GBV include representations of diverse community members and are accessible by all language groups.

- Use radio as well as visual IEC materials to reach women and girls with visual or hearing disabilities.

- Implement a range of community outreach approaches that meet the needs of diverse women and girls. For example, reach out to adolescent girls in and out of school, organize different meeting times and places to engage a wider range of women and girls.

- Work with other social change and inclusion actors, such as disability, older age, and LGBTQI actors and community and religious leaders with diverse ethnic and religious affiliations to co-host outreach events that reach specific groups of diverse women and girls and the wider community.

- Discuss with adolescent girls and female and male caregivers how to safely engage adolescent girls to lead some types of community peer-to-peer outreach activities.

- Following guidance in communication materials, portray diverse women and girls in positive ways – for example, offering help to other women or being activists.

- Implement listening sessions or other preferable feedback mechanism with diverse women and girls to get feedback on outreach activities and adjust programming based on the recommendations of diverse women and girls.

RISK REDUCTION FOR WOMEN AND GIRLS IN EMERGENCIES

In emergencies, diverse women and girls face a host of safety and security risks linked to displacement. Many of these risks, when identified, can be safely and quickly addressed by humanitarian actors. However, humanitarian agencies may unintentionally increase these risks through assistance programs and services designed to improve efficiency, without properly identifying and addressing the needs of diverse women and girls and the potential obstacles they may face in accessing services safely.

When GBV actors implement inclusive and effective GBV programming that engages and supports diverse women and girls, GBV risk mitigation

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activities will document the specific risks and barriers facing diverse women and girls in each context. There are also many GBV risk reduction activities that can be routinely conducted to meet the needs of diverse women and girls in every context. For example, in all humanitarian settings, toilets and wash facilities should be sex-segregated, age-appropriate, locked, well-lit, located within safe reach of women and girls, and accessible for women and girls with disabilities and limited mobility. In addition, water and fuel should be located within safe reach of women and girls and accessible for women who are older, women and girls with disabilities, women with young children, and pregnant women and adolescent girls. Shelter, food, cash, and non-food items (NFI) distribution, as well as education and livelihood programming should be accessible to diverse women and girls suited to their needs. Monitoring should be in place to ensure diverse women’s and girls’ safe and equitable access to these basic needs.

GBV risk mitigation actions should include reducing the risk of sexual exploitation and abuse (SEA) perpetrated by humanitarians. Women and girls who experience intersecting inequalities based on age, disability, sexual orientation, gender identity, ethnicity, religion, or other axis of oppression are more likely to be targeted and abused by humanitarians. Including their voices and paying attention to the barriers and risks facing their access to humanitarian aid are priorities in GBV response programming.

**KEY ACTIONS:**

- Assume GBV is happening to diverse women and girls in every context and implement inclusive GBV risk mitigation actions, including for sexual exploitation and abuse.

- Influence humanitarian actors to address the identified risks and barriers affecting diverse women and girls through coordination and advocacy.

- Review the GBV Guidelines risk mitigation actions to inform your safety analysis and consider the different barriers and risks faced by diverse women and girls for each humanitarian service.

- Use adapted safety audits that include questions capturing the specific risks and barriers facing diverse women and girls.

- Consult regularly with women and girls on GBV risks that diverse women and girls face and strategies to address them.

- Identify strategies, in consultation with diverse women and girls, to overcome constraints to their participation in and access to aid delivery, services, or participation in activities (e.g., timing, location, safety of travel, and safety of activities).

- Promote the meaningful participation of diverse women and girls in humanitarian programming planning and decision-making.

**INFORMATION MANAGEMENT AND SHARING**

It is important to consider how and why we use information about diverse women and girl survivors of GBV in emergencies and to adhere to consistent ethical principles in data collection. GBV data collection is extremely sensitive, especially in the context of service delivery. The management of that data is complex and requires that systems and safeguards be in place to ensure data security and the safety of everyone involved, including the survivors who are reporting, the communities, and those involved in collecting the information. Responsibility for collecting GBV data also comes with the responsibility to protect it. Respecting inter-agency information-sharing protocols by all agencies is critical to the safety of women and girl survivors, particularly those most at risk.

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The GBV informed consent and case intake forms routinely capture information on age, disability, and ethnicity. GBV actors are therefore able as part of routine service data analysis to consider whether adolescent girls, women who are older, women and girls with disabilities, and women and girls from diverse ethnic groups are accessing GBV response services. Where they are not accessing services, individual interviews or focus group discussions are recommended to identify barriers to accessing services. Where population data is available on the age, disability, and ethnicity of women and girls, it is possible to analyze whether the case load of a GBV response is proportional to the diversity of the local population.

Women and girls from diverse sexual orientation and gender identities will also be present in every population of displaced women and girls. After training your GBV response team to make sure they are inclusive of diverse women and girls, you may consider adding a separate section – where it is safe to do so – to capture sexual orientation and gender identity. For example, you could have a section that asks: cisgender or transgender female for gender identity; and lesbian, bisexual, or heterosexual for sexual orientation. Do not adapt the case intake form to add a section on sexual orientation and gender identity without first training your staff and ensuring services are inclusive of diverse women and girls. Where being a lesbian, bisexual, or transgender woman or girl is criminalized, do not document their sexual orientation.

**KEY ACTIONS:**

- Assume GBV is happening to diverse women and girls in every context and implement inclusive GBV response programming. Do not wait to collect data first!
- Ensure informed consent forms are suited for use with diverse women and girls, including with respect to language, age, ability, and the developmental capacity of the individual.
- Use the standard GBV case intake forms to capture information about women’s and girls’ diversity safely and store confidentially in a locked cabinet or encrypted database.
- Use the data gathered in the GBV case intake form to complete trend analysis and develop program recommendations based on uptake of services by diverse groups of women and girls.
- Make sure all GBV response actors who are using the GBV case intake form with additional data points on sexual orientation and gender identity are first trained on inclusive GBV programming.
- Ensure data about women and girl survivors of GBV are kept secure and used ethically to improve programming and deliver quality services.

**GBVIMS intake form** captures information on age, disability, and ethnicity

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Coordination and advocacy are closely linked and aim to ensure resources, support, and programming are used effectively for diverse women and girls. Advocacy is a common thread throughout GBV work and is integral to every level of intervention – structural, systemic, operative – when addressing violence against women and girls in emergencies. Utilizing data and stories about women and girls for advocacy during an emergency requires strict attention to ethical guidelines established to protect women and girls and mitigate the risks of GBV programming in emergencies. When disaggregating data to highlight the specific needs of diverse women and girls, it is essential to still check that this data is non-identifying and safe to share. It may be possible that being too specific about the identity of a woman or girl could put her at risk of harm or retaliation by the perpetrator or subject her to community stigma.

In order to complete an inclusive advocacy strategy problem analysis, consider adding the following reflection questions:

- What problems do diverse women and girls face in the community?
- What is the greatest priority for women? Is this the same for diverse women and girls?
- Why is this a problem?
- What needs to be done to address this problem and help women or survivors? Does this solution work as well for diverse women and girls?
- What solution is the most likely to succeed? Are we leaving any women and girls behind?
- How can we ensure that the way in which diverse women’s and girls’ needs are communicated through advocacy does not increase risks to their safety?
- How can we ensure that the content of our advocacy messaging on diverse women’s and girls’ needs does not increase risks to their safety?
- Are there any possible unintended consequences of advocacy and coordination communication that could do harm to women and girls? Can these risks be mitigated?

Connecting across social change movements can be a powerful way to increase the effectiveness of advocacy in addressing GBV against diverse women and girls in emergencies. Doing so provides opportunities for other social change movements to consider GBV against diverse women and girls and highlight this issue in their own advocacy on disability, older age, LGBTQI, or child rights.

**KEY ACTIONS:**

- Ensure campaign and advocacy events safely and ethically engage a diversity of women and girl activists.
- Support representation of a diversity of women and girls in community leadership structures and support capacity development of female leaders on women’s rights, leadership skills, negotiation skills, and public speaking.
- When influencing humanitarian leaders and donors with advocacy activities, ensure the stories and voices of diverse women and girls are represented.
- Ensure that advocacy strategy problem analysis highlights risks and barriers affecting diverse women and girls and presents solutions from diverse women and girls.
- In local, national, or international advocacy reports or events, use data and stories to ethically and safely illustrate the needs and priorities of diverse women and girls.
- When identifying and working with allies at the local and international level, work across movements to engage disability, LGBTQI, older age, child rights, and other social change movements.

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GBV Emergency Preparedness aims to establish a standing capacity to respond to violence against women and girls in a range of humanitarian crisis situations that may affect a country or region by putting in place a broad set of preparedness measures. Pre-positioning supplies is an important GBV preparedness activity. When stockpiling supplies of dignity kit materials, consider whether sanitary practices are different for the diverse ethnic groups who may be affected by a crisis in the local context. When creating IEC materials with simple messages promoting access to services in an emergency, make sure the language is inclusive of diverse ethnic groups and that pictures of women and girls include various ages, ethnicities, those with disabilities, and a range of gender identities.

Training diverse local women’s groups and GBV actors to be ready to respond to an emergency is another important GBV preparedness activity that presents an opportunity to implement inclusive GBV programming. Make sure to engage women’s groups within larger social change movements. For example, approach organizations for people with disabilities, LGBTQI rights, or religious and ethnic communities to find out if they have women’s groups; find out if youth groups or forums have groups for adolescent girls, and so on.

Many organizations may plan their preparedness activities by pre-training a GBV response team that can be deployed if an emergency occurs. Modelling diversity is important in your GBV response team. Make sure the women engaged to manage the team and deliver services come from diverse backgrounds.

**KEY ACTIONS:**

- Review the emergency deployment toolkit and materials check list and make sure that supplies being stockpiled are accessible for diverse women and girls, including dignity kits and IEC materials.
- When training women’s groups and women-led organizations in crisis-prone contexts, be sure to identify and train groups that support and include diverse women and girls.
- When implementing preparedness training of local GBV actors, social workers, and health workers in crisis-prone contexts, aim to engage women service providers representing a breadth of ethnic groups, languages, ages, women with disabilities, and local gender diversities.
- When implementing preparedness service mapping activities, make sure to review the referral pathway for accessibility and add additional entry points to suit the needs of diverse women and girls in the local context.
- Make sure the referral pathway is shared with local social change groups and organizations who engage diverse women and girls.
- Review your preparedness budget to ensure adequate resources to deliver inclusive GBV response programming for all women and girls.
- Update and integrate risks, security, and safety concerns for staff from diverse background. Ensure corrective action is taken to result in inclusive service delivery to women and girls when issues are identified.
- Integrate diversity and inclusion sensitization in GBV emergency preparedness and response training to staff.

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