Putting Survivors at the Center

Programming for Non-GBV Specialist Organizations to Support GBV Survivors

The Global Women's Institute
THE GEORGE WASHINGTON UNIVERSITY

WOMEN FOR WOMEN INTERNATIONAL

USAID
FROM THE AMERICAN PEOPLE

Acknowledgements

This guidance package has been developed by the Global Women's Institute (GWI) at the George Washington University and Women for Women International (WfWI). It was made possible by the generous support of the American people through the United States Agency for International Development (USAID) as well as contributions from WfWI and GWI to finalize these materials. The contents are the responsibility of GWI and WfWI and do not necessarily reflect the views of USAID or the United States Government.

We would like to thank everyone who contributed to the development of these programmatic approaches, this guidance package and the associated support materials. This includes: Maureen Murphy, Gabriella Nassif, Katie Allen-East, Annastacia Olembo, Sirisha Bhadriraju, Helen Shipman, Eva Noble, Joseph Habamungu, Zawadi Angelique, Marie-Marthe Munyangi, Jean-Baptiste Cibogo, Vanessa Byangoy, Iman Shakor, Abbas Abbas, Fatan Mohammed, Israa Ali, Rebar Mohammed, Joanna Alhaybe, Martina Wilson, Manuela Sunday Cosmas, Moses Abure, Laki Solomon and Patrick Vuonze, our partners Mercy Corps, Réseau d'Innovation Organisationnelle, Centre Heri Kwetu and Agency for Research and Development Initiative, as well as many other colleagues who shared their insights and learnings.

We would also like to thank members of our Technical Advisory Groups (globally and in each pilot country) for sharing their expertise during the development of programming approaches. This includes global members: Erin Patrick, Claude Cheta, Zayid Douglas, Leisha Beardmore, Jennifer Chase, Rachell Pell, Ashley Ausburger, Reem Khamis, Kevin McNulty, Jacqueline Ogega and Dashakti Reddy; DRC members: Viviane Nabintu Kafumba, Solange Lwashiga, Brigitte Mapenzi Kyahi, Yvette Mushigo, Dr Alida Bulambo, Therese Kwamiso, Kulimushi Biruru, Marie Therese Munyerenkana, Nelly Adidja, Edwidge Cishimbi, Deogratias Bahizire; Iraq members: Sabat J.Mustafa, Diana Salman, Noor Esam Al-Khateeb, Omar Saady, Jwan Zeyad Yaseen, Dilzar Mustapha, Vanda George Al-Saeed, Kamiran Shivan Othman, Zana Aula Smail; and South Sudan members: Rev. Fr. Simon Khamis, Medina Jackline, Juma David, Rev. Taban Francis Amos, Cicilia Sitima, Resale Roy Simon, Maneno Grace, Ngongi Pete.

Suggested citation: The Global Women's Institute and Women for Women International (2025). Putting Survivors at the Center: Programming for Non-GBV Specialist Organizations to Support GBV Survivors.

Introduction

Putting Survivors at the Center (PSC) is an approach that seeks to build the capacity of organizations not specialized in gender-based violence (GBV) to better support survivors who spontaneously disclose experiences of violence. It was designed by the Global Women's Institute at the George Washington University and Women for Women International, with support of the USAID's Bureau of Humanitarian Assistance (BHA). The program approaches were co-created and piloted with inputs from stakeholders in the Democratic Republic of Congo (DRC), Iraq and South Sudan.

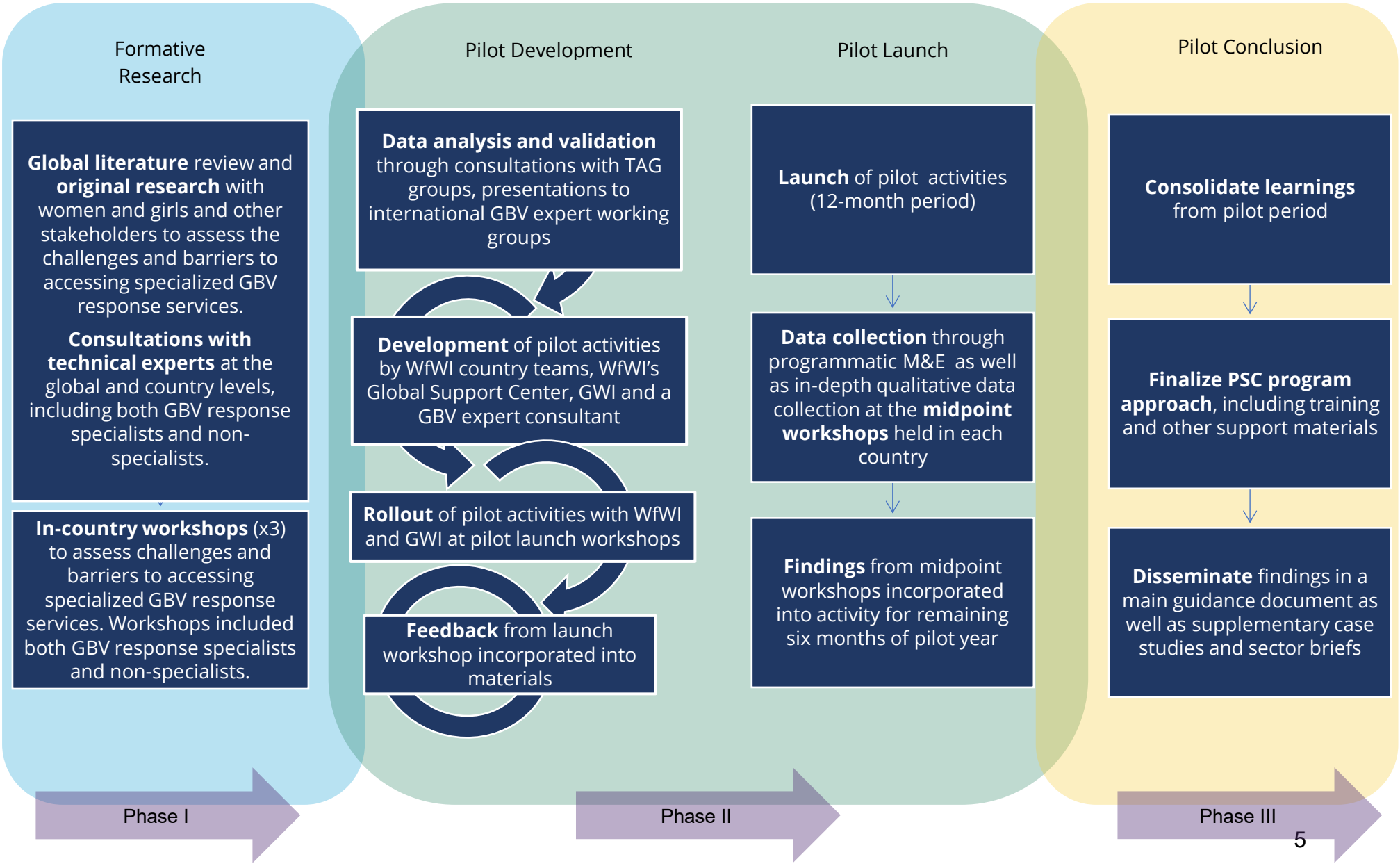
PSC responds to the direct needs of non-GBV response specialist organizations whose staff are not trained in GBV and do not have experience working directly with survivors of GBV, but who frequently receive spontaneous disclosures from survivors.

These organizations recognize that they have an important role to play in their communities, as facilitators between GBV survivors and specialized GBV services. They want to be **better prepared to support survivors following a disclosure**; they want **more knowledge about their roles and responsibilities as non-GBV specialists** to survivors; and they want to **support GBV specialists** in their communities in order to facilitate stronger referrals.

PSC has developed a **suite of activities** for non-GBV response specialist organizations to consider when preparing to better support GBV survivors in their communities. These activities aim to accommodate different organizational capacities and desires and exist along a spectrum – ultimately leading to the view that "supporting survivors is everyone's responsibility."

PSC is built on a foundation of participatory action research and collaboration. During program development, we used a three-prong approach to assess the challenges to and barriers preventing survivors from accessing specialized GBV services in humanitarian contexts. This included a **global literature review**; **original research** with GBV specialists and non-specialists, GBV survivors, and subject matter experts; and **validation workshops** in each program country.

Figure 1: The Program Development Process



Three key thematic areas of concern emerged from initial research findings, which then informed activities that frontline non-specialist staff and GBV technical experts designed to be piloted over the course of a 12-month period:

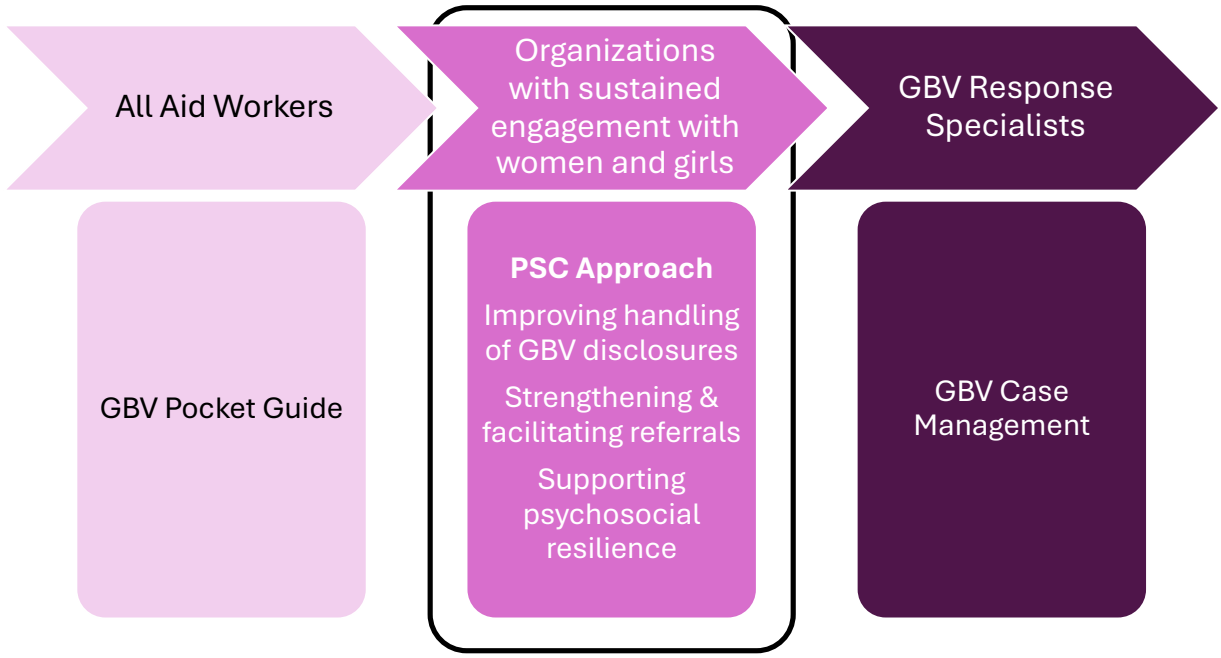
Thematic Area	Key Program Activities
Improved Immediate Handling of GBV Disclosures	1. Training frontline staff, community leaders and other stakeholders (e.g., police, school staff, etc.) on appropriately handling GBV disclosures *Pilot Locations: DRC, Iraq, South Sudan*
Connecting to and Supporting Existing Specialist Services	2. Strengthening survivor-centered care and gender equitable attitudes among GBV service providers *Pilot Location: DRC*
	3. Strengthening coordination between GBV response specialists and non-specialists *Pilot Locations: DRC, South Sudan, Iraq*
	4. Strengthening and facilitating referrals *Pilot Locations: DRC, South Sudan, Iraq*
Supporting Psychosocial Resilience	5. Provision of informal psychosocial support approaches such as self-care as well as group and individual psychosocial support sessions *Pilot Locations: Iraq, DRC*
Key Sectors Engaged:	Education; Nutrition; Health; Mental health/psychosocial support; WASH

After the pilots, the PSC team consolidated learnings from front frontline service providers and global experts, resulting in the development of the recommendations in this document and supplementary case studies, sector briefs, and program training materials.

How does PSC work with/fit in with other efforts to support GBV survivors?
At its core, GBV response programs are led by GBV specialist services providers in areas such as GBV health response, legal aid and case management. These activities should only be offered by GBV response specialists with the required training and expertise. PSC does not focus on the work of these specialists, for whom existing training materials and support (e.g. Interagency Case Management Guidelines) already exist.

For non-GBV response specialist service providers, the *GBV Pocket Guide* is a step-by-step resource available to assist non-GBV actors to respond to disclosures from GBV survivors in a survivor-centered manner in locations where there are no specialized GBV actors present. This document remains a core foundation for all humanitarian aid workers to understand basic principles of support (e.g. GBV Guiding Principles and Psychosocial First Aid).

Figure 2: Which Resource is for Which Organization



PSC builds on the work of the GBV Pocket Guide – including utilizing some of their training materials to ensure alignment in what the limits for non-specialist response staff should be. PSC differs from the Pocket Guide as it 1) provides longer and more detailed training – appropriate for staff who have considerable engagement with women and girls and are likely to receive spontaneous GBV disclosures during their work and 2) goes beyond the initial disclosure and referral process to consider other ways that non-GBV specialists can strengthen the support GBV survivors receive. The GBV Pocket Guide remains a core guiding document

that should be utilized by all NGOs that operate where no specialized GBV response services are available.

Who should use these materials?
Any organization that doesn't provide specialist GBV case management can use aspects of the PSC programming materials. Organizations that have close interaction with women and girls throughout their programming (e.g. economic empowerment, health, education, nutrition, etc.) will likely find the materials most useful. The materials can be used in locations where specialized GBV services are available, as they work best as a mechanism to strengthen referral pathways and complement the work of these specialized services providers.

The PSC Approach

Thematic Area 1: Improved Immediate Handling of GBV Disclosures

Program Activities

One of the primary goals of the PSC approach is to improve the immediate handling of GBV disclosures by frontline staff, volunteers and community-level actors. To accomplish this, the ***Handling GBV Disclosures and Safe Referrals*** **training** was developed. This 3-day, 6-module training[1] aims to better prepare these actors to respond in a safe and survivor-centered manner following a spontaneous disclosure of GBV. Specifically, the training equips participants with:

- Knowledge about the survivor-centered approach, and how to apply it in practice.
- The ability to use the principles of psychosocial first aid (PFA) for GBV: Prepare, Look, Listen, and Link.
- Practical experience from role play exercises about how to support a survivor following a spontaneous disclosure of GBV.
- A clear understanding of the boundaries and limitations of their roles as non-GBV response specialists.
- The recognition of the importance of referring survivors to GBV case management, if and when possible.
- Tips for practicing confidentiality following a spontaneous disclosure.
- Practical solutions for a variety of situations, for example, what to do when a survivor refuses a referral or how to respond if a survivor reports that their case has not been accepted by a GBV response specialist organization.

The *Handling GBV Disclosures and Safe Referrals* training was co-designed with frontline staff and piloted in three country locations: the DRC, Iraq and South Sudan. These training materials can be utilized with frontline staff in multiple sectors where staff and volunteers have prolonged engagement with women or girls - for example school or nutrition center staff. It emphasizes

[1] Module 1: Introduction to gender; Module 2: Introduction to GBV and GBV principles; Module 3: GBV disclosures and the role of non-GBV response actors; Module 4: Receiving GBV disclosures in a survivor-centered manner; Module 5: Making safe referrals; and Module 6: Receiving GBV disclosures from child survivors. The Handling GBV Disclosures & Safe Referrals Training also includes an optional module, Module 7: Ensuring your organization is ready to receive GBV disclosures. This module is intended for managers and directors of non-GBV response specialist organizations and focuses on organizational preparedness.

participatory and engaged learning using role play activities and ample discussion time. Participants have multiple opportunities to work in small groups and in plenary to practice handling a spontaneous disclosure of GBV using what they have learned in the training. Role play activities build on one another to give participants the chance to act out each step of the process of handling a spontaneous disclosure: for example, as participants learn the basics of PFA for GBV survivors, they will have the chance to practice each step separately to ensure that they feel confident with each skill. An additional 7th module is included in the training materials, which focuses on the roles of senior staff, M&E staff and managers. This should be administered with this smaller group separately from the main training. Refresher training materials (1.5- 2 days' worth of content) are also available to administer with staff approximately 6 months after the original training.

Supplementing this training is the ***Receiving GBV Disclosures Training for Community Leaders,*** which was adapted from the *Handling GBV Disclosures and Safe Referrals* training package. The community leader's version of the training is shorter and simplified, with more emphasis on low/no literacy approaches to adult learning. Over the course of two initial days of training and two days of refresher training (to be delivered three to six months after the completion of the original training course), participants have multiple opportunities to work in small groups and in plenary to practice handling a spontaneous disclosure of GBV using what they have learned in the training. Across the two days[2] of the training, role play activities build on one another to give participants the chance to act out each step of the process of handling a spontaneous disclosure: for example, as participants learn the basics of PFA for GBV survivors, they will have the chance to practice each step separately to ensure that they feel confident with each skill. It was piloted with community leaders in South Sudan and the DRC. Materials to support a two-day refresher training two to six months after the initial training sessions are also available.

In addition to these two training guides, a **guidance note on how to respond to GBV disclosures from survivors living with disabilities** was also developed in collaboration with a local Congolese organization (Centre Heri Kwetu). These guidelines were created to provide additional support and guidance to frontline staff in situations where survivors with disabilities disclose experiences of GBV to them. It covers key considerations and principles for working with survivors with disabilities, using the framework of the four steps of PFA. It should be used in conjunction with the Handling Disclosures and Safe Referrals Training Guide.

[2] Covering introductions to gender and GBV and providing survivor centered PFA, including linking to further specialist support, for GBV survivors

Learning from the Pilot

> *"Before, I pretended to be a GBV specialist. Now I know how to refer cases, I understand who to refer to, where they should go and how to do it."*
>
> - Participant from South Sudan

Overall, learning from the pilot suggests that the trainings for both staff and community leaders led to considerable improvements in how staff and community leaders engaged with survivors of violence. For both groups, some of the key outcomes were **reductions in potentially harmful practices**. For example, prior to the training many frontline staff reported going beyond their roles and sought to mediate in cases of violence, conducting home visits or other interventions to try to help the survivor manage cases of violence locally. After the training, these staff now understood the limits of their role – and what they should and shouldn't do to appropriately support a survivor experiencing violence.

They also gained **practical skills,** including being able to administer PFA, and better understood how to apply the GBV guiding principles in their work. Both staff and community leaders also demonstrated that they retained this learning in 4-6 months post training follow-ups, where they were still able to articulate how to apply PFA (prepare, look, listen, link) and could describe how they now applied the GBV guiding principles. For example, religious leaders described how they used to tell other members of their congregation about survivors' experiences but now, after the training, they knew to keep it a secret. They were also able to articulate how to apply a survivor-centered approach by allowing the survivor to decide what she wanted to do next, rather than the leader mandating what should happen. Similarly in 6-month follow-up assessments with staff who were trained, participants were able to articulate how to apply the four principles of PFA and how to appropriately support survivors who disclosed to them. This demonstrates that the learning from the training was internalized and applied by participants in the course of their routine work.

Finally, both staff and community leaders who went through the training had more understanding of the **referral process** and reported that they were more likely to share referral information with survivors. In particular, staff now knew that a key aspect of their role was to share information about specialist services that were better placed to help the survivor and knew the referral processes (e.g. contact information, forms needed, etc.) to appropriately link the survivor to care.

Available Support Materials

If your organization would like to utilize the PSC approach, training materials and other supporting documents are available for your adaptation and use.

Thematic Area 1 Support materials		
Name	**Summary**	**Available Support Materials**
Handling GBV Disclosures and Safe Referrals Training	• 3-day training package for frontline staff • 1 additional module for managers and senior staff • Materials for a 1.5-to-2-day refresher training	Training Manual, Handouts and Slides Refresher Training Materials Support Materials Case Study
Receiving GBV Disclosures Training for Community Leaders	• 2- day training package for community leaders • Materials for a 1-day refresher training	Training Manual and Handouts Refresher Training Materials Support Materials Case Study
Guidance on Handling Disclosures and Safe Referrals for Survivors with Disabilities	• Guidance on how to support survivors with disabilities	Guidance Note

Thematic Area 2: Connecting to and Supporting Existing Specialist Services

Program Activities

As part of the ***Handling GBV Disclosures and Safe Referrals Training*** (explored in more detail above) staff learn about existing local referral pathways and any locally relevant procedures (e.g. referral forms, focal points) to facilitate these referrals in a safe and efficient manner. In general, staff are encouraged to refer survivors to GBV case management specialists if they are available. If they are not, or if the survivor does not want to access these services, the roles and locations of wider referral pathway actors (e.g. health, police, legal etc.) are also explored.

This training can be complemented by other efforts by non-GBV response specialist organizations to strengthen referrals, such as:

1. **Strengthening survivor-centered care and gender equitable attitudes among GBV service providers**

PSC's approach to supporting GBV specialist actors focuses on building their capacity to better support survivors within their care. This can take two forms. First, stakeholders who are part of the referral pathway (e.g. police, health, psychosocial and legal) but may not have received training on how to support survivors of gender-based violence who they engage with, can also benefit from the ***Handling GBV Disclosures and Safe Referrals Training.*** Through this training, they can learn about the GBV

Security sector staff participate in a Gender Power Walk during training in South Sudan

Guiding Principles, how to utilize PFA to support survivors and how to safely refer them onto other actors within the referral pathway.

Secondly, specialist service providers can be trained to build some of the "soft" skills needed to support survivors such as gender sensitive attitudes and best practices in handling survivors (e.g. upholding confidentiality, providing psychosocial support, and believing and supporting survivors). PSC developed a training package specifically for health clinic staff (e.g. doctors, clinical officers, nurses, etc.) on basic gender and GBV concepts, their role as health care providers, understanding their own values and beliefs, basic psychosocial support and maintaining confidentiality. This ***Gender Equitable Attitudes Training*** can be delivered in two days and the modules include: 1) GBV and GBV Concepts; 2) What is a Survivor-Centered Approach; 3) What is Gender-Equitable Support; 4) Promoting Safety, including Protecting Confidentiality; 5) The Importance of Initial Contact; 6) Listening to Survivor's Experiences; 7) Empowering GBV Survivors.

2. **Strengthening coordination between GBV response specialists and non-specialists**

Knowledge about available services is not enough to break down all barriers to care. Even when non-specialists knew in theory of specialist services, there were often other barriers such as a lack of trust in the quality-of-care survivors would receive at the points. To strengthen these relationships, non-GBV response specialist organizations can seek to build relationships with these GBV specialist organizations. This includes:

1. Attending local **GBV coordination meetings** (e.g. sub-cluster, working group, etc.) to learn more about available services and to troubleshoot problems that are occurring when the non-specialist agency tries to refer survivors;
2. Setting up **facilitated dialogues** between GBV response specialists and non-specialists to discuss issues and challenges with referrals;
3. Supporting GBV specialists to establish, update and share information about **local services and referral pathways.**

These mechanisms can help promote openness and trust between GBV response specialists and non-specialists. For example, facilitated dialogue sessions can be utilized to build consensus around key coordination issues such as identifying any problems or concerns with the referral pathway; as well as be used as a mechanisms to build the capacity of both specialists and non-specialists, with the opportunity for different organizations to present to the group about the work that they do in relation to women and girls, and survivors.

Non-GBV response specialists also need access to **updated and accurate referral information** in order to facilitate efficient and appropriate referrals for survivors**.** The lack of

up-to-date referral information was one of the primary challenges non-specialist front liners reported as a barrier that prevented them from referring women and girls who disclosed that they were experiencing violence. While maintaining and updating this information is primarily the role of the GBV sub-cluster/working group, there are roles for non-GBV specialist organizations to support this process. In some cases, this might be as simple as providing financial resources to print and distribute physical copies of referral pathway posters for front line offices/service points. In others, higher tech solutions, such as mobile phone applications may be utilized to ensure staff have access to the information they need at their fingertips. While the exact modality of communicating this information may shift depending on your setting, the key aspect is ensuring that updated referral information is shared regularly with frontline providers so that they have current information about service providers. Non-specialist staff can also support the service mapping process, including participating in updating the referral pathway together with specialist GBV organizations to gain awareness of the existing service points and building trust in the process.

See the PSC Case Study on Improving Coordination for more details.

3. Strengthening and facilitating referrals

Some of the primary barriers for survivors that prevent their access to specialized care are a lack of knowledge about available services, unsupportive attitudes in the community that stigmatize survivors and costs that are associated directly (e.g. payment for services) or indirectly (e.g. costs for transport, childcare, pharmaceutical drugs, etc.) with these services.

PSC staff engage with community members in the DRC

In order to breakdown these first two barriers (**knowledge and attitudes**), the PSC approach promotes awareness raising and attitude change efforts with community m embers. While these efforts are not a replacement for wider social norms change efforts (e.g. SASA!), complementing service strengthening efforts with wider community campaigns can increase awareness and acceptance of GBV specialist support. For example, during the pilot in Iraq, Mercy Corps, played a crucial role in raising awareness and reducing the stigma surrounding GBV. They conducted awareness-

raising sessions with parents to foster a supportive environment for adolescent girls. In South Sudan and DRC, contextualized awareness raising videos, posters, radio programs and other community-based activities, including educational activities with adolescents at safe spaces led by our local partner RIO in the DRC and at nutrition centers led by ARDI in South Sudan, were held to increase knowledge of community members about the importance of survivor's accessing specialist support care.

To break down cost barriers that prevented access to services, dedicated funds can be established to support survivors to access these services. The mechanisms for these funds may look different depending on the context and any donor restrictions in place. If possible, providing a **sub-grant to health facilities,** which allows them to charge back costs as needed for survivors who come to them to access services, is the most flexible option. This allows health care providers the most freedom to determine what treatments/costs are needed and reduces any delays in payment. If it is not possible to provide this more flexible sub-grant, then an agreement can be signed with health facilities to reimburse allowable costs. This provides more oversight of the costs but can lead to delays in payment and differing views as to what costs are allowable. Finally, **un-restricted cash** (ideally given via mobile money to avoid physical cash changing hands) can be provided to the survivor to pay medical costs and/or other costs (e.g. transport, lodging, medicines, etc.) that they may encounter.

For any of these mechanisms, but particularly for the distribution of cash, organizations should carefully consider the **risks that may be introduced by providing cash and create mitigation plans**. Key considerations include:

- If GBV response organizations are already administering emergency funds, they are best placed to continue this work. See how your organization can work with or refer to these case management specialists rather than administering cash on your own.
- Consider how to minimize the distribution of physical cash through direct payments to service providers and/or the use of mobile money rather than cash.
- Do not require survivors to come back and present receipts or track their payments in your records by their names or other identifying information.
- Do not give cash if the survivor thinks it will put her more at risk and do not probe about their financial situation prior to giving cash.

In addition, as with any intervention involving the provision of cash, it is important to think through the potentially sustainability of any action. Is this something your organization has the funding or interest in investing in long term? What will happen if the funds supporting this intervention cease? For example, cash may be more appropriate in an emergency context but may be less useful for contexts transitioning to development (particularly for costs transferred to government service points where these services may again cease if the program stops supporting them). Alternatively, consider if the provision of cash can be mainstreamed into other longer-term programming to ensure these efforts are able to be maintained.

See PSC's Case Study on Emergency Funds for more details on considerations that are needed when making these choices and learnings from how these funds were set up during our pilots.

Learning from the Pilot

Overall, we found that trainings associated with this thematic area led to considerable **improvements in the knowledge and attitudes** of service providers. For referral pathway actors (e.g. police, security actors) who participated in the Handing GBV Disclosure and Safe Referrals training, these stakeholders had a better understanding of how to support survivors (including key principles such as confidentiality and survivor centered care). For health care workers who participated in the Gender Equitable Attitudes training there were improvements on both knowledge and attitudes including "learning how to listen" to survivors, the importance of keeping cases confidential, having empathy for survivors and a better understanding of the referral pathway.

> *"Before the training, we took survivors 'lightly'. Their experiences of violence were not taken too seriously. But after the training, we changed our attitude[s]. We have empathy for them."*
>
> – Participant DRC

Efforts to **strengthen coordination** were also largely seen as positive in the pilot. First, representatives from non-GBV specialist organizations who started attending GBV coordination meetings felt they had a better understanding of the GBV referral processes and were better able to work through issues with the referral pathway. Similarly, the "facilitated dialogues" that were held to provide dedicated spaces for specialists and non-specialists to come together to work though issues were also well received with participants noting how they were able to build **trust and understanding** of each other's roles and responsibilities through these meetings.

Importantly, GBV specialists were supportive of non-GBV response organizations efforts to strengthen their work. For example, in Yei, South Sudan, the service mapping and referral pathways were outdated due to gaps in funding for GBV specialist organizations. By coming in to help bridge this gap, in coordination with the local GBV-sub cluster, these materials were updated and disseminated amongst frontline staff. In Iraq, a non-GBV specialist organization, WfWI, worked closely with UNFPA and the GBV Working Group to finalize and roll out at mobile application that will help facilitate referrals. This process not only showed that non-GBV specialist organizations can support specialists to disseminate information about referral points but that these processes can also build understanding and trust between these organizations and GBV specialists.

Finally, efforts to reduce knowledge, attitudes and financial barriers led to considerable learning. Awareness raising efforts – while not able to fully change attitudes or norms – were

seen as essential first step on the pathway to change. Interactive methods – such as videos followed by community discussions or awareness sessions with parents as part of PTA meetings – were seen as most promising as they led to deep engagement with community members of complex issues such as gender-norms and stigma. In addition to reduce financial barriers that prevent service access, the use of flexible funds – for example grants to health facilities – was seen as an impactful way of supporting survivors. More complex and potentially bureaucratic efforts – such as setting up Memorandums of Understanding (MoUs) about allowable costs and reimbursing health centers – was seen as less efficient and more complex than these more flexible funds. Providing unrestricted cash directly to survivors was also a promising practice, with a considerable increase in referrals in South Sudan once this mechanism was introduced midway through the pilot. Key lessons from administering this fund include the importance of making these transfers: unrestricted, through mobile money, and only provided after conducting a risk assessment with the survivor. Overall, the provision of this cash was well received by front line service providers and survivors themselves who felt it helped to overcome barriers that prevented access to specialized services, however it was not necessarily seen as sustainable, particularly in settings transitioning from emergency to development contexts. Given this, emergency funds may be more appropriate for emergency settings where immediate support is needed, rather than as a longer-term intervention in a less acute emergency.

Available Support Materials

If your organization would like to utilize the PSC approach, training materials and other supporting documents are available for your adaptation and use.

Thematic Area 2 Support materials		
Name	**Summary**	**Available Support Materials**
Handling GBV Disclosures and Safe Referrals Training	• 3-day (6 module) training package for frontline staff • 1 additional module for managers and senior staff • Materials for a 1.5-to-2-day refresher training	Training Manual, Handouts and Slides Refresher Training Materials Support Materials Case Study

Gender Equitable Attitudes Training	• 2- day training package for a mixed group of health care providers	Health Care Workers Training Guide, Handouts and Slides
Emergency Fund	• Summary of recommendations to set up an emergency fund	Case Study Example Protocol

Thematic Area 3: Supporting Psychosocial Resilience

Program Activities

PSC's approach seeks to build the capacity of survivors and frontline staff to use informal psychosocial support techniques such as group and individual self-care activities. This program aims to respond to the wide array of psychological support needs expressed by women and girls in humanitarian contexts, including but not limited to GBV. The Inter-Agency Minimum Standards for GBV in Emergencies Programming lays out how the MHPSS pyramid of specialization applies to GBV programming (*see Figure 3 below*). The psychosocial support activities implemented under PSC fall under layer 2 "Family and Community Supports," as they are informal in nature and aim to build well-being and resilience rather than providing specialist counselling or case management. PSC activities complement the existing programming of non-GBV specialist organizations to ensure the sustainability of this support and to create safe spaces for women and girls who participate in these activities.

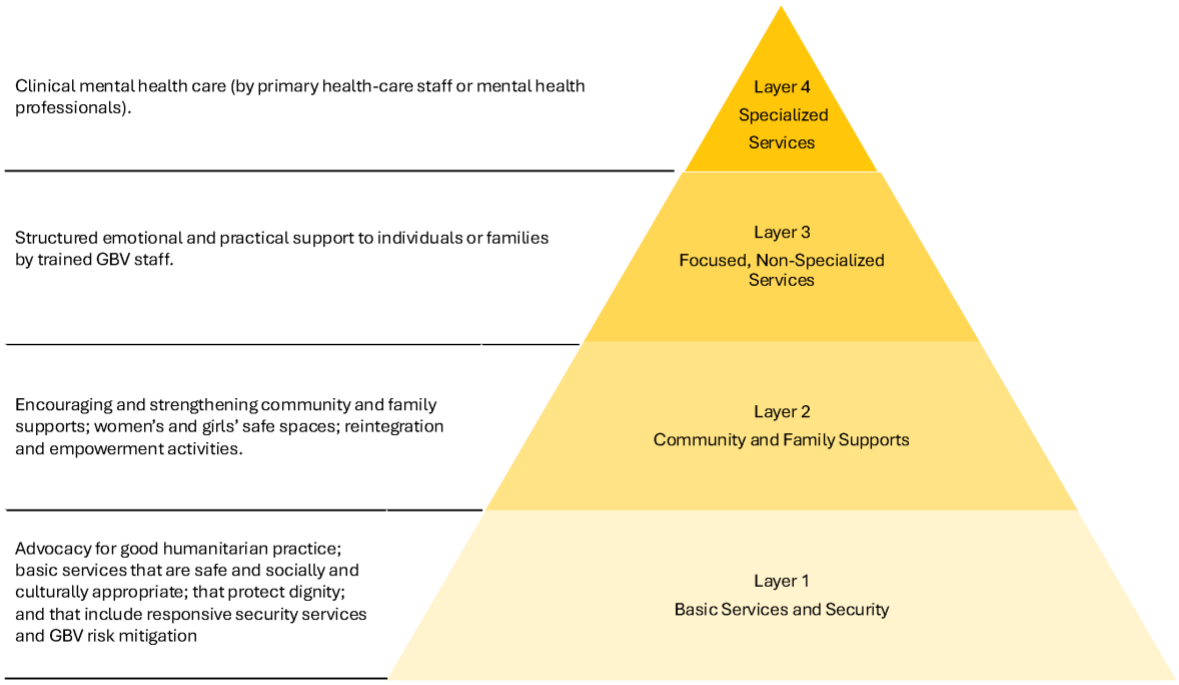


Figure 3: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings adapted for the GBV AoR (2019)

In general, PSC's informal PSS activities work with women and girls overall, rather than targeted work with survivors. This approach allows for improved wellbeing amongst the wider population, of which survivors of violence are generally assumed to make up at least 30%.[3] These **group self-care activities** can be led by trained community leaders, staff or volunteers. Eight total modules covering the following themes are available: 1) Stressors, 2) Recognizing signs of stress, 3) Relaxation Café, 4) Taking time for fun, 5) Planning for stressful situations, 6) Asking for help, 7) Cultivating social support networks, and 8) Prioritizing our wellbeing (self-care).These activities can improve participants' wellbeing and confidence as well as increase their awareness of the importance of mental health.

Engaging with program participants in Iraq

A specialized version of **group self-care techniques for adolescents** was also developed by Mercy Corps in Iraq for use with adolescents in school settings. These activities can be run by teachers, counsellors or other key focal points in school settings and include 10 self-care techniques that that adolescents can use to monitor their stress and emotions, as well as to identify when they might need to seek additional specialized support. Training for school focal points focuses on 1) creative facilitation skills for working with adolescents and how to provide psychosocial support including personal skills (enhancing creativity, self-confidence, focus, and emotional awareness, helping students navigate daily life) and peer support (improving social skills, teamwork, and communication).

If your organization has staff with experience in MHPSS counselling or GBV case management service provision, these group activities can be complemented by direct engagement (**"one-on-one self-care activities")** with women who disclosed experiences of violence. These tools require more technical skill than group activities, and any direct engagement with survivors can

[3] https://iris.who.int/bitstream/handle/10665/341604/WHO-SRH-21.6-eng.pdf?sequence=1

increase risks, therefore these one-on-one self-care activities should only be done if the organization has staff with this background.

It is important to note that these tools are not case management or counselling and should only be delivered if a survivor refuses a referral to specialized services. These tools focus on supporting survivors to build resilience and manage their emotions and cover: 1) identifying emotions, 2) understanding stress, 3) regulating emotions, 4) building self-esteem, 5) practicing self-care, and 6) increasing preparedness (e.g., knowing specialist and informal support options).

The staff members and survivor work through tool 1 (identifying emotions) during the first session and then select the remaining tools they will utilize. It is recommended that no more than 2 sessions are held with survivors. These one-on-one services should not be advertised, as the overall goal should still be to refer survivors to specialist care and not to provide in house counselling. However, these one-on-one sessions can be an important step on the path towards supporting survivors to build the mental strength needed to consider taking further steps to ensure their safety.

Supplementing these outward facing activities is a **Self-Care Training for Staff.** This is a one-day training which aims to provide frontline staff with several informal PSS strategies to help manage stress and to recognize more serious mental health issues such as burnout, chronic anxiety, and/or depression. It also builds the capacity of frontline staff to support each other more effectively and to recognize signs of mental health distress in their colleagues and among their program participants. Using interactive role play scenarios and a variety of different participatory activities, the training gives frontline staff the opportunity to learn about mental health coping strategies and allows them to practice these activities throughout the course of the one-day training.

Learning from the Pilot

Overall, activities held with women and girls during the pilot were highly successful and there were **considerable increases in women and girls being referred to GBV specialized support services** in the locations where they were held. For the group-based activities with women, staff members observed improvements in the moods of women after the activities were administered and throughout the pilot more women would sign up to participate than spots were available, indicating the enthusiasm felt by the women for the activities. The frequency of these sessions also increased over the course of the pilot due to the demand. Self-care sessions with adolescents were also well received. These sessions led to conversations about key concerns of students – such as bullying from peers. School Counselors reported that the structure of the sessions provided them a safe space where they felt secure and able to share their thoughts and feelings without fear of judgment as well as helped to build trust and open communication.

> *"I believe these sessions have given survivors strength, especially with the information we've shared. The sessions help increase their self-confidence, which makes it easier for them to face difficult issues, such as family violence, where they need to deal with judges and lawyers. These sessions gave them the strength and confidence to speak up. I've seen women who came back to the sessions start to speak up and share their opinions more confidently, and they are now able to defend themselves."*
>
> – Participant Iraq

For one-on-one sessions with women, the approaches were most useful for women who had relatively non-complex issues (e.g. stress, anxiety). These short approaches were able to help women to identify and consider their emotions and think about simple coping mechanisms they would employ. These sessions are **not a replacement for case management**, and it is important that, if utilized, these sessions be seen as an intermediate step that may help survivors eventually seek specialized care, rather than an end point themselves.

For the self-care training for frontline staff, participants reported that the training was an important opportunity to explore mental health and to address the stigma often associated with this issue in the community. In addition, post-tests with training participants showed that those trained felt that the curriculum would enable them to provide better care and support to survivors following a spontaneous disclosure of GBV. Similarly, participants believed that other organizations in their community would be interested in offering this training to their frontline staff, highlighting the acceptability of the content even in contexts where mental health service provision is not common.

Available Support Materials

If your organization would like to utilize the PSC approach, training materials and other supporting documents are available for your adaptation and use.

Thematic Area 2 Support materials		
Name	**Summary**	**Available Support Materials**
Group-based self-care activities	• 8 modules that can be administered in group settings by staff, volunteers or community leaders	Activity Manual and Handouts Case Study
One-on-one self-care activities	• 6 tools that can be administered by staff with a background in MHPSS or GBV counselling	Toolkit Case Study
Self-care training for staff	• 1 day training for staff on self-care techniques	Training Manual, Slides and Handouts Case Study

Conclusions

Overall, the learnings from our piloting process helped develop the approaches laid out in this document. They provide entry points for non-GBV response specialist organizations to appropriately consider how they can support survivors and use their resources/capacity to build the capacity of GBV response specialists. Given the crisis of funding for humanitarian settings, working together and pooling our resources to better support survivors is becoming increasingly essential. While none of the approaches highlighted in this document could or should replace GBV specialist services, they do highlight how all humanitarian actors have a role to play in supporting survivors.