GBV WG

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ASSESSMENT OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT APPROACHES IN THE GBV SECTOR IN LEBANON

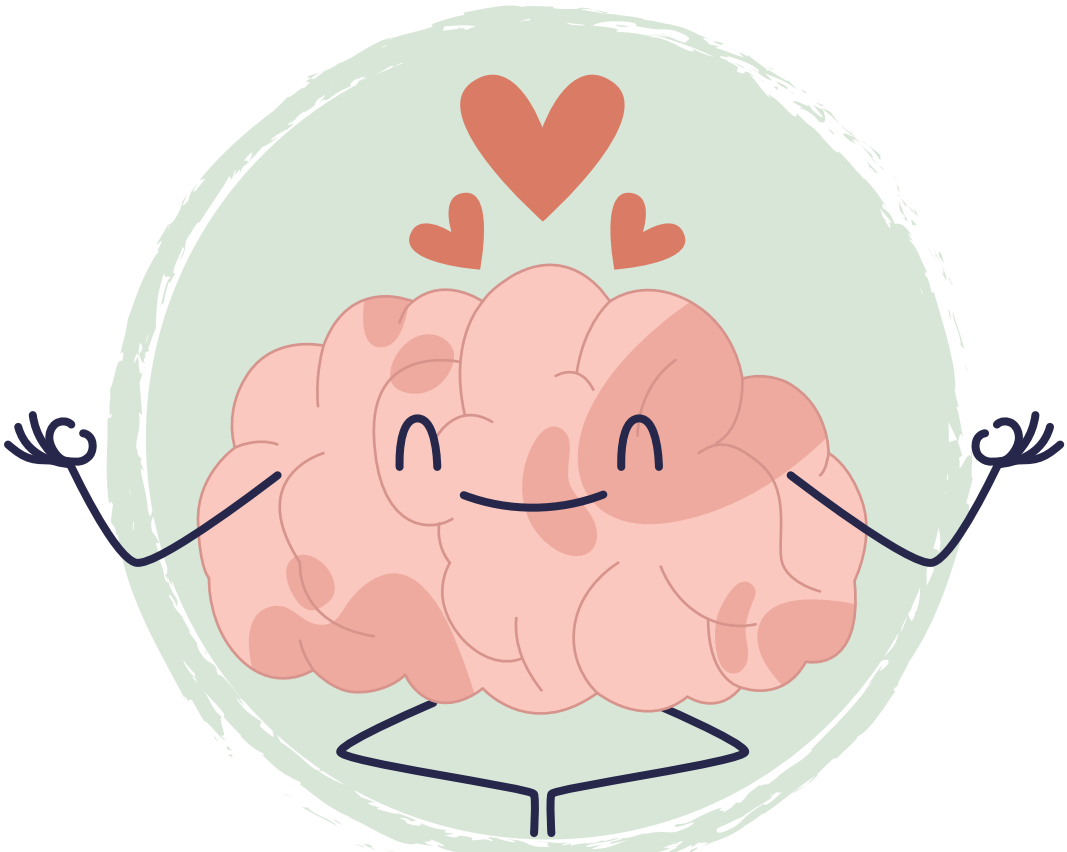

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Table of Content

List of Acronyms

- **AG** Adolescent girl
- **CM** Case management
- **CBT** Cognitive behavioural therapy
- **EMDR** Eye movement desensitization and reprocessing
- **FGD** Focus group discussion
- **FPSS** Focused psychosocial support
- **GBV** Gender-based violence
- **GBViE** Gender-based violence in emergencies
- **IPV** Intimate partner violence
- **KII** Key informant interview
- **MHPSS** Mental health and psychosocial support
- **NMHP** National Mental Health Program
- **OPD** Organization for people with disability
- **PM+** Problem management +
- **PPD** Postpartum depression
- **PSEA** Protection from exploitation and abuse
- **PSS** Psychosocial support
- **PWD** Person with disability
- **SOGIESC** Sexual orientation, gender identity, expression and sexual characteristics
- **SEA** Sexual exploitation and abuse
- **WGSS** Women and girls' safe spaces

Introduction

Survivors of GBV, women at risk and other community members who go through armed conflict, displacement and other forms of crises can experience self-blame, guilt, mood swings, stress and anxiety, anger and other psycho-social problems such as isolation and stigma. Situations of crises have an impact on individuals' wellbeing and the quality of their relationships to themselves and to others.

The adjustment and coping skills of individuals are affected especially when they[1] experience loss in its different forms.

In GBV programming, psychosocial support and protection interventions are intimately connected and are designed in view of increasing the safety and empowerment of women and girls including GBV survivors. When women and girls feel safer and are empowered on different levels, their psycho-social wellbeing is enhanced.

Psychosocial support is the largest response area in the GBV programming, yet several members use different approaches, tools, and definitions. The stressors facing women, girls and GBV survivors have been changing as a result of the different crises the country is going through, therefore showing new or ongoing psychosocial needs that require a variety of programmatic approaches and interventions. In view of harmonizing approaches, an analysis is needed to clarify what partners are doing, showing the impact of interventions and providing evidence-based recommendations for GBV programming.

The purpose of this assessment is to understand the MHPSS practices in the GBV sector in Lebanon. More specifically, this assessment will map the PSS approaches used, document best practices and lessons learnt and define sectoral minimum standards of care and tools to be adopted by sector members. This was done in consultation with key relevant actors in the fields of GBV and MHPSS and with program beneficiaries in close collaboration with the GBV WG. One of the products that will be developed after this assessment is guidelines on psychosocial support approaches in the GBV sector in Lebanon that will be shared in a separate document for dissemination in the GBV WG.

Literature Review

Gender-based violence (GBV) is an umbrella term used to describe any harmful act perpetrated against a person's will, based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering; threats of such acts; coercion; and other deprivations of liberty.
The historical and widely prevalent unequal power balance between men and women has led to worldwide disadvantages for women and girls in terms of social influence, access to and control of resources, and control of their own bodies and lives.
These circumstances have created an environment where GBV has a greater impact on women and girls.[2]

Mental health and psychosocial support (MHPSS) is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and prevent or treat mental conditions.[3]

Feminism is the belief that women and girls have the same value and worth as men and boys; and it is a commitment to take action to change inequitable social norms and reduce the structural inequalities which prevent the advancement of women's and girls' rights. Feminism is intersectional meaning that it recognizes that women are not a homogenous group; it recognizes how our multiple and complex identities interact and overlap to create different experiences of power, oppression, discrimination and privilege.[4]

The types of GBV include different forms of sexual violence, physical violence, emotional violence, and socio-economic violence. GBV is linked to a wide range of health, mental health, and social consequences for survivors. The health consequences include injury, sexually transmitted infections, HIV, fistula, unwanted pregnancy, complications in pregnancy, unsafe abortions, and in some cases GBV can lead to death. The social consequences include stigma, isolation, rejection from family, discrimination, challenges in social integration. The mental health consequences include high levels of distress (e.g. fear, sadness, anger, self-blame, sadness, etc.) and anxiety (including post-traumatic stress disorder); problems with controlling mood, including depression, self-harm and suicidality; substance abuse; unresolved or unexplained somatic complaints; and phobias. Studies indicate that the severity and duration of exposure to violence are predictive of the likelihood and severity of current and future mental health outcomes.[5]

[1] ABAAD, International Rescue Committee, Emotional Support Group Curriculum

[2] IASC (2015) IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Settings IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, 2015 | IASC (interagencystandingcommittee.org)

[3] IASC (2007) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007 | IASC (interagencystandingcommittee.org)

4 Raising Voices (2017) What is a feminist-informed approach to preventing violence against women? What is a feminist-informed approach to preventing violence against women? - Raising Voices

5 Ward, Jeanne (2020) Feminist Approaches to Specialized Mental Health Care for Survivors of Gender -based Violence, GBV AoR Helpdesk learning brief Learning Brief - Feminist Approaches to Mental Health Care for GBV Survivors - 29.05.2020.pdf (gbvaor.net)

6 Astbury, Jill (2001) Gender disparities in mental health. In: Mental health. Ministerial Round Tables 2001, 54th World Health Assemble, 2001, Who, Geneva, Switzerland. Gender disparities in mental health | VU Research Repository | Victoria University | Melbourne Australia

Rates of depression in adult life are three to four times higher for women exposed to childhood sexual abuse or physical partner violence compared to non-victims. Evidence also indicates that the higher rates of depression and other mental health conditions that women experience compared to men reflect women's higher level of exposure to a variety of mental health risks. Additionally, female survivors make up the single largest cohort of PTSD sufferers globally, with an estimated one in three survivors of rape experiencing PTSD. [6]

Standard 6 of the GBViE minimum standards is dedicated to Mental health and psychosocial support and considers that creating accessible 'safe spaces' where female GBV survivors [7] can go to receive services, support or seek immediate safety if they are at risk of GBV is an effective MHPSS intervention that promotes safety, healing and recovery.
The GBV prevention and response activities happening at the women and girls' safe spaces mostly fall under layer 2 and layer 3 of the IASC MHPSS pyramid.

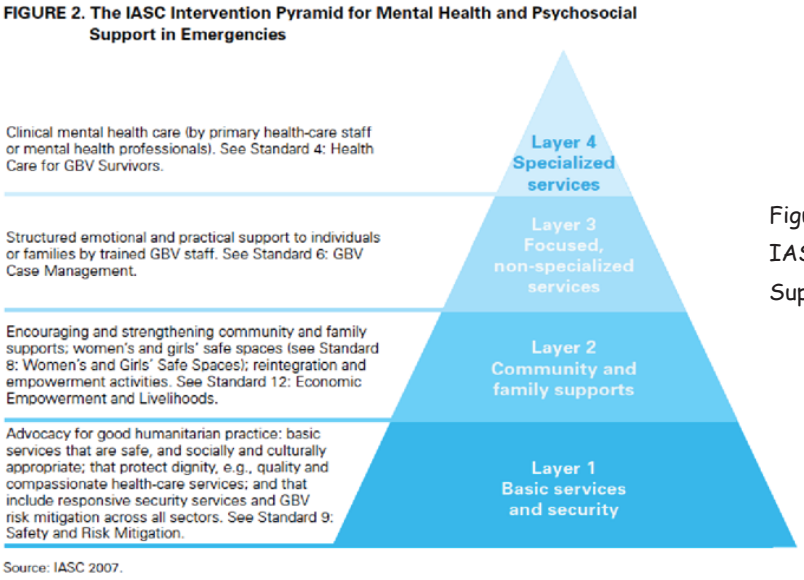


Figure 1: GBV AoR, 2019, adapted from IASC, 2007. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

The Global Women's Institute at George Washington University (GWI) and Trócaire recently developed a resource package[8] exploring the intersections of MHPSS and GBV response in order to build consensus between both sectors on what constitutes survivor-centered MHPSS interventions and approaches to GBV survivors in humanitarian settings.
They highlight the importance of GBV-CM as a primary MHPSS intervention with GBV survivors offered by GBV actors, being a layer 3 focused PSS intervention in the MHPSS pyramid that includes practical support and is rooted in feminist principles. They also highlight the importance of specific mental health conditions that involve risks of suicide and they consider that the coordination of MHPSS responses to suicide should ideally be led by the MHPSS technical working group.

[7] UNFPA (2015) Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies (unfpa.org)
[8] Trocaire, The Global Women's Institute at George Washington University (2023) Supporting Uptake of Survivor -Centered Practice: Building Consensus Between GBV And MHPSS Workers Around Shared Guiding Principles and Recommendations for Progressing Practice https://gbvaor.net/node/1880
[9] In line with their qualifications and skills, the GBV service provider can provide needed services and support to survivors directly and with the supervision of persons specialized in mental health, or they can link to available mental health services.

Literature Review

GBV actors should involve MHPSS service providers for further assessment, management, and follow-up of survivors with suicidal ideation or behaviors with the survivor's consent.[9] More importantly, the resource package developed by The Global Women's Institute at George Washington University (GWI) and Trócaire outlines the core concepts and guiding principles whichmust be adhered to when providing MHPSS interventions for GBV survivors in humanitarian settings.

Core Concepts and Guiding Principles when providing MHPSS interventions for GBV survivors in humanitarian settings

GBV GUIDING PRINCIPLES [11]

SURVIVOR-CENTERED: Encompasses the principles of safety, confidentiality, respect, and non-discrimination with an emphasis on respecting the survivor's dignity and right to self-determination.

RIGHTS-BASED: Address root causes of inequality and ensure everyone has the right to live with freedom and dignity, safe from violence, exploitation and abuse

COMMUNITY-BASED: Ensures that affected populations are engaged actively as partners in development of programming, including women, girls, and other at-risk groups

HUMANITARIAN PRINCIPLES: Humanity, impartiality, independence and neutrality are essential to maintaining access to affected populations and enduring effective humanitarian response

DO NO HARM: Taking all possible measures to avoid exposing people to further harm as a result of humanitarian action

PRINCIPLES OF PARTNERSHIP: Humanitarian actors should follow principles of equality, transparency, results-oriented programming, responsibility, and complementarity, highlighting local and national response capacity and enhance the effectiveness of the response

BEST INTERESTS OF THE CHILD: Adolescent and child GBV survivors have a right for their best interests to be assessed, determined, and taken as primary consideration in all decisions affecting them

MHPSS CORE PRINCIPLES [12]

HUMAN RIGHTS AND EQUITY: Protect and support the rights of all persons and maximize the equity in access to MHPSS services

PARTICIPATION: Promote participation from affected population in response and programming

DO NO HARM: Reduce the risk of unintended harm from MHPSS services by working to minimize gaps and duplication of services, supporting transparency and accountability in programming, and designing culturally sensitive, relevant, and evidence based interventions **BUILDING ON AVAILABLE RESOURCES AND CAPACITIES:** Strengthen local resources to promote sustainability **INTEGRATED SUPPORT SYSTEMS:** Services should be integrated to increase reach to the affected population, promote sustainability, and reduce stigma **MULTILAYERED SUPPORTS:** A layered system of supports provides appropriate services to meet the complex needs of an affected population

FEMINIST APPROACHES [13]

RIGHTS-BASED: Asserts that women and girls have a right to live a life free from violence

PRIORITIZES WOMEN AND GIRLS: Women and girls' safety, priorities, and needs are considered of the utmost importance in the design, implementation, and sustainability of programming

GENDER EQUALITY: Recognizes that gender inequality is at the root of gender-based violence

GENDER TRANSFORMATIVE: Works to actively shift harmful power dynamics that are at the root of GBV - at the individual and community level

DO NO HARM: Strives to **reduce** the risk of unintended harm from interventions **WOMEN-LED:** Women and girls play an active role in strategic planning, intervention design, implementation, and monitoring.

'TRAUMA-INFORMED CARE [14]

SAFETY: Survivors and service providers feel both physically and psychologically safe

TRUSTWORTHINESS & TRANSPARENCY : Interventions are provided with the intention of building trust between the survivor and service provider

PEER SUPPORT: Survivors are encouraged to actively engage in service delivery

COLLABORATION: Staff work to reduce power-imbalances between service providers and survivors

EMPOWERMENT: Strength and resilience are recognized and validated

HUMILITY & RESPONSIVENESS: Service providers work to recognize and address biases that may impact care

[10] Ibid

[11] The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming https://www.unfpa.org/minimum-standards

[12] IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings https://reliefweb.int/report/world/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings?psafe_param=1&gad_source=1&gclid=CjwKCAiA_5WvBhAEiwAZiCU7zFa0aIDEAa9yYMb09RD9dd9h6XSCJLFOE1nzZnB1Zr1s5vhxWZYyhoCiDkQAvD_BwE

[13] Raising Voices, What is a feminist-informed approach to preventing violence against women? https://raisingvoices.org/resources/what-is-a-feminist-informed-approach-to-preventing-violence-against-women/

[14] What is trauma-informed care? Trauma-Informed Care Implementation Resource Center. (2022, July 7). https://www.traumainformedcare.chcs.org/

Building on the above-mentioned core principles, and in line with standard 1 on participation of the GBViE minimum standards, the international Rescue Committee and International Medical Corps' toolkit on WGSSs [15] considers that PSS activities in the WGSS should first and foremost empower women and girls by promoting their agency and offering them opportunities to make effective choices to transform their lives. In order to achieve that, it is very important to break down existing barriers between service providers and beneficiaries by ensuring implementation of activities "informs, consults, involves, collaborates and empowers women and girls as co-creators of the WGSS program. It is the collective process – between women and girls who, daily, choose to gather and contribute whether as beneficiaries, members, facilitators, mentors, service providers, agents of change or in any other capacity – which creates the relevant space for women's and girl's empowerment."[16]

The same toolkit highlights four types of empowerment that WGSS activities should promote:
1. **Personal empowerment** (power within): encompasses activities which develop women's and girls' self-confidence, self-awareness, self-respect, ability to assert their rights and make choices.
2. **Cognitive empowerment:** encompasses activities and opportunities which allow women and girls to gain new skills and knowledge so they can make choices and take control of their lives.
This includes knowledge about rights, services and how to access them.
3. **Psychosocial empowerment:** includes activities and services which recognize women's and girls' strengths. These support women's and girls' freedom of expression, ability to cope positively with stress, and mutual support through strengthened social networks.
4. **Socio-civic empowerment:** encompasses activities and services to enhance women's and girls' participation in public life, as well as opportunities to mobilize and organize for social change.

The toolkit also described the different objectives of a WGSS, of which objective 2 is dedicated to support women's and girls' psychosocial well-being and creation of social networks.
The different types of PSS activities that support achievement of this objective include: arts-based activities (e.g. music, dancing, theatre, drawing), exercise and sport (e.g. yoga, volleyball, football), leisure and relaxation activities (e.g. coffee or tea ceremonies, meditation, storytelling, movies), craft-making (e.g. soap making, tailoring, beading, basket making), community development initiatives (e.g. gardening, rehabilitation of community spaces), positive support groups, communal income-generating activities to support the WGSS.
Other activities such as life skills activities are included in Objective 1 on access to knowledge, skills and services, while objective 3 of the toolkit focuses on safety and includes safety audits and awareness raising.

The resource package[17] developed by The Global Women's Institute at George Washington University and Trócaire indicates some essential safeguards to take into consideration when offering focused group PSS. Groups should never consist of survivors only, survivors should be safely integrated into group interventions and never identified to group members. Group composition should take into consideration factors that influence the group dynamic. Expectations and group agreements around safety, confidentiality and mutual respect and support must be established at the outset. A group safety assessment should be conducted prior to starting the group-based activities to identify risks that women, girls, and GBV survivors may face. Community safety mapping should be used with the group to determine risks and mitigation actions. Group-based discussions about safety and risk should not include any questions about violence experienced or perpetrated by participants. If someone expresses serious safety concerns or discloses harm, the PSS worker should refer them for individual risk assessment.

[15] International Rescue Committee, International Medical Corps (2020) Women and Girls Safe Spaces: A Toolkit for Advancing Women 's and Girls' Empowerment in Humanitarian Settings https://reliefweb.int/report/world/women-and-girls-safe-spaces-toolkit-advancing-women-s-and-girls-empowerment
[16] Ibid Page 390

Situational analysis in the Lebanon context:

Since 2019, Lebanon has witnessed a multi-layered crisis propelled by civil unrest, political instability, economic and financial challenges further exacerbated by the Beirut Port Explosion, COVID-19, and the Cholera Outbreak.

Since October 2023, hostilities in the South of Lebanon have created further fear and instability and resulted in casualties, loss of property and a wave of internal displacement. Lebanon continues to host the highest number of displaced people per capita in the world. While the population as a whole is deeply affected by the country-wide crisis, the most vulnerable populations remain the most affected. Food Security remains a major source of concern for both host and refugee communities in Lebanon.

The World Bank estimates that more than half of the Lebanese population is reported to be under the national poverty line; meanwhile, 90% of Syrian households are living under the survival minimum expenditure basket. The 3RP 2024 regional strategic overview indicates that in Lebanon, over half of Syrian households are living in shelters that are either overcrowded or below humanitarian standards, 22% of Syrian girls and young women between the age of 15-19 are married , 84% of Syrian refugees, 85% of Lebanese, 68% of migrants and 78% of Palestinians reported difficulty accessing needed medication (VASyR, MSNA).

According to OCHA[19], approximately 393,000 people across 26 districts were in need of GBV services in 2022, a significant increase from 67,000 people in need in the 2021 ERP. Around a quarter of Lebanese households reported having safety and security concerns for women in their community (including sexual violence and harassment, kidnapping, and sexual exploitation), and the percentage is even higher, if girls are considered (34%).The GBVIMS data of 2023 [20] shows that women and girls continue to constitute the majority (98%) of survivors of GBV. Female survivors are disproportionately exposed to gender-based violence related risks due to several factors linked to the existing patriarchal structures and power dynamics in the community. For female survivors, physical assault and psychological/emotional abuse present the most reported types of GBV incidents, accounting for 28% and 27% respectively. Forced child marriage is the third most reported GBV type with 21%, followed by sexual violence, including rape and sexual assault, and denial of resources and opportunities, with 18% and 6% respectively.

According to the gender findings of UNICEF's report[21] on multidimensional child poverty, adolescent girls, regardless of their nationality, shared experiences of harassment in public spaces and restriction of their mobility preventing them from accessing services. Furthermore, 22% of Syrian girls aged 15-18 who do not attend school report marriage as the main reason behind this. In a research undertaken with adolescent girls and young women by Plan International[22] , regardless of age, nationality and location, adolescent girls and young women reported common barriers related to education and livelihoods, as well as access to protection and SRH services. Adolescent girls and young women report being exposed to catcalling, stalking, inappropriate touching, and rape when on the streets or in public spaces in general.

They voluntarily avoid walking on the streets, especially if alone or at night, or are forbidden to do so by their parents and brothers.

The GBVIMS 2023 midyear report indicates that while 14% of displaced Syrians have reported living with a disability (according to Vasyr report), and 32% of Syrian households having at least one member living with a disability, only 1% of all GBV incidents reported were recorded for persons living with a disability with no change compared to 2022. This trend requires efforts of GBV service providers to reduce barriers on PWDs to access information and services.

The inclusion of women and girls living with disability in WGSSs is paramount for their empowerment and protection. To add to that, and according to the UNFPA's situational analysis on gender-based violence against women and girls with disabilities in Lebanon[23] , several barriers limit the access of GBV survivors living with disabilities to services and opportunities in the community. GBV actors operating WGSSs who should try as much as possible to reduce such barriers in the set-up, activities and modalities adopted in the safe spaces.

[18] these statistics are from 2022. Preliminary data from Vasyr 2023 assessment shows that this number increased again to 25%

[19] OCHA: Increasing Humanitarian Needs in Lebanon - Increasing Humanitarian Needs in Lebanon, April 2022 [EN/AR] - Lebanon | ReliefWeb

[20] Gender-Based Violence (GBV) Information Management System (IMS), Overview of GBV trends in Relation to Lebanon's Situation, 2023 Midyear Report

[21] United Nations Children's Fund (2022). "Deprived Childhood" - https://www.unicef.org/lebanon/reports/deprived-childhoods

[22] Voices of youth amidst Lebanon's economic collapse, 2022 needs assessment and gender analysis, PLAN International - https://plan-international.org/lebanon/publications/voices-of-youth-amidst-lebanons-economic-collapse/

[23] Situation Analysis on Gender Based Violence Against Women and Girls with Disabilities in Lebanon, UNFPA, Lebanon: https://lebanon.unfpa.org/en/node/108432

[24] 2022, Lebanese American University, Egna Legna Besidet, Acknowledged but Forgotten: The Gender Dimensions of Sexual Violence Against Migrant Domestic Workers in Post-Crisis Lebanon https://soas.lau.edu.lb/files/PDF%20%20Final%5B2%5D.pdf

[25] 2022, ABAAD and The Global Women's Insitute George Wahington University, The Sorrow Remains Inside https://www.abaadmena.org/resources/the-sorrow-remains-inside-full-report/

The GBVIMS report also indicates that persons with diverse SOGIESC remain one of the vulnerable groups that face GBV, and they often have safety and protection concerns due to the ongoing risks of bullying, sexual violence, exploitation and discrimination they are subjected to at home and in the community. Field reports indicate that people with diverse SOGIESC "may be reluctant to report a GBV incident, because of expected further abuse or stigmatization from the community, as a result of the norms-based discrimination".

A study by Egna Legna Besidet and the Lebanese American University[24] on the Gender Dimensions of Sexual violence against migrant domestic workers conducted with 913 migrant workers from different nationalities in Lebanon, revealed that 68% of the interviewed domestic workers confirmed being subjected to sexual abuse and 70% of survivors confirmed that the perpetrator is the male employer.
The study also shows the impact of violence on domestic workers which includes thoughts about self-harm, anxiety, substance abuse, sleep disorders, depression, stress, eating disorders, withdrawal from society/ isolation, suicidal thoughts/tendencies and an overall sense of 'constantly living in fear.'

In The Sorrow Remains Inside[25], a mixed method approach to understand the relationship between Gender-based Violence and Mental Health of the Lebanese and Syrian populations in Lebanon, 79% of study participants have experienced at least one act of IPV in their lifetime, 19% reported unwanted s exual touching, 9% said they were offered money or other favors in exchange of sex, 4% experienced attempted rape, while 2% of Syrian women and 1% of Lebanese women have experienced rape.[26]
Key factors increasing risks of non-partner sexual violence against women are young age, engaging in income-generating activities outside the home, as well as region. Women in the North are nearly twice as likely as women in the Bekaa to experience sexual assault or transactional sex.[27]
All forms of GBV were significantly associated with severe distress. Women who have experienced sexual violence in particular have significantly higher rates of sever distress. Women who have been offered money or other favors in exchange of sex were 4.2 times more likely to experience severe psychological distress. Nearly 80% of women who have experienced each dimension of IPV had severe psychological distress in the past 30 days, compared to 65-68% of women who did not experience the same form of violence. Women who experienced child marriage are three times more likely to experience severe psychological distress. Additionally, serious problems affecting women's ability to move safely in public and private spaces were associated with highest rates of severe psychological distress.

The study also shows the relation between each form of violence and mental health:

Type of violence	**Associated mental health issues**
Economic violence in the context of IPV	Inability to make decisions (lack of agency) Low self confidence
Emotional violence in the context of IPV	Hesitation in making decisions and lack of ability to apply them Depression Isolation Stress Mental fatigue
Physical violence in the context of IPV	Fear Increased disrupted sleep Stress Lack of comfort
Social norm/violence	Pressure Mental Fatigue Stress Hesitation in making decisions and lack of ability to apply them
Child marriage	Pressure Depression Increased burden Stress

There is no specific gender analysis on mental health problems in Lebanon. However, according to the national mental health program, anecdotal data from observations tend to internalizing problem behavior in women (withdrawal, anxiety, depression, emotional problems) and more externalizing problem behavior in men (aggression, impulsivity, substance use).
Very insightful research on Maternal mental health[28] conducted by the National Mental Health Program and UNFPA as part of the Maternal Mental Health Guidelines for Healthcare Providers, shows high rates of postnatal psychological difficulty and mental health disorders in Lebanon compared to global trends. It has been identified that around 10% of pregnant women and 13% of women in the postpartum period have some type of mental health problem with anxiety and depression being the most common.[29]
In low to medium income countries, the rates increase to 15.6% of pregnant women and 19.8% of women in the postpartum period experienced psychological distress .[30]
In Lebanon, general postpartum psychological distress were found in 84% of Lebanese women from 40 days up to 6 months postpartum .[31]

Globally, postpartum depression (PPD) rates are around 10-15% of women. The prevalence rates in Lebanon are close to those reported in Low-and Middle-Income Countries which range between 19-25 %[32] and those in the Arab region ranging between 15-25%.[33] Additionally, refugee mothers residing in Lebanon have shown higher levels of PPD compared to low-income Lebanese mothers[34] and prevalence of PPD was found higher in Lebanese rural areas compared to Beirut .[35]

Anxiety disorders were found to have a 15-20% prevalence rate in pregnant women, a 10% prevalence rate in postpartum women and were found to be more prevalent in Low-to-Middle-Income Countries .[36]
In Lebanon, a study by Hobeika et al. (2020) found high prevalence rates of anxiety among Lebanese mothers with 54.7% of Lebanese mothers having mild to moderate symptoms and 13% showing severe symptoms of anxiety 4-6 weeks postpartum.[37]
The treatment gap found in new mothers suffering from postpartum mental health conditions was a more concerning finding. In Lebanon, the vast majority of these women were unlikely to seek professional psychological or psychiatric care.[38] It seems that despite the elevated rates of perinatal psychological distress in low to medium income countries, the Arab region, and in Lebanon specifically, there is major scarcity in maternal mental health resources and support centers in this region .[39]

[26] The study's sample was drawn from ABAAD's service population exclusive of case management beneficiaries, it is therefore safe to consider that the rates of GBV incidents observed are under-estimates.

[27] The trend of high SEA in the North was observed in a recent UNFPA assessment on WGSSs, and was also shared by anecdotal data from the field.

[28] 2021, National Mental Health Program, UNFPA, Maternal Mental health: Guidelines for Healthcare Providers https://www.moph.gov.lb/userfiles/files/Programs%26Projects/MentalHealthProgram/MaternalMental-Health-Guidelines-for-Healthcare-Providers.pdf

[29] Hendrick, V.; Altshuler, L.; Cohen, L.; Stowe, Z. (1998). Evaluation of mental health and depression during pregnancy: Positon paper. Psychopharmacol. Bull. 34, 297–299, cited in 2021, National Mental Health Program, UNFPA, Maternal Mental health: Guidel ines for Healthcare Providers.

[30] Fisher, J.; De Mello, M.C.; Patel, V.; Rahman, A.; Tran, T.D.; Holton, S.; Holmes, W. (2011). Prevalence and determinants ofcommon perinatal mental disorders in women in low-and lower-middle-income countries: A systematic review. Bull. World Heal. Organ., 90, 139–149, cited in ibid.

[31] Kabakian-Khasholian T, Shayboub R, Ataya A. Health after childbirth: patterns of reported postpartum morbidity from Lebanon. Women Bir th. 2014 Mar;27(1):15-20. doi: 10.1016/j.wombi.2013.02.002. Epub 2013 Mar 7. PMID: 23473844, cited in ibid.

[32] Rahman A, Iqbal Z, & Harrington R. (2003). Life events, social support and depression in childbirth: perspectives from a rura l community in the developing world. Psychol Med. 33(7):1161–7. [PubMed: 14580070], cited in ibid.

[33] Ayoub, K., Shaheen, A., & Hajat, S. (2020). Postpartum Depression in The Arab Region: A Systematic Literature Review. Clinical practice and epidemiology in mental health : CP & EMH, 16(Suppl-1), 142–155. https://doi.org/10.2174/1745017902016010142, cited in ibid.

[34] Stevenson, K., Alameddine, R., Rukbi, G., Chahrouri, M., Usta, J., Saab, B., Bennett, P., Glover, V., & Reynolds, R. M. (2019). High rates of maternal depression amongst Syrian refugees in Lebanon - a pilot study. Scientific reports, 9(1), 11849. https://doi.org/10.1038/ s41598-019-48247-5, cited in ibid.

[35] Chaaya M, Campbell OM, El Kak F, Shaar D, Harb H, Kaddour A: Postpartum depression: prevalence and determinants in Lebanon. A rch Womens Ment Health. 2002, 5: 65-72. 10.1007/s00737-002-0140-8, cited in ibid.

[36] Dennis C.L., Falah-Hassani K., & Shiri R. (2017). Prevalence of antenatal and postnatal anxiety: systematic review and meta-analysis. Br J Psychiatry, 210:315-23, cited in ibid.

[37] Hobeika E, Outayek M, Malaeb D, et al. (2020). Postpartum Depression and Anxiety among Lebanese women: correlates and scales validation. Research Square. DOI: 10.21203/rs.3.rs-15821/v1, cited in ibid.

[38] Kabakian-Khasholian T, Shayboub R, Ataya A. Health after childbirth: patterns of reported postpartum morbidity from Lebanon. Women Birth. 2014 Mar;27(1):15-20. doi: 10.1016/j.wombi.2013.02.002. Epub 2013 Mar 7. PMID: 23473844, cited in ibid.

[39] World Health Organization (2011). Maternal, child and adolescent mental health: challenges and strategic directions for the Eastern Mediterranean Region. WHO Regional Office for the Eastern Mediterranean, Cairo, cited in ibid.

Methodology

The methodology used for this assessment includes the following:

- A literature review of global guidelines and resources, as well as relevant studies and assessments in the Lebanon context.
- Key informant interviews (KIIs) with key GBV actors as well as the national mental health program.
- Focus group discussions with diverse women and girls participants in PSS activities offered by the GBV actors.

Ten KIIs were conducted with GBV actors (six local NGOs and four INGOs) and one KII was conducted with the national mental health program. The KIIs with the different GBV actors looked at their observation of the psychosocial needs of women and girls they serve, the definitions and PSS approaches they use, the objectives and desired outcomes they set for focused PSS, their ability to include diverse women and girls in PSS interventions, the minimum standards they apply, their perception of the beneficiaries feedback, the monitoring and evaluation tools they use, innovative PSS approaches they know about, their ability to include women and girls in program design and implementation, as well as their collaboration with the MHPSS actors.

The key informant interview with the national mental health program focused on the mental health needs identified at women, girls and GBV survivors, the PSS approaches used by MHPSS actors to respond to those needs, the intersectional considerations for diverse women and girls, the minimum standards and guidelines used, as well as the collaboration with the GBV actors.

Four focus group discussions with women and two with girls were conducted. The number of participants in FGDs were between eight and twelve. Women participants were Lebanese and Syrians. The age group of women participants varied between late twenties and late fifties. The area of residence of women included Tripoli, Baalbek, Saida, Hay el Sellom, Furn el Chebak and surrounding. Girls FGD participants were Syrians and Lebanese between fourteen and eighteen years old residing in Tripoli and in Hay el Sellom. Some are school students while others are out of school girls with some attending vocational training. The focus group discussions with women and girls looked at their perception of the psychosocial needs of diverse women and girls and how they have been affected by the different crises, their feedback on the different PSS activities they received, their perception of the changes they experience after participating in PSS activities, their opinions regarding the methodologies and approaches used, as well as their recommendations regarding any changes to be made or additional activities they suggest.

Below is a table showing the different actors involved in the assessment:[40]

Organization	KII	FGD women	FGD girls	Location of FGDs
DRC	X			
LECORVAW	X	X	X	Tripoli, North
LUPD	X	X		Baalbek, Bekaa
WVI	X			
KAFA	X			
ABAAD	X	X		Furn el Chebak, Beirut
AMEL	X	X	X	Hay el Sellom, Beirut
IRC	X			
IMC	X	X		Saida, South
Makhzoumi	X			
NMPH	X			

Executive Summary of Findings

The psychological challenges observed among women beneficiaries include emotional pressure and stress, low self-worth, signs of trauma, psychosomatic symptoms, co-dependency towards perpetrator, anger, self-harm, suicidal thoughts, signs of anxiety and depression and violence against their children. As for girls, the challenges are related to the struggle with negative self-image, emotional emptiness, lack of safety, and not feeling heard.

The protection concerns affecting the psycho-social wellbeing of women and girls include IPV, violence from parents affecting girls, child marriage, denial of resources, sexual harassment, sexual exploitation, bullying and racism, kidnapping.
The key contributing factors to the psychological distress were the deterioration of the financial situation, the reduced safety and security and the political deadlock.

[40]A full list of the key informant is available in the annexes

When it comes to the needs based on **intersectional identities** of program beneficiaries, AGs were considered to have additional needs for social and emotional connection and are at further risks of child marriage and harassment. Women heads of household are at risk of sexual harassment, sexual exploitation, and emotional violence from in-laws.
Older women were considered as a vulnerable group more affected by the financial crisis, and not included enough in safe space activities. Migrant workers constitute a vulnerable group due to their legal status and lack of social networks and support. PWDs struggle with access to services, are more isolated and dependent, and are at additional risk of different forms of violence.

As a **result of the different crises** the country went through in the last three years, the deterioration in the economic situation is shifting priorities and making beneficiaries more focused on basic needs. More fear is expressed as a result of the recent hostilities in the South. Climate change is an emerging risk factor especially affecting beneficiaries who work in agriculture. An increase in service seeking behaviour at the Lebanese community due to the economic crisis was observed as well as more demand on MHPSS services which could be linked to the increased needs or to the increased awareness of existing services.

The harmful coping mechanisms observed include school drop-out, child labor, and reduced food intake especially at the Syrian population while the Lebanese are mostly resorting to debt, selling their belongings, or relying on remittances. IPV seems to be a negative coping mechanism used across nationalities. PWDs have reduced access to medication and healthcare and increased social isolation and lay off from jobs.

The Psychosocial support activities offered by GBV actors include information and awareness sessions, community events, men engagement programs, recreational activities, life skills activities, skills building and vocational training, parenting sessions, a variety of curriculum-based focused PSS, case management and psychotherapy.
From the perspective of women in FGDs, the most important activities to improve their wellbeing are the **group PSS** (focused PSS), **income generating activities,** and the **recreational activities.**
They especially stressed on the importance of **going on trips.** Girls mentioned group PSS and recreational activities.

Focused PSS is one of the most essential MHPSS activities offered by most GBV actors, offering a safe space for women and girls to come together, share experiences, build a supportive network, while promoting positive coping mechanisms and reducing protection risks.
Most actors are focusing on topics related to improving relationship with oneself, emotional awareness and regulation, relational skills, as well as GBV and gender equality topics.
The guidelines that should be followed when offering focused PSS need more clarity and harmonization among actors. While they all agree on some modalities such as the space, capacity building of facilitators, number of sessions, topics, and facilitation techniques, the main areas of divergence are related to the group composition as well as the safety assessments conducted before the intervention.

Inclusion of diverse women is an area that requires more harmonization and efforts among GBV actors. Several actors mentioned the importance of including PWDs starting from the outreach phase, the importance of physical adaptations for people with mobility issues, the use of the Washington questionnaire, the use of mobile safe spaces to increase access to PWDs, as well as the collaboration with OPDs to adapt PSS material and train staff on inclusion. Fewer actors mentioned adaptations of sessions to work with sensory or intellectual disabilities. Some actors are not doing any inclusion work. Conflict sensitivity is used by some actors to ensure different nationalities can be included in the same groups. Only a couple of actors mentioned diverse SOGIESC without specifying clear approaches for inclusion. Women in FGDs mentioned that starting a certain age (sometimes thirty-five years old), women are no longer included in activities, especially skills building which is creating considerable frustration and feelings of being excluded.

GBV actors mentioned that in order to measure the outcome of **focused PSS activities,** they use a variety of internally developed tools including pre and post-tests, FGDs, and satisfaction surveys. Most actors using tool 1 of Activity Info mentioned that not all the questions are relevant to the modules they are using. All actors noted substantial change they see in women who attended the focused PSS activities including increased self-awareness, increased self-confidence, giving time to themselves and prioritizing self-care, feeling that they are achieving something, feeling more empowered to take decisions, emotional awareness, emotional regulation, more joy, improved social networks and solidarity, ability to resolve conflicts, ability to re-establish positive relations with children, improved communication skills, ability to put boundaries, increased awareness of their rights. This was confirmed by FGD participants who are **clearly benefitting from focused PSS activities.**

When asked about what can be improved in the safe space activities, women in all FGDs mentioned that they would like to receive vocational training, entrepreneurship training, and any support to find employment or start their own businesses. They would also like to receive more recreational activities and the opportunity to go on trips, Girls mentioned they would like to receive more recreational activities, skills building activities and go on trips.

Participation of women and girls in designing and delivering some of the WGSS activities is limited to consulting with program beneficiaries on activity topics for some organisations, while others already have women focal points or women committees who conduct activities such as outreach, awareness raising, help in organizing some aspects of the safe space, collect trends from the field, support in safe identification and referral of GBV survivors, or offer skills building activities. Participation of women and girls in program implementation is showing great impact on their empowerment and wellbeing.

One of the areas that requires further attention is the option for women and girls to **hangout freely in the safe spaces outside of the structured activities.**
Few are the organizations who are giving this chance to the beneficiaries. They noted how important it is for women and girls to feel that they can come whenever they want and feel that the space belongs to them and how it increases their sense of ownership leading to improved psychosocial wellbeing, which was confirmed by program beneficiaries.

When it comes to referrals to specialized MHPSS services, some of the GBV organizations already received MHPSS safe identification and referral training and/or are using a determined checklist to assess the need for referral to specialized mental health services. Individual psychotherapy within WGSSs is offered by four out of the ten GBV actors assessed. The main approaches used include CBT, Trauma psychosocial support +, narrative therapy, mindfulness, (EMDR), PM+, Self-Help+, systemic therapy, and one actor mentioned they occasionally use psychoanalytical approach. All actors are focusing on short term interventions and have in-house supervision in place. The trainings they offered to their psychotherapists include GBV core concept and safe referrals, cultural sensitivity, trauma informed care, crisis management, dynamics of IPV, PFA, self-care, as well as technical trainings in the different therapeutic approaches.

GBV actors mentioned different **challenges** in MHPSS program implementation including challenges in the communication between the GBV case workers and the psychotherapists leading to fragmented care plans, unclear roles between GBV CM and MHPSS CM and who should offer the service to GBV survivors, skills building activities requested by women often falling within traditional gender norms, challenges in offering solid livelihood projects which requires a lot of resources and donors prioritizing youth in such programs, the need to have access to new FPSS curricula, the current Activity Info M&E toolkit not measuring the improved MHPSS wellbeing of beneficiaries, challenges in including women with diverse SOGIESC, and the need to do more men engagement work.

Assessment Findings

The different GBV actors included in this assessment had different perceptions of what Psychosocial Support means. The aspects mentioned include a set of **prevention and response** activities aiming to **promote and strengthen the wellbeing** of individuals, support them to feel better, express themselves, access a supportive network, receive emotional support, receive information, work on behavioural change and prevent further MHPSS harm. The focus on prevention and risk mitigation was mentioned, as well as the support to overcome difficulties and reinforce a sense of safety and stability. Some actors mentioned that PSS activities constitute a safe space for **identification and referral** of survivors to GBV case management or to specialized MHPSS services. According to the national mental health program (NMHP), when we say PSS we speak about the activities implemented with the purpose of enhancing the mental health and wellbeing of the population served, and in line with the MHPSS pyramid.
It is interesting to note that none of the GBV actors made any reference to the MHPSS pyramid.
Some aspects of **safety** and **empowerment** were repeatedly mentioned by GBV actors without having a comprehensive and standardized description of how those two aspects are related to PSS in GBV programming.

Overview of psychosocial needs and challenges

The psychological challenges observed by the GBV actors among program beneficiaries include emotional pressure and stress, low self-worth related to violence, signs of trauma, psychosomatic symptoms, co-dependency towards perpetrator, anger, self-harm, suicidal thoughts, signs of anxiety and depression and violence against their children. Women in the FGDs spoke about pressure related to the economic situation and its repercussion on tension and violence inside the household. They also spoke about the stress related to parenting within these challenging conditions. Girls in FGDs mentioned the struggle with negative self-image, emotional emptiness, lack of safety, and not feeling heard that many of them or their peers are facing.

The protection concerns affecting the psycho-social wellbeing of women and girls according to GBV actors include intimate partner violence, violence from parents affecting girls, child marriage, denial of resources, sexual harassment, and sexual exploitation and bullying. Women in FGDs mentioned bullying, racism, and patriarchal norms affecting women, and that women with disability have reduced access to healthcare, information, awareness and recreational activities, further exacerbated by the financial crisis. Girls in FGDs said they are affected by bullying, tension and violence in the households due to the financial situation, decreased ability to focus on their studies due to stress. They feel they have to sacrifice their future because of the financial situation. They mentioned that many girls might seek support from people who might harm them (mostly in romantic relationships).

The key contributing factors to the psychological distress (as well as to the increase in violence)
were considered to be the deterioration of the financial situation, as well as the reduced safety and security and the political deadlock.

The psycho-social needs expressed by beneficiaries include the need to be heard, repeatedly expressed in the FGDs: "We need someone to listen to us, to feel us, we need to know that we have the right to take care of ourselves and feel strong", "At home I don't feel I can talk without being interrupted, here I feel I am a person, and someone is listening to me and respecting my confidentiality".
Girls in the FGDs also mentioned the importance of finding trustful people who can listen and support them. From the perspective of the NMHP, protection of women and girls is considered as an essential PSS need.

Intersectional needs: When it comes to the needs based on intersectional identities of program beneficiaries, different actors had different levels of understanding of those. Some mentioned that adolescent girls have additional needs for acquiring social and emotional connection, improved relational skills (i.e. with their parents), the need for recreational activities, as well as protection from specific types of violence such as child marriage.

One actor mentioned an increase in women heads of household as a result of the wave of deportation of men. Those women are at risk of sexual harassment, sexual exploitation, as well as emotional violence from in-laws. Older women were considered as a vulnerable group more affected by the financial crisis, and not included enough in safe space activities. Most actors agreed that migrant workers constitute a vulnerable group as they have additional needs related to their legal status and don't have enough social networks and support.

Most actors mentioned additional layers of discrimination and risks facing PWDs as they struggle with access to services, are more isolated and dependent, and are at additional risk of different forms of violence. According to LUPD who is a specialized actor working with PWDs, preliminary findings from two field assessments they conducted in the Bekaa and South show that the majority of PWDs face psychological challenges affecting their life and ability to be assertive and participate in society.[41] A smaller percentage of PWDs have critical symptoms including suicidal thoughts, aggressiveness, and signs of acute depression. Among the needs observed at program beneficiaries, it was noted that women need considerable support in improving their self-awareness and self-worth.

As for the women participants in FGDs, they considered that women heads of households, adolescent girls, older women and women with chronic health conditions to be the most vulnerable.Girls considered that the most vulnerable are those who don't know their rights, who don't have support from their parents, girls with disability, orphan girls (father passed away) who were considered to be more prone to sexual harassment.

Changes in needs: When it comes to the changes in needs perceived in the last three years as a result of the different crises the country went through, most GBV actors mentioned the deterioration in the economic situation which is shifting priorities and making beneficiaries more focused on basic needs and economic support.
One actor mentioned more fear expressed as a result of the recent hostilities in the South. Another actor mentioned climate change as an emerging risk factor affecting some beneficiaries, especially those who work in agriculture. Some actors mentioned increased service seeking behavior at the Lebanese community due to theeconomic crisis.
Actors also mentioned an increased demand on MHPSS services which could be linked to the increased needs or to the increased awareness of existing services. Several actors mentioned an increase in mental health symptoms observed such as suicidal thoughts, sleep interruption, phobias, signs of depression, anxiety and psychotic symptoms.

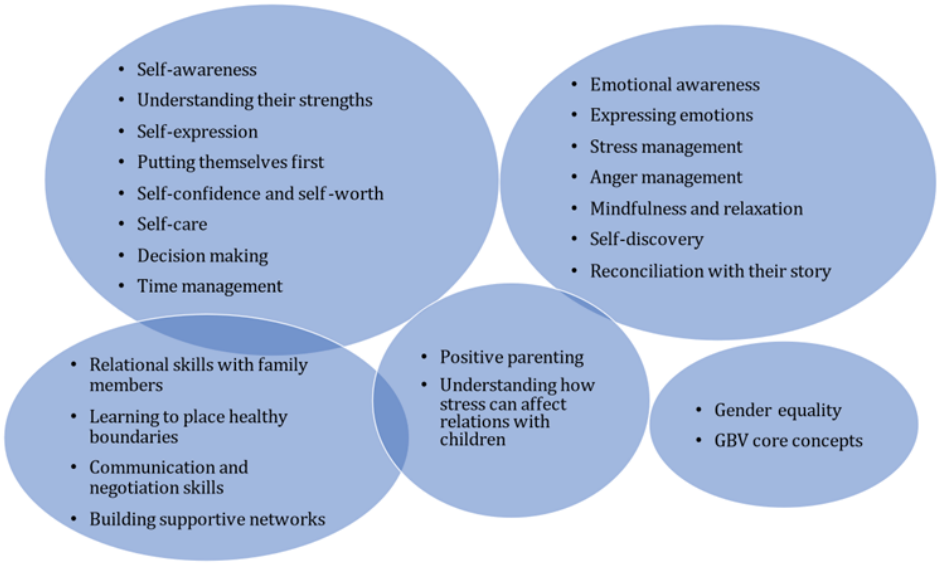
When asked about the changes experienced by them and their peers in the last three years, FGD participants spoke about increased anxiety, stress, fear, psychosomatic symptoms, anger, lack of concentration, increased tension within the household, fear of the future, pressure on parents who cannot provide the basic needs for their children. They also mentioned increased protection risks such as exposure to IPV, increased bullying and racism towards Syrians. Girls mentioned more kidnapping and thefts in the streets which increases feelings of unsafety. Additionally, they mentioned that they are hearing of more divorce cases of early married girls.

Harmful coping mechanisms: Some actors mentioned observing harmful coping mechanisms to deal with the deteriorated economic situation such as school drop-out, child labor, and reduced food intake especially at the Syrian population. One actor mentioned that Lebanese are mostly resorting to debt, selling their belongings, or relying on remittances. IPV seems to be a negative coping mechanism used across nationalities. As for negative coping mechanisms affecting PWDs, they include - according to LUPD - reduced access to medication and healthcare and increased social isolation, while they are experiencing increased violence[42]. Additionally, since the beginning of the financial crisis, one of the first cohorts to lose their jobs are PWDs and this affected their psychosocial wellbeing, self-image and ability to feel included.

Psychosocial support activities offered
In order to contribute to improving the psychosocial wellbeing of women and girls, different actors mentioned a variety of interventions that they offer. This ranges from information and awareness sessions, community events, men engagement programs, recreational activities, life skills activities, skills building and vocational training, parenting sessions, a variety of curriculum-based focused PSS, case management and psychotherapy.
From the perspective of women in FGDs, the most important activities to improve their wellbeing are the group PSS (focused PSS), income generating activities, and the recreational activities (creative activities, yoga, gardening). They especially stressed on the importance of going on trips which was mentioned in every single FGD.
Girls mentioned group PSS to be the most important and stressed on topics related to self-development and growth, expressing emotions, decision making, relational topics, and reproductive health. They also mentioned recreational activities such as signing, dancing, sports and yoga.

When asked specifically about the objectives of having focused PSS activities, most GBV actors mentioned that those group sessions offer a safe space for women and girls to come together, share experiences, build a supportive network and benefit from peer support. This helps women feel less isolated, less ashamed and more capable to share their struggles with someone else. Group activities aim at promoting positive coping mechanisms, preventing further mental health concerns, and reducing protection concerns. Actors also mentioned that participants learn skills to be able to take decisions and protect themselves from harm. Sessions help them build confidence, feel a sense of agency and feel empowered to make transformations in their lives. Additionally, sessions include an awareness raising component to help women learn about their rights for safety. Group PSS facilitate inclusion of women PWD and help them belong to a group, feel understood, feel less isolated, increase their self-confidence and integration in society, which is very empowering. Several actors mentioned that one of the objectives of focused PSS is to create safe entry points to facilitate disclosures of GBV incidents and safely refer survivors to case management services.All actors mentioned one or both of two key objectives of group PSS which are safety and empowerment.

GBV actors considered that the topics most appreciated by women in focused PSS are as follows:



41 Those assessment are expected to be published in 2024

42 According to LUPD, violence increased against all PWDs not only women and girls. The latter are specifically facing more IPV, harassment in multiple public places, physical and emotional abuse inside the household, and emotional abuse in non-marital intimate relations.

Additionally, several actors stressed on the importance of games and recreational activities that are included in the PSS sessions, as part of the interactive nature of the sessions. Actors mentioned that the recreational and fun aspect is of extreme importance to participants and it helps them unwind and feel good. On a related note, all actors agreed that sessions should be interactive and should include role plays, exercises, audio-visual material, IEC, case studies, in addition to ice-breakers.

Another important aspect of the session that was mentioned was the importance of creating a safe space where participants feel heard and are able to freely express themselves and share experiences. One actor quoted a woman participant who said "it's the first time someone hears me, asks me about me, gives me the chance to thank myself". It is therefore important to consider time for sharing and expression during the sessions. This aspect was totally confirmed in all FGDs where women and girls stressed on the importance to have a space where they can freely express themselves and feel heard.

Below is the list of the different curricula used by the GBV actors assessed:

GBV Actor	Curricula for Focused PSS with women and girls	Other curricula used
AMEL	AMEL Focused PSS curriculum, AMEL ESG curriculum	
KAFA	Internally developed curriculum (including ESG, life skills, parenting session, GBV and legal topics)	Working with perpetrators program
ABAAD	Basic Life Skills Curriculum, ESG (both ABAAD curricula)	Positive parenting, Program Ab, Program Ra (programs developed by Abaad)
LECORVAW	Women Rise (IRC), Girl Shine (IRC), AWSO (IRC), early marriage tailored package (IRC), child marriage toolkit (IRC), Life skills through drama for AGs (IRC)	Positive parenting
LUPD	Women Rise (IRC), Girl Shine (IRC), AWSO (IRC)	
IRC	Women Rise (IRC), Girl Shine (IRC), ESG (internal)	EMAP, gender discussion groups
IMC	ESG (IRC and ABAAD), My safety My wellbeing (IRC), AG curriculum adapted from different sources	Positive parenting, intergender dialogue, stress and anger management for men, cycle of violence for men,
MAKHZOUMI	Women Rise (IRC), Girl Shine (IRC), ESG (IRC and ABAAD)	PSS sessions (ABAAD curriculum on gender equality), gender sessions with couples
DRC	ESG (IRC and ABAAD) + working on updating it	Positive parenting, EMAP (IRC)
WVI	Life skills for girls as part of CP program (internal)	

When asked about the PSS approaches offered by MHPSS actors to respond to the needs of diverse women, girls and GBV survivors, the NMHP mentioned that the focused group PSS generally offered by MHPSS service providers are focused on addressing the mental health concerns (i.e. depression). GBV is considered a risk factor and the focus of the support is rather on the mental health conditions of the population served. In general, PSS modules used by MHPSS actors are the same for men and women. However, some minor aspects can be adapted based on gender, since gender specific stressors might be different.

When asked about the **guidelines** that should be followed in group PSS (focused PSS), most actors needed prompts to be able to answer this question, showing a need for more clarity and standardization in this area.

The following are the areas that most actors agreed on:

The facilitators: Most actors agreed that facilitators should be trained on communication and facilitation skills and on the content of the curricula. Other important aspects mentioned by GBV actors related to safeguards and do no harm include the need for facilitators to avoid giving advice and to clarify to participants that each person's experience is different and that some of the tips shared in the sessions might not apply to everyone.
The space: most actors agreed that the space should be safe, comfortable, well lit and ensures confidentiality of participants.
Number of participants: Some actors suggested 8 to 10 participants while others mentioned a maximum of 15 participants.

Session duration and frequency: Most actors agreed that sessions should be around 90 minutes. The frequency of the sessions should be once a week to allow time for processing in between sessions.

Facilitation techniques: Actors spoke about the importance of adding psycho-education messages, while also ensuring interactive facilitation techniques to allow for experiencial learning.

The main area of divergence in the answers is related to the group composition as well as the safety assessments:

Group composition: some actors mentioned the importance of homogeneity in the group which can be achieved by identifying similar age groups and marital status or by identifying common needs such as similar social concerns, or similar types of violence. Some GBV actors are offering ESG for survivors only, and a couple of actors mentioned forming specific groups based on the types of violence (i.e. group of physical abuse survivors). One actor described how women with similar types of violence can listen to the experiences of other women and get inspired by specific decisions that the latter were able to take, which can motivate them to also take action (i.e. leave the perpetrator).
Other GBV actors highlighted the importance of not singling out survivors in one group as it might lead to stigmatization and safety concerns.
They include survivors in exiting groups with other women at risk and don't discuss individual experiences of violence within the group sessions. This creates more diversity in the group where women with different needs can reflect on topics that all women can relate to.
One actor even noted that when they group married and non-married women in the same group, this enriches the discussions as women learn from each other.

Safety assessments: Only a couple of actors mentioned the importance of doing safety audits or conflict sensitivity assessments in the area to understand the safety concerns and needs, and to ensure the composition of the group is safe and ensures confidentiality. One actor mentioned the importance of not inviting family members to the same group as they might not feel comfortable sharing some personal details. This approach seems to be very appreciated by program beneficiaries and they highlighted it in the FGD: "They made sure that relatives don't attend the same group. This is better so we feel more comfortable, we can easily cry in front of people we didn't know but we can't in front of family members." Other conflict sensitivity aspects such as clashes between two families are also taken into consideration.

On another note, it was mentioned that FPSS can only take place when we are 100% sure that GBV case management services are available and accessible within the same organization or a partner organization working closely. Several actors also mentioned that facilitators should be able to identify additional mental health needs and know when to refer to specialized MHPSS services.

From the perspective of women in the FGDs, they mentioned that eight sessions are not enough and they would like to receive more sessions. Many women wished sessions could be twice a week. They considered that 60 to 90mn session is enough so they don't stay away from household responsibilities for too long. Women considered that the aspect that matters the most in the sessions is the attitude of the facilitators who should smile, have good listening skills, be patient, respectful, compassionate, non-judgmental, supportive and encouraging, have strong technical skills and knowledge, respect confidentiality, and offer a space where women feel safe and able to express themselves.

Inclusion of diverse women

GBV actors were asked about the steps that need to be taken in order to ensure inclusion of diverse women in the groups PSS (age, nationality, diverse SOGIESC, PWDs).
Divergent answers were noted in this area as some GBV actors are a few steps ahead of others when it comes to PWD inclusion. Several actors mentioned the importance of including PWDs starting from the outreach phase. A couple of actors mentioned that they collaborate and receive referrals from other departments within their organizations supporting PWDs. Different actors mentioned the importance of physical adaptations for people with mobility issues, fewer actors mentioned adaptations of sessions to work with sensory or intellectual disabilities. Other ideas mentioned included the use of the Washington questionnaire, the use of mobile safe spaces to increase access to PWDs, as well as the collaboration with OPDs to adapt PSS material and train staff on inclusion. One actor mentioned that inclusion is hard because it requires a specialized team and that it's preferrable for OPD only to work with PWDs. On the other hand, one actor mentioned that they have a group of PWDs only who receive PSS activities, the same way they have an elderly group, as well as other groups segregated by age, nationality or other characteristics.

According to LUPD, the perspective of women inclusion starts with the attitude of the organization and real participation of PWDs begins at the start of the project cycle, at the assessment phase.
When it comes to age, a couple of actors mentioned using an approach of evolving capacities. Conflict sensitivity was also mentioned to ensure different nationalities can be included in the same groups. Only a couple of actors mentioned diverse SOGIESC without specifying clear approaches for inclusion.

From the perspective of women in FGDs, it was repeatedly mentioned that starting a certain age (sometimes thirty-five years old), women are no longer included in activities, especially skills building. This is creating considerable frustration and feelings of being excluded that was expressed by many women. "Organizations should make sure activities are reaching women from all ages including older women so they don't feel excluded".
"We want activities to be for all women of all ages. Women above thirty are not included much. This in itself can cause psychological distress in women".
Women with disability who were part of the FGDs expressed a wish to share the following messages with GBV organizations:
"We need inclusion for more than one or two people per activity"; "We need to change the culture and bring awareness to NGOs so they know that when they make the space and services accessible, we can participate"; "There are trainings available to support organizations on inclusion.
We as women committee are ready to offer such trainings".

Outcome of focused PSS activities

GBV actors mentioned that in order to measure the outcome of focused PSS activities, they use a variety of internally developed tools including pre and post-tests, FGDs, and satisfaction surveys.

Four out of ten GBV actors assessed are using tool 1 of Activity Info. Most actors using tool 1 mentioned that not all the questions are relevant to the modules they are using. One actor mentioned that the tool should be tailored and adaptable to the different curricula, while another actor suggested that topics used in the curricula should be harmonized so that the different actors find tool 1 relevant and applicable to them.

GBV actors were asked to describe the changes they see in women who attended the group PSS. Actors mentioned one or more of the following observations:

Changes in their physical appearance, body language and how they carry themselves; Increased self-awareness; Increased self-confidence; Giving time to themselves and prioritizing self-care; Ability to express themselves in public; The feeling that they are achieving something; Feeling more empowered to take decisions; Ability to feel they exist again and they are connected with themselves; More initiative taking and ability to speak their minds in the group.	Ability to name their emotions; Expressing that they started to love life; More joy; Increased psychological resilience; Motivation to conduct their hobbies; Increased ability to manage stress; Ability to deal with challenges; Girls mentioned that they were able to discuss topics they cannot discuss at home	Ability to say no; Feeling supported; improved social networks and solidarity; Feeling less lonely; Learned active listening; Learned how to deal with family members; Ability to resolve conflicts; Ability to re-establish positive relations with children; Improved communication skills at girls;	Increased awareness of their rights; Reduced stigma around mental health; Women encourage other women to attend sessions so they can also benefit; Girls in school are also requesting us to support other girls; Established committees of women with disability was empowering and allowed them to make changes on a personal level as well as in their communities

This was confirmed by FGD participants who, in addition to the above, mentioned becoming calmer, more patient, working on their personal growth, better coping with pressure, finding their inner strength, realizing their potential, breaking away from traditional parenting approaches, changing their perspective regarding what women can achieve, and discovering that they have a role to play in society.

This was confirmed by FGD participants who, in addition to the above, mentioned becoming calmer, more patient, working on their personal growth, better coping with pressure, finding their inner strength, realizing their potential, breaking away from traditional parenting approaches, changing their perspective regarding what women can achieve, and discovering that they have a role to play in society.

Some of the quotes mentioned include:

"The most important thing is to learn how to love ourselves, then we can take care of others".
"I used to feel very weak and lacked confidence. Group support helped me find additional aspects of my personality to feel stronger, it also helped me improve my relations at home."
"One day I was feeling very sad and I randomly found a piece of paper from the last session where I wrote "Grateful", this made me automatically change my mood and feel better".
"We didn't know our rights when we were younger. Right now, our goal is to raise awareness on disability rights".
"When I know there's a session, I feel so excited and start getting ready two days in advance".
"I have a goal now and I know I can reach it".
"Before coming here I used to take anti-depressants and used to be aggressive with my husband and my kids. Since I started coming to the center I changed completely. They taught me breathing exercises to calm down".

Girls mentioned that they feel stronger, less isolated, they understand their emotions more, learned to do anger management, learned to face pressure and ask for help when needed, became much more self-aware, learned to put boundaries and improved relational skills, acquired social skills and met new friends, learned to express their opinions, learned to take decisions, learned how to choose the right people to trust, became aware of the risks of child marriage, and learned to love themselves. "I had a difficult childhood, my father died, then I left school and thought I have no future, I was so isolated. When I came to this space, I took vocational training and I improved my social skills. My image for the future changed. My future is now about my skills, I want to create my own business."

When asked about what can be improved in the safe space activities, women in all FGDs mentioned that they would like to receive **vocational training, entrepreneurship training,** and any support to **find employment or start their own businesses.** In most FGDs women considered that the current skills building trainings offered are not enough to help them achieve financial independence, which will be the biggest contributor to improve their wellbeing. On the other hand, they also considered that they would like to receive more **recreational activities** and the opportunity to go on **trips,** a topic that was mentioned more than once in all FGDs. According to them, this will have a great impact on improving their wellbeing. Women noted that considering the social norms and the financial struggles, it would not be possible for them to carry out fun or recreational activities on their own. When it's offered by the organizations, it will become more possible for them to join without feeling the guilt associated with putting themselves first. Girls also mentioned they would like to go on trips "anywhere, we just want to have the opportunity to go somewhere".
They also requested recreational activities including singing and dancing, yoga, sports, meditation, handicraft, and painting. Girls also wish they can receive more skills building activities (cooking, make up, hairdressing, languages, first aid, music classes).

When asked about their perception of **innovative approaches to PSS** interventions, one actor mentioned Trauma psychosocial support + an approach to working with individuals or groups based on the eye movement desensitization and reprocessing (EMDR) therapy. Without exception, the rest of the GBV actors mentioned activities that include a **community-based dimension or a family intervention dimension.** This includes activities where different family members are involved such as the Rebel activity for working with AGs and their parents or community based interventions such as the SASA approach where women committees start and sustain their own safe spaces, innovative labs for youth who come up with their own initiatives, Access-kitchen: a protection and livelihood project for women with disabilities that also includes an awareness raising component led by women to shift perceptions in their communities, crime prevention through sports, as well as nutrition committees. It might be worth considering to expand on community-based interventions in the future since most actors perceived such initiatives with enthusiasm and considered them to be effective.

The NMHP mentioned two innovative approaches to be considered which are problem management+ and self-help+.

Participation of women and girls

When it comes to participation of women and girls in designing and delivering some of the WGSS activities, differences were perceived among organizations. For some participation is limited to consulting with program beneficiaries on activity topics, while others already have women focal points or women committees who conduct activities such as outreach, awareness raising, help in organizing some aspects of the safe space, collect trends from the field, support in safe identification and referral of GBV survivors, or offer skills building activities. One organization is helping women from the community to develop leadership skills so they can become activists, another one is supporting girls to become leaders and offer sessions to other girls, while for one organization the management includes women with disability, and they also have GBV community mobilizers with disability as well as committees of women with disability who organize activities.
Those organizations who already offer opportunities for participation of women and girls in the program mentioned how important this is for women to feel "worthy, important, and more responsible". "They feel empowered because they feel involved not only receivers". "Community based approach and participation increases confidence, social connectedness, and communication skills". "Women who offered skills building said that their confidence increased, they acquired research skills, they felt proud that they can offer the sessions. Other participants also felt hopeful they can be like them". This was confirmed by FGD participant who said "When I finish giving a session to others, I feel joy and positivity. Offering sessions makes us feel empowered".

When this question was asked to women who are not yet given the opportunity to volunteer in the WGSSs, the excitement was visible in all FGDs. Women mentioned that they would like to volunteer in the spaces without any financial incentive. They said they can offer skills building classes or help in any other possible way. "If we can volunteer, we would be very happy as it will increase our self-confidence, will help us feel capable, and will help us meet new people". "We would love to but haven't given the chance yet. We would do it for free. We would feel we achieved something, we have worth, we're doing something useful, we're helping others". In FGDs with girls, those who are given the chance to contribute to organizing some aspects of the safe spaces said that this makes them feel more worthy and confident because they feel that their opinions matter.
Girls who are not involved in participating to the safe space activities said they would love to volunteer and offer recreational activities.

One of the areas that requires further attention is the option for women and girls to hangout freely in the safe spaces outside of the structured activities. Few are the organizations who are giving this chance to the beneficiaries. They noted how important it is for women and girls to feel that they can come whenever they want and feel that the space belongs to them which increases their sense of ownership leading to improved psychosocial wellbeing. This was confirmed in the FGDs where women and girls have the chance to hang freely in the safe space:
"Sometimes my girl is feeling down at home I tell her go to the center". It's crucial that all organizations consider making adaptations to their programs to allow women and girls to hangout freely in the safe space as this is one of the objectives of having a WGSS.
One FGD participant said: "We would like to have the possibility to come to the center whenever we want. Sometimes we are so stressed and we don't know where to go, it would be good if we can come to the center".

PSS activities in an emergency setting

When asked about the most effective PSS activities to be implemented in an emergency setting (i.e. recent displacement due to the hostilities in the South), the majority of the actors mentioned psychological first aid as the priority activity, in addition to PSEA awareness. The focus on basic needs was also mentioned which includes distribution of MHM kits. Some actors mentioned recreational activities to help IDPs maintain a sense of normalcy. Awareness related to emotional regulation and coping with stress was also mentioned. Some actors also mentioned the importance of offering awareness sessions on different types of risks and how to stay safe, while other actors suggested GBV case management as a priority activity.

Collaboration with the MHPSS sector

When it comes to referrals to specialized MHPSS services, some GBV actors have a psychotherapist in-house within the GBV program, some have a separate MHPSS department within the same organization[43], while others refer to external MHPSS services.
Some of the GBV organizations already received MHPSS safe identification and referral training and/or are using a determined checklist to assess the need for referral to specialized mental health services. All actors mentioned a list of signs based on which they choose to refer to specialized services.

Of those we mention: suicidal thoughts and attempts, self-harm, feeling jumpy, agitation during the session, inability to focus and showing signs of dissociation, inability to function on a daily basis, sudden changes in mood during the session, inability to control emotions or behavior, heightened anxiety and fears, signs of severe depression, psychotic symptoms (strange behavior, lack of coherence in the narration of events, general feeling of being persecuted, hallucination).
Additionally, a survivor would be referred to MHPSS when she is unable to set a care plan for case management due to her mental health state, when her emotional situation is not improving after many case management sessions, or when she is personally requesting it.

The GBV actors were asked to list the trainings they should receive in order to ensure smooth referral to MHPSS services. All actors mentioned training on MHPSS safe identification and referral. Some actors also requested the need for training on handling suicidal cases where referral should take place without the consent of the survivor. Trainings on tools that GBV case workers can use to do crisis management or to handle cases with MHPSS concerns was mentioned, understanding drug abuse, trauma, and other important mental health topics. One GBV actor mentioned MHGAP.
According to the NMHP, the trainings that GBV actors would benefit from are MHPSS safe identification and referral, PFA and Emotional crisis management – how to deal with a person when they are in heightened emotional state, help her calm down and ensure safety.
GBV actors were also asked about the trainings they think MHPSS staff should receive in order to ensure smooth collaboration and referrals to the GBV sector. Most GBV actors mentioned GBV core concepts and safe identification and referral as the main training to be offered to MHPSS actors. This was confirmed by the NMHP who also requested CP safe identification and referral. Some GBV actors also stressed on the importance of explaining the process of GBV case management so that MHPSS organizations understand why it's important to refer to GBV case management. One actor mentioned that training topics should also include the cycle of violence, importance of putting boundaries to the perpetrator, safety risks, legal awareness and when to refer to forensic doctor.
Two GBV actors mentioned GBV case management training as part of the trainings that MHPSS actors should receive, showing the need for more clarity when it comes to the roles and responsibilities between the two sectors.

Individual psychotherapy within WGSSs

Four out of the ten GBV actors assessed are offering individual psychotherapy within their WGSSs as part of the GBV program and two others have a separate MHPSS department where survivors are referred. Actors are using diverse psychotherapy approaches based on the needs of the survivors.
The main approaches used include Cognitive Behavioural Therapy, Trauma psychosocial support plus, narrative therapy, mindfulness, eye movement desensitization and reprocessing (EMDR), Problem Management Plus, Self-Help Plus, systemic therapy, and one actor mentioned they occasionally use psychoanalytical approach. All actors are focusing on short term interventions with a number of sessions ranging between 12 and 20. Once actor mentioned that session can go up to 25. All actors have in-house supervision in place. The trainings they offered to their psychotherapists include GBV core concept and safe identification and referral, cultural sensitivity, trauma informed care, crisis management, dynamics of IPV, PFA, self-care, as well as technical trainings in the different therapeutic approaches. Actors add special considerations related to working with survivors such as using a survivor-cantered approach, cultural sensitivity, and an empowerment approach.

It is worth noting that actors who have a separate MHPSS department are offering psychotherapy to survivors in a more generic way, following humanitarian principles in general. However, one of those actors have integrated special considerations for GBV survivors in their protocol for management of high-risk cases.

Challenges in program implementation

When asked about the challenges they face in implementing MHPSS approaches, GBV actors listed the following challenges:

- When a survivor receiving GBV case management in the WGSSs is referred to an external MHPSS actor for specialized mental health services, GBV actors are noticing challenges in communication between the GBV case worker and the psychotherapist leading to fragmented care plans. Sometimes, the psychotherapist might present a patronizing attitude with the case worker, telling them what they should do. This is not in line with the survivor-cantered approach where the survivor should take the lead in her care plan.
- When a GBV survivor discloses a GBV incident to an MHPSS service provider, the latter usually continues offering MHPSS case management focusing on the MH needs of the survivor and don't refer the survivor to GBV case management. This might present a gap in service provision where aspects of safety planning, legal support and other GBV CM components might not be offered in the MHPSS case management.
- Some GBV actors mentioned that the current MHPSS referral pathways are not easily accessible making it hard to refer survivors to specialized MH services.[44]
- The skills building activities requested by women often fall within traditional gender norms such as sewing and hairdressing. GBV actors would like to challenge that while still respecting the wishes of the beneficiaries which is challenging.
- Offering solid livelihood projects within GBV program requires a lot of resources which is challenging for GBV actors. Additionally, donors are prioritizing youth in such programs, leaving older women behind.
- Some GBV actors mentioned the need to have access to new FPSS curricula. IRC has recently released Women Rise and Girl Shine. However, other actors cannot access them and use them before receiving a comprehensive training on the packages, which might be stretching the resources of IRC.
- The current Activity Info M&E toolkit and namely tool 1 does not measure the improved MHPSS wellbeing of beneficiaries receiving focused PSS.
- GBV actors are facing challenges in including women with diverse SOGIESC in their activities considering the sensitivity of the context and the difficulty in creating a safe environment for this cohort who prefers to seek support in SOGIESC specialized organizations only.
- Organizations mentioned that more work is needed to engage men as allies to prevent GBV.

Reccomendations

Recommendations to GBV organisations:

- Follow a standardized approach when it comes to group composition in focused PSS in order to include women in all their diversity in the groups. It is important to include different nationalities in the same group as long as participants speak the same language. It's also important to include women with diverse abilities (and not to create separate groups for PWDs). When it comes to age, it's important to segregate by age brackets for AGs and young women below twenty-five. Actors should avoid having survivors only groups, or discussing individual GBV incidents inside the group sessions.

- Consider adding a safety assessment prior to starting a FPSS cycle which can look into safety concerns of women as well as conflict sensitivity aspects within the group.

- Make efforts to include women of all ages in group activities including skills building activities, and avoid excluding older women.

- Continue and increase efforts to include women with disability in the various PSS activities and starting from the early stages of the program cycle. It is recommended that GBV actors receive training on inclusion from OPD organizations and collaborate with those to receive support in program adaptations.

- Consider strengthening the skills building activities by offering longer courses, start-up kits and entrepreneurship trainings if budget allows. Alternatively, consider partnering with a livelihoods organization that can offer this component in the spaces of all the partners.

- Ensure that projects are designed in a way that allows women and girls to hang out in the safe space outside of the structured activities and to be able to come to the space whenever they need it. Women and girls should have the chance to meet, have coffee, hang out, read books, do artwork, play board games, decorate their space in order to feel a real ownership and belonging to the space.

- Consider giving the option for women and girls to volunteer in the safe spaces, by helping in safe space management and by co-facilitating some sessions in the safe spaces especially recreational activities, and awareness sessions, or through outreach, which is very empowering for women and girls.

- Organize trips and outings to women and girls even to nearby locations taking into account safety and logistics. Going on any form of trips will allow women and girls to feel able to disconnect from the daily sources of stress and to change mood, and feel they are prioritizing their self-care.

- Expand on the existing recreational activities offered in the safe spaces by assessing women and girls' preferences, and consider the importance of recreational activities in improving the wellbeing of beneficiaries.

- Strengthen the community-based approaches of the different projects by training community volunteers/focal points or women committees. This will ensure empowerment and participation of community members while also ensuring reach to the most vulnerable and sometimes invisible beneficiaries.

- Continue and increase trainings on GBV core concepts, safe identification and referral to the MHPSS service providers.

- Ensure that GBV staff have access to MHPSS safe identification and referral training.

- Consider offering a training on feminist approaches to mental health to MHPSS organizations.

Recommendations to the GBV sector:

- Review Tool 1 of Activity Info to make sure it reflects the topics covered in the different curricula used by GBV actors while also encouraging GBV actors to follow harmonized topics in their different curricula.
- Collaborate with the MHPSS sector to develop joint training modules that integrate elements of both GBV response and MHPSS, while adding a feminist lens. These modules can address the intersectionality of GBV and mental health issues, ensuring that service providers are equipped to provide comprehensive care to survivors. This will support the endorsement of the GBV guidelines by the MHPSS sector.
- Develop a training plan for the capacity development of GBV actors on MHPSS topics, and the capacity development of MHPSS actors on GBV core concepts and their role in the GBV response. Track trainings offered by different actors.
- Work together with the MHPSS sector to ensure their involvement in the referral pathways of GBV services, and ensure referrals are completed from the MHPSS actors to GBV services.
- Advocate for the integration of MHPSS components into GBV response policies and programming among all the GBV actors at the national level.

Recommendations to the MHPSS sector:

- Continue and increase trainings to the GBV organizations on MHPSS safe identification and referral, PFA, Emotional crisis management (during GBV CM), as well as other relevant mental health topics (i.e. drug abuse, trauma, suicide risks).
- Collaborate with the GBV sector to develop joint training modules that integrate elements of both GBV and MHPSS addressing the intersectionality of the two sectors.

Annexes

ANNEX 1
List of key informants interviewed

Key informant name	Organization	Title
Lama Jradi	ABAAD	Senior Prevention Program Lead
Sarah Chreif	International Medical Corps	GBV program coordinator
Monica Rahal	International Rescue Committee	WPE coordinator
Samar Tfaily	Lebanese Union for People with Physical Disability	Program manager
Maya Dbouk	Danish Refugee Council	Protection Coordinator - GBV
Chourouk Koteich	World Vision International	Gender equality, Disability, and social inclusion Coordinator
Mariam Masri	Makhzoumi Foundation	SGBV Team leader
Rose Boghosian	KAFA	Psychotherapist
Lama Ajrouch	AMEL	GBV program coordinator
Monique Mikhael Rebecca Khodeir Rima Deguise	Lebanese Council to Resist Violence Against Women	Senior case worker Senior community mobilizer M&E assistant
Dr. Rabih El Chammay	National Mental Health Program	Head of Program

ANNEX 2
List of topics per FPSS curriculum

AMEL Emotional Support Group
Session 1. Introduction + Agreement + Psychological Wellbeing pre-test
Session 2. Self-identity
Session 3. Self affirmation
Session 4. Emotional awareness
Session 5. Gratitude
Session 6. Boundaries
Session 7. Psychological Wellbeing pre-test + closure.

AMEL FPSS curriculum
Self-identification
Session 1: Let's meet
Session 2: Identity and story
Session 3: Discovering myself

My relationships:
Session 4: My family and I
Session 5: My peers and I
Session 6: My society and I

My feelings and behavior
Session 7: Discover my mood, feelings..
Session 8: Early marriage
Session 9: My role and my gender
Session 10: Self-care

Emotional Support Group – ABAAD/IRC

Session 1: Introducing the ESG and, assessing group resources, needs and specificities and working with participants on common understanding of expression tools and group ground rules.
Session 2: Working on main stressors and resources on the individual, family, community and gender related levels.
Session 3: Developing participant's emotional self-awareness by developing their capacity to identify the emotion and express them, to link the emotion to specific situations and working on negative feelings
Session 4: two evolutions are possible depending on the group specificities and interaction:
Possible evolution 1: Give the participants an active role in their communities by finding a group objective/community initiative and by planning for it and implementing it
Possible evolution 2: Developing participants' expression and listening skills
Session 5: Evaluation and closure session where all the process will be recapitulated
Session 6: A follow up session at least 3 weeks after the ESG to evaluate with participants the impact of the ESG on their lives

Arab Women Speak Out – IRC/UNICEF

Session 1: Introduction, goal of the activity and baseline assessment
Session 2: Understanding sex and gender
Session 3: Self-esteem and self-confidence – part 1
Session 4: Self-esteem and self-confidence – part 2
Session 5: Decision making – part 1
Session 6: Decision making – part 2
Session 7: Negotiation skills – part 1
Session 8: Negotiation skills – part 2
Session 9: Social networks and social support – part 1
Session 10: Social networks and social support – part 2
Session 11: Closure and celebration

Early marriage tailored package - IRC

Module 1: Introduction: Introduction and Pre-assessment- Introduction and Trust Building
Module 2: Self-esteem and Friendships Expressing Identity and Self-esteem- Making and Keeping Friends [45]
Module 3: Communication in Healthy Relationships: Gender Roles - Power Balance in Relationships - Healthy Relationships
Module 4: Coping with Stress and Dealing with Emotions: Understanding and Managing Emotions- Coping with Stress
Module 5: Problem Solving and Decision making: Decision Making -Problem Solving
Module 6: Time and Money Management: Time Management - Financial Literacy
Module 7: Reproductive Health
Module 8: Pregnancy Care and Family Planning: Family Planning -Pregnancy Care
Module 9: Our Safety in GBV Contexts: Types of Violence and Possible Strategies- No to Abuse, Yes to a Safer Future
Info Session: Marriage/Birth/Divorce Registration

Life skills through drama - IRC [46]

Module 1: Trust and Support - Foundations of Healthy Relationships
Session 1: Introduction and Trust Building
Session 2: Trust and Support Networks
Module 2: Assertive Communication in Healthy Relationships
Session 1: Power Balance in Relationships
Session 2: Assertive Communication
Module 3: Self Esteem and Self Confidence
Session1: Expressing Identity and Self Esteem
Session 2: Maintaining Confidence
Module 4: Coping with Stress and Dealing with Emotions
Session 1: Understanding and Managing Emotions
Session 2: Coping with Stress
Module 5: Problem Solving and Decision Making
Session 1: Problem Solving and Decision making in the context of Early Marriage
Session 2: Problem Solving and Decision Making
Module 6: Our Safety in GBV Contexts
Session 1: Types of Violence and Possible Strategies
Session 2: No to Abuse, Yes for a Safer Future

Women Rise - IRC [47]

Session 1 - Introduction
Session 2 - Being a Woman
Session 3 - Understanding Emotions
Session 4 - Understanding Stress Reactions
Session 5 - Exploring Difficult Emotions
Session 6 - Option A Shame and Self-blame
Session 6 Option B Anger
Session 6 Option C Grief
Closing Session 1
Looking Forward
Closing Session 2
Closing the Group

[46] This curriculum can only be offered after receiving a training from IRC
[47] This curriculum can only be offered after receiving a training from IRC

My safety My wellbeing – IRC

Session 1: Introduction and Goals
Session 2: Skills Identification
Session 3: Making and Keeping Friends
Session 4: Relationships with Parents/Caregivers
Session 5: Non-Verbal Communication
Session 6: Decision Making
Session 7: Problem Solving
Session 8: Managing Emotions
Session 9: Confidence Building and Self Esteem
Session 10: Reproductive Health Part One
Session 11: Reproductive Health Part Two
Session 12: Healthy Relationships

KAFA internal FPSS curriculum:

Session 1: GBV core concept
Session 2: Legal awareness on rights and legislations
Session 3: Emotional support, emotional violence and internal resources
Session 4: Awareness on mental health and when we need support
Session 5: Psychological resilience
Session 6: Support system (putting ourselves first, self-reliance) + social support and how to give and receive support
Session 7: Positive parenting
Session 8: Decision making

ABAAD – Basic Life skills curriculum

Part 1: A tour in my internal world
Session 1: Self-esteem is a need
Session 2: My decision: my choice and my responsibility
Session 3: I am unique
Session 4: I want to be
Session 5: Everything has a timing
Part 2: The basket of my emotions
Session 1: Stress is acceptable but not all the time
Session 2: Let's chill
Session 3: My health
Session 4: I identify my emotions to I control the situation

Part 3: Constant communication
Session 1: My communication my image
Session 2: Differences not conflict
Session 3: Maybe correct but not the only option
Session 4: My communication with my children
Session 5: We listen, we understand
Part 4: We can change if we know
Session 1: I can't, he can
Session 2: Blue, pink
Session 3: Violence is not a type
Session 4: Don't be lenient
Session 5: It's not your fault
Session 6: We play, we benefit
Part 5: I am part of my community
Session 1: Respecting the laws
Session 2: I am a human with rights to be respected
Session 3: I am told, I know, I shine
Session 4: Goals requires passion
Part 6: My health is very important
Session 1: How to deal with disease
Session 2: Health is not a game
Session 3: Prevention is crucial
Session 4: Balanced food, balanced health
Session 5: Reproductive health
Part 7: Adolescence
Session 1: No one understands me
Session 2: As we grow up
Session 3: I am still young
Session 4: Hygiene
Session 5: Take care
Session 6: Heart or mind