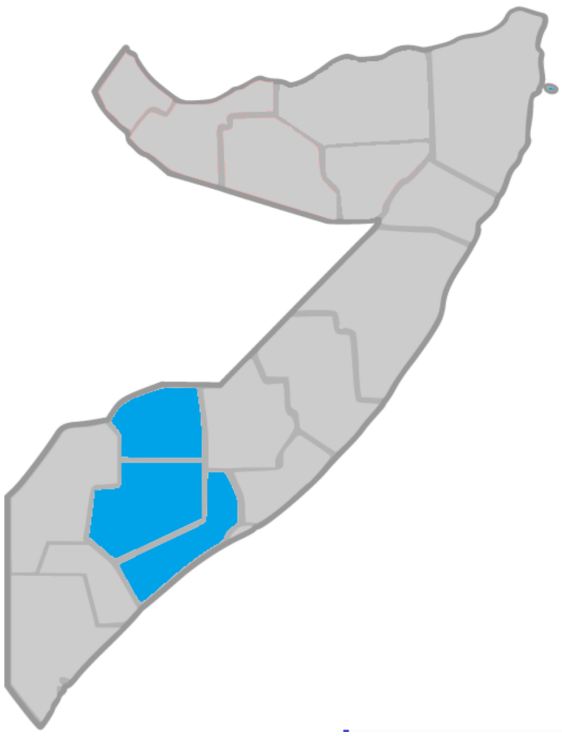
PSYCHOSOCIAL SUPPORT SERVICES FOR GENDER-BASED VIOLENCE IN SOUTHWEST STATE SOMALIA

A Field Guide for Best Practices



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Introduction

Gender-based violence (GBV), specifically violence against women, continues to be an issue in Somalia, a country where deeply embedded gender inequality prevails. The customary traditions and code of honor that used to regulate conflict between clans and ensure that women and children of any clan were protected from violence have been widely violated during the war. Women and girls have been targeted for rape, sexual exploitation, abduction, and clan-related revenge killings.[1] Other forms of GBV and harmful practices include early and forced marriages, female genital mutilation (FGM) and intimate partner violence (IPV). This violence may be perpetrated by armed actors, but it is important to note that women and girls are vulnerable to violence occurring in the domestic sphere which include intimate partners and family members.

Decades of civil conflict, drought and sociopolitical instability have affected the mental well being of communities. Poor mental health is highly prevalent among women and girls accessing services. Studies show that women and girls who experienced sexual violence or conflict related violence is linked to many poor health outcomes including long term mental disorders such as anxiety, depression and PTSD.[2] GBV has also been associated with adverse physical and psychosocial outcomes that may contribute to mental health problems such as unwanted pregnancies, sexually transmitted infections and discrimination, stigmatization and ostracism within family or community.[3] However, there is a lack of adequate mental health and psychosocial support services in the region, while stigma prevents many from seeking help.

The main purpose of this field guide is to assess the psychosocial support services available in the South West State of Somalia for survivors of gender based violence, specifically women and girls. The regions we will be focusing on include: Bay, Bakool and Lower Shabelle. The study will provide GBV psychosocial support services with feedback on how to improve service delivery, provide recommendations to reduce stigma, and promote community-based approaches to reach those vulnerable.

This guide was developed to support the protection cluster including: field staff, mental health practitioners, local leaders and community members who support the mental health and psychosocial needs of Somali women and girls. It describes key principles, appropriate support to those providing direct assistance and for those implementing community based services and practices.

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[1] Musse, Fouzia. "The Complexity of Sexual and Gender-Based Violence Insights from Mogadishu and South Central Somalia." *Human Rights Documents Online*, 2015.

[2] Hossain M, et al. "Gender-Based Violence and Its Association with Mental Health among Somali Women in a Kenyan Refugee Camp: A Latent Class Analysis."*Journal of Epidemiology and Community Health* 75, no. 4 (2020): 327–34

[3] Hossain M, et al. J Epidemiol Community Health 2020 327-34

Background

Historically, rape has been weaponized during conflict to control and terrorize. Such forms of gender based violence include rape, early and forced marriages, sexual exploitation and abuse, intimate partner violence and FGM. Widespread FGM and forced marriage at a very early age may also prove as potent risk factors for mental illness and psychosocial disruption in young women.[4] Women and young girls often resort to harmful coping mechanisms such as early marriage and sex in exchange for favors, thus exposed to a higher risk of experiencing harmful ordeals leading to psychological problems and increased psychosocial vulnerability, which if not addressed through community support structures and/or focused services, can become chronic and long-lasting.

GBV service provision remains low as compared to the need and geographical landscape in Somalia. Since Somalia is a resource-limited country it is least likely capable of addressing the serious challenges posed by a pandemic of such magnitude. The healthcare system in Somalia has never developed beyond providing the most basic functions and has negligible capacity to the level of mental health conditions facing its citizens. Limited availability of specialized services such as treatment for rape survivors, case management including psychosocial support (PSS) and higher levels of mental health care for traumatized women and girls are major gaps for GBV service provision. This is compounded by the limited number of specialized service providers.[5] As an additional barrier, women are less likely than men to utilize Mental Health and Psychosocial Support (MHPSS) services when available.[6]

Efforts to combat GBV are hampered by poor or nonexistent reporting mechanisms or lack of coordination between civil society organizations and institutions to support survivors.[7] This could imply the need to widely disseminate information on existing referral pathways and prioritize integrated referral pathways.

Context Analysis

In our assessment, when asked where does sexual violence typically occur, 57 percent of our respondents reported that sexual violence occurs in host communities, 27 percent reported that it occurs within IDP camps and 16 percent indicated that it occurs at homes (see figure 1). In post

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[4] O'Neill, Sarah, and Christina Pallitto. "The Consequences of Female Genital Mutilation on Psycho-Social Well-Being: A Systematic Review of Qualitative Research." *Qualitative Health Research* 31, no. 9 (2021): 1738–50.

[5] Thomsen, Anders, Nkiru Igbelina-Igbokwe, and Ridwaan Abdi. "Overview of Gender-Based Violence in Somalia - Advocacy Brief, 2021." UNFPA Somalia. United Nations Population Fund Somalia Country Office, March 9, 2021.

[6] Cavallera V, et al. "Culture, Context and Mental Health of Somali Refugees: A Primer for Staff Working in Mental Health and Psychosocial Support Programmes." UNHCR, 2016.

[7] Lulo, Sara, Rashida Manjoo, and Calleigh McRaith. Essay. In *Gender-Based Violence and Justice in Conflict and Post-Conflict Areas* 44, 44:11–30. Ithaca, NY: Cornell Univ., 2011.

conflict settings, displaced women are at risk of experiencing further sexual violence while in transit to and within refugee camps or host-communities.[8]

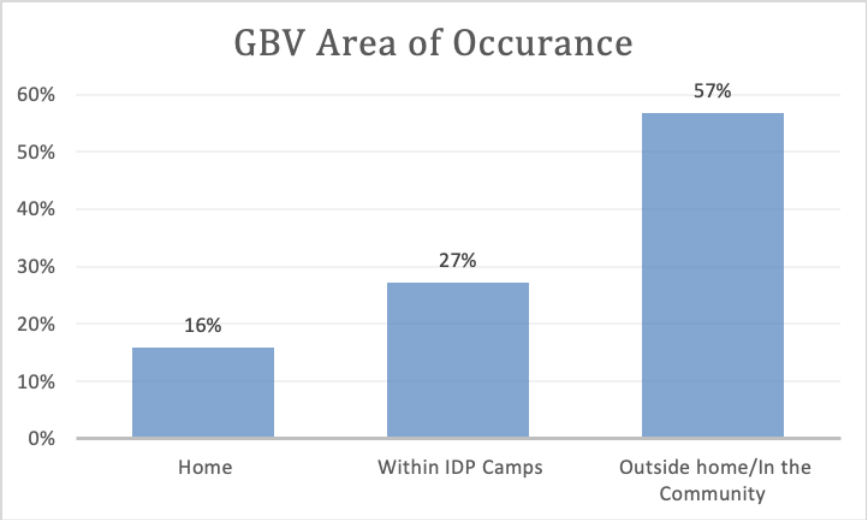


Figure 1: GBV Area of Occurrence

However, evidence shows that women in conflict affected settings face many forms of SGBV. When participants were asked about what forms of sexual gender-based violence occurs in the community, 25 percent of responses indicated forced and early Marriage, 21 percent indicated sexual exploitation and abuse, 19 percent indicated FGM, 18 percent indicated rape and 17 percent indicated IPV (see figure 2).

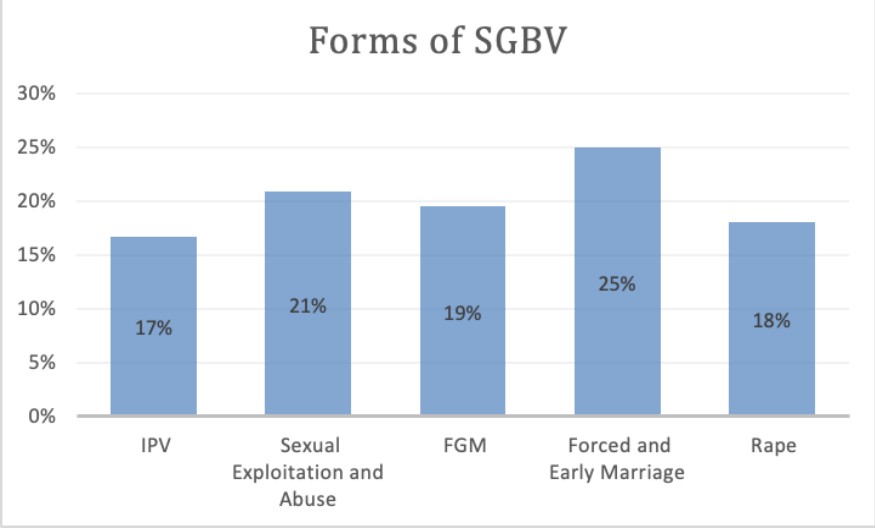


Figure 2: Forms of SGBV that occurs in the community

[8] Hossain M, et al. J Epidemiol Community Health 2020

Analysis of GBV Cases

- **FGM** A severe form of gender-based violence that continues to be almost universal among women and girls in Somalia is female genital mutilation (FGM). It is normalized violence in Somalia as most girls and women are mutilated and perceive it as normal. FGM is socially accepted to be for the good and protection of the female child and it is not understood as a violation of the human rights of women and girls. It has remained pervasive and a strong social norm because of its requirement for marriage for girls.[9] It has become more compelling for families seeking to escape poverty and build social acceptance and affinity by mutilating their female children.

- **Intimate Partner Violence (IPV)** IPV has consistently remained the highest reported incidence of GBV by the GBVIMS in Somalia and women and girls in marriage relationships or cohabiting are the major survivors of IPV. Incidents of IPV are attributed to tensions in families because of limited financial resources which affects prioritization of issues that are of concerns to women and adolescent girls (a key example is access to reproductive health services).[10] Changing roles of provision and targeting of cash vouchers assistance are also major factors that can bring misunderstanding among women and men cohabiting or married. Loss of esteem and confidence that accompany the men's inability to provide for their families can cause them to resort to violence to reclaim traditional male authority in households. IPV is also due to the lack of adequate private living quarters and overcrowding in camps which creates situations of tension among women and men.

- **Early and Forced marriage** Early and forced marriage continue to be pervasive in Somalia especially within the context of prevailing poverty and the perceptions around the value of girls versus boys in families and communities. Girls are usually married at an early age because of the need for families to ensure social and economic security. Women are traditionally valued according to their ability to procreate. Marriage provides the platform for women and young girls to demonstrate this value to society to retain the privilege of respect and recognition as a mother of children. Early marriage is perceived to be both a cultural and a religious requirement in Somalia as there continues to be a lack of consensus among key stakeholders (religious and Government actors) on the age of marriage/maturity.

- **Sexual violence, exploitation and abuse** Increased hostilities perpetuated by communal violence and struggle over scarce resources such as land and water also impact on already displaced women and girls living in IDP camps and unfamiliar environments. There have been incessant cases of rape of adult, adolescent, and young female children over the years. However, more recently, adolescents and children have become the major target. Long distances to seek health services, schools, water points and latrines are major factors that continue to increase the risks of rape of women and girls in Somalia.

[9] Harte, Aoife. "Irish Somali Woman Steps up Campaign against Female Genital Mutilation." UNHCR, 2021.
[10] Thomsen, Igbelina-Igbokwe and Abdi Advocacy Brief, 2021

Coping Mechanisms

Negative coping mechanisms used by survivors include withdrawal, social isolation, victim blaming, silencing, restriction of movements, suicide or attempted suicide, child marriage and survival sex (sex in exchange for favors) and perpetuation of FGM to promote marriageability of girls and social affinity.[11]

Positive coping mechanisms include self-care, seeking help from others including family members, relatives, intimate partners and trusted members of the community, participating in outreach awareness, seeking support services, engaging in trauma healing activities such as building self-esteem, studying, physical exercise or journaling.[12]

As you can see in figure 3, our assessment indicated that oftentimes survivors resort to negative coping mechanisms such as silencing (19 percent) withdrawal (14 percent) and isolation (14 percent).

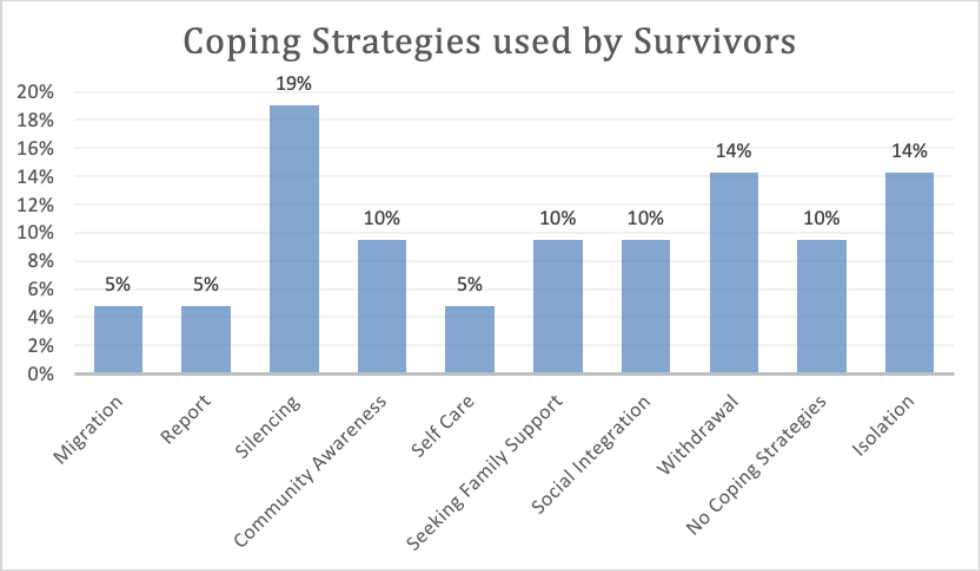


Figure 3: Coping strategies used by survivors

Study shows that sexual violence in post conflict settings has negatively affected survivors' relationships with their community, family, and partners due to stigma surrounding the

[11] Thomsen, Igbelina-Igbokwe and Abdi Advocacy Brief, 2021

[12] Thomsen, Igbelina-Igbokwe and Abdi Advocacy Brief, 2021

experience and its consequences.[13] Due to traditional gender and societal norms and practices, the stigma associated with mental illness and psychosocial problems inhibit all avenues and opportunities for recovery. Stigma experiences can include the perception of maltreatment by others (perceived stigma) and/or having been subjected to harmful behaviors or acts of discrimination (enacted stigma) on account of being a survivor of sexual violence. Survivors may also internalize stigma associated with experiences of violence, developing feelings of shame, and withdrawing from others. Further, experiences of stigma may mediate the impact of sexual violence on women's wellbeing. One way stigma impacts overall health is by discouraging survivors from seeking out informal and formal support.

When asked about the barriers survivors face when seeking psychosocial support, 22 percent of responses indicated that stigma was an important barrier (see figure 4).

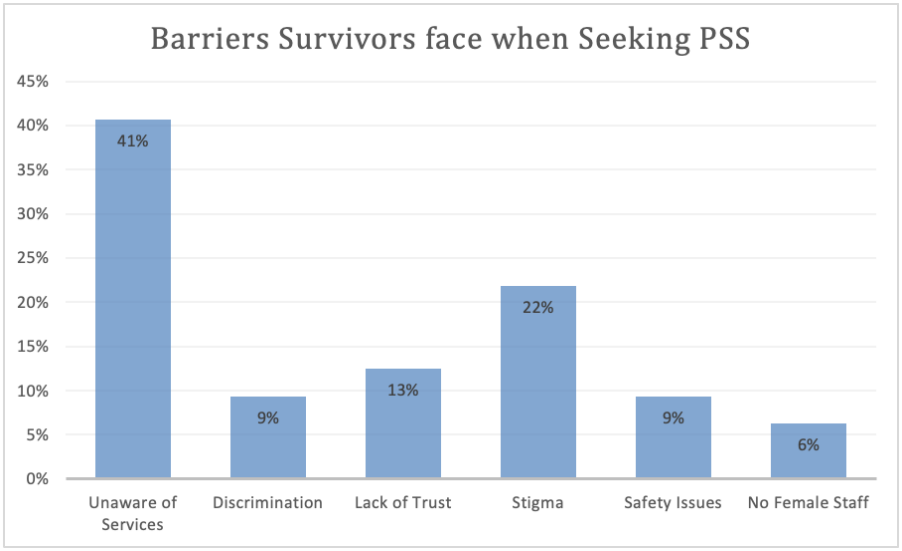


Figure 4: Barriers survivors face when seeking psychosocial support

The most common response was that survivors are either unaware of services that are provided or do not have access to such services (41 percent).

[13] Murray Sarah, et. al "Measuring Sexual Violence Stigma in Humanitarian Contexts: Assessment of Scale Psychometric Properties and Validity with Female Sexual Violence Survivors from Somalia and Syria." *Conflict and Health* 15, no. 1 (December 24, 2021).

Psychosocial Support Services

The term 'psychosocial' captures how psychological well being is directly linked to one's social surroundings, including family, community, and cultural networks.[14] Psychosocial support (PSS) for GBV survivors include services and assistance aimed at addressing the harmful psychological, emotional, and social effects of GBV. It seeks to improve a survivor's well being and focuses broadly on the individual.

The Inter-Agency Standing Committee for Gender-Based Violence in Emergencies Programming outlines the Mental Health Psychosocial Support (MHPSS) Intervention Pyramid (see figure 5).[15] Protection staff do not need to be experts in GBV when working in PSS interventions at layers 1 and layers 2 of the MHPSS intervention pyramid.

PSS best practice

There are five empirically sound intervention principles that guide PSS programmes across humanitarian contexts globally:

1. Promote sense of safety;
2. Promote calming;
3. Promote sense of self- and collective-efficacy;
4. Promote connectedness;
5. Promote hope.

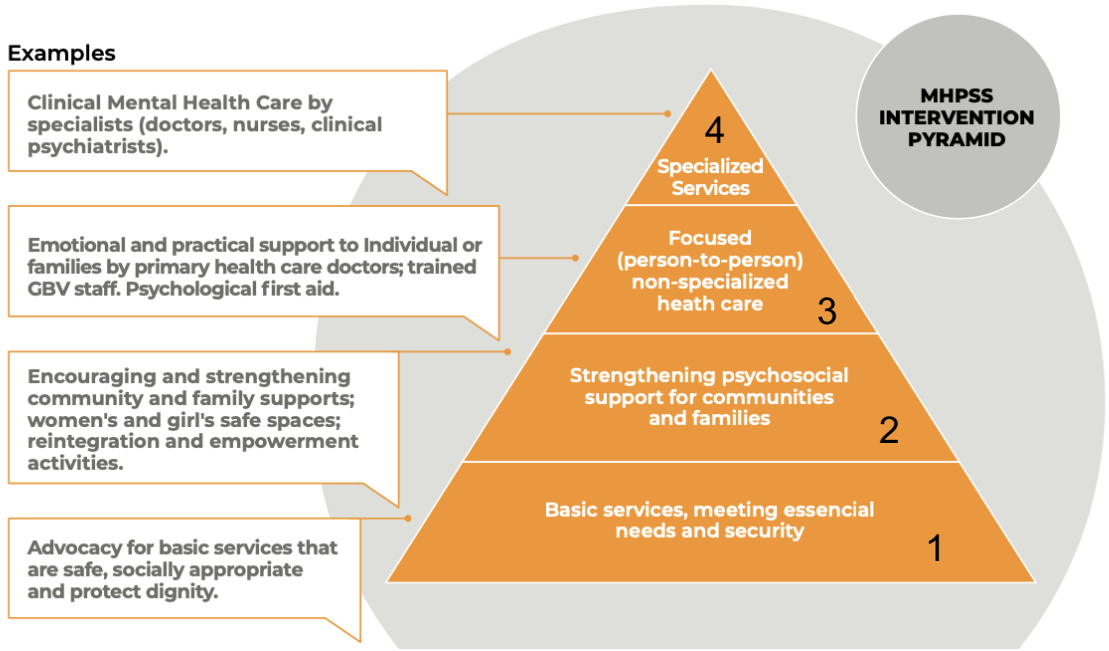


Figure 5: Mental Health and Psychosocial Support in emergencies intervention pyramid

[14] McGee, Siobhan. "Gender Based Violence and Psychosocial Support Irish Consortium on Gender Based Violence Learning Paper." The Irish Consortium on Gender Based Violence, December 2019

[15] Inter-Agency Minimum Standards on GBViE

Survivors of GBV experience long lasting psychological and social challenges. As discussed previously, there is a culture of stigma around GBV and there are inadequate GBV response services available. As a result, it is necessary to make available confidential, safe and quality services with a **survivors–centered approach.**

Since GBV occurs within the context of a specific society due to the gender roles established as well as unequal power relationships between women and men, community-based support approaches are pivotal to support the psychosocial wellbeing and the resilience of women and girls. These approaches minimize their exposure to violence as well as to create a safe and enabling environment for survivors of violence to heal, reestablish relationships, and reintegrate into their communities.[16]

What GBV Actors Are Doing

There are opportunities throughout this strategy to engage a broad range of actors at the community level. GBV actors who provide community-based support approaches include the following:

- **Women and Girls Safe Spaces (WGSS)** are essential entry points for women and girls to report protection concerns, receive care and services, express their needs, engage in empowerment activities and connect or re-integrate with the community. Creating women and girls only safe spaces ensures tangible outcomes for prevention and response to violence against women and girls.[17] WGSS provides a space where women and girls are free from harassment while creating opportunities for survivors to exercise their rights and promote their own safety.

- **Psychosocial Support Activities** are either formal support groups or recreational activities that are designed and implemented based on the priorities of women and girls and customized according to the survivors specific needs. Recreational activities can include tea and coffee sessions, henna applications and sewing. These activities are usually around a core psychosocial empowerment activity such as informal and formal life skills training that are within age and context appropriate. They are designed to support the development of abilities for adaptive and positive behavior which enable victims to deal effectively with the demands and challenges of everyday life

- **Skills Development and Livelihood Activities** include skill based classes, communal and individual income generating activities, formal vocational training. These activities

[16] Thomsen, Igbelina-Igbokwe and Abdi Advocacy Brief, 2021

[17] GBV-Sub Cluster (Turkey Hub – Syria). "Standard Operating Procedures for Gender-Based Violence ... - Reliefweb." GBV Sub Cluster, November 2018.

facilitate women's meaningful participation in public life, including job skills training that will enable women to access the job market and increase their resilience. Although informal skill based courses can be overseen and directly implemented by GBV actors, it is recommended to work with women's livelihood and economic empowerment experts through referral systems.[18]

- **Information and Awareness Raising** increases women's access to information and resources that contribute to their cognitive empowerment. Formal awareness raising activities can serve as entry points for sharing knowledge and information. . Topics may include available services and how to access them; risk identification and reduction strategies; sexual and reproductive health; women's rights; infant and young child feeding practices; positive coping strategies; life skills; and hygiene promotion. It is important to create a dynamic supportive and empowering forum that community members can also participate in.

In our assessment, we found that over 48 percent of respondents said there are no available safe spaces within Southwest State Somalia (see figure 6). When asked about the safety of these facilities, over 40 percent of our respondents indicated that facilities are not safe for women and girls to access while 33 percent of our respondents say that there are limited constraints when accessing these facilities (see figure 7).

[18]GBV-Sub Cluster (Turkey Hub – Syria). Reliefweb." GBV Sub Cluster, November 2018.

Availability of Safe Spaces			
Regions	**No**	**Yes**	**Grand Total**
Bakool	**3**	**4**	**7**
Hudor	1	2	3
Waajid	2	2	4
Bay	**7**	**5**	**12**
Baidoa	3	1	4
Berdaale	4		4
Buurhakaba		4	4
Lower Shabelle	**3**	**5**	**8**
Afgooye	3	1	4
Baraawe		4	4
Grand Total	**13**	**14**	**27**

Figure 6: Availability of safe spaces in South West State Somalia

Safety of Facilities				
Regions	**Limited constraints**	**No**	**Yes**	**Grand Total**
Bakool	**3**	**2**	**2**	**7**
Hudor	2		1	3
Waajid	1	2	1	4
Bay	**3**	**6**	**3**	**12**
Baidoa	1	2	1	4
Berdaale		4		4
Buurhakaba	2		2	4
Lower Shabelle	**3**	**3**	**2**	**8**
Afgooye	1	3		4
Baraawe	2		2	4
Grand Total	**9**	**11**	**7**	**27**

Figure 7: Safety of facilities in South West State Somalia

What are beneficial or harmful strategies?

Table 1 provides details about beneficial and harmful approaches

Do's	Do Nots
Activities should reflect the range of needs, ages, experiences and comfort levels of both the survivors and as well as organizational expertise and capacity.	No women or girl should feel pressured to share as this can cause survivors to feel negative emotions. This practice raised concerns about confidentiality .
Prioritize the recruitment of female staff with good social skills and invest in their capacity and professional development.	Language matters. It is important not to target survivors to give them messages, but rather engage with them.
Do inform them about all available options for services. Services and activities should be consulted with women and girls so that activities are responsive to their needs.	Perform an assessment or intervention addressing specific psychological problems while the survivor is still confined with the perpetrator.
Do create a participatory environment in order to ensure that objectives of community based support PSS are relevant and women and girls feel free to contribute during facilitation sessions.	Do not trivialize or minimize the violence. This can serve as a barrier for a survivor when seeking support.
Do allow the survivor to take back some control in their life by allowing them to make their own decisions.	Do not make unrealistic promises or give survivors false information.
GBV actors must be aware of their own biases and prejudices so that they set them aside.	Do not exaggerate your skills.
Do believe them.	Do not ask for proof or evidence in order to collaborate the incident of gbv.

Table 1: Beneficial and harmful approaches when responding to GBV disclosures

The survivor-centered approach

Survivors of GBV experience long lasting psychological and social challenges. As discussed previously, there is a culture of stigma around GBV and there are inadequate GBV response services available. As a result, it is necessary to make available confidential, safe and quality services with a survivors–centered approach. The survivor-centered approach means that the survivor's wishes and rights are upheld and put first. They should be treated with dignity and respect and their safety should be ensured.[19]

[19] Cowater International , "Gender-Based Violence Programming Tool ," Gender-based Violence Programming Tool For Cowater projects and partners, 2017

Table 2 provides details of the guiding principles and core skills when caring for GBV survivors.

Guiding Principle	Skills
Safety Essential services must prioritize the safety of women and girls. This principle refers to physical, psychological and emotional safety. Those working with survivors need to remember that she might be frightened and need assurance that she is safe. One needs to ensure that she is not placed at risk of further harm. It is important to take into account the safety needs of the survivor, her family members and those who care for and support them including counselors, friends and community members.These risks are specific to the survivor's unique circumstances and must be analyzed in the context of social confinement or movement restrictions.	• Conduct conversations, assessments and interviews in a quiet and private place. • Assess the safety of the survivor and promote security measures the survivor believes should be taken. • Only take action with the informed consent of the survivor.
Confidentiality Confidentiality refers to one's right to the confidential collection, use and secure storage of information provided by her. It also refers to the survivor's right to have such information not be shared or disclosed without their informed consent. Survivors have the right to choose who they feel comfortable sharing their story with. Any information about them should only be shared with the informed consent of the survivor. One of the main concerns that survivors face when seeking support is the lack of trust (see figure 4). Therefore the aspect of confidentiality is important when working with survivors.	• Share only relevant information and do not share the name, identifying information or story of survivors with others. • If you need to share information with professionals (i.e., for referrals), you may only do so if the survivor has given their consent. • Keep records in a secure location at all times. Do not include identifying information on records. Files should be identified by a number or code, and not by an individual's name.
Respect and Dignity All actions taken by staff should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to the survivor. The objective of PSS is to restore the survivor's respect and dignity, recognizing that incidents of	• Respect the strength and capacities of the survivor to cope with what has happened to them. • Show that you believe the survivor, that you don't question or blame the survivor, and that you respect their privacy. • Provide emotional support to the survivor. Show sensitivity, understanding and

GBV can have serious consequences in these areas is important. This also means recognizing and accepting survivors' decisions, even if their decision is to refuse the services or to abstain from engaging in legal actions in response to acts of violence. Failure to abide by this principle may increase feelings of impotence, shame and lack of control over the situation. It can also lead to feelings of guilt and reduce the likelihood of an effective response, possibly resulting in more harm and revictimization for survivors.	willingness to listen to their concerns and story with a caring attitude. ● Do not make judgments. ● Provide the survivor with information about available services and the quality of these services. ● Allow the survivor to make choices about the care and support they want. Avoid advising the survivor. ● Be clear about your role and about the type of support and assistance you can offer. Never make promises that you cannot keep ● Make sure you are well informed about the options for referral (e.g., medical, psychosocial, economic, judicial), including what services are available, the quality of these services and the safety for survivors when accessing these services. ● Consider the possibility of accompanying the survivor throughout the process, if necessary. ● Ensure attention to survivors' various needs, including medical and psychosocial needs, material needs and the need for safety and security.
Non-Discrimination This principle speaks to the delivery of all service provisions free from any form of discrimination based on gender, age, disability, tribal group, political views, sexual orientation, social class, or any other factor. Service providers should provide support following a human rights approach and adhere to the principle of non-discrimination which is a core human right.	● Treat all survivors equally and in a dignified way. ● Do not make assumptions about the history or background of a survivor. ● Be aware of your own prejudices and opinions about GBV, and do not let these influence the way you treat a survivor. ● Ensure you have been trained on human rights, humanitarian principles, and relevant agency non- discrimination policies.
Perpetrator Accountability We never condone, minimize or excuse violence. We never place the responsibility for violence with survivors.	

Table 2: Five guiding principles and core skills to care for survivors of GBV

Referral Pathways and Mechanisms

Referral mechanisms are how referrals are made and feedback provided between caseworkers and service providers following agreed information sharing protocols and defined referral pathways.[20] Referral pathways map the process of referral to services and support for specific types of threats, violations and vulnerabilities.

Referrals can happen in various ways and among different actors. Table 3 indicates types of possible referrals.

From	To	Type of Referral
Any community member or humanitarian actor	GBV case management actors	Professional care and GBV case management
GBV case management actors	GBV case management actors	Referring to another GBV specialist to provide case management in another area may be necessary
GBV case management actors	Multi-sectoral response services	According to the survivor's needs and initial assessment, care should be provided and comprehensive information about other services and the consequences and benefits of accessing them should be given. At this point, the survivor will be referred to additional services of his/her choice and based on her/his needs.
GBV case management actors	Other services	During or following the period of time when a survivor is receiving care from specialists, they may also be in need of additional services not directly GBV-related (e.g. food assistance, shelter, NFI, education, etc.) as part of their case management action plan. GBV case management actors

[20] Inter-Agency CPCM

		will refer survivors to the relevant agencies, and follow up if they are acting as case managers for the survivor.

Table 3: Types of referrals

Once community members or service providers identify those who may need case management, they should take the following initial steps:

1. Provide a safe and caring response
2. Respect the confidentiality and wishes of the individual
3. Provide information about available case management services and seek consent/assent from child and family
4. Facilitate referral to relevant case management services
5. For survivors of sexual violence promote immediate (within 72 hours) access to medical care, mental health and psychosocial support
6. No referral should be made without explicit consent/permission, except in case of an immediate security or safety risk of a child

Community members and other service providers who often encounter vulnerable individuals should be trained on how to identify at risk individuals and how to conduct safe referrals.

Informed Consent

Informed consent is a vital step in providing quality care and response to a survivor of GBV.[21] The purpose of documenting the incident and gaining the survivor's consent to share the information with other organizations and services is to facilitate protective measures and the healing process of the survivor through appropriate referrals. Informed consent is an important step in recognizing the fundamental rights of the individual of taking care of their own life.[22] It places the survivor at the center of the healing process. It empowers them to decide what to do about their life and body.

Adults If the survivor does not consent to sharing information, information cannot be shared with outside organizations. Even if a survivor does not provide their consent to share information with other organizations, they are still entitled to receive appropriate and timely care.

[21] Bacci, Irina, and Patricia Rangel. "Psychosocial Support for Women Survivors of Violence in Yemen - UNFPA." UNFPA Mental Health and Psychosocial Support, September 2019.

[22] GBV-Sub Cluster (Turkey Hub – Syria). Reliefweb." GBV Sub Cluster, November 2018.

The generally accepted approach to obtaining informed consent is as follows[23]:

- Read aloud to the survivor the consent statement included in the standard informed consent form, allowing time for the survivor to ask questions and seek clarification of individual points.
- After explaining the key points, ask the survivor to repeat back in their own words why they think consent is being requested, what they think they will gain from providing consent, what they have agreed to consent to, what the potential consequences of giving consent might be, and what would happen if they refused to give consent. This will allow the service provider to assess the survivor's understanding of each issue and if necessary, reinforce anything that was not clearly understood and/or correct any misunderstanding.

Children When children have experienced GBV, they generally do not disclose it directly. Identification is more common.[24] For example, when the child becomes pregnant, when someone witnesses a child sexual abuse or when the child contracts a STI.

As a general principle, consent is provided by both the child and their caregiver, unless it is deemed inappropriate to involve the caregiver. Permission to proceed with care is sought by obtaining "informed consent" and /or "informed assent".

- Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide "informed consent" the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent.
- Informed assent is the expressed willingness to participate in services.

Table 4 provides a summary of the guidelines for obtaining informed consent/assent from children.

Age Group	Child	Caregiver	If no caregiver or not in the child's best interest	Means
0-5	-	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent

[23] GBV-Sub Cluster (Turkey Hub – Syria). Reliefweb." GBV Sub Cluster, November 2018.
[24] GBV-Sub Cluster (Turkey Hub – Syria). Reliefweb." GBV Sub Cluster, November 2018.

6-11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, Written consent
12-14	Informed assent	Informed consent	Other trusted adults or childs informed assent. Sufficient level of maturity can take weight	Written assent, written consent
15-18	Informed consent	Obtained informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

Table 4: Summary of guidelines for obtaining consent from children

Methodology

Systematic Literature Review The search strategy used to create this guide was designed to capture relevant clinical and social science literature examining the sociocultural aspects of mental health within the Somali population. Since there is no primary database for Somalia's public health research, the main databases used for mental health in this study included the following:

- Medline, PubMed, CINAHL, PsycINFO, Google Scholar.
- Additional searches on specific websites such as those of '*Bildhaan: An International Journal of Somali Studies'*, UNHCR, nongovernmental organizations (NGOs), and MHPSS.net were used.

Qualitative Methodology The qualitative data provided an in depth information regarding the psychosocial support services available in the Southwest State of Somalia.
We conducted interviews with local experts on gender-based violence which include the following individuals: a psychosocial counselor, religious leader, line ministry and community member. The online data collection tool used was KoboToolBox. See ***Appendix A*** for the ***interview protocol.***

Key Informant Interviews

- Face to face in depth interviews 3 Regions: Bay, Bakool and Lower Shabelle. 7 Districts within those regions: Baidoa, Buurhakaba, Berdaale, Xudor, Wajid, Afgooye and Baraawe

- 34 questions completed by 27 people
- The interview questions included: General information, Location, Demographic of survivors, Attitudes and Help Seeking Behaviors, Safety and Security of Women and Girls, Availability and Accessibility of Services, Recommendations for Improving Services and Access, and Recommendation to Reduce GBV.
- When reviewing and analyzing the open-ended questions, I used thematic analysis. All analysis was done on Excel.

To ensure participants are comfortable discussing their experience, we assured respondents that all responses are kept confidential. Please see **A*ppendix B*** for the ***consent form***

Challenges

- **Lack of available safe spaces and access**: Limited availability of specialized services, psychosocial support, and higher levels of mental health care for traumatized women and girls in Southwest State Somalia
- **Lack of humanitarian access**: In severely remote communities and conflict affected areas, the provision of services as well as the ability of civilians to reach this assistance is limited
- **Stigma**: Gender Based Violence is heavily stigmatized and many incidences go unreported
- **Data**: There are continuing gaps in the literature that explores effectiveness of mental health and psychosocial support interventions. There is a lack of reliable data and research on the impact of the conflict on GBV hinders efforts to inform the wider humanitarian response.

Key Lessons on Gender Based Violence and Psychosocial Support Services:
Incorporating essential community outreach and preventative work into GBV responses is key. Prevention consists of community education and mobilization activities that increase knowledge and change attitudes regarding gender among women, men, youth, service providers, and leaders. The multifaceted community mobilization platforms help bring attention to GBV issues and reduce stigma for women who are survivors of GBV related issues.

Safe spaces provide an entry point for comprehensive GBV interventions such as psychosocial counseling, life skills, livelihood, and referrals for specialized services.

Working with traditional leaders is vital to identify customary legal or decision making practices that are protective of survivors. Their engagement in ensuring the abandonment of traditional practices that harm women and girls as well as endorsing and strengthening key community-based protection structures are critical.

Involvement in the community is essential for smooth implementation and for facilitating the work of service providers. The engagement of institutions and communities also helps create better acceptance for the services provided.

Recommendations

- Adoption of policies and implementation of actions that promote justice and the human rights of GBV survivors
  - Put in place mechanisms to enhance collaboration, coordination and communication between local leaders and authorities on issues concerning SGBV.
  - Work with the GBV coordination mechanisms to identify relevant gaps and to ensure access to technical support and coordination with other actors, and work with other sectors to enhance multi-sectoral support to survivors.
- Provision of quality services to GBV survivors
  - Address barriers to access to services
- Civic education, community dialogue and reconciliation to build peace and reduce GBV in families and communities
  - Provide civic education for community members, IDPs, host communities and minorities, on citizen participation, human rights and governance.
  - Facilitate community dialogues between clans about the history of violence, normalization of violence, social norms and hate narrative, and how they contribute to SGBV today. These dialogues will encourage face-to-face conversations on SGBV between stakeholders – community elders, religious leaders, women's groups, youth groups, service provider
- Addressing traditional harmful practices (FGM/child marriage)
  - Engage with prominent opinion leaders who are already opposed to harmful practices, such as religious leaders, to discuss with mothers and FGM practitioners the health and psychological consequences of FGM/child marriage and the religious stand on harming girls through FGM and child marriage

Appendices

Appendix A: Interview Protocol

Opening Script
Hi, my name is… and I am a research volunteer who works at…

Purpose of Project

- The purpose of this interview is to assess the psychosocial support services available in the community for survivors of gender based violence, specifically women and girls. The purpose of this study is to learn more about the services currently being provided in your community. The study will provide GBV Psychosocial Support Services with feedback on how to improve service delivery as well as potentially addressing challenges.

Participant Info

- We assure you that your responses are completely anonymous and any identifying information including your name will be kept confidential

Structure for Conversation/Logistics

- The interview questions will last about 30 minutes. I will ask you questions and I will type your responses in Kobotoolbox, a data collection tool. I will try to capture your answers, but some of them may be summarized. I will go over once I recorded it to make sure I have not misunderstood you
- Only members of the research team will have access to the recording and all results will be kept confidential
- If you do not understand a question, feel free to ask me to clarify. Also, you can decline to answer a question if you wish.

Interview Protocol

Section 1: General Information

- Gender
    - Male
    - Female
- What is your role in the community?
    - Psychosocial Counselor
    - Religious Leader
    - Community Member (women or youth group)
    - Line Ministry
- Name of Organization you're affiliated with
- Type of organization

    - National NGO
    - International NGO
    - Other

Section 2: Location

- Region of Operation
    - Bay-
    - Bakool- hodor wajir
    - Lower Shabelle-Barawe Afgoye
- District
    - Afgooye
    - Baidoa
    - Baraawe
    - Berdaale
    - Buurhakaba
    - Hudor
    - Waajid

- Type of site/location
    - Urban
    - Rural
    - IDP Camp
    - Host Community

- Population estimate of site

Section 3:Demographic of Survivors

- What are the typical age groups of survivors who receive services (select all that apply)
    - 0-9
    - 10-15
    - 16- 21
    - 22-30
    - 31-45
    - 45-60
    - >60
- Average Marital Status of survivor
    - Married
    - Forced Marriage

    - Widowed
    - Not Married
- Groups of people with specific needs (select all that apply)
    - pregnant female under 18 years
    - mothers under 18 years
    - persons with known or visible mental and/or physical disability
    - Elderly
    - Persons with Chronic Diseases or Serious Medical Conditions
    - widows (female whose husband has died)
    - minors under 18 years whose both parents have died
    - minority groups
    - others (Specify)

Section 4: Attitudes and Help Seeking Behaviors

- Has there been an increase in psychosocial distress in women and girls
    - Yes
    - No
    - I don't know
- If yes, What are the changes in behaviors you notice?
- What are the survivors' main worries?
- What are the coping strategies used by survivors of sexual violence?
- What barriers do women and girls face in seeking psychosocial support?
- What barriers do women and girls face in reporting GBV in this community?

Section 5: Safety and Security of Women and Girls

- Has the problem of GBV in this community gotten worse, better, or stayed the same in the last year?
    - Gotten worse
    - Stayed the same
    - Gotten better
- What forms of GBV do you think occurs the most in this community? (select all that apply)
    - IPV
    - Rape
    - Sexual exploitation and abuse
    - FGM
    - Forced and early marriage
- Where does sexual violence usually occur? (select all that apply)

    - Home
    - Outside home/ In the community
    - Within IDP camps
- What do people at-risk do to protect themselves from gender based violence?
- What usually happens to perpetrators when they are caught?

Section 6: Availability and Accessibility of Services

- Who provides support to the individuals who are unable to conduct daily activities due to mental health issues? (select all that apply)
    - Family and friends
    - Religious leaders
    - Medical doctors
    - Trained counselors
    - Nobody
    - Other
- Where do women and girls most commonly seek help when they are exposed to sexual violence? (select all that apply)
    - Nowhere
    - Local organizations
    - Hospitals
    - Mosque
- Are there Psychosocial services or activities available to support survivors in your location?
    - Yes
    - No
    - I Don't Know
- If yes, what kind of services are available? (select all that apply)
    - Psychological First Aid
    - Structured psychosocial groups
    - Individual counseling
    - Group counseling
    - Child Friendly Space Recreational Psychological Activities
    - Other
- Are there safe spaces provided for S/GBV survivors?
    - Yes
    - No
- Is it safe and secure to access the services provided?
    - Yes
    - Limited constraints

- No

Sections 7: Recommendations for Improving Services, Including Access

- What do you think needs to be done to break the barriers women and girls face to report GBV and access post-GBV services in this community?
- What are some of the challenges experienced by service providers when working with GBV survivors?
- What are commonly used best practices that make psychosocial support interventions for GBV survivors successful?
- What can community members do to better provide access to psychosocial support services? (ex: referral pathways)

Section 8: Recommendation to Reduce GBV

- What does the community member do to protect people from the risk of GBV? (Please include title of individual)

Appendix B: Consent Form

Psychosocial Support Service for GBV Field Work Consent Form

Primary Study Contact: If you have any questions about your participation in this study, please contact Shamsa Dhayow at sdhayow@sas.upenn.edu or 651-757-0491

What is the purpose of the study? You are invited to participate in a research study that will assess the psychosocial support services available in the community for survivors of gender based violence, specifically women and girls. The purpose of this study is to learn more about the services currently being provided in your community. The study will provide GBV Psychosocial Support Services with feedback on how to improve service delivery as well as potentially addressing challenges.

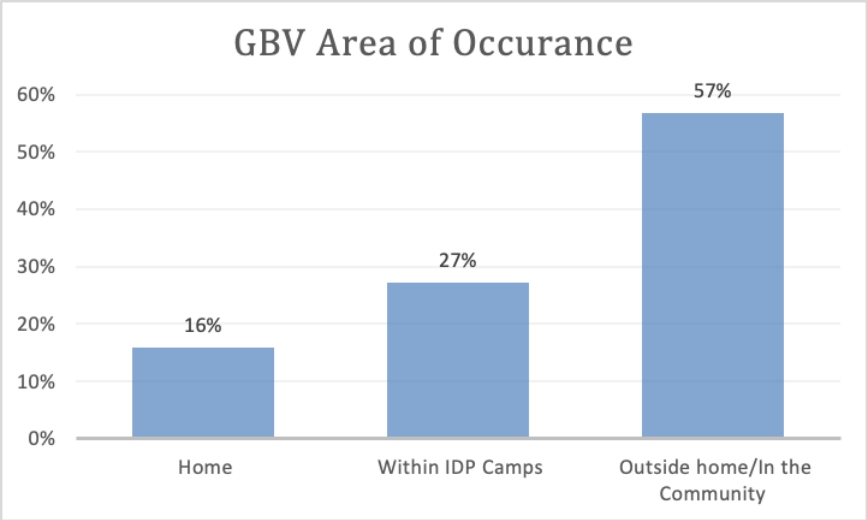
What will you be asked to do? Participating in the study will entail being interviewed. Each interview will take approximately 30 minutes.

What happens if I do not choose to join the research study? Your participation is voluntary, and there is no penalty if you choose not to join the research study. Your relationship with administration will not be affected by your decision to participate or not participate in this study.

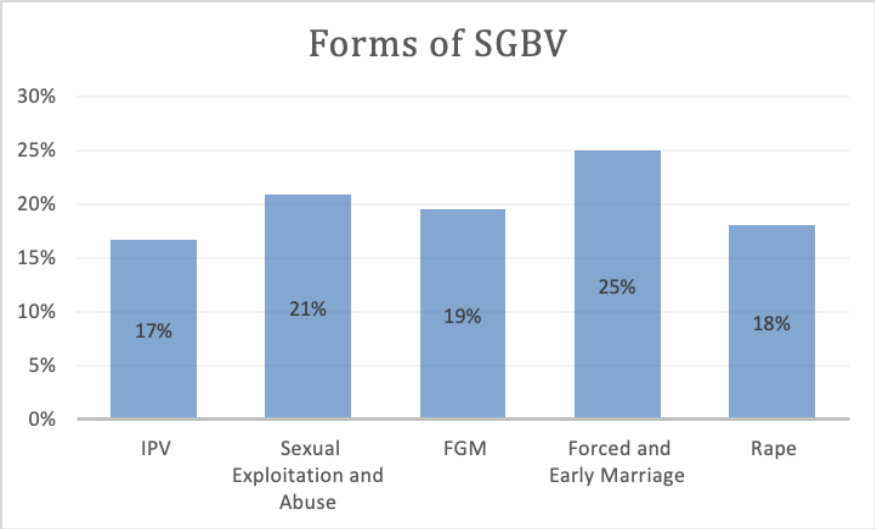
How will confidentiality be maintained and your privacy protected? The research team will make every effort to keep all the information you tell us during the study strictly confidential, as required by law. The University of Pennsylvania is responsible for protecting the rights and welfare of research volunteers like you. All data collected in the study will be kept strictly confidential and separate from the organization you are affiliated with. No staff members will have access to your individual interview responses. Tapes, notes, and transcripts will only be viewed by members of the research team.

I'd like your permission to tape our conversation. No one other than the research team will have access to this recording, but it will be helpful in the analysis of all the information collected. Your participation is voluntary and you are free to stop at any time or skip any questions you chose not to answer.

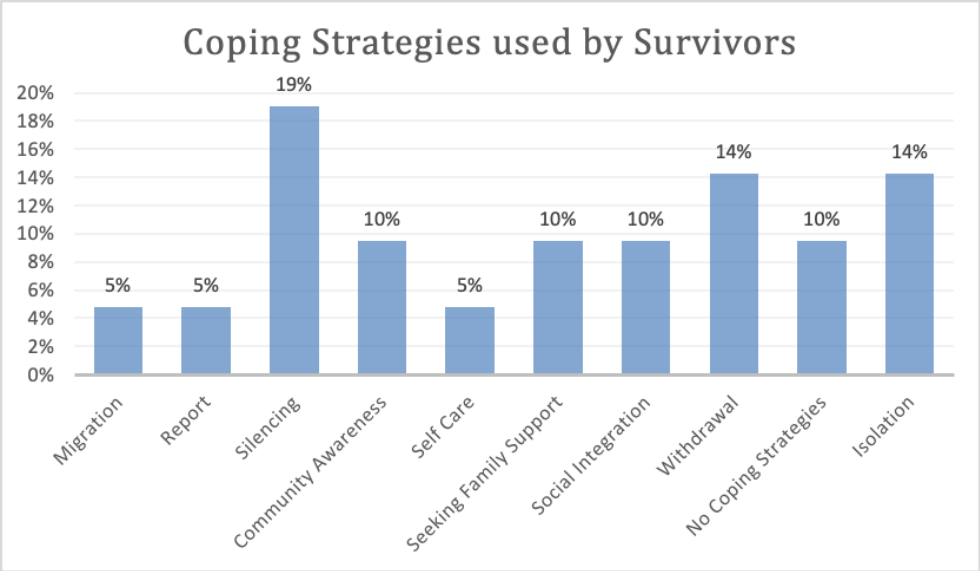
Appendix C


GBV Area of Occurance
60%
50%
40%
30%
20%
10%
0%
16%
27%
57%
Home
Within IDP Camps
Outside home/In the Community

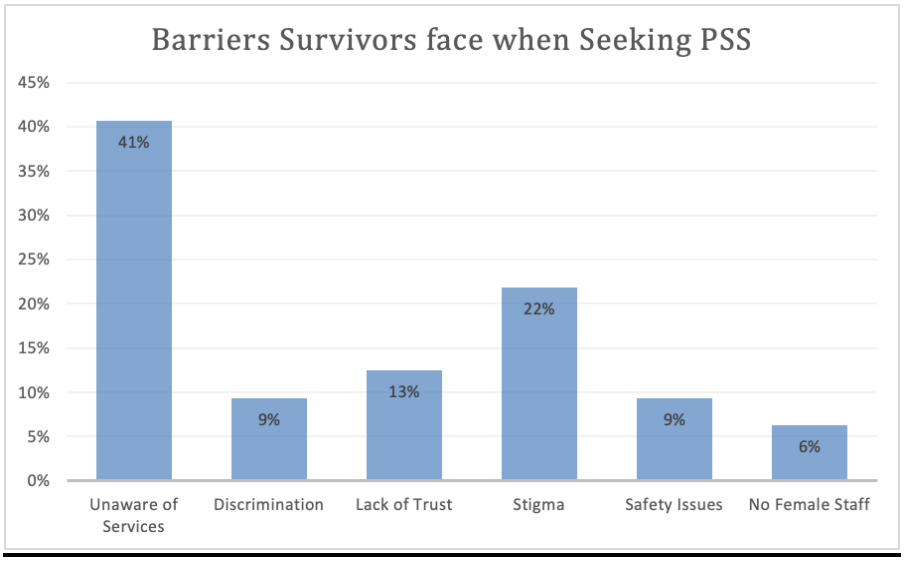
Appendix D


Forms of SGBV
30%
25%
20%
15%
10%
5%
0%
17%
21%
19%
25%
18%
IPV
Sexual Exploitation and Abuse
FGM
Forced and Early Marriage
Rape

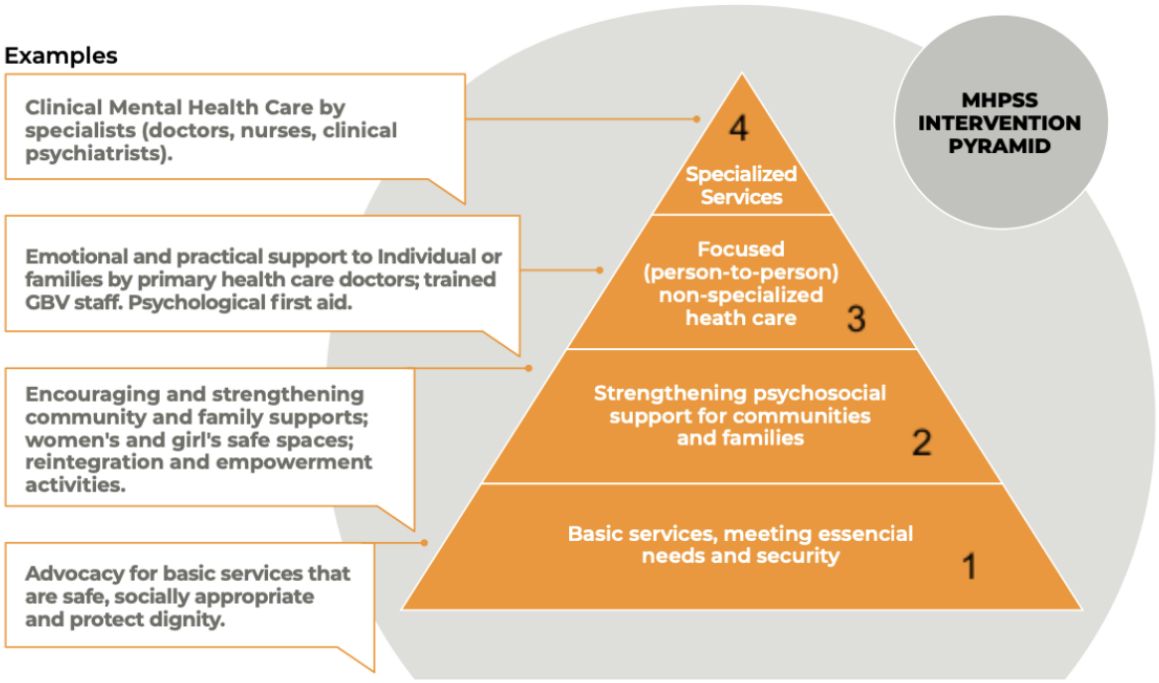
Appendix E


Coping Strategies used by Survivors
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
5%
5%
19%
10%
5%
10%
10%
14%
10%
14%
Migration
Report
Silencing
Community Awareness
Self Care
Seeking Family Support
Social Integration
Withdrawal
No Coping Strategies
Isolation

Appendix F


Barriers Survivors face when Seeking PSS
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
41%
9%
13%
22%
9%
6%
Unaware of Services
Discrimination
Lack of Trust
Stigma
Safety Issues
No Female Staff

Appendix G


Examples
Clinical Mental Health Care by specialists (doctors, nurses, clinical psychiatrists).
Emotional and practical support to Individual or families by primary health care doctors; trained GBV staff. Psychological first aid.
Encouraging and strengthening community and family supports; women's and girl's safe spaces; reintegration and empowerment activities.
Advocacy for basic services that are safe, socially appropriate and protect dignity.
MHPSS INTERVENTION PYRAMID
4
Specialized Services
Focused (person-to-person) non-specialized heath care
3
Strengthening psychosocial support for communities and families
2
Basic services, meeting essencial needs and security
1

Appendix H

Availability of Safe Spaces			
Regions	**No**	**Yes**	**Grand Total**
Bakool	**3**	**4**	**7**
Hudor	1	2	3
Waajid	2	2	4
Bay	**7**	**5**	**12**
Baidoa	3	1	4
Berdaale	4		4
Buurhakaba		4	4
Lower Shabelle	**3**	**5**	**8**
Afgooye	3	1	4
Baraawe		4	4
Grand Total	**13**	**14**	**27**

Appendix I

Safety of Facilities				
Regions	**Limited constraints**	**No**	**Yes**	**Grand Total**
Bakool	**3**	**2**	**2**	**7**
Hudor	2		1	3
Waajid	1	2	1	4
Bay	**3**	**6**	**3**	**12**
Baidoa	1	2	1	4
Berdaale		4		4
Buurhakaba	2		2	4
Lower Shabelle	**3**	**3**	**2**	**8**
Afgooye	1	3		4
Baraawe	2		2	4
Grand Total	**9**	**11**	**7**	**27**

Appendix J

Do's	Do Nots
Activities should reflect the range of needs, ages, experiences and comfort levels of both the survivors and as well as organizational expertise and capacity.	No women or girl should feel pressured to share as this can cause survivors to feel negative emotions. This practice raised concerns about confidentiality .
Prioritize the recruitment of female staff with good social skills and invest in their capacity and professional development.	Language matters. It is important not to target survivors to give them messages, but rather engage with them.
Do inform them about all available options for services. Services and activities should be consulted with women and girls so that activities are responsive to their needs.	Perform an assessment or intervention addressing specific psychological problems while the survivor is still confined with the perpetrator.
Do create a participatory environment in order to ensure that objectives of community based support PSS are relevant and women and girls feel free to contribute during facilitation sessions.	Do not trivialize or minimize the violence. This can serve as a barrier for a survivor when seeking support.
Do allow the survivor to take back some control in their life by allowing them to make their own decisions.	Do not make unrealistic promises or give survivors false information.
GBV actors must be aware of their own biases and prejudices so that they set them aside.	Do not exaggerate your skills.
Do believe them.	Do not ask for proof or evidence in order to collaborate the incident of gbv.

Appendix K

Guiding Principle	Skills
Safety Essential services must prioritize the safety of women and girls. This principle refers to physical, psychological and emotional safety. Those working with survivors need to remember that she might be frightened and need assurance that she is safe. One needs to ensure that she is not placed at risk of further harm. It is important to take into account the safety needs of the survivor, her family members and those who care for and support them including counselors, friends and community members.These risks are specific to the survivor's unique circumstances and must be analyzed in the context of social confinement or movement restrictions.	• Conduct conversations, assessments and interviews in a quiet and private place. • Assess the safety of the survivor and promote security measures the survivor believes should be taken. • Only take action with the informed consent of the survivor.
Confidentiality Confidentiality refers to one's right to the confidential collection, use and secure storage of information provided by her. It also refers to the survivor's right to have such information not be shared or disclosed without their informed consent. Survivors have the right to choose who they feel comfortable sharing their story with. Any information about them should only be shared with the informed consent of the survivor. One of the main concerns that survivors face when seeking support is the lack of trust (see figure 4). This is why the aspect of confidentiality is important when working with survivors.	• Share only relevant information and do not share the name, identifying information or story of survivors with others. • If you need to share information with professionals (i.e., for referrals), you may only do so if the survivor has given their consent. • Keep records in a secure location at all times. Do not include identifying information on records. Files should be identified by a number or code, and not by an individual's name.
Respect and Dignity All actions taken by staff should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to the survivor. The objective of PSS is to restore the survivor's respect and dignity, recognizing that incidents of GBV can have serious consequences in these areas	• Respect the strength and capacities of the survivor to cope with what has happened to them. • Show that you believe the survivor, that you don't question or blame the survivor, and that you respect their privacy. • Provide emotional support to the survivor. Show sensitivity, understanding and willingness to listen to their concerns and story with a caring attitude.

is important. This also means recognizing and accepting survivors' decisions, even if their decision is to refuse the services or to abstain from engaging in legal actions in response to acts of violence. Failure to abide by this principle may increase feelings of impotence, shame and lack of control over the situation. It can also lead to feelings of guilt and reduce the likelihood of an effective response, possibly resulting in more harm and revictimization for survivors.	● Do not make judgments. ● Provide the survivor with information about available services and the quality of these services. ● Allow the survivor to make choices about the care and support they want. Avoid advising the survivor. ● Be clear about your role and about the type of support and assistance you can offer. Never make promises that you cannot keep ● Make sure you are well informed about the options for referral (e.g., medical, psychosocial, economic, judicial), including what services are available, the quality of these services and the safety for survivors when accessing these services. ● Consider the possibility of accompanying the survivor throughout the process, if necessary. ● Ensure attention to survivors' various needs, including medical and psychosocial needs, material needs and the need for safety and security.
Non-Discrimination This principle speaks to the delivery of all service provisions free from any form of discrimination based on gender, age, disability, tribal group, political views, sexual orientation, social class, or any other factor. Service providers should provide support following a human rights approach and adhere to the principle of non-discrimination which is a core human right.	● Treat all survivors equally and in a dignified way. ● Do not make assumptions about the history or background of a survivor. ● Be aware of your own prejudices and opinions about GBV, and do not let these influence the way you treat a survivor. ● Ensure you have been trained on human rights, humanitarian principles, and relevant agency non- discrimination policies.
Perpetrator Accountability We never condone, minimize or excuse violence. We never place the responsibility for violence with survivors.	

Appendix L

From	To	Type of Referral
Any community member or humanitarian actor	GBV case management actors	Professional care and GBV case management
GBV case management actors	GBV case management actors	Referring to another GBV specialist to provide case management in another area may be necessary
GBV case management actors	Multi-sectoral response services	According to the survivor's needs and initial assessment, care should be provided and comprehensive information about other services and the consequences and benefits of accessing them should be given. At this point, the survivor will be referred to additional services of his/her choice and based on her/his needs.
GBV case management actors	Other services	During or following the period of time when a survivor is receiving care from specialists, they may also be in need of additional services not directly GBV-related (e.g. food assistance, shelter, NFI, education, etc.) as part of their case management action plan. GBV case management actors will refer survivors to the relevant agencies, and follow up if they are acting as case managers for the survivor.

Appendix M

Age Group	Child	Caregiver	If no caregiver or not in the child's best interest	Means
0-5	-	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent
6-11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, Written consent
12-14	Informed assent	Informed consent	Other trusted adults or childs informed assent. Sufficient level of maturity can take weight	Written assent, written consent
15-18	Informed consent	Obtained informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

References

Bacci, Irina, and Patricia Rangel. “Psychosocial Support for Women Survivors of Violence in Yemen - UNFPA.” UNFPA Mental Health and Psychosocial Support, September 2019. https://unfpa.org/sites/default/files/resource-pdf/19-255-MHPSS-Case-YEMEN-2019-10-04-1718.pdf.

Cavallera, Vanessa, Massimiliano Reggi, Peter Ventevogel, and Saida Abdi. “Culture, Context and Mental Health of Somali Refugees: A Primer for Staff Working in Mental Health and Psychosocial Support Programmes.” UNHCR, 2016. https://www.unhcr.org/protection/health/5bbb73b14/culture-context-mental-health-somali-refugees-primer-staff-working-mental.html.

Cowater International . “Gender-Based Violence Programming Tool .” Gender-based Violence Programming Tool For Cowater projects and partners, 2017. https://www.cowater.com/wp-content/uploads/2020/12/Cowater-GBV-Response-Tool-.pdf.

GBV-Sub Cluster (Turkey Hub – Syria). “Standard Operating Procedures for Gender-Based Violence ... - Reliefweb.” GBV Sub Cluster, November 2018. https://reliefweb.int/sites/reliefweb.int/files/resources/gbv_sc_sops_2018_english_final.pdf.

Harte, Aoife. “Irish Somali Woman Steps up Campaign against Female Genital Mutilation.” UNHCR, 2021. https://www.unhcr.org/en-us/news/stories/2021/8/610aaaee4/irish-somali-woman-steps-campaign-against-female-genital-mutilation.html.

Hossain, Mazeda, Rachel Jane Pearson, Alys McAlpine, Loraine J Bacchus, Jo Spangaro, Stella Muthuri, Sheru Muuo, et al. “Gender-Based Violence and Its Association with Mental Health among Somali Women in a Kenyan Refugee Camp: A Latent Class Analysis.” *Journal of Epidemiology and Community Health* 75, no. 4 (2020): 327–34. https://doi.org/10.1136/jech-2020-214086.

Lulo, Sara, Rashida Manjoo, and Calleigh McRaith. Essay. In *Gender-Based Violence and Justice in Conflict and Post-Conflict Areas* 44, 44:11–30. Ithaca, NY: Cornell Univ., 2011.

McGee, Siobhan. “Gender Based Violence and Psychosocial Support Irish Consortium on Gender Based Violence Learning Paper.” The Irish Consortium on Gender Based Violence, December 2019. https://www.trocaire.org/news/irish-consortium-on-gender-based-violence-launches-strategic-plan-2021-2026/.

Murray, Sarah M., Molly E. Lasater, Marie-France Guimond, Ohemaa Poku, Rashelle Musci, Manal Al-Fataftah, Lilian Kasina, Mercy Lwambi, Asma Salaimeh, and Kathryn Falb. “Measuring Sexual Violence Stigma in Humanitarian Contexts: Assessment of Scale Psychometric Properties and Validity with Female Sexual Violence Survivors from

Somalia and Syria." *Conflict and Health* 15, no. 1 (December 24, 2021). https://doi.org/10.1186/s13031-021-00431-z.

Musse, Fouzia. "The Complexity of Sexual and Gender-Based Violence Insights from Mogadishu and South Central Somalia." *Human Rights Documents Online*, 2015. https://doi.org/10.1163/2210-7975_hrd-1920-2015036.

O'Neill, Sarah, and Christina Pallitto. "The Consequences of Female Genital Mutilation on Psycho-Social Well-Being: A Systematic Review of Qualitative Research." *Qualitative Health Research* 31, no. 9 (2021): 1738–50. https://doi.org/10.1177/10497323211001862.

Thomsen, Anders, Nkiru Igbelina-Igbokwe, and Ridwaan Abdi. "Overview of Gender-Based Violence in Somalia - Advocacy Brief, 2021." UNFPA Somalia. United Nations Population Fund Somalia Country Office, March 9, 2021. https://somalia.unfpa.org/en/resources/overview-gender-based-violence-somalia-advocacy-brief-2021.