WOMEN'S REFUGEE COMMISSION

DELIVERING PEER SUPPORT GROUPS TO ADOLESCENT BOY AND MALE YOUTH SURVIVORS OF SEXUAL VIOLENCE, INCLUDING LGBTQI+ YOUTH, IN HUMANITARIAN CONTEXTS

A training curriculum for frontline workers without specialization in the provision of mental health and psychosocial support, to facilitate group-based peer support

Part I: Training of Trainers

The Women's Refugee Commission (WRC) improves the lives of women, children, and youth displaced by conflict and crisis, and protects their rights. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

Bandhu Social Welfare Society (Bandhu) implements essential sexual and reproductive health and rights activities in Bangladesh, including HIV intervention, legal support, capacity building, and policy advocacy. It aims to bring positive changes to the lives of thousands of community members by addressing the social, religious, cultural, and legal impediments in terms of their rights and freedom.

The Humanitarian Gender-Based Violence Coordination Space, Colombia, was created in 2009 as part of the Inter-agency Gender Group, to address issues of sexual violence in conflict. Since 2015, this gender-based violence (GBV) coordination space has operated as a GBV subgroup within the national humanitarian architecture.

The MENA Organization for Services, Advocacy, Integration & Capacity building (MOSAIC-MENA) is a holistic program committed to improving the health and well-being of marginalized and vulnerable groups in Lebanon and beyond. MOSAIC provides specialized and comprehensive services for marginalized groups, and research and advocacy for policy reform, develops knowledge and capacities on sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC) issues, and engages society in the fight against human rights violations, especially against rights violations against LGBTQI+ (lesbian, gay, bisexual, transgender, queer or questioning, intersex) individuals.

UN Women is the United Nations entity dedicated to gender equality and the empowerment of women. A global champion for women and girls, UN Women was established to accelerate progress on meeting their needs worldwide.

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This training curriculum was written by Roei Shaul Hillel, Dr. Koen Sevenants, and Dr. Keven Bermudez (independent consultants) and Katherine Gambir, Monica Giuffrida, Aditi Bhanja, and Ava McLaughlin Gagliardi (Women's Refugee Commission). Technical reviews of the curriculum were completed by Sophie Browne (UN Women), Robyn Shortall (Danish Refugee Council), Leisha Beardmore (Save the Children), Jennifer van Wyck (Norwegian Church Aid), and Ian Kikomeko (Reproductive Health Uganda). The curriculum was edited and designed by Strategic Agenda.

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Acronyms and abbreviations

ABMY	Adolescent boys and male youth
CBT	Cognitive behavioral therapy
CRSV	Conflict-related sexual violence
GBV	Gender-based violence
LGBTQI+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex
MHPSS	Mental health and psychosocial support
PTSD	Post-traumatic stress disorder
SGBV	Sexual and gender-based violence
SOGIESC	Sexual orientation, gender identity, gender expression, and sex characteristics
SVAMB	Sexual violence against men and boys

Overview of the training curriculum

Evidence shows that practitioners and service providers lack the tools and resources to effectively address sexual abuse and conflict-related sexual violence (CRSV) perpetrated against male survivors, including adolescent boys (aged 10–19) and male youth (aged 15–24) (ABMY), in humanitarian and conflict-afflicted settings. Practitioner and provider attitudes, biases, and misconceptions, as well as a lack of resources, have been found to be major deterrents to male survivors accessing and receiving quality services and care that meet their immediate and longer-term needs following sexual violence and abuse, including in humanitarian and conflict-afflicted settings.

The provision of services and care that aim to address the mental and psychosocial needs of survivors, including ABMY survivors, is essential as experiences of sexual abuse and conflict-related violence can have severe and long-lasting impacts on an individual's mental health and overall well-being. Sexual abuse and violence can contribute to a range of psychological and emotional difficulties, and can impact a person's ability to function in their daily life. Male survivors of sexual abuse and CRSV, including ABMY, may face additional challenges in seeking and receiving such support due to societal expectations, norms, and stigmas surrounding men, masculinities, sexual violence, and mental health.

Peer support groups, often led by a trained facilitator with some level of specialization in the delivery of mental health and psychosocial support (MHPSS), can provide all survivors with a safe and supportive space to process their experiences alongside people who understand what they are going through, and thus begin to heal. They can also help to connect survivors with key resources, such as legal assistance and financial support, which may be particularly important as survivors may face new or increased social and economic vulnerabilities as a result of their abuse or violence. In humanitarian and conflict-afflicted settings, a dearth of clinical and otherwise specialized staff does not facilitate such support to survivors of sexual violence.

This training curriculum aims to help fill the critical gap in the delivery of non-clinical, group-based peer support to ABMY survivors in all their diversity by building the capacity of non-specialist MHPSS frontline workers to design, implement, monitor, and evaluate peer support group activities with and for crisis-affected ABMY survivors, including those with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC). Non-specialist MHPSS workers include those who work with affected communities in humanitarian settings but who do not hold an MHPSS-related certification. A peer support group is an intervention model that provides an opportunity for people facing shared experiences to regularly gather and provide one another with different types of support. Through peer support groups, ABMY survivors and those at risk may also have the opportunity to partake in culturally relevant and appropriate activities that promote their mental health and psychosocial well-being,[1] including those that promote self-care and self-compassion, such as mindfulness practices, expressive arts, or physical exercise.

1 Erica M.S. Sibinga et al., "Mindfulness-based stress reduction for urban youth," *The Journal of Alternative and Complementary Medicine* 17, no. 3 (March 2011): pp. 213–218.

What are the objectives of this training curriculum?

Using a feminist intersectional approach, this training curriculum aims to improve the knowledge and capacities of frontline humanitarian workers who do not have specialized education and experiences in MHPSS to design, implement, monitor, and evaluate peer support group models and activities with and for ABMY survivors of sexual abuse and CRSV that work to promote their mental health and psychosocial well-being.

Through improved knowledge and capacity among frontline humanitarian workers, this training curriculum aims to

1. increase good-quality, appropriate non-clinical mental health services for ABMY survivors in all of their diversity; and

2. ensure that LGBTQI+ populations are included in sexual violence response measures that target mental health and psychosocial well-being.

Who participates in this training?

The training is intended for frontline workers who 1) work with adolescent boy and male youth (ABMY) survivors of sexual violence, including those with diverse SOGIESC, in humanitarian contexts; and 2) do not have a specific MHPSS-related certification. These frontline workers may come from various fields, such as health care, social work, education, and humanitarian aid, and can include community social workers, youth instructors, teachers, and group organizers. While they may not have specialized training in the delivery of MHPSS, these frontline workers often have the most immediate and sustained contact with crisis-affected individuals and communities, including ABMY survivors. This makes them the ideal candidates for this training, and for implementing the peer support group models and corresponding activities. Specialized MHPSS practitioners may also participate in this training to learn how to implement the peer support group model approach.

What does this training curriculum include?

This training curriculum consists of eight modules that cover key theoretical concepts and intervention guidance for non-MHPSS specialists to improve their capacities and implement, monitor, and evaluate peer support group models and corresponding activities with and for ABMY survivor participants in all their diversity.

The theoretical modules, which form a training of trainers (ToT) that is facilitated by an experienced MHPSS specialist, aim to ensure that frontline non-MHPSS humanitarian workers and staff use human rights-based approaches that are holistic, dignified, and unbiased to engage with and address the diverse identities, needs, culture, and wishes of ABMY survivors. Those trained on the theoretical modules during the ToT will then train non-specialist peer support group leaders, and prepare them to deliver peer support groups and corresponding activities to ABMY survivors (peer support group training).

The intervention modules, led by an experienced non-MHPSS specialist, should be delivered directly to the non-specialist peer support group leaders. These modules should provide them with the information and guidance necessary to adapt, implement, monitor, and evaluate peer support groups and corresponding activities that are relevant to their particular context and needs.

PART I: Theoretical modules

- Module 1: Introduction and Welcome
- Module 2: Sexual and Gender Diversity Workshop
- Module 3: Introduction to Gender-Based Violence and Sexual Violence Against Men and Boys
- Module 4: Youth Emotional Development, and Focus on Adolescent Boy and Male Youth Survivors
- Module 5: Adolescent Boy and Male Youth Survivors of Conflict-Related Sexual Violence

PART II: Intervention modules

- Module 6: Peer Support Groups
- Module 7: Guidance for Urban Service Providers Working with Displaced LGBTQI+ Youth
- Module 8: Guidance for Developing and Implementing a Monitoring and Evaluation Framework for Your Peer Support Group

Although this training curriculum aims to address ABMY in all their diversity, Module 7 was developed to strengthen humanitarian practitioners' strategies and frameworks to meet the specific needs of crisis-affected lesbian, gay, bisexual, transgender, queer or questioning, intersex (LGBTQI+) survivors of sexual violence, with a focus on girls and female youth with diverse SOGIESC.

Why does this training curriculum use a feminist intersectional approach?

The term "intersectionality" refers to specific forms of interconnected oppressions (such as intersections of race and gender, or intersections of sexuality and nationality), and how those inequalities operate together and exacerbate each other to create compounding experiences of discrimination for a particular individual. By considering the intersecting identities of an individual, frontline workers can work across sectors to address the societal factors of the individual that they are working with.

An "intersectoral approach" refers to collaborative efforts that involve multiple entities, including government agencies, nongovernmental organizations, stakeholders, and other groups, working together toward a shared objective of addressing a specific issue.[2] This approach often involves forming relationships across various ministries and sectors to achieve a comprehensive and coordinated response. In the context of this curriculum and larger work, an intersectoral approach involves coordinating a response that promotes the mental health and psychosocial well-being of ABMY survivors in all their diversity, whereby frontline workers from different fields and sectors are pulled in to address their multifaceted needs. MHPSS requires a collaborative approach between different humanitarian services and disciplines, so that ABMY in all their diversity will be provided with adequate services and care.

A feminist approach entails recognizing the impact of gender inequality and power dynamics on mental health and well-being.[3] This approach also requires addressing the unique challenges faced by marginalized and underrepresented groups, including girls, women, and LGBTQI+ individuals, and prioritizing their voices and experiences so that they are integrated into all aspects of program design and implementation. It also involves creating safe and inclusive spaces, where individuals can share their experiences without fear of judgment or discrimination.

2 Michelle Amri, Ali Chatur, and Patricia O'Campo, "Intersectoral and multisectoral approaches to health policy: An umbrella review protocol," *Health Research Policy and Systems* 20, no. 1 (February 2022).

3 United States Agency for International Development, *How to Integrate Mental Health and Psychosocial Interventions in Gender-Based Violence Programs in Low-Resource Settings*, How-to Note Series #4 (April 2022).

Part I – Training of Trainers

Background

The Women's Refugee Commission's intersectional feminist approach

WRC's work with men and boys uses an intersectional feminist approach that acknowledges diversity and inclusion as essential to achieving gender equality. This approach values lived experiences by examining overlapping and interdependent dimensions of discrimination and inequality manifested by intersecting social categorizations such as race, class, sexual orientation, and gender as they apply to a given group or individual.

WRC's work with men and boys prioritizes accountability to women and girls. We do this by

- exploring the ways in which sexual violence against men and boys (SVAMB) impacts the lives of women and girls;
- exploring the ways in which SVAMB intersects with violence against women and girls;
- advocating for services for, and attention to, male and female survivors;
- working to dispel the myth that post-sexual-violence services are widely available for women and girls but not for men and boys—across humanitarian settings, they are frequently weak for all survivors; and
- including experts on violence against women, girls, and persons with diverse SOGIESC on our Global Advisory Committee.

While this tool kit focuses on ABMY, including those with diverse SOGIESC, WRC acknowledges that women and girls are subjected to widespread gender-based violence (GBV) around the world, and bear the brunt of sexual violence. Violence against women and girls is driven by systemic inequality between men and women. Men and boys might also experience violence related to their socially determined gender roles and norms, especially those with diverse SOGIESC.

The Sexual Violence Project

In 2018, WRC launched its Sexual Violence Project, a multiyear initiative to document the diverse characteristics, scope, and consequences of sexual violence against people in humanitarian crises who identified as male or were designated as male at birth, including persons with diverse SOGIESC, such as cisgender men and boys, gay and bisexual men, and transgender women and transgender men. WRC's work to better understand, prevent, and respond to sexual violence in humanitarian settings encompasses survivors of all gender identities.

In Phase 1 (2018–2021) of the project, WRC conducted research in three refugee settings: the Rohingya refugee community in Cox's Bazar, Bangladesh; among refugees and migrants traveling the Central Mediterranean route through Libya to Italy; and among refugees in Nairobi and Mombasa, Kenya.

Phase 2 (2021–2024) seeks to both leverage Phase 1 learnings, and focus further on the unique MHPSS risks of sexual violence that ABMY, including those with diverse SOGIESC, face as a result of conflict and displacement. Alongside project collaborators, WRC is working to build humanitarian practitioner capacity, catalyze tool uptake, raise awareness, and expand service provision to more appropriately meet the needs of displaced ABMY survivors of sexual violence and those at risk.

Evidence base for this training curriculum

The tool kit draws on a review of existing research, literature, and guidance materials on sexual violence against men and boys, sexual exploitation of children and youth, gender-based violence, and child protection. This literature review provided an overview of the existing knowledge base on effective MHPSS interventions and approaches to working with displaced ABMY, including those who identify as part of the LGBTQI+ community, survivors of sexual violence, or those at risk of sexual violence. Data were reviewed and synthesized from 41 documents from a wide variety of settings (humanitarian, non-humanitarian, low-, middle-, and high-income countries) to provide a comprehensive overview of effective and ineffective MHPSS interventions, good practice examples, implementation challenges, and gaps in MHPSS programming and evidence.

In addition, key informant interviews were conducted with seven global and regional experts and 36 staff from humanitarian and civil society organizations, United Nations agencies, and service providers in Bangladesh, Colombia, and Lebanon to further contextualize the literature review findings.

Together, findings from the literature review and key informant interviews have guided the development of this training curriculum. Key findings from both methods are available in the Annex.

Glossary of key concepts and terms

When working with ABMY survivors of sexual violence, we want to make sure that we are providing services that are respectful and empowering, and that do no harm. The following key concepts and terms, grouped by topical area, are critical to understanding the content presented in this curriculum. **This section should be referenced throughout the curriculum implementation to ensure that all participants are informed and knowledgeable about the needs and experiences of ABMY survivors of sexual violence in humanitarian settings.**

Concepts and terms related to the humanitarian system

Child sexual abuse material (CSAM)

CSAM, also known as child pornography, is any representation of a child engaged in real or simulated explicit sexual activities, or any representation of the sexual parts of a child's body for primarily sexual purposes.[4]

Conflict-related sexual violence (CRSV)

CRSV is the incidents or patterns of sexual violence that occur in conflict or post-conflict settings or other situations of concern (e.g., political strife). CRSV includes rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, forced witnessing of sexual acts, forced stripping, or any other form of sexual violence of comparable gravity, against women, men, girls, or boys. CRSV has a direct or indirect nexus with the conflict or political strife itself, through a temporal, geographical, and/or causal link.[5]

Gender-based violence (GBV)

GBV refers to "any harmful act directed against individuals or groups of individuals on the basis of their gender."[6] It is deeply rooted in gender inequality, the abuse of power, and harmful cultural and societal norms. GBV takes various forms, including physical, sexual, psychological, and economic harm, inflicted in public or private spaces. It includes threats, manipulation, coercion, and other forms of abuse that can result in forced or early marriage, trafficking, sexual assault, intimate partner violence (IPV), domestic violence, child marriage, female genital mutilation, and "honor crimes".[7] The complexity and severity of GBV require an in-depth understanding of the issue, and it is essential to draw attention to its various forms and their underlying causes.

4 CRC Committee, *Guidelines Regarding the implementation of the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography*, September 2019, CRC/C/156.

5 United Nations Secretary General, *Conflict Related Sexual Violence* (2019). https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/04/report/s-2019-280/Annual- report-2018.pdf. See also https://www.womensrefugeecommission.org/wrc-news/a-theory-of-change-for-addressing-conflict-related-sexual-violence/.

6 Office of the United Nations High Commissioner for Human Rights, *Sexual and Gender-Based Violence in the Context of Transitional Justice* (2014).

7 Ibid.

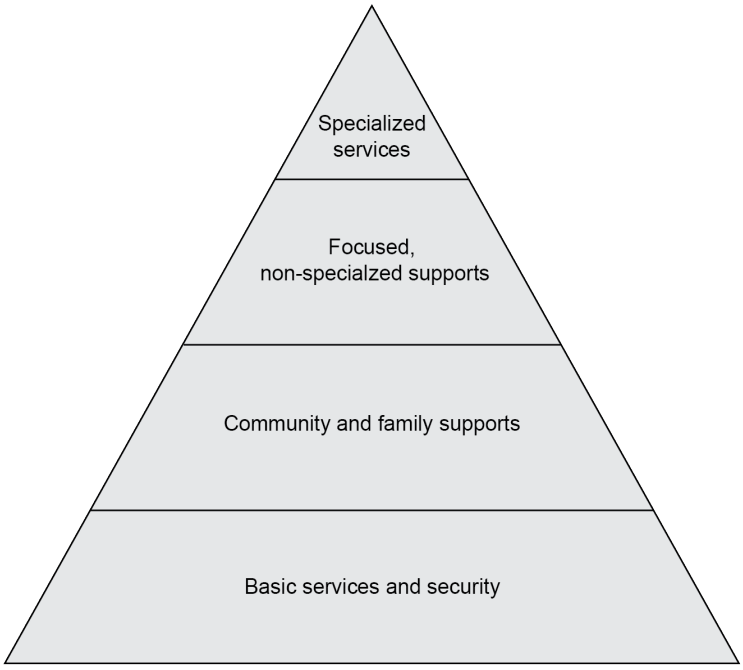
The IASC MHPSS Intervention Pyramid

Developed by the Inter-Agency Standing Committee (IASC), the longest-standing and highest-level humanitarian coordination forum of the United Nations system, the MHPSS Intervention Pyramid guides practitioners to implement interventions to address the MHPSS-related needs of individuals, families, and communities in all humanitarian contexts.[8]

The model forms a pyramid, which is divided into four separate levels:

1. Basic services and security: The well-being of all persons must be preserved through regaining security and services that serve their basic physical needs, including food, shelter, water, basic health care, and the control of communicable diseases.
2. Community and family supports: Facilitation of community mobilization, capacity strengthening, and development of ownership are required.
3. Focused, non-specialized support: Communities, and specifically children and youth, must be provided with activities to restore routine, social networks, and a sense of purpose. This layer includes, for example, psychological first aid (PFA) and basic mental health care by primary health care workers.
4. Specialized services: The top layer represents the additional support required for the small percentage of the population whose needs, despite the previous levels of support, may continue to face substantial difficulties. Specialized services include psychological or psychiatric supports for people with severe mental disorders.

Figure 1: Intervention pyramid for MHPSS in emergencies [9]



8 Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2006), https://hr.un.org/sites/hr.un.org/files/Guidelines%20IASC%20Mental%20Health%20Psychosocial_0.pdf.

9 Ibid.

Mental health and psychosocial support (MHPSS)

MHPSS includes any interventions that individuals, groups, and communities receive to care for or enhance their mental health and psychosocial well-being.[10] Approaches include the treatment and prevention of mental health disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD), as well as support for psychosocial well-being more generally.[11] In humanitarian settings, MHPSS actors often cooperate with local mental health agencies, promoting both short- and long-term interventions to alleviate emotional suffering in times of crisis.[12]

MHPSS is critical as war and conflict fragment societies and damage the capacity for recovery.[13] The negative impacts of war and conflict affect future generations, as the memory of trauma and violence is transmitted across generations. This intergenerational trauma erodes the cultural, physical, and socioemotional conditions of a society.[14] Research has shown that the effects of post-conflict trauma on communities include high levels of social fragmentation, broken families and warring communities, high levels of violence and aggression, high levels of GBV, negative economic productivity trends, alcohol and drug abuse, and high levels of depression and suicide.[15]

Sexual and gender-based violence (SGBV)[16]

Sexual violence "encompasses any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. Sexual violence takes multiple forms and includes rape, sexual abuse, forced pregnancy, forced sterilization, forced abortion, forced prostitution, trafficking, sexual enslavement, forced circumcision, castration and forced nudity."[17] SGBV usually refers to sexual violence that has its basis in gender norms and unequal power relationships between men and women. However, it is important to remember that SGBV is also used against people with diverse SOGIESC.[18]

Concepts and terms related to sexuality, gender, and identity

Empowerment

Empowerment is about women, men, girls, and boys—and all genders—taking control of their lives by setting their own agendas, developing skills (including life skills), building self-confidence, solving problems, and developing self-reliance. The empowerment process allows people to question existing inequalities and enact change.[19]

10 Wietse A. Tol et al., "Mental health and psychosocial support in humanitarian settings: a public mental health perspective," *Epidemiology and Psychiatric Sciences* 24, no. 6 (September 2015): pp. 484–494.

11 Katherine Rehberg, "Revisiting therapeutic governance: The politics of mental health and psychosocial programs in humanitarian settings," *American Journal of Medical Research* 2, no. 2 (2015): pp. 130–169.

12 Wietse A. Tol et al., "Mental health and psychosocial support in humanitarian settings: a public mental health perspective," *Epidemiology and Psychiatric Sciences* 24, no. 6 (September 2015): pp. 484–494.

13 Maryam Rokhideh, "Peacebuilding and psychosocial intervention: the critical need to address everyday post conflict experiences in northern Uganda," *Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas* 15, no. 3 (November 2017): pp. 215–229.

14 Amy Lehrner and Rachel Yehuda, "Trauma across generations and paths to adaptation and resilience," *Psychological Trauma: Theory, Research, Practice, and Policy* 10, no. 1 (January 2018): pp. 22–29.

15 Kristina Roepstorff, "A call for critical reflection on the localisation agenda in humanitarian action," *Third World Quarterly* 41, no. 2 (February 2020): pp. 284–301.

16 See https://www.womensrefugeecommission.org/focus-areas/sexual-gender-based-violence/.

17 Office of the United Nations High Commissioner for Human Rights, *Sexual and Gender-Based Violence in the Context of Transitional Justice* (2014).

18 Ligia Kiss et al., "Male and LGBT survivors of sexual violence in conflict situations: A realist review of health interventions in low-and middle-income countries," *Conflict and Health* 14, no. 11 (February 2020): pp. 1–26.

19 United Nations Children's Fund, *Gender Toolkit: Integrating Gender in Programming for Every Child in South Asia* (2018), https://www.unicef.org/eca/media/15101/file.

Gender

"The socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for individuals based on the sex they were assigned at birth."[20]

Gender equality

A goal that means that women (girls), men (boys), and other genders enjoy the same rights, opportunities, life chances, and status on political, social, economic, and cultural levels. It means that these factors are not limited by their gender or sex.[21]

Gender equity

Gender equity refers to the fair and just distribution of benefits and responsibilities of all genders based on their respective needs. It is regarded as an important step toward achieving gender equality in terms of rights, benefits, obligations, and opportunities. Gender equity may entail the use of temporary special measures to compensate for historical or systemic bias or discrimination in order to ensure equality of outcomes and results, rather than just equality of opportunities.[22]

Gender expression

The "external appearance of one's gender identity, usually expressed through behavior, clothing, body characteristics or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine."[23]

Gender mainstreaming

Gender mainstreaming is the process of assessing implications for women, men, girls, and boys of any planned action, including legislation, policies or programs at all levels. It refers to a strategy for taking into consideration the experiences, concerns, and needs of all genders into different stages of humanitarian programs: research, design, monitoring and evaluation, etc. The ultimate goal of gender mainstreaming is gender equity.[24]

Gender norms

The accepted characteristics of male and female gendered identity at a given time for a given society or community. Gender norms are the standards and expectations to which gender identity generally conforms, within the context of a specific society, culture, and community at the time. Gender norms are beliefs about how men, women, girls, and boys should behave. Gender norms that are learned early in life can create a life cycle of gender socialization and stereotyping.[25]

Gender parity

"Gender parity is a numerical concept. Gender parity concerns relative equality in terms of numbers and proportions of women and men, girls and boys. For example, the ratio of girls and boys enrolled in school."[26]

Gender roles

"Gender roles are learned from the time of birth and are reinforced by parents, teachers, peers, and society. These gender roles are based on the way a society is organized and vary by age, class, and ethnic group."[27]

20 International Organization for Migration, *SOGIESC: Full Glossary of Terms* (2020), https://www.iom.int/sites/g/files/tmzbdl486/files/documents/IOM-SOGIESC-Glossary-of-Terms.pdf.

21 Céline M. Goulart et al.,"Tools for measuring gender equality and women's empowerment (GEWE) indicators in humanitarian settings," *Conflict and Health* 15, no. 1 (May 2021): pp. 1–16.

22 Ibid.

23 Human Rights Campaign, *Sexual Orientation and Gender Identity Definitions*, https://www.hrc.org/resources/sexual-orientation-and-gender-identity-terminology-and-definitions.

24 United Nations Children's Fund, *Gender Toolkit: Integrating Gender in Programming for Every Child in South Asia* (2018), https://www.unicef.org/eca/media/15101/file.

25 Ibid.

26 Ibid.

27 Ibid.

Sex

The classification of a person as having male/female and/or intersex bodily characteristics. At birth, infants are typically assigned a sex based on the appearance of their external anatomy. A person's sex is combined of bodily characteristics such as chromosomes and reproductive organs, and secondary sex characteristics. It is a biological marker.[28]

Sex orientation

Sexual orientation refers to a person's pattern of sexual attraction or emotional and romantic attraction to others, which may include individuals of the same gender, a different gender, or multiple genders. Common sexual orientations include heterosexuality (attraction to the opposite gender), homosexuality (attraction to the same gender), and bisexuality (attraction to both the same and opposite gender). It is a fundamental aspect of a person's identity and is often seen as an innate characteristic that cannot be changed.[29]

SOGIESC or LGBTQI+?

- **LGBTQI+:** "An acronym for lesbian, gay, bisexual, transgender, intersex, and queer. The plus sign represents people with diverse SOGIESC who identify using other terms."[30]
- **SOGIESC:** "An acronym for sexual orientation, gender identity, gender expression, and sex characteristics. ['People with diverse SOGIESC' is often used as an] umbrella term for all people whose sexual orientations, gender identities, gender expressions, and/or sex characteristics place them outside culturally mainstream categories."[31]

The terminology used to describe SOGIESC differs greatly from place to place, and is influenced by factors such as geographical location, language and dialect, age, and cultural and religious/spiritual references. However, there are some terms that are commonly used in international contexts. It is important for us to respect each individual's definition and understand that these terminologies aim to assist people to feel more comfortable with themselves, rather than putting them into boxes. In addition, much of the terminology used as part of the acronym LGBTQI+ (lesbian, gay, bisexual, transgender, queer or questioning, intersex) is of Western origin and, particularly in humanitarian settings, might not provide individuals with enough flexibility to define themselves. Hence, this tool kit often uses the term "SOGIESC" rather than "LGBTQI+", however main terminologies will be explained. We encourage all individuals and service providers who work with ABMY with diverse SOGIESC to explore further the definitions and terminologies used in their own context.

Concepts and terms related to mental health and psychological well-being

Acute stress

Acute stress denotes a reaction that occurs no less than three days and no more than four weeks following a traumatic event.[32]

ADHD

ADHD, or attention-deficit/hyperactivity disorder, is a behavioral condition that makes it difficult to focus on daily requests and routines. People with ADHD frequently struggle with organization, staying focused, making realistic plans, and thinking before acting. They may be unsettled and noisy, and may struggle to adapt to changing situations.[33]

28 Office of the United Nations High Commissioner for Refugees, *Protecting Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) Persons*, https://emergency.unhcr.org/entry/221506/lesbian-gay-bisexual-transgender-and-intersex-lgbti-persons.

29 Anna C. Salomaa and Jes L. Matsick, "Carving sexuality at its joints: Defining sexual orientation in research and clinical practice," *Psychological Assessment* 31, no. 2 (February 2019): pp. 167–180.

30 International Organization for Migration, *SOGIESC: Full Glossary of Terms* (2020), https://www.iom.int/sites/g/files/tmzbdl486/files/documents/IOM-SOGIESC-Glossary-of-Terms.pdf.

31 Ibid.

32 Mehdi Fanai and Moien A.B. Khan, *Acute Stress Disorder*, July 2023, https://www.ncbi.nlm.nih.gov/books/NBK560815/.

33 American Psychological Association, ADHD, https://www.apa.org/topics/adhd.

Anxiety

An emotion characterized by feelings of tension, worried thoughts, and physical changes, including increased blood pressure. Individuals with anxiety disorders often have recurring intrusive thoughts or concerns, and may avoid certain situations out of worry.[34]

Complex post-traumatic stress disorder (complex PTSD)

"A disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse)." Its symptoms "cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning."[35]

Depression

Individuals with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, sleep disorders, lack of energy, inability to concentrate, feelings of worthlessness or extreme guilt, and thoughts of death or suicide. It is the most common mental health condition.[36]

Dissociation

Dissociation is "a defense mechanism in which conflicting impulses are kept apart or threatening ideas and feelings are separated from the rest of the psyche."[37]

Gaslighting

Gaslighting is an insidious form of manipulation and psychological control. Victims of gaslighting are deliberately and systematically fed false information that leads them to question what they know to be true, often about themselves. They may end up doubting their memory, their perception, and even their sanity. Over time, a gaslighter's manipulations can grow more complex and potent, making it increasingly difficult for the victim to see the truth.[38]

Mental health

According to the World Health Organization (WHO), mental health is a "state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships, and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community, and socioeconomic development. Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress, and potentially very different social and clinical outcomes. People with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always or necessarily the case."[39]

Minority stress

Minority stress is the additional stress that individuals in minority groups, including ABMY with diverse SOGIESC, experience as a result of their marginalized social status and the negative attitudes, behaviors, and policies of the dominant group. Minority stress can have negative impacts on the mental and physical health of minority individuals and can be caused by various factors, including discrimination, prejudice, and social exclusion.[40]

34 American Psychological Association, Anxiety, updated April 2018, https://dictionary.apa.org/anxiety.
35 World Health Organization, ICD-11: *International Classification of Diseases* (11th revision), 2019, https://icd.who.int/en.
36 American Psychological Association, Depression, updated April 2018, https://dictionary.apa.org/depression.
37 American Psychological Association, Dissociation, updated April 2018, https://dictionary.apa.org/dissociation.
38 American Psychological Association, Gaslight, updated November 2023, https://dictionary.apa.org/gaslight.
39 World Health Organization, Mental Health, June 2022, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
40 I. H. Meyer, "Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence," *Psychological Bulletin* 129, no. 5 (2003): pp. 674–697, https://doi.org/10.1037/0033-2909.129.5.674.

Post-traumatic stress disorder (PTSD)

A condition that develops in some people after experiencing extremely traumatic events. People with PTSD may relive the event through intrusive memories, flashbacks, and nightmares, or avoid anything that reminds them of the event.[41]

Resilience

Resilience is "the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility, and adjustment to external and internal demands. A number of factors contribute to how well people adapt to adversities, predominant among them (a) the ways in which individuals view and engage with the world, (b) the availability and quality of social resources, and (c) specific coping strategies."[42]

Re-traumatization

Re-traumatization is defined as an individual's reaction to a traumatic exposure that is colored, intensified, amplified, or shaped by their reactions and adaptational style to previous traumatic experiences. Re-traumatization typically refers to the reemergence of symptoms previously experienced as a result of the trauma.[43]

Concepts and terms related to community-based mental health care

Community-based mental health care[44]

Community-based mental health care refers to any type of care, supervision, or rehabilitation provided by community-based health workers, social workers, peers with lived experience, family members, or other non-specialist health or social workers outside of a hospital setting. It includes a range of services aimed at promoting recovery and improving mental health and well-being. This may include psychosocial support, counseling, medication management, and rehabilitation services provided within the community and that are accessible, affordable, and culturally appropriate for the population being served.[45]

Non-specialist MHPSS humanitarian practitioners

Non-specialist MHPSS humanitarian practitioners are personnel who are not certified in MHPSS-affiliated professions with an academic degree (i.e., they are not therapists, psychologists, psychiatrists, nurses, or clinical social workers). However, it should be noted that MHPSS practitioners can vary according to the culture and setting, and non-Western local healing practices may be considered as specialized services in some settings. Non-specialist MHPSS humanitarian practitioners often include community social workers, youth instructors, teachers, and group coordinators. These supervised care providers, who may not have MHPSS training, deliver interventions for specific populations and groups who require more focused care. Oftentimes, we will see them deliver activities at levels 1, 2 and 3 of the MHPSS pyramid, and facilitate case management and referrals between layers of the MHPSS pyramid.[46] This is an important distinction, as level 4 interventions are delivered by mental health clinicians and specialized service providers.[47]

Support groups

A group where members consult and provide each other with emotional support and relief through their shared experiences. Often, a professional or agency-based facilitator who does not share the problem of members leads

41 American Psychological Association, Posttraumatic Stress Disorder (PTSD), updated November 2023, https://dictionary.apa.org/posttraumatic-stress-disorder

42 American Psychological Association, Resilience, updated April 2018, https://dictionary.apa.org/resilience.

43 P.C. Alexander, "Retraumatization and revictimization: An attachment perspective," in M.P. Duckworth and V.M. Follette, eds., *Retraumatization: Assessment, Treatment, and Prevention* (New York: Routledge/Taylor & Francis Group, 2012), pp. 191–220).

44 See also https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-community-based-approaches-mhpss-programmes-guidance-note.

45 World Health Organization, *mhGAP Intervention Guide - Version 2.0* (2016), https://iris.who.int/bitstream/handle/10665/250239/9789241549790-eng.pdf?sequence=1.

46 Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2006), https://hr.un.org/sites/hr.un.org/files/Guidelines%20IASC%20Mental%20Health%20Psychosocial_0.pdf.

47 Ibid.

the group and facilitates their discussion. In addition, support groups often last for only a limited, predetermined number of sessions, which often include the following themes, either directly or indirectly: friendship, mutual support, experiential knowledge, individual and group identity, and a sense of belonging.[48]

Trauma-informed intervention

This centrally involves providing clients with evidence-based interventions that are proven to be effective in reducing the negative effects of exposure to trauma. There are trauma-informed interventions that also address training staff on how to provide more trauma-informed care.[49]

Other key concepts and terms

Therapeutic approaches to mental health care

The following concepts and terms cover some of the key therapeutic approaches that may be used to provide MHPSS to survivors of sexual abuse and violence. These approaches are delivered by specialized providers and practitioners who have undergone dedicated training and education. They are not to be delivered by non-specialized practitioners.

For the purpose of this training curriculum, non-specialized practitioners who aim to adapt and implement peer support groups should review and be aware of these key therapeutic approaches.

Therapeutic approaches

The philosophy that a therapist uses to shape their perspective on client issues and human connections is known as a therapeutic approach. A therapeutic approach can be thought of as the frame through which a therapist views and addresses the issues facing one of their clients. A broad spectrum of therapeutic approaches is available, such as psychoanalysis and psychodynamic therapies, behavioral therapy, cognitive therapy, and integrative or holistic therapies.[50]

Cognitive behavioral therapy (CBT)

A common form of psychological treatment that is often short-term and solution-based. CBT has been implemented to address a variety of issues, including depression, anxiety disorders, difficulties with alcohol and other drugs, marital issues, eating disorders, and serious mental disease. Numerous studies have found that CBT significantly enhances functioning and quality of life.[51]

Common elements treatment approach (CETA)

A scientifically proven solution to reducing mental health problems in low- and middle-income countries. CETA uses elements that are common to effective treatments for mental health problems, such as depression and trauma, and combines them into a single treatment model for all these problems.[52]

Cognitive processing therapy (CPT)

A type of CBT that has been shown to be effective in reducing PTSD symptoms caused by a variety of traumatic events such as child abuse, combat, rape, and natural disasters. CPT is typically delivered over 12 sessions, and teaches patients how to challenge and modify unhelpful trauma-related beliefs. In doing so, the patient develops a new understanding and conceptualization of the traumatic event, reducing its long-term negative effects on their current life.[53]

48 American Psychological Association, Support Group, updated April 2018, https://dictionary.apa.org/support-group.

49 Patricia K. Kerig, "Trauma-informed assessment and intervention," Los Angeles, CA: National Center for Child Traumatic Stress (2013).

50 American Psychological Association, Different Approaches to Psychotherapy, 2009, https://www.apa.org/topics/psychotherapy/approaches.

51 American Psychological Association, What is Cognitive Behavioral Therapy?, 2017, https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

52 Laura K. Murray et al., "A common elements treatment approach for adult mental health problems in low-and middle-income countries," *Cognitive and Behavioral Practice* 21, no. 2 (May 2014): pp. 111–123.

53 American Psychological Association, Cognitive Processing Therapy (CPT), updated July 2017, https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-therapy.

Eye movement sensitization and reprocessing (EMDR)

A type of psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences. During EMDR therapy, the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Be aware that the use of EMDR techniques is allowed only by EMDR practitioners who are certified by official EMDR institutions.[54]

Mindfulness

From a therapeutic point of view, mindfulness is a conscious awareness of our present moment. This includes being open to the experience, and not passing judgment on it. It is frequently used in conjunction with other types of therapy, such as CBT, dialectical behavior therapy (DBT), or acceptance and commitment therapy (ACT). Mindfulness therapy is not concerned with relaxation, though certain practices may result in it. The emphasis is on becoming more aware of the thoughts, feelings, and actions that impede our progress. We can engage with those aspects of ourselves, learn to tweak our language, and choose how to respond when we are more capable of doing so.[55]

Narrative exposure therapy (NET)

A treatment for trauma disorders, particularly in people who have experienced complex and multiple trauma. It has been most commonly used in community settings and with individuals who have experienced trauma as a result of political, cultural, or social forces (such as refugees). NET is typically delivered in small groups of four to ten people, but it can also be delivered individually. It is understood that the story a person tells himself or herself about their life influences how the person perceives their experiences and well-being. Framing one's life story solely around traumatic experiences leads to a sense of ongoing trauma and distress. This treatment is conditionally recommended for PTSD.[56]

54 Alişan Burak Yaşar and Emre Konuk, "EMDR therapy," *Bulletin of Clinical Psychopharmacology* 28, S1 (2018): pp. 368–369.

55 J. David Creswell, "Mindfulness interventions," *Annual Review of Psychology* 68, no. 1 (January 2017): pp. 491–516.

56 American Psychological Association, Narrative Exposure Therapy (NET), updated July 2017, https://www.apa.org/ptsd-guideline/treatments/narrative-exposure-therapy.

Implementing the training curriculum

This training curriculum aims to build the capacity of non-specialist MHPSS humanitarian practitioners to design, implement, monitor, and evaluate peer support group activities with and for crisis-affected ABMY who are survivors of sexual abuse and violence.

The training curriculum is composed of a set of modules. The theoretical modules (modules 1–5) are intended to be delivered during a training of trainers (ToT) for non-MHPSS specialists and program staff, who will then train non-specialist peer support group leaders on the content and help them prepare to adapt, implement, monitor, and evaluate peer support groups and corresponding activities. The intervention modules (modules 6–8) are aimed to be delivered directly to the peer support group leaders.

An overview of the training curriculum in full, including both the theoretical and intervention modules and their respective learning objectives, is outlined below. The training is expected to take place in-person over the course of three days. Table 1 (below) is designed for training facilitators. It breaks down each of the day's activities, their approximate timings, and the materials required.

Table 1. Overview of the training curriculum

Module	Learning Objective(s)	Approx duration (hours, minutes)
Modules 1–5: Training of trainers These modules are for MHPSS specialists and program staff, who will then train non-specialist peer support group leaders on the content and help prepare them to adapt, implement, monitor, and evaluate peer support groups and activities.		
1. Introduction and Welcome	• Create a safe space • Familiarize participants with the workshop agenda. • Establish ground rules for a safe and secure environment.	1 hr 15 min
2. Sexual and Gender Diversity Workshop	• Understand and describe sex, gender, and sexual orientation. • Understand some of the challenges that adolescents and youth with diverse SOGIESC face. • Explore the role of frontline workers in providing support to adolescents and youth with diverse SOGIESC.	2 hr 15 min
3. Introduction to Gender-based Violence and Sexual Violence Against Men and Boys	• Define GBV and explore the relationships between gender-based violence, power, sex, and gender. • Understand the vulnerabilities of men and boys in relation to sexual exploitation and sexual violence against men and boys	3 hr 25 min
4. Youth Emotional Development, and Focus on Adolescent Boy and Male Youth Survivors	• Understand opportunities and limitations for providing survivor-centered care to ABMY survivors in crisis contexts.	11 hr 5 min
5. Adolescent Boy and Male Youth Survivors of Conflict-Related Sexual Violence	• Define CRSV and learn about its gendered aspects, symptoms, and effects. • Differentiate CRSV from sexual abuse, including that by family/ community members. • Explore the unique needs of survivors of CRSV, including ABMY, and the elements necessary to address their needs through a survivor-centered approach.	3 hr 20 min

6. Peer Support Groups	• Acquire the knowledge and skills to train non-specialist group facilitators to establish and run peer support groups involving crisis-affected ABMY survivors of sexual abuse and conflict-related sexual violence. • Learn survivor-centered approaches that frontline humanitarian workers can use during peer group sessions to address symptoms of non-pathological distress	Approximately 15 hrs
7. Guidance for Urban Service Providers Working with Displaced LGBTQI+ Youth	• Understand unique risks and capacities for LGBTQI+ youth in urban contexts. • Understand key considerations and approaches for adapting the peer group model to LGBTQI+ youth in urban settings who are survivors of sexual violence. • Understand promising non-specialized activities that aim to improve the mental health and well-being of urban LGBTQI+ youth survivors of sexual abuse and conflict-related sexual violence. • Understand key considerations for working with crisis-affected girls and female LGBTQI+ youth in urban settings.	3 hr 45 min
8. Guidance for Developing and Implementing a Monitoring and Evaluation Framework for Your Peer Support Group	• Enhance knowledge on the utility of M&E, and the basic processes and principles that guide its development and implementation. • Learn the information and provide the guidance necessary for a non-specialist-led peer support group to tailor and implement a comprehensive M&E plan and corresponding activities for ABMY in all their diversity who are at risk, or survivors, of sexual violence in crisis settings.	2 hr 30 min
Closing and post-test	• Reflect on key learnings and provide feedback on the training. • Participate in post-test to evaluate changes in understanding on key topics during the course of the training	30 min

Table 2. Proposed agenda for facilitators implementing the training curriculum

Day 1 **Establishing ground rules and exploring key definitions and concepts**		
Time	**Module**	**Materials**
9:00-10:15	1: Introduction and Welcome	Name tags (1 per participant), paper (1 per participant), pens (1 per participant), flip chart, markers, training schedule overview (1 per participant
10:15-10:30	Break	
10:30-12:45	2: Sexual and Gender Diversity Workshop	Large flip chart/poster paper, markers, Handouts 2.2 and 2.5
12:45-13:45	Lunch break	
13:45-15:00	3: Introduction to Gender-based Violence and Sexual Violence Against Men and Boys	1 copy of Handouts 3.2, 3.3, and 3.4; pens (1 per participant); highlighters (1 per participant), 10 markers; 1 flip chart; 8 x 11 paper (2 sheets per participant, plus approximately 10 additional sheets of paper)
15:00-15:10	Break	
15:10-17:10	3: Introduction to Gender-based Violence and Sexual Violence Against Men and Boys (continued)	1 copy of Handouts 3.2, 3.3 and 3.4; pens (1 per participant); highlighters (1 per participant), 10 markers; 1 flip chart; 8 x 11 paper (2 sheets per participant, plus approximately 10 additional sheets of paper)
17:10-17:30	Close	Feedback form (1 per participant
Day 2 **Youth Emotional Development, and Focus on Adolescent Boy and Male Youth Survivors**		
9:00-10:35	1: Introduction	Flip chart paper and (printed) copies of Table 6. Overview of workshop on youth emotional development and focus on ABMY survivors (1 per participant), PowerPoint slide or flip chart to share information on the “do no harm” principle
10:35-10:50	Break	
10:50-13:30	4: Psychological and emotional reactions to sexual violence by survivors	1 large paper per group of 4–6 participants, markers for each participant, computer, projector, PowerPoint slides, 3 plastic cups, copies of Handout 4.B5 (1 per participant), tape (not clear)
13:30-14:30	Lunch break	

14:30-15:45	4: Sexual violence and its impact on the developing adolescent or youth	LCD projector, computer, PowerPoint slide, copies of the article "Suicide in the Context of Adolescent Development: What Humanitarian Actors Can Do" (1 per participant), paper, pens, flip chart paper, markers
15:45-15:55	Break	
15:55-16:40	4: Assisting ABMY survivors – How to assist ABMY survivors with acute stress	Computer with internet connection, LCD projector with audio output, SH+ Session 1 recording, printed copies of "Problem Management Plus (PM+)" (1 per participant), resources on longer-term emotional distress (1 per participant), PowerPoint slides, paper and pens, handout on resources (1 per participant)
16:40-17:00	Close	
Day 3 **Assisting Adolescent Boy and Male Youth Survivors including Survivors of Conflict-Related Sexual Violence**		
9:00-10:00	4: Assisting ABMY survivors – How to assist ABMY survivors with longer-term emotional distress and Ensuring quality in psychological support	2 or 4 large blank sheets of paper (depending on if you form 2 or 4 groups), pens and colored pencils, Handout 5.2, chosen article(s) printed, pens, PowerPoint slides, projector, flip chart
10:00-10:10	Break	
10:10-12:40	4: Assisting ABMY survivors – Guidelines for suicide prevention and Mapping existing services and referral protocols	Handout 5.3.1, Handout 5.3.2, pens, computer with internet and projector to show YouTube video and PowerPoint presentation
12:40-13:40	Lunch break	
13:40-14:40	5: Introduction and Diving Deeper	2 or 4 large blank sheets of paper (depending on if you form 2 or 4 groups), pens and colored pencils, Handout 5.2, chosen article(s) printed, pens, PowerPoint slides, projector, flip chart
14:40-15:40	5: Differentiating CRSV from sexual abuse, including that by family/ community members and Barriers and challenges for ABMY survivors of CRSV	Handout 5.3.1, Handout 5.3.2, Handout 5.4.1, pens, computer with internet and projector to show YouTube video and PowerPoint presentation
15:40-15:55	Break	
15:55-16:45	5: A survivor-centered approach to addressing CRSV and We are all in this together	Handout 5.5, pens, Handout 5.6

16:45-17:25	Closing and post-test	Training evaluation form, Handout 5.7 (1 per participant), training certificates (1 per participant)
Day 4 **"Let's get down to business": Improving our practice and support**		
9:00-9:30	Introduction, and re-cap of day 3	
9:30-10:15	6: Getting Started - Setting up a peer group meeting space	Handout 6.3, Flip chart and markers, PowerPoint slides, handouts (see Part II for Specifications)
10:15-10:30	Break	
10:30-12:00	6: Getting Started - Preliminary identification of prospective group participants and screening interview	Organization's child protection policy
12:00-13:00	Lunch break	
13:00-14:15	6: Getting Started - Preliminary identification of prospective group participants and screening interview (continued)	Organization's child protection policy
14:15-15:45	6: Getting Started - Guidance on identifying ABMY survivors and those at risk to join peer support groups	Flip chart and markers
15:45-16:00	Break	
16:00-17:40	6: Getting Started - Screening prospective ABMY peer support group members	Screening interview guide for prospective ABMY peer support group members handout (Handout 6.4); article excerpt (Handout 6.5); data recording form (Handout 6.7); list of identified organizations, centers, and associations that provide services/ programming/information to ABMY in the community
17:40-18:00	Close	
Day 5 **"Let's get down to business": Improving our practice and support (continued)**		
9:00–9:30	Introduction, and re-cap of day 4	
9:30-10:35	6: Getting Started - Screening prospective ABMY peer support group members (continued)	See above
10:35-10:45	Break	
10:45-13:00	6: Getting Started - Screening prospective ABMY peer support group members (continued)	See above

13:00-14:00	Lunch break	
14:00-15:00	6: Getting Started - Facilitating ABMY linkages with the peer support group	Data recording form (Handout 6.7); Promoting social engagement with reference to the socioecological model (Handout 6.9), PowerPoint slides or flip chart with the barriers to social participation that the interviewer pairs identified and recorded during their initial interviews with ABMY, flip chart, markers
15:00-15:10	Break	
15:10-16:10	6: Getting Started - Facilitating ABMY linkages with the peer support group (continued)	See above
16:10-16:30	Close	
Day 6 **Supervising, monitoring, and evaluating a peer support group**		
9:00–9:30	Introduction, and re-cap of day 5	
9:30-11:30	6: Peer support group activities – group grounding activities	Flip chart, Post-it notes, markers, Handout 6.10, Handout 6.11
11:30-11:45	Break	
11:45-12:45	6: Peer support group activities – group grounding activities (continued)	Flip chart, Post-it notes, markers, Handout 6.10, Handout 6.11
12:45-13:45	Lunch break	
13:45-15:15	6: Peer support group activities – group grounding activities (continued)	Flip chart, Post-it notes, markers, Handout 6.10, Handout 6.11
15:15-15:30	Break	
15:30-17:00	6: Peer support group activities - Building a cohesive peer group	Pre-prepared short life story of a young male that reflects similar struggles as those group members are going through, copies of Handout 6.12, flip chart, markers
17:00-17:20	Close	
Day 7 **Supervising, monitoring, and evaluating a peer support group (continued)**		
9:00-9:30	Introduction, and re-cap of day 6	
9:30-11:00	6: Peer support group activities – Recognizing each other as sources of meaningful support	Flip chart, markers
11:00-11:15	Break	

11:15-12:45	6: Peer support group activities – Recommended thematic sessions (continued)	A4 sheets of paper, flip chart, pens/colored markers, 10 physical objects, Handout 6.13
12:45-13:45	Lunch break	
13:45-15:15	6: Peer support group activities – Recommended thematic sessions (continued)	A4 sheets of paper, flip chart, pens/colored markers, 10 physical objects, Handout 6.13
15:15-15:30	Break	
15:30-17:00	6: Peer support group activities – Group Action Plan	Flip chart paper, markers, Handout 6.13, Handout 6.14, Handout 6.15, Handout 6.16, PowerPoint slides (see session for instructions)
17:00-17:20	Close	
Day 8 **Supervising, monitoring, and evaluating a peer support group (continued)**		
9:00-9:30	Introduction, and re-cap of day 7	
9:30-11:00	6: Peer support group activities – Implementing the collective action plan	Flip chart paper, markers, Handout 6.17
11:00-11:15	Break	
11:15-12:00	6: Peer support group activities – Group closing activities	Flip chart, Post-it notes, markers, Handout 6.10, Handout 6.11
12:00-13:00	6: Facilitating group supervision	Handout 6.19
13:00-14:00	Lunch break	
14:00-15:00	6: Facilitating group supervision (continued)	Handout 6.19
15:00-15:50	8: Overview of Monitoring and Evaluation	Projector, PowerPoint slides
15:50-16:05	Break	
16:05-17:30	8: Overview of Monitoring and Evaluation (continued)	Projector, PowerPoint slides
17:30-18:00	Conclusion, reflection, feedback & next steps	Projector, PowerPoint slides

Note: In this proposed agenda, Module 7 on Guidance for Urban Service Providers Working with Displaced LGBTQI+ Youth is optional to include in the training.

Facilitating the training curriculum

Facilitators are critical to the success of any training curriculum. They are in charge of leading discussions, guiding and supporting participants, and assisting in the creation of a safe and inclusive learning environment.

Identifying and selecting facilitators

Facilitator requirements differ by section of the training. An experienced MHPSS specialist is required to facilitate the **Workshop on Module 4: Youth Emotional Development, and Focus on Adolescent Boy and Male Youth Survivors.** Although it is preferable to have the same MHPSS specialist also facilitate theoretical modules 1–5 and implementation modules 6–8, it is possible to have an experienced non-MHPSS specialist facilitate. A non-specialist who has relevant experience working with ABMY survivors of sexual violence, including LGBTQI+ youth, in humanitarian contexts can also bring valuable skills and knowledge to the role. Therefore, it is important to prioritize selecting a facilitator who has the necessary competencies, such as experience working with youth who have gone through trauma; cultural sensitivity and competency; the ability to lead group discussions, facilitate interactive activities, and manage group dynamics, and an understanding of sexual violence—even if they are non-MHPSS specialists.

Who is considered an MHPSS specialist?

MHPSS specialists are individuals who specialize in MHPSS. They have already been trained or educated in the field of mental health, and they support individuals and communities affected by conflict, disaster, or other stressors. MHPSS specialists can come from a variety of professional backgrounds, and can include, but are not limited to the following:

- **Mental health professionals:** This can include psychologists, psychiatrists, social workers, and counseling professionals who have specialized training in MHPSS.
- **Health care professionals:** This can include physicians, nurses, and other health care professionals who have received training in MHPSS.
- **Humanitarian and development professionals:** This can include individuals working in organizations that provide relief and support to individuals and communities affected by conflict, disaster, or other stressors, and have received training in MHPSS.
- **Community-based workers:** This can include individuals who work directly with communities and have received training in MHPSS.

It is important to note that traditional healers or spiritual leaders may also play a role in providing MHPSS. These individuals may have different professional backgrounds, and may use different approaches to address mental health needs. It is crucial to be mindful of the cultural context and local resources available for MHPSS in order to provide contextualized support.

Additional criteria for facilitators

When selecting facilitators to implement this training curriculum, the following factors should be considered:

- **Subject matter expertise:** The facilitator should have a thorough understanding of the topic being covered in the training curriculum, including the specific challenges and needs of ABMY survivors of sexual violence, as well as LGBTQI+ youth in humanitarian settings. They must have relevant education, training, and professional experience in MHPSS.
- **Cultural sensitivity and competency:** The facilitator must be able to create a safe and inclusive learning environment for all participants, free from any prejudice. This includes being aware of, and respectful of, diversity and differences, as well as being able to communicate with and support people from various cultural

groups.

- **Ability to lead group discussions, facilitate interactive activities, and manage group dynamics:** The facilitator should have strong facilitation skills and experience leading trainings or workshops, as well as a deep understanding of the issues faced by ABMY survivors of sexual violence, including LGBTQI+ youth, in humanitarian contexts. Experience with adult learning principles, effective communication skills, and the ability to create a safe and inclusive learning environment are all examples of qualifications. They should also be able to adapt to the needs and learning styles of the group, and facilitate in an engaging and interactive manner.
- **Trauma-informed approach:** Because the training will focus on supporting ABMY survivors of sexual violence, the facilitator must take a trauma-informed approach. This means they are aware of the potential impact of trauma on an individual's mental health, and can create a safe and supportive learning environment that takes this into consideration.

After identifying potential facilitators, it is critical to evaluate and select the best candidates for the training curriculum. This can be done using a variety of techniques, including interviews, reference checks, and sample facilitation exercises. It is critical to consider potential facilitators' experience and skills in working with ABMY survivors of sexual violence, including LGBTQI+ youth, in humanitarian settings when evaluating them. Consider their facilitation skills and experience, as well as their ability to create a safe and inclusive learning environment.

Preparing facilitators for the training

Before facilitating the training, facilitators should:

- **Review the training curriculum:** Before implementing the training, it is important that facilitators review each of the training modules and workshops carefully to make sure they are based on evidence and meet the needs of frontline workers. This could include talking to experts in the field, looking at research and best practices, and asking potential participants for their thoughts, as well as preparing any recommended handouts, slides, or activities. These items should be easy to understand, clear, and to the point. It might help to test the materials with a small group of participants first to get feedback and make any necessary changes.
- **Set up the training processes:** Before the training starts, it is important to set up processes for daily sign-in, logistics (including food and space rental), and monitoring and evaluation. This could mean coordinating with venues and vendors, and adapting evaluation tools such as pre- and post-training tests.
- **Contextualize the training for specific settings:** It is important to tailor the training to the specific setting where it will be given. This could mean making changes to the training so that it respects the participants' cultures and meets their needs. It might also mean aligning the training with the type of work done by participants.

  For example:

  - The concept of a "safe space" may need to be introduced differently, as not all cultures have a direct equivalent term.
  - Ground rules may need to be adjusted based on cultural norms around communication and interaction. The terminology and concepts around SOGIESC may be different or nonexistent in some cultures, so additional explanation and sensitivity may be needed.
  - The challenges faced by adolescents and youth with diverse SOGIESC may differ based on cultural norms and laws around sexuality and gender. The vulnerabilities of men and boys may vary based on cultural norms around masculinity and male sexual behavior.
- **Set the date and time of the workshop:** The date and time of the workshop should be carefully thought out to make sure they suit the participants and give them enough time to learn. It might be helpful to ask the participants about their availability and what they would like to do.
- **Model MHPSS and LGBTQI+ friendly language use:** It is important to use language that is inclusive and respectful of diversity, including diversity of gender, sexual orientation, and identity. This could mean avoiding words that make people feel bad about themselves or are offensive, and instead using words that are inclusive and positive.

- **Prepare for potential triggers that may arise:** It is important to be ready to help people who talk about violence or abuse during the training. This could mean having a plan for how to handle disclosures, and giving participants who may need more help access to further resources. It might also be helpful to teach people how to spot the signs of trauma and how to offer care that takes trauma into account.
- **Reach out to the participants:** If possible, try to speak with the participants before the training. Try to get to know them and their expectations, and invite them to participate and be active during the training.

Theoretical Modules

MODULE 1

Introduction and Welcome

Module 1: Introduction and Welcome

Summary description

During this module, the facilitator allows the participants to introduce themselves and works with them to develop ground rules for group engagement. The facilitator should share the objectives of the group, and work to understand the participants' expectations. As sexual and gender-based violence (SGBV) is a delicate subject that may be challenging for some to openly discuss, it is critical that the facilitator work with the participants to establish and maintain a safe and inviting environment from the very beginning.

Overall time needed: 75 minutes

Overall objectives:

- Get to know the participants and familiarize them with the training objectives.
- Establish ground rules for a safe and secure environment.

Table 3. Overview of Introduction and Welcome

Step	Time estimated (minutes)	Materials
1: Introduction	10	None
2: Icebreaker – Getting to know each other	20	Name tags, paper, and pens (1 per participant)
3: Creating a safe space for our training	25	Flip chart, markers
4: Logistics and other needs	20	Training schedule overview (1 per participant)

Step 1: Introduction

Time: 10 minutes

Materials: None

Objective: Introduce yourself and provide participants with an overview of the training.

Instructions for the facilitator:

1. Welcome the group to the training by sharing information about yourself (name, pronouns, your professional background, and something interesting about yourself) (3 minutes).

2. Tell participants where they can get refreshments (if any), where the toilets are located, and any safeguarding issues (e.g., curfew, dress code) related to the venue (1 minute).

3. State the objectives of this training, and provide an overview of the training curriculum and upcoming activities (6 minutes). Please tell participants:

   "This training curriculum aims to build the capacity of humanitarian practitioners who are not specialized in the provision of mental health and psychosocial support (MHPSS) to design, implement, monitor, and evaluate peer support group activities with and for crisis-affected adolescent boys and male youth (ABMY) who are survivors of sexual and gender-based violence (SGBV). These activities should promote their mental health and psychosocial well-being.

   It is essential to acknowledge that participants come from diverse backgrounds and experiences. While some may have direct personal and/or professional experiences of SGBV and with survivors of SGBV, others may not. The topics that we discuss over the next three days will be interpreted through the lenses of these experiences, such as the perspective of a teacher, a community worker, or a policy maker. It is important that we respect the viewpoints and experiences of all participants and work together to increase our knowledge and skills so that we can better support crisis-affected ABMY in all their diversity.

   Over the course of the next three days, we will use eight modules to cover key theoretical concepts and intervention guidance for capacity building on mental health and psychosocial well-being and the delivery of peer support group models and corresponding activities.

   Our overall objectives are to

   - increase good-quality, appropriate mental health services for ABMY survivors in all of their diversity; and
   - ensure the inclusion of LGBTQI+ populations in sexual violence response measures that target mental health and psychosocial well-being."

4. Conclude the session by saying that today, we'll get to know one another and establish the ground rules for our engagement over the course of the training.

Step 2: Icebreaker – Getting to know each other

Time: 20 minutes

Materials: Name tags, paper and pens (1 per participant)

Objective: Allow the participants to introduce themselves to the group.

Instructions for the facilitator:

1. Tell the participants that we will now take a few minutes to get to know one another.
2. Share the name tags, paper, and pens (1 per participant) with the participants.
3. Ask the participants to fill out the name tags with their name and preferred pronouns. They can then wear the name tags (3 minutes).
4. Divide the participants into pairs.
5. Instruct the pairs to ask each other the following questions and write the responses on their papers. Tell them that they will use these responses to introduce their partner to the group (5 minutes).
6. Questions for paired introductions:
    - What is your name and your preferred pronouns?
    - What is your professional background?
    - Do you have any expertise in offering MHPSS to male survivors? If so, please describe briefly, without providing names or other identifiable information.
    - What brought you to this training?
    - What goals do you have for this training?
    - What questions would like to have answered through this training?
7. Reconvene the group, and ask each pair to introduce their partner using the responses to the questions above (12 minutes).

Step 3: Creating a safe space for our training

Time: 25 minutes

Materials: Flip chart, markers

Objective: Create “ground rules” for the training.

Notes for the facilitator: Training participants should establish “ground rules” for the training. Ground rules are essential agreements, agreed-upon behaviors, norms, and expectations that guide how participants interact with each other during training or group work to ensure a safe and respectful learning environment. This short activity proposes a way for groups to establish and agree on training ground rules.

Instructions for the facilitator:

1. Tell the group, “We will now work together to develop ground rules for the training. Ground rules are standards for group engagement that aim to help us respectfully learn from and engage with one another. Ground rules encourage a safe, inclusive, and interactive training and create a ‘contract’ among participants that may be referred to throughout the training session.”Share the name tags, paper, and pens (1 per participant) with the participants.
2. Ask participants to share ground rules for this training. Write their responses on the flip chart so that everyone can see. Alternatively, you can ask participants to write their responses on the flip chart. Use the following example ground rules to facilitate the brainstorming process (12 minutes).

Examples of ground rules include:

- Turn off your cell phone during the training.
- Be on time to the training.
- Give the person talking your full attention.
- Do not talk or interrupt when someone else is talking.
- Everyone is welcome to share their point of view during the training.
- What is discussed during the training will not be shared with those outside the training.
- If other people tell you about their experiences, don't judge them.
- Do not share names and other identifiable information when discussing the experiences of survivors of sexual violence.
- The workshop will cover difficult subjects, and personal experiences may be shared. If the presentations or activities are upsetting, you can take a break at any time.
- Questions are encouraged. They help clear up confusion and make things clearer.

3. Go over each of the proposed ground rules that have been noted on the flip chart with the group. For each proposed rule, ask the group if they approve of its inclusion in the ground rules or would like it revised or not included. Make changes accordingly (12 minutes).
4. After the session, pull all the ground rules into one or two flip chart sheets and/or PPT slides that you can reference throughout the training.

Step 4: Logistics and other needs

Time: 20 minutes

Materials: Training schedule overview (1 per participant)

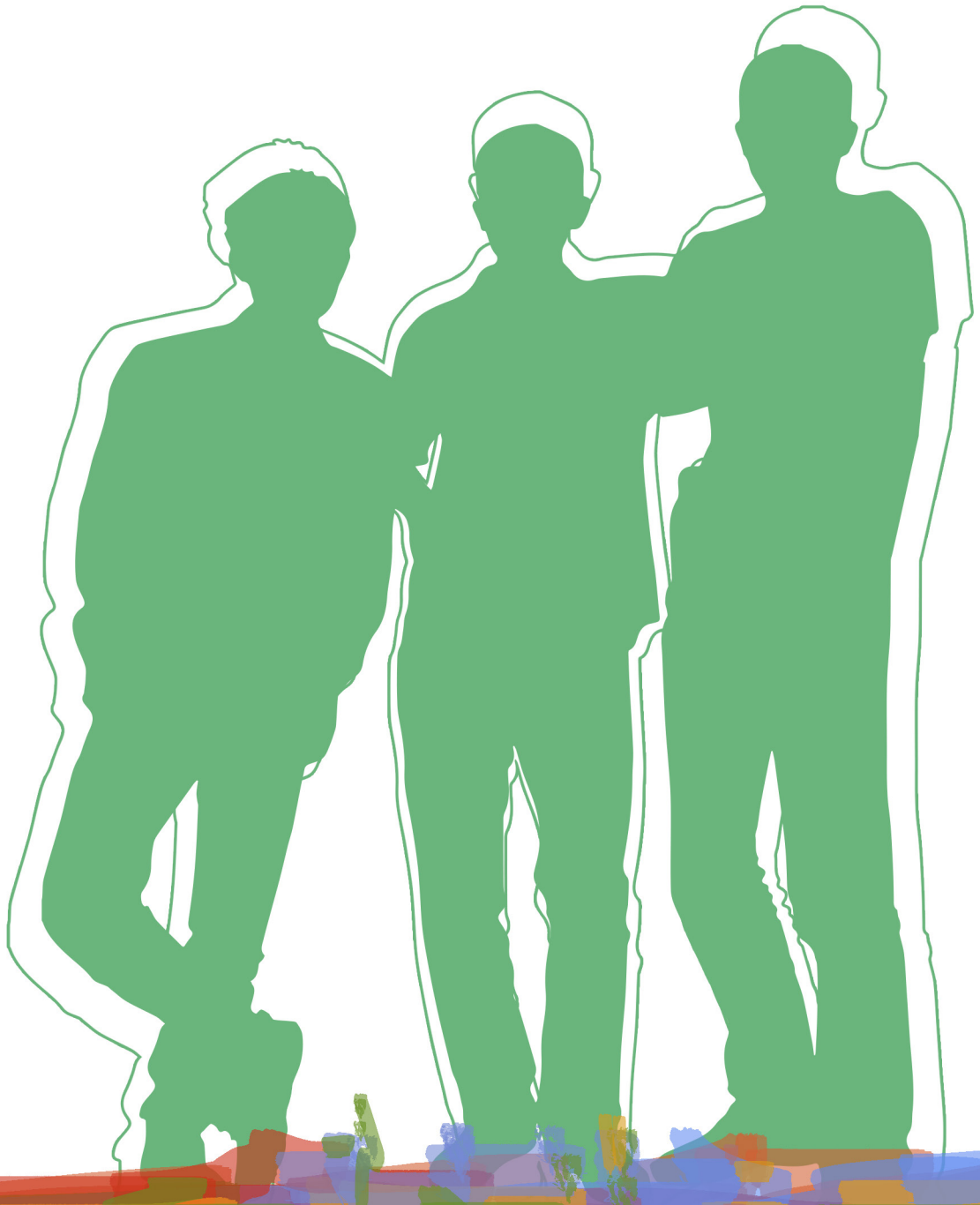
Objective: Provide participants with the information (including logistics) needed to actively participate in the training.

Instructions for the facilitator:

1. Tell the participants that we will now spend a few minutes discussing key information (including logistics) for the training.
2. Ask the participants if this is a convenient day and time to meet, and if not, establish a new day and time that works better for the group (3 minutes).
3. Ask the participants if this is a safe and secure space to meet. If not, determine whether a new space is needed or if changes can be made to the existing space to improve safety and security (3 minutes).
4. Share the training schedule and provide an overview of the different modules (See Tables 1 and 2). Make a note of start and end times, and breaks. If possible, print and distribute a copy of the schedule to each participant, so they can refer to it throughout the training. Alongside this schedule, note information that can be used to contact you if participants are running late or need to miss a session, as well as information on self-care and any resources (i.e., national hotline, the contact information for an available social worker) that participants can access as needed.

MODULE 2

Sexual and Gender Diversity Workshop



Module 2: Sexual and Gender Diversity Workshop

Summary description

This module aims to help participants better understand and differentiate between the key concepts and terms that are associated with sex, sexual orientation, and gender. “Sex” refers to the biological aspects of an individual, whereby they may be classified as male, female, or intersex based on their physical and physiological features, including chromosomes, gene expression, hormone levels and function, and reproductive/sexual anatomy. “Sexual orientation” refers to patterns of sexual, romantic, and emotional attraction, and an individual’s sense of identity based on those attractions. “Gender” refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for an individual based on the sex that they were assigned at birth.

Understanding the key concepts and terms that are presented in this module is critical, as they support the overall aim that humanitarian workers will support and empower all survivors of sexual violence, including those with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC). When exploring and trying to understand these concepts and terms, we should use a sociological–not a clinical–lens, as this will allow us to consider social and community norms and the ways in which sex, sexual orientation, and gender may interact with the lives, perceptions, and treatment of adolescent boys and male youth (ABMY), including survivors. Remember, this training is aimed at people not specialized in mental health and psychosocial support (non-MHPSS specialists); therefore, the conversation and activities should align with their experiences and expertise.

Overall time needed: 135 minutes

Overall objectives:

- Understand and describe sex, gender, and sexual orientation.
- Understand some of the challenges that ABMY with diverse SOGIESC face in their daily lives.
- Explore the role of frontline workers in providing support to adolescents and youth with diverse SOGIESC.
- Establish ground rules for a safe and secure environment.

Table 4. Overview of Sexual and Gender Diversity Workshop

Step	Time estimated (minutes)	Materials
1: Introduction to gender, sex, and sexual orientation	25	Flip chart, markers, pens (1 per participant) and paper (1 per pair)
2: Core concepts and terms related to gender, sex, and sexual orientation	25	Flip chart, markers, Handout 2.2 (1 copy on 8.5 x 11 paper per participant)
3: Society and gender	20	None
4: People with diverse sexual orientation, gender identity, gender expression and sex characteristics	30	Flip chart and markers or PPT presentation slides (your choice), paper and pens
5: Minority stress	35	Paper, pens, Handout 2.5 (1 copy, with each scenario contextualized as needed and cut out)

Step 1: Introduction to gender, sex, and sexual orientation

Time: 25 minutes

Materials: Flip chart, markers, pens (1 per participant) and paper (1 per pair)

Objective: Provide participants with an opportunity to start reflecting on gender, sex, and sexual orientation, and the ways in which they influence their daily lives..

Instructions for the facilitator:

1. Tell the participants that this module aims to explore sex, sexual orientation, and gender, as well as the various concepts and terms that relate to each of these topics. This is an opportunity to reflect, ask questions, and challenge ourselves to explore our own biases. Remind participants about the training's ground rules and how we will work together to maintain a safe learning environment for all participants (2 minutes).
2. Ask the participants to split into pairs. Give each participant a pen and each pair a sheet of paper (2 minutes).
3. Ask the pairs to work together to define gender on one side of the paper (4 minutes).
4. Ask a few pairs to share their definitions with the larger group. Write any keywords, phrases, and concepts that they share on a flip chart for everyone to see (5 minutes).
5. Ask the pairs to think of a moment when they felt that they were treated differently based on their gender. This can be a moment that they have both experienced (for example, being split into different groups in school) or a moment that only one of the members of the pair has experienced. They are welcome to write any key points from that moment and how they felt in it on the other side of the paper (4 minutes).
6. Ask a few pairs to share the moment and how they felt in it with the larger group. Write any keywords and phrases that they share on a flip chart sheet that is positioned next to the one on gender (5 minutes).
7. Conclude the activity by sharing with the participants that gender, together with sexual orientation, gender identity, age, and sex, can affect our lives in many different ways, including how people treat us and our access to resources. In this module, we aim to break down core concepts and terms related to gender; differentiate them from terms and concepts related to sex and sexual orientation; and better understand how sex, gender, and sexual orientation may affect the ABMY, including those with diverse SOGIESC, that that we work with (3 minutes).

Step 2: Core concepts and terms related to gender, sex, and sexual orientation

Time: 25 minutes

Materials: Flip chart, markers, Handout 2.2

Objective: Facilitate an understanding of the core concepts related to gender diversity, and build a knowledge base to discuss challenges faced by SOGIESC individuals.

Notes for the facilitator: It is important for the facilitator to be sensitive and understanding when participants share their views and experiences, and to approach any questions with patience and kindness. If a participant mixes up the concepts of sex and gender, for example, the facilitator should gently clarify the difference, without correcting or placing judgment on the participant. The facilitator can also provide the participant with information and resources that may clarify these concepts more fully.

It is also important to recognize that it is not the facilitator's role to dictate or judge how someone understands their own identity. A facilitator should instead create and maintain a safe and inclusive space for all participants to share their experiences and learn from one another.

Instructions for the facilitator:

1. Tell the participants that this activity will further explore gender and differentiate it from sex and sexual orientation..
2. Read the following definitions out loud to the group, and summarize them in your own words on the flip chart (5 minutes):

- **"Gender:** The socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for individuals based on the sex they were assigned at birth.[57]

- **Sex:** The classification of a person as having male/female and/or intersex bodily characteristics. At birth, infants are typically assigned a sex based on the appearance of their external anatomy. A person's sex is combined of bodily characteristics such as chromosomes and reproductive organs, and secondary sex characteristics. It is a biological marker.[58]

- **Sexual orientation**: Sexual orientation refers to a person's pattern of sexual attraction or emotional and romantic attraction to others, which may include individuals of the same gender, a different gender, or multiple genders. Common sexual orientations include heterosexuality (attraction to the opposite gender), homosexuality (attraction to the same gender), and bisexuality (attraction to both the same and opposite gender). It is a fundamental aspect of a person's identity and is often seen as an innate characteristic that cannot be changed."[59]

3. Ask the participants to describe any key differences between gender, sex, and sexual orientation based on these definitions. Note these differences by circling keywords and making notes on the flip chart. Facilitate the discussion by asking participants to consider the ways in which appearance, roles, responsibilities, and power feed into gender, sex, and sexual orientation. You can share with the participants the following simplified explanation of the key differences by saying: " 'Gender' refers to the expectations and behaviors that a particular society associates with being male or female, based on the sex assigned at birth. 'Sex' refers to the biological traits that we are born with, such as our reproductive organs and chromosomes. 'Sexual orientation' is about who we are attracted to romantically or sexually. It can be heterosexual (attracted to the opposite gender), homosexual (attracted to the same gender), or bisexual (attracted to two genders). So, while gender is about societal expectations, sex is about biology, and sexual orientation is about who we are attracted to. Traditionally, society has thought of gender and sexual orientation in terms of only two categories: male or female, and heterosexual or homosexual. But in reality, people's identities can be more complex and varied than just fitting into one of these categories. For example, some people don't feel that they fit neatly into the categories of 'male' or 'female.' They might identify as non-binary, which means that they don't feel they are strictly male or female, but somewhere in between or outside of those categories. Additionally, people's sexual orientation can also be more complex than just being attracted to one gender or another. For example, someone might be attracted to people of multiple genders, or they might not feel that their attraction to others is limited by gender at all. Acknowledging the existence of this spectrum allows us to better understand and accept the diversity of human experience. It also allows individuals to explore and express their identities in a way that feels authentic to them, rather than feeling limited by strict societal categories." After concluding this portion, share Handout 2.2, and instruct the group to use this as a reference throughout the training on the differences between gender (including gender identities and expression), sex, and sexual orientation (10 minutes).

4. Ask the participants, "How is each concept understood by the communities you work with?" (5 minutes). As you facilitate the discussion, you can use the definitions of gender, sex, and sexual orientation above to make clarifications.

    a. **Gender:** In some cultures, there are specific roles and expectations for people based on their gender. For example, in some societies, men are expected to be the breadwinners and women are expected to take care of the home and children. In other cultures, there may be more fluid gender roles or a recognition of more than two genders.[60]

57 International Organization for Migration, *SOGIESC: Full Glossary of Terms* (2020), https://www.iom.int/sites/g/files/tmzbdl486/files/documents/IOM-SOGIESC-Glossary-of-Terms.pdf.

58 Office of the United Nations High Commissioner for Refugees, *Protecting Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) Persons*, https://emergency.unhcr.org/entry/221506/lesbian-gay-bisexual-transgender-and-intersex-lgbti-persons.

59 Anna C. Salomaa and Jes L. Matsick, "Carving sexuality at its joints: Defining sexual orientation in research and clinical practice," *Psychological Assessment* 31, no. 2 (February 2019): pp. 167–180.

60 Janet Shibley Hyde et al., "The future of sex and gender in psychology: Five challenges to the gender binary," *American Psychologist* 74, no. 2 (February–March 2019): pp. 171–193.

b. **Sex:** In some cultures, the concept of sex is binary, with people being classified as male or female based on their genitalia at birth. In other cultures, there may be a recognition of intersex people who have genitalia that do not fit neatly into male or female categories.[61]

c. **Sexual orientation**: Different cultures have different attitudes toward sexual orientation. For example, in some cultures, homosexuality is accepted and even celebrated, while in others it is stigmatized and even criminalized. In some cultures, there may not be specific terms or labels for different sexual orientations, or terms and labels may differ from those commonly used in Western cultures.[62]

5. Conclude the activity by telling participants, "In subsequent activities, we will further explore gender, sex, and sexual orientation, and the ways in which they fit within the daily lives of ABMY, particularly those with diverse SOGIESC. In order to facilitate that reflection and discussion, we should aim to use the definitions that were presented in this activity in an appropriate and informed manner, while also continuing to maintain a safe space where all participants feel comfortable to ask questions and to challenge any biases that they may have" (2 minutes).

Step 3: Society and gender

Time: 20 minutes

Materials: None

Objective: Explore the concept of gender and how it is shaped by norms and expectations in the community.

Instructions for the facilitator:

1. Start the activity by stating, "As we discussed in the previous activity, society often constructs and assigns roles, behaviors, activities, and attributes to individuals based on the sex that they were assigned at birth. Gender norms and roles, which are taught from birth and are reinforced by parents, teachers, peers, and society at large, can impact the ways that individuals,

   It is critical to consider, however, that gender and its norms and roles are not static. For example:

   - In the past, there were strict gender roles and expectations around how individuals who identify as male and individuals who identify as female should dress and groom themselves. These expectations have become more relaxed in many countries, with people being able to express their gender in a wider range of ways.
   - Historically, there were expectations that individuals who identify as male should be tough and emotionless, while individuals who identify as female should be more emotional and nurturing. Today, there is a greater recognition that individuals who identify as male and individuals who identify as female can express a range of emotions, and that it is healthy for people of all genders to do so.

   Can you think of some ways in which gender norms and roles effect the ways in which ABMY are seen and treated in your community?" (3 minutes)

2. Facilitate a group discussion based on the question above using the following prompts (13 minutes):

   - "In your community, how should ABMY behave? What are some characteristics to describe them? How do those behaviors and characteristics differ from those of adolescent girls and female youth?
   - In your community, are there certain roles and responsibilities that ABMY have that adolescent girls and female youth do not? Provide some examples.

61 Reubs Walsh and Gillian Einstein, "Transgender embodiment: a feminist, situated neuroscience perspective," *INSEP–Journal of the International Network for Sexual Ethics and Politics* 8, Special Issue 2020: pp. 9–10.

62 Evelyn Blackwood, *The Many Faces of Homosexuality: Anthropological Approaches to Homosexual Behavior* (Routledge, 2019).

- How are ABMY with diverse SOGIESC viewed in your community? What roles, behaviors, activities, and attributes does your community construct and assign to them? How do these compare and differ from ABMY more generally? Provide some examples."

3. Share with participants:

   "As we discussed in the previous activity, 'sexual orientation' is about who we are attracted to romantically or sexually. 'Sexual attraction' is a feeling of desire or attraction towards someone, specifically in a sexual or romantic way. Sexual attraction is a natural and normal human experience. It is often based on a person's physical appearance, but it can also be influenced by their personality, interests, and values.

   It is important to remember that sexual attraction is not the same thing as consent. Just because someone feels sexually attracted to someone else does not mean that they have the right to pursue them or engage in any sexual activity without their explicit and enthusiastic consent.

   Some people may feel sexually attracted to a wide range of people, while others may feel attracted to only a specific type of person. People who are heterosexual, for example, typically feel sexual and romantic attraction toward people who are of a gender different than their own. Men who identify as heterosexual, for example, typically feel sexual and romantic attraction toward people who identify as female. While some people are attracted to a gender different than their own, others may feel sexually attracted to people of the same gender or of more than one gender. There are a lot of sexual orientations, and people may find that who they are attracted to changes over time.

   Recognition and acceptance of people with diverse sexual orientations have changed over time in different parts of the world and in different cultures. Similarly, recognition and acceptance of people with diverse ways of viewing and expressing their own gender have changed over time and place. Our next activity will explore the unique needs and issues faced by people with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC), including ABMY."

Step 4: People with diverse sexual orientation, gender identity, gender expression and sex characteristics

Time: 30 minutes

Materials: Flip chart and markers or PPT presentation slides (your choice), papers and pens

Objective: Explore the unique needs and issues faced by people with diverse SOGIESC.

Notes for the facilitator: Terms and concepts for this activity should be chosen based on the culture and setting where the training is taking place. If, for example, the acronym "SOGIESC" is not generally used or recognized in the setting to describe people with diverse sexual orientation, gender identity, gender expression and sex characteristics, it may be preferable to focus the discussion on breaking down the acronym "LGBTQI+".

Instructions for the facilitator:

1. Review the activity below, making changes as necessary to the terms and concepts included (see note above for more information).

2. Prepare trivia questions and answers using either a PowerPoint presentation or flip chart papers. Specific terms to ask about in this activity include gender, gender equity, gender norms, gender roles, sex, sexual orientation, and individuals with diverse SOGIESC. See here for the definitions of these terms. Prepare a flip chart to use as the scoreboard.

3. Tell the teams that we will be playing a trivia game on the key concepts and terms that we have discussed so far in this training.

4. Divide the participants into two teams. Each team should have an equal number of players. Give each team paper and pens.

5. Read a question to the teams. Give the teams 30 seconds to discuss and write their answer on a piece of paper.

6. After 30 seconds, ask the teams to reveal their answers. Award points to the team(s) with the correct answer. As needed, facilitate discussion on the questions and answers to ensure that the concepts and terms are well understood. Keep track of the scores on the scoreboard.

7. For the following 25 minutes, continue to read the questions, review responses, and award points until all of the questions have been asked.

8. At the end of the game, the team with the most points is declared the winner.

Note: Some variations of the game may have additional rules, such as allowing teams to pass on a question or awarding bonus points for particularly difficult questions. It is up to the facilitator and the participants to decide on any additional rules for the game.

Step 5: Minority stress

Time: 35 minutes

Materials: Paper, pens, Handout 2.5 Minority Stress: Case Studies (1 copy, with each scenario contextualized as needed and cut out)

Objective: Explore the concept of minority stress and how it should inform the delivery of services for ABMY survivors.

Notes for the facilitator:

- It is important for facilitators to create a safe and welcoming space for participants to share their experiences and reflections, and to encourage open and honest dialogue. Facilitators should also be prepared to provide additional resources or referrals as needed.
- The case studies presented below provide some examples of minority stress. Minority stress can affect individuals in a wide range of minority groups and can be caused by various factors. Facilitators are welcome to tailor the case studies to better fit the needs and experiences of those in their setting.

Instructions for the facilitator:

1. Begin the activity by telling the participants, "People with diverse SOGIESC, including ABMY, may face abuse, harassment, and discrimination at home and in their communities. Due to their gender identity and/or sexual orientation, they may, for example, face discrimination in getting hired for a job and/or face harassment when seeking health services or care. The high levels of stress, and the internalization of that stress, that members of stigmatized minority groups, such as people with diverse SOGIESC, experience in their daily lives as a result of the discrepancy and conflict that arise between the values of the minority group and the dominant culture or society is called 'minority stress'."[63](2 minutes).

2. Ask the participants the following questions (3 minutes):
    - *"Have you ever heard the term 'minority stress'?"*
    - *"What words come to mind when you hear this term?*"

3. After participants have replied, continue the discussion by saying (2 minutes): "Minority stress is the additional stress that individuals in minority groups, including ABMY with diverse SOGIESC, experience as a result of their marginalized social status and the negative attitudes, behaviors, and policies of the dominant group. Minority stress can have negative impacts on the mental and physical health of minority individuals and can be caused by various factors, including discrimination, prejudice, and social exclusion.[64]

    Some examples of minority stress are:

    - Refugee stress: Refugees are often a minority group in the countries in which they seek asylum, and may face discrimination, prejudice, and other forms of mistreatment. This can lead to minority stress among refugees, which can have negative impacts on their mental and physical health.
    - LGBTQI+ stress: LGBTQI+ individuals may experience minority stress due to the discrimination and

63 I. H. Meyer, "Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence," *Psychological Bulletin* 129, no. 5 (2003): pp. 674–697, https://doi.org/10.1037/0033-2909.129.5.674.

64 Ibid.

prejudice they face because of their sexual orientation or gender identity. This can be particularly pronounced in humanitarian settings, where there may be limited support or acceptance for LGBTQI+ individuals."

4. Ask the participants if they can think of other examples of minority stress. Then say that we're going to explore some other examples in the next few minutes (3 minutes).

5. Divide the participants into small groups of three or four participants (2 minutes).

6. Give each group a different scenario related to minority stress from the handout. Tell participants that each group should review their scenario and discuss the minority stress that the individual is experiencing and the ways in which they might cope with or mitigate that stress (5 minutes). **Note: PRIOR to implementing this activity, review the examples and adapt the descriptions to highlight minority groups in your context.** Here are some examples from the handout:

    - A Muslim woman experiences discrimination and prejudice because of her religion and culture, leading to increased stress and anxiety.
    - A transgender man faces challenges in accessing health care and employment due to discrimination, resulting in increased financial and emotional stress.
    - A person with a disability experiences social exclusion and limited access to public spaces, leading to feelings of isolation and loneliness.
    - A Black man experiences racial profiling and discrimination from law enforcement, causing increased fear and stress
    - A lesbian couple faces discrimination and prejudice when seeking to adopt a child, causing additional stress and emotional distress.

7. Once the groups have finished discussing the scenarios, bring everyone back together, and have each group present their scenario and ideas on coping (2 minutes per group).

8. Lead a debriefing discussion to review what participants have learned about minority stress and how it affects individuals in minority groups (10 minutes). Encourage participants to share their own experiences and insights, and provide additional resources or referrals as needed. Here are some probing and guiding questions that you could use to facilitate participatory reflection:

    - *"What have you learned about minority stress so far in this workshop?"*
    - *"Can you think of a time when you or someone you know experienced minority stress? What was the situation, and how did it affect you or them?"*
    - *"How might minority stress affect the health and well-being of ABMY with diverse SOGIESC?"*
    - *"What can individuals, including ABMY with diverse SOGIESC, do to cope with or mitigate minority stress?"*
    - *"What role do you think allies and advocates can play in supporting individuals, including ABMY with diverse SOGIESC, who may be experiencing minority stress?"*
    - *How can you apply what you have learned about minority stress to your own life and work?"*

9. Conclude the module by saying, "Understanding minority stress can be particularly important for humanitarian workers who support adolescent boys and male youth (ABMY) in all their diversity, including those who are survivors of sexual violence. ABMY survivors may experience minority stress due to the stigma and discrimination associated with being a survivor of sexual violence, as well as other factors related to their gender, sexual orientation, and identity.

By learning about minority stress and its root causes, humanitarian workers can better understand the challenges and vulnerabilities faced by ABMY survivors and provide more targeted and effective support to these individuals, and create more inclusive and supportive environments for them

The following modules will let us dive deeper into the challenges that ABMY survivors of sexual violence cope with on a daily basis, and help us understand how we can support them.” (2 minutes)

MODULE 3

Introduction to Gender-based Violence and Sexual Violence Against Men and Boys

Module 3: Introduction to Gender-based Violence and Sexual Violence Against Men and Boys

Summary description

This module will explore the core concepts related gender-based violence (GBV), such as abuse of power and violence. It will then explore the relationships between these concepts and sex and gender, define GBV, and define and discuss sexual exploitation and sexual violence against men and boys (SVAMB).

Overall time needed: 205 minutes

Overall objectives:

- Define GBV and explore the relationships between GBV, power, sex, and gender.
- Understand the vulnerabilities of men and boys in relation to SVAMB.

Table 5. Overview of Workshop on Introduction to Gender-based Violence and Sexual Violence Against Men and Boys

Step	Time estimated (minutes)	Materials
1: Defining GBV	30	Flip chart, markers, pens (1 per participant) and paper (1 per pair)
2: Analyzing power dynamics	30	Flip chart, markers, pens (1 per participant) and paper (1 per pair)
Break	15	
3: Understanding SVAMB	75	Flip chart, markers, pens (1 per participant) and paper (1 per pair)
Break	5	
4: Talking about "victims," "patients," and "survivors" of sexual violence	50	Flip chart, markers, pens (1 per participant) and paper (1 per pair)

Notes for the facilitator: The term "gender-based violence" (GBV) is frequently used to emphasize how systemic inequality between men and women, and between boys and girls, serves as a core aspect of violent offenses against women and girls. We define GBV as "any hurtful act committed against a person or a group of individuals on the basis of their gender." GBV can include forced, early, or child marriage, trafficking, sexual assault, and domestic violence.[65] Forced marriage is an act of GBV because it involves coercing or pressuring one person, disproportionately women and girls, to marry against their will. Domestic violence can also be an example of GBV as it is often perpetrated by men against women and is motivated by the desire to control and dominate the victim/survivor.

In this module, it is important to understand how the drivers of GBV—including patriarchy, misogyny, and queerphobia—also underpin sexual violence against men and boys, including adolescent boys and male youth (ABMY) and those with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC). "Patriarchy" is a cultural system that prioritizes masculinity and male power, leading to unequal distribution of power and resources and GBV, including sexual violence and domestic violence.[66] "Misogyny" refers to hatred or prejudice against women and reinforces patriarchal values, contributing to GBV.[67] "Queerphobia" refers to fear of, or hatred against, LGBTQI+ individuals and contributes to GBV, particularly against LGBTQI+ individuals.[68] Addressing GBV and SVAMB requires recognizing the interconnected nature of patriarchal, misogynistic, and queerphobic oppression and implementing a comprehensive and intersectional approach.

Finally, it is important to consider that participants in this module might feel shy or uncomfortable sharing their views and/or experiences related to GBV and SVAMB. Please continue to work to make this a welcoming and safe space, where all participants may feel comfortable sharing their opinions, attitudes, and experiences. Remember also to state that participants are encouraged to be kind to themselves and take a break at any time.

65 Office of the United Nations High Commissioner for Human Rights, *Sexual and Gender-Based Violence in the Context of Transitional Justice* (2014).

66 Denise Buiten, "A Framework for Gender-Based Violence," in *Familicide, Gender and the Media: Gendering Familicide, Interrogating News* (Singapore: Springer Nature Singapore, 2022), pp. 43–63

67 Selaelo Thias Kgatla, "Addicts of gender-based violence: Patriarchy as the seed-bed of gendered witchcraft accusations," *Studia Historiae Ecclesiasticae* 46, no. 3 (December 2020): pp. 1–18.

68 Rhys Allison, "Colonialism and queer migration humanitarianism," *The Macksey Journal* 2, no. 1 (2021).

Step 1: Defining GBV

Time: 30 minutes

Materials: sheets of 8 x 11 paper (1 per participant, plus an additional sheet of paper for each group of two participants); pens (1 per participant); highlighters (1 per participant), flip chart, 1 marker

Objective: Explore the concept of gender and how it is shaped by norms and expectations in the community.

Instructions for the facilitator:

1. Before Step 1 begins, write the definition of GBV on a flip chart sheet and then cover this sheet with another sheet. Note that you will reveal the definition later in the activity.

    - **GBV definition:** Any harmful act directed against individuals or groups of individuals on the basis of their gender.[69] It is deeply rooted in gender inequality, the abuse of power, and harmful cultural and societal norms. GBV takes various forms, including physical, sexual, psychological, and economic harm, inflicted in public or private spaces. It includes threats, manipulation, coercion, and other forms of abuse that can result in forced or early marriage, trafficking, sexual assault, intimate partner violence (IPV), domestic violence, child marriage, female genital mutilation, and "honor crimes".[70]

2. Welcome the participants and tell them that this module is going to focus on gender-based violence (GBV). State that this is a very sensitive topic and that they are encouraged to be kind to themselves and take a break at any time.

3. Give each participant a sheet of paper and a pen.

4. Ask the participants to define GBV in their own words on the paper (5 minutes). As they define GBV, ask them to reflect on who perpetrates this form of violence against whom, why they perpetrate this violence, and how this violence manifests. Ask them to include these considerations in their definition as appropriate. Give each participant a sheet of paper and a pen.

5. Once the participants have defined GBV on their own, divide them into pairs. Give each pair an additional sheet of paper and two highlighters.Give each participant a sheet of paper and a pen.

6. Ask the participants to share their definitions of GBV with their partners, and then work together to write a shared definition of GBV on the additional sheet of paper (10 minutes)

7. When the pairs have finished writing their shared definition of GBV, ask for a few pairs to present their shared definition and to explain how they came to this agreement (5 minutes). As pairs present, use the marker to make notes on the flip chart of any keywords and concepts that they shared that relate to power, gender, violence, and informed consent.

8. Facilitate a group discussion on any differences and similarities between the GBV definitions that are shared (5 minutes). Probe with the following questions:

    - *"How might definitions of GBV be affected by your/their own gender? By your/their background? By your/their work experience?"*

    - *"What other factors may have affected the definitions shared by the group today?"*

9. End the session by revealing the flip chart sheet that notes the definition of GBV (5 minutes). Define GBV for the group, and state that the following activities in this module will help us to explore the relationships between GBV, power, sex, and gender.

69 Office of the United Nations High Commissioner for Human Rights, *Sexual and Gender-Based Violence in the Context of Transitional Justice* (2014).

70 Ibid.

Step 2: Analyzing power dynamics

Time: 30 minutes

Materials: Handout 3.2 (1 copy)

Objective: Explore the relationship between choice and power, and how the degree of choice that an individual has in life correlates with their perceived level of power.

Notes for the facilitator: Choice, or the lack thereof, correlates with power. The more power we have, the more options we have in terms of deciding where and how we live and what we do in our daily lives. People belonging to underprivileged and marginalized groups often have fewer options and less decision-making power, making them more susceptible to exploitation and abuse. This activity will explore the relationship between choice and power, and how the degree of choice that an individual has in life is correlated with their perceived level of power.

Assure participants that they are under no obligation to share their experiences with the group unless they choose to do so. For those who would like to share their experiences with the group, work with them to reflect on what—status, money, responsibility, age, experience, gender—this power was based on.

Instructions for the facilitator:

1. Before starting the activity, it is recommended that the facilitator review each of the characters described in Handout 3.2 and revise and adapt the names and characters to suit their particular setting. The facilitator should then cut out each character strip. It is also recommended that the facilitator review each of the statements and make revisions and adaptations as needed to suit their particular setting.
2. Start the activity by saying, *"For the second activity, we will try to understand how the term 'power' is manifested in our own lives to better understand the implications of power on GBV."*
3. Ask the participants to spend a few minutes thinking about a situation in their own lives where they had power over someone else, as well as a situation where someone else had power over them. Have a few participants share their situations with the group (7 minutes).
4. Say, *"We will now discuss how gender is related to power and how it manifests in GBV."*
5. Give each participant a character strip and ask them to think about the power, or lack thereof, that this character may have in their everyday life
6. Tell the participants that you will read a series of statements to them. If they feel that the statement accurately describes their character and their power, tell them to move to a designated end of the activity space. If they feel that the statement DOES NOT accurately describe their character and their power, tell them to move to the opposite end of the activity space. They can also move anywhere between these two ends if they feel that the statement somewhat describes their character and their power or that it may do so under certain circumstances.
7. Read out loud each of the statements below to the participants, pausing between each statement to allow participants to move to their chosen area of the activity space. Ask one or two participants after each statement why they chose to stand where they are standing (18 minutes). This exercise can be especially powerful for male participants in understanding the challenges faced by women and people with diverse SOGIESC.

   Sample statements to read out loud:

   - *"I am the same gender as law enforcement, community leaders, and religious leaders."*
   - *"I usually do not encounter discrimination."*
   - *"I have had the opportunity to access education."* (Adapt this as appropriate to the local context; often boys and girls may have had an opportunity to go to school at early ages, but this may be different as they get older. Point this out if it's relevant.)
   - *"I choose when I want to engage in sexual relations."*
   - *"I am not afraid for my safety when I move around after dark."*
   - *"I am not afraid walking unaccompanied in the streets."*

- *"I might not have the right papers or documents for my chosen sex and/or gender, which makes it hard for me to get help or services."*
- *"I might be afraid of being punished or hurt because of who I am."*
- *"I don't have a safe place to live, which makes it harder to cope with what happened to me."*
- *"I may feel pressure to act a certain way because of my gender."*
- *"I may feel ashamed or embarrassed to talk about what happened to me."*
- *"I may feel alone because no one else seems to understand what I'm going through.*"

8. Gather the group back together and facilitate a discussion on the activity and lessons learned (5 minutes). Use the following prompts to facilitate the discussion: .
    - *"What differences did you notice in the power between people who identified as women and people who identified as men? What did you notice about those with diverse SOGIESC?"*
    - *"Were there any other factors that impacted your perceptions of their power? Did age, sexual orientation, race, nationality status, socioeconomic background, etc. have a role to play, and how did these factors affect their vulnerability and power?"*

Step 3: Understanding SVAMB

Time: 75 minutes

Materials: Handout 3.3; sheets of 8 x 11 paper (1 per participant); pens (1 per participant), 10 markers, 1 flip chart

Objective: Define sexual exploitation and sexual violence against men and boys (SVAMB), and explore key psychological, social, and physical effects.

Notes for the facilitator:[71] Key psychological, social, and physical effects of SVAMB include:

Psychological effects

- Feelings of fear, insecurity, shame, self-hate, blame, hopelessness
- Anxiety, depression, difficulty concentrating, being constantly alert, flashbacks, nightmares, withdrawal, changes in eating or sleeping habits, increased substance use

Social effects

Survivors are often blamed for what happened to them and may be stigmatized and isolated from their families and communities. This may lead to rejection and withdrawal from loved ones, family members, friends, and so on. It can also lead to loss of employment and income.

Physical effects

- Injury and pain
- Sexually transmitted infections
- Pregnancy (for women, girls, and transgender men)

There is also an increased risk of suicide and being exposed to further violence from the community.

Note that we will discuss the effects of SVAMB during this activity. Please do not share information on these effects until directed to do so.

71 Kelly A. McBride et al., "Building mental health and psychosocial support capacity during a pandemic: The process of adapting problem management plus for remote training and implementation during COVID-19 in New York City, Europe and East Africa, " Intervention 19, no. 1 (January–June 2021): pp. 37–47.

Instructions for the facilitator:

1. Before Step 3 begins, review each of the scenarios and characters described in the handout and revise and adapt them to suit the setting. Cut out each strip from the handout. Please also write the definition of SVAMB on a flip chart sheet and then cover this sheet with another sheet. Note that you will reveal the definition later in the activity.

   SVAMB definition: Sexual violence against men and boys (SVAMB) is a term used to describe any form of sexual abuse, assault, or exploitation that occurs to boys or men. This can include acts such as rape, sexual assault, sexual harassment, and child sexual abuse. SVAMB is often underreported and under-recognized due to sociocultural norms, stereotypes, and misconceptions about masculinity and male survivors of sexual violence.

2. Tell the participants that this activity is going to focus on sexual violence against men and boys (SVAMB). State that this is a very sensitive topic and that they are encouraged to be kind to themselves and take a break at any time.

3. Hand out one sheet of paper and one pen to each participant, and ask them to define SVAMB in their own words.

4. Give the participants 5 minutes to define SVAMB in their own words on the paper (5 minutes). As they define SVAMB, ask them to reflect on who perpetrates this form of violence and against whom, why they perpetrate this violence, and how this violence manifests. Ask them to include these considerations in their definition as appropriate.

5. Ask for a few volunteers to share their definition with the group (5 minutes). As they present, use the marker to make notes on the flip chart of any keywords and concepts that they share.

6. Reveal the flip chart sheet containing the definition of SVAMB (10 minutes). Define SVAMB for the group, and discuss the similarities and differences between their definitions and this definition.

7. Ask about the differences and similarities between GBV, SVAMB, and sexual exploitation (5 minutes). Get some responses from participants.

8. Say, *"Both GBV and SVAMB are caused by people abusing power and disregarding human rights. Since the root cause of GBV against women and girls is gender inequality between women and men, 'GBV' is not usually used to describe sexual violence that is perpetrated against men and boys. However, men and boy survivors may have many of the same feelings, symptoms, and reactions as other survivors of sexual assault, abuse, and violence. They may also, however, face some additional challenges because of social attitudes and stereotypes about men and masculinity. In addition, we consider SVAMB as linked to GBV, as gender can be perceived in many ways, and queerphobia is a part of GBV. Sexual exploitation also differs from GBV and SVAMB in that it involves a specific type of abuse of power for financial gain or other benefits. This can include trafficking, prostitution, and the production and distribution of sexually explicit materials. However, it is often connected to, and reinforces, patriarchal attitudes and gender-based power imbalances, making it similar to GBV and SVAMB in its root causes."*

9. Ask the participants to form groups of four.

10. Give each group a sheet of flip chart paper and markers, as well as a handout strip. Ask each group to write three headings at the top of the paper (psychological effects, social effects, and physical effects)

11. Tell the groups to read the scenario noted on the handout strip and work together to write down the psychological, social, and physical effects of the assigned case scenario on the flip chart sheet (10 minutes).

12. Ask each group to present their case study and effects (5 minutes per group). After each group has presented, facilitate a discussion on key recommendations for implementing survivor-centered approaches to address the effects identified, asking, "*How may you address these effects using survivor-centered approaches?"* (5 minutes per group). Refer to the answers provided with the handout, which give examples of the psychological, social, and physical effects of the assigned case scenarios, as well as recommendations.

13. End the activity by saying, *"The next activities will include more in-depth theoretical knowledge, as well as practical tools for working with ABMY survivors. Throughout the training, we will also explore how sexual violence against ABMY impacts women and girls, and the intersections of sexual violence against ABMY and GBV against women and girls. However, the focus of this training is to strengthen our capacity to understand*

and address the diverse needs of AMBY survivors and those who have experienced conflict-related sexual violence."

Step 4: Talking about "victims," "patients," and "survivors" of sexual violence

Time: 50 minutes

Materials: Handout 3.4, 4 sheets of 8 x 11 paper, 4 pens, 1 marker, 1 flip chart

Objectives:

- Gain insight into the experiences and needs of ABMY survivors and the impact of sexual violence on their mental health and well-being.
- Engage participants in a discussion on the importance of empowering survivors, including ABMY, and the role of language in providing psychosocial support during the rehabilitation process.

Notes for the facilitator: Those who have experienced sexual violence are never to blame. The decision to use violence is always made by the perpetrator. This is a fundamental tenet of SGBV case management practice, but it may take some time for participants who are new to SGBV work in general and case management in particular to fully understand and assimilate it. This is because many people will enter this work with preconceived notions about the blame that should be placed on survivors of violence. Continue to examine and push these views throughout the training if and when they are brought up, rather than ending the conversation and questions, by informing participants up front that survivors are not at fault.

Instructions for the facilitator:

1. Before Step 4 begins, review each of the scenarios and characters described in the handout, and revise and adapt them to suit your particular setting. Cut out each strip from the handout.
2. Tell participants that we're going to discuss how words convey meaning, and how our perceived notions about who is/can be a survivor of sexual and gender-based violence (SGBV) can affect how we deliver quality services to survivors.
3. Say, *"What kind of person do you envision when you hear the word 'victim'? What does a 'victim' look like?"* Facilitate a discussion based on these questions (3 minutes). Probes include: *"What kinds of attitudes and behaviors are associated with the word 'victim'? What types of body language do 'victims' possess?"*.
4. Then, switch the reference to "survivors." Say, "*What kind of person do you envision when you hear the word 'survivor'? What does a 'survivor' look like?"* Facilitate a discussion based on these questions (4 minutes). Probes include: *"What kinds of attitudes and behaviors are associated with the word 'survivor'? What types of body language do 'survivors' possess? Who delivers services to 'survivors' and what kind of services do 'survivors' receive?"*
5. Finally, switch the reference to "patients." Say, *"What kind of person do you envision when you hear the word 'patient'? What does a 'patient' look like?"* Facilitate a discussion based on these questions (4 minutes). *Probes include: "What kinds of attitudes and behaviors are associated with the word 'patient'? What types of body language do 'patients' possess? Who delivers services to 'patients' and what kind of services do 'patients' receive?"*
6. Say, *"How we talk about those who have experienced sexual violence may affect the ways that they see themselves and how others see them. In our work, we use the term 'survivor' to describe a person who has experienced sexual and gender-based violence (SGBV), because this term centers on the strengths of the individual, rather than how the experience (negatively) affected them."*
7. As a lead-in to the next part of the activity, say, *"Survivors of sexual and gender-based violence, including ABMY, need to feel in control of their life to recover. The term 'survivor' is used to emphasize the empowerment and control that survivors obtain during the rehabilitation process."*
8. Divide the participants into groups of four or five individuals.
9. Provide each group with one piece of paper, one pen, and a scenario in which an SGBV survivor is seeking support and is referred to using different terms such as "victim", "patient", and "survivor". Ask them to designate one group member as the notetaker.

10. Ask each group to review their scenario and discuss the implications of using the term provided (10 minutes). Have the notetaker write down any key notes on these implications and how the term might affect the survivor's sense of self, empowerment, and control.

11. Ask each group to present their scenario and implications (4 minutes per group). Write down any key points that they make on the flip chart using your marker.

    Here are some guiding points that you, as facilitator, can reference:

    - **Victim:** Calling a person a "victim" may make them feel powerless and ashamed. Those who use this term, including health care and other professionals, may unknowingly add to the person's sense of disempowerment, which can make it harder for them to ask for help and make their recovery more difficult.
    - **Patient:** Calling a person a "patient" might make them feel like they are being seen solely for a medical condition and not in consideration of any emotional and psychological trauma. This term may also make them feel distant from health care professionals.
    - **Survivor:** Calling a person a "survivor" acknowledges their strength and agency in overcoming what they have experienced. This term recognizes their resilience and may make him feel more empowered to seek the care and support they need.

12. After all the groups have presented, bring the groups back together, and facilitate a discussion by using the following guiding probes and guiding points (10 minutes):

    a. What are some of the key takeaways from this activity?

        i. Understanding the impact of language on survivors of SGBV.

        ii. Recognizing the importance of using empowering language to support survivors in their healing process.

        iii. Learning practical ways to incorporate empowering language when working with SGBV survivors.

    b. How can the way we refer to survivors impact their sense of empowerment and control?

        i. The language used to refer to survivors can either reinforce or challenge power dynamics and the perception of control.

        ii. Using labels that reduce survivors to their trauma or victimhood can be disempowering.

        iii. Referring to survivors as "survivors" instead of "victims" acknowledges their resilience and strength.

        iv. Allowing survivors to choose their own labels and language can increase their sense of control and agency.

    c. How can we use language to empower survivors during the rehabilitation process?

        i. Using language that reinforces survivors' agency and autonomy can help them feel empowered.

        ii. Encouraging survivors to identify their own strengths and resources can help them build confidence.

        iii. Validating survivors' experiences and emotions through empathetic language can help them feel heard and supported.

        iv. Reframing negative thoughts and beliefs into positive language can help survivors develop a more optimistic outlook

    d. What are some practical ways that we can incorporate empowering language when working with SGBV survivors?

        i. Use survivor-centered language that puts the survivor's needs and preferences first.

        ii. Avoid using language that blames or shames the survivor for the violence they experienced.

iii. Acknowledge the survivor's strength and resilience by using positive and affirming language.

iv. Allow the survivor to choose their own labels and language

v. Use language that reinforces the survivor's agency, autonomy, and control.

vi. Validate the survivor's emotions and experiences through empathetic language

vii. Use language that encourages the survivor to identify their own strengths and resources.

13. Conclude by saying, *"As we have seen from the scenarios we discussed, the language we use and the way we refer to survivors can have a significant impact on their sense of empowerment and control during the rehabilitation process. It is important to remember that survivors are not just passive recipients of support; they are active agents in their own healing process. As health care professionals, counselors, and aid workers, we have a responsibility to empower survivors by using language that respects their autonomy and agency. Let's commit to incorporating empowering language in our interactions with SGBV survivors and to involving them in the decision-making process for the support they receive."*

MODULE 4

Youth Emotional Development, and Focus on Adolescent Boy and Male Youth Survivors

Module 4: Youth Emotional Development, and Focus on Adolescent Boy and Male Youth Survivors

Summary description

This module, led by a qualified mental health specialist, will delve into the emotional development of adolescent boys and male youth (ABMY), with a focus on how sexual violence can impact their mental health and well-being. We will discuss the societal challenges that this population may face, and explore strategies for supporting them and fostering their recovery and resilience following sexual violence. By the end of this workshop, we hope that participants will have a deeper understanding of the socioemotional needs of ABMY survivors and feel more prepared to provide support and assistance in the face of these challenges.

Notes for the facilitator: This module must be facilitated by a qualified mental health specialist. A mental health specialist in this context refers to a mental health professional with a university-level education and experience in both clinical work and mental health and psychosocial support (MHPSS).

A mental health specialist is essential for facilitating this training because they bring clinical and psychosocial expertise that complements the manual's contents. Their role is to provide additional insights and examples, and answer questions from participants. Mental health issues are complex, and specialists are trained to approach them holistically. By having a mental health specialist, participants will receive accurate and up-to-date information, enabling them to develop skills to provide effective support to individuals and communities. It is also an opportunity for participants to receive support and guidance as they navigate the challenges and complexities of working to support ABMY survivors.

This module cannot be provided virtually and requires face-to-face contact with a qualified mental health specialist to better support participants in case they experience any emotional stress due to the content involved.

Overall time needed:11.5 hours, including breaks

Overall objective:

- Participants understand opportunities and limitations for providing survivor-centered care to ABMY survivors in crisis contexts

Table 6. Overview of Workshop on Introduction to Gender-based Violence and Sexual Violence Against Men and Boys

Session	Objectives	Time estimated (minutes)	Steps
A. Introduction and Welcome	• Introduce yourself to the participants (and vice versa) if you don't know each other already. • Develop ground rules for participation during this training. • Introduce the "do no harm" principle and discuss its relation to sexual violence response.	95	1. Icebreaker – Getting to know each other 2. Workshop agenda, ground rules, and practicalities 3. The "do no harm" principle
Break		15	

B. Psychological and emotional reactions to sexual violence by survivors	• Explore psychological and emotional reactions to sexual violence in the short-term and the longer-term. • Understand common pathways for healing for survivors of sexual violence.	160	1. Brainstorming reactions to sexual violence 2. Re-traumatization following sexual violence 3. Dissociation and derealization following sexual violence 4. Longer-term consequences of sexual violence 5. Possible phases in healing from sexual violence 6. Resiliency following sexual violence
Break		60	
C. Sexual violence and its impact on the developing adolescent or youth	• Explore the impact of sexual violence on the socioemotional development of adolescents.	75	1. Introduction to the developing adolescent and youth 2. Group work on sexual violence and its impact on the developing adolescent and youth
Break		10	
D. Assisting ABMY survivors	• Develop an understanding of different ways and strategies to help ABMY survivors of sexual violence. • Explore pertinent resources and protocols that can be used by non-MHPSS specialists.	215	1. How to assist ABMY survivors with acute stress 2. How to assist ABMY survivors with longer-term emotional distress 3. Ensuring quality in psychological support 4. Guidelines for suicide prevention 5. Mapping existing services and referral protocols
Break		15	
E. Closing	• Summarize the day's activities and learnings	20	

Background information for facilitators

Overview:

It is essential to understand the unique emotional challenges and needs of ABMY in order to support their recovery and well-being. ABMY who have experienced sexual violence may struggle with a range of psychological and emotional issues, such as depression, anxiety, and post-traumatic stress disorder (PTSD), as well as societal challenges that result from their experiences, including stigma, discrimination, and a lack of understanding or support. These challenges can intersect and combine to create a complex array of vulnerabilities and needs that can significantly impact ABMY's ability to function in their daily lives. For some, these challenges may require professional treatment.

Instructions for facilitators:

Prior to implementing this workshop, please read the following background information on the effects of sexual violence on ABMY survivors of sexual violence. For additional information, please reference the preceding chapters of this training curriculum and the literature cited throughout this section.Please note, if the facilitator delivered earlier modules in this training curriculum, Session A can be skipped. However, at this stage, the facilitator must remind the trainees of the "do no harm" principle.

Fears, concerns, worries, and subjective psychosocial issues raised by survivors of sexual violence

Common psychosocial effects of sexual violence among survivors, including ABMY, are deep shame and guilt. The main reasons include stigma and discrimination against males who experience sexual violence, directly related to discrimination against individuals with non-conforming gender identities and/or sexual orientation. In addition, issues related to the "honor" of the family being harmed have been raised, alongside questions regarding masculinity (specifically disturbances related to sexual arousal and to penetration),[72] including fear of social stigma, social sanctions by family/community members, and concern that others locally and in their country/region of origin would find out what happened to them.[73] Possible sanctions that survivors may experience include being shunned, humiliated, ostracized mutilated, alienated and rejected from their community, hunted, their family members being hurt, repetitive sexual violence by same perpetrators[74] and others, incarceration, and trafficking.[75]

Psychological distress, mental health, and serious and persistent mental illnesses

The main symptoms and behavioral responses associated with sexual violence that were represented in the research included substance use; impaired memory and concentration; low self-esteem; difficulty relating to others; dissociation; panic disorders; depression; suicidal ideation, gradually leading to the development of PTSD; difficulty engaging in intimate relationships; angry outbursts; explosive rage; struggling with emotional regulation; intense anger; emotional and social withdrawal; detachment; lack of adherence to family and community life; self-mutilation; sleep disturbances; nightmares; apathy; helplessness; and cognitive impairment.[76] Research shows that individuals who experience abuse during childhood are three to five times more likely to develop suicidality later in development.[77]

72 Ligia Kiss et al., "Male and LGBT survivors of sexual violence in conflict situations: A realist review of health interventions in low-and middle-income countries," *Conflict and Health* 14, no. 11 (February 2020): pp. 1–26.

73 Sarah K. Chynoweth, Julie Freccero, and Heleen Touquet, "Sexual violence against men and boys in conflict and forced displacement: implications for the health sector," *Reproductive Health Matters* 25, no. 51 (December 2017): pp. 90–94.

74 Jerker Edström et al. "Therapeutic activism: Men of Hope Refugee Association Uganda breaking the silence over male rape in conflict-related sexual violence," No. IDS Evidence Report (182) (Institute of Development Studies, 2016)

75 Lisa Aronson Fontes, "Sin vergüenza: Addressing shame with Latino victims of child sexual abuse and their families," *Journal of Child Sexual Abuse* 16, no. 1 (February 2007): pp. 61–83.

76 Ligia Kiss et al., "Male and LGBT survivors of sexual violence in conflict situations: A realist review of health interventions in low-and middle-income countries," *Conflict and Health* 14, no. 11 (February 2020): pp. 1–26.

77 Brian C. Thoma et al. "Disparities in childhood abuse between transgender and cisgender adolescents," *Pediatrics* 148, no. 2 (August 2021): pp.

The literature seems to differentiate between assigned-at-birth males and females when it comes to mental health issues. Anxiety and depression were noted to be more common among assigned-at-birth females, while assigned-at-birth males are commonly connected with externalizing behaviors such as antisocial behaviors and substance use. A feminist-queer approach is barely found; when it does exist, it is in professional guidelines and tool kits concerning the LGBTQI+ community.

Victimization and survival following sexual violence

This section talks about how men who have survived sexual violence may see themselves as victims or survivors. Some of them may feel that being called a "victim" makes them weak, while others see it as a way to express the harm that they experience or have experienced. They may also have different ideas about what it means to "survive" sexual violence. In some cases, it may mean simply staying alive, while in others, it may involve healing from emotional and spiritual hardships. Overall, this section discusses how male survivors of sexual violence have complex perceptions of their experiences, and how their identities are shaped by their experiences of victimization and survival.

The effects of victimization are central to the self-identification and development of males, including ABMY, following sexual violence. During a workshop conducted by the Refugee Law Project for 150 male survivors of sexual violence in Kampala, Uganda,[78] participants discussed issues related to sexual and gender-based violence (SGBV), including the effects that sexual violence has on them as survivors. In one of the workshop groups, five of the 13 men interviewed self-identified only or primarily as "victims of sexual violence" rather than "survivors" or any other title of identity, including gender, sexual orientation, ethnicity, or race.[79] This suggests that for some male survivors of sexual violence, victimization is a crucial part of their self-identification and that they may not feel empowered to claim other identities beyond being a victim.

Other literature supports these complex perceptions of victimization and survival by male survivors of sexual violence, including ABMY survivors. Survival was seen as either problematic or positive. Survival was perceived as problematic especially in more religious communities and internally displaced persons (IDP) communities, rather than refugee communities.[80] In some situations, cultural and societal norms about gender roles and masculinity may have played a part in this perception. Only focusing on surviving physically might not be enough to address the emotional and spiritual challenges that male survivors of sexual violence experience. Sometimes, the trauma is so severe that survival can feel like a heavy burden, leading to feelings of shame or guilt. However, in other contexts, survival was perceived as not only physically surviving death, but also either ambiguously "surviving" a spiritual/emotional hardship, or seen as a process to healing. However, victimization was seen only as negative and problematic, often connected to perceptions of femininity.[81]

78 Jerker Edström et al. "Therapeutic activism: Men of Hope Refugee Association Uganda breaking the silence over male rape in conflict-related sexual violence," No. IDS Evidence Report (182) (Institute of Development Studies, 2016).

79 Ibid.

80 Lisa Aronson Fontes, "Sin vergüenza: Addressing shame with Latino victims of child sexual abuse and their families," Journal of Child Sexual Abuse 16, no. 1 (February 2007): pp. 61–83.

81 Ligia Kiss et al., "Male and LGBT survivors of sexual violence in conflict situations: A realist review of health interventions in low-and middle-income countries," Conflict and Health 14, no. 11 (February 2020): pp. 1–26.

Session A: Introduction

Summary description

This introductory session sets the stage for engagement over the course of the workshop by facilitating introductions, establishing ground rules, and introducing the "do no harm" principle. **Please note, this session can be skipped if the facilitator and participants are familiar with one another. For example, if the facilitator has delivered earlier modules in this training curriculum.**

Overall time needed: 95 minutes

Overall objective:

- Introduce yourself to the participants (and vice versa) if you don't know each other already.
- Develop ground rules for participation during this training.
- Introduce the "do no harm" principle and discuss its relation to sexual violence response

Table 7. Overview of Session A

Step	Time estimated (minutes)	Materials
1: Getting to know each other	30	None
2: Workshop agenda, ground rules, and practicalities	30	Flip chart paper and 1 copy (printed) of Table 6. Overview of workshop on youth emotional development and focus on ABMY survivors for each participant
Break	10	
3: The "do no harm" principle	25	PowerPoint slide or flip chart to share information on the principle

Step 1: Getting to know each other

Time: 30 minutes

Materials: None

Objective: Facilitate icebreaker activities for participants to get to know each other, including their names, organizations, functions, and what motivates them in their jobs.

Instructions for the facilitator:

1. Introduce yourself to the participants, telling them your name, preferred pronouns, MHPSS specialization, and professional experience (3 minutes).
2. Describe the purpose of this workshop to the participants, noting that during today's sessions, we will explore the emotional development of adolescent boys and male youth (ABMY), with a focus on how sexual violence can impact their mental health and well-being. We will also discuss the societal challenges that this population may face, and explore strategies for supporting them and fostering their recovery and resilience following sexual violence (2 minutes).
3. Tell the participants that we are going to start with an interactive activity to get to know one another (or get to know one another better if they have taken part in the previous sessions together). Ask participants to walk around the space aimlessly until you clap your hands, at which point they will pair up and ask their partner:

    a. Their name, organization, function, and what gives them the passion to do their job *(If they have not yet met)*

    OR

    b. What gives them the passion to do their job and what they find to be most challenging thing about their job *(If they have met and taken part in the previous sessions together)*

    Tell them that they will then present their partner's answers to the group (2 minutes).
4. Ask participants to walk around the space aimlessly (1 minute).
5. Clap your hands after 2 minutes and remind participants to partner up and to ask each other the questions noted above (5 minutes).
6. Bring the participants back together and ask every participant to share the information that they learned about their partner to the group (17 minutes).

Step 2: Workshop agenda, ground rules, and practicalities

Time: 30 minutes

Materials: Flip chart paper and 1 copy (printed) of Table 6. Overview of workshop on youth emotional development and focus on ABMY survivors for each participant

Objective: Provide information on the workshop ground rules and practicalities in order to create a safe and supportive environment for participants.

Instructions for the facilitator:

1. Prior to the workshop start, print Table 6. Overview of workshop on youth emotional development and focus on ABMY survivors so that each participant can have a copy. In addition, write "Ground Rules" on a sheet of flip chart paper and fix this sheet to a place in the room where everyone can easily see it.
2. Hand out Table 6. Overview of workshop on youth emotional development and focus on ABMY survivors to each participant (1 minute).
3. Go over some key logistics and practicalities with the group (5 minutes), including:
    - the names and (general) purposes of each session
    - the times and durations of the breaks.

- the location of the restrooms
- the location of a safe room (if available) where people can take a few moments to relax at break times
- the location of any food and beverages
- the Wi-Fi information (as available)

4. Explain that in this workshop, we will talk about sensitive topics that might be painful, confusing, and overwhelming for some. Therefore, mention that you will be available after the training to chat further as needed. Also explain that participants can take a break at any time during the workshop if the content is causing stress and emotional pain (2 minutes).

5. At the start of the workshop, tell the group, *"Just like in the previous parts of this training, we will work together to develop ground rules for this workshop. Ground rules are standards for group engagement that aim to help us respectfully learn from and engage with one another. Ground rules encourage a safe, inclusive, and interactive training and create a 'contract' among participants that may be referred to throughout the training session."* (2 minutes)

6. Ask participants to reflect on the ground rules from the previous parts of this training and share which rules worked well, which rules may need to be improved, and which rules may need to be added. Write their responses on the flip chart sheet. Use the ground rules from the previous parts of this training to facilitate the brainstorming process (10 minutes).

7. Go over each of the proposed ground rules that have been noted on the flip chart with the group. At each proposed rule, ask the group if they approve of its inclusion in the ground rules or if they would like it to be revised or not included. Make changes accordingly (10 minutes).

8. After the session, pull all the ground rules into one or two flip chart sheets and/or PPT slides that you can reference throughout the training.

Step 3: The "do no harm" principle

Time: 25 minutes

Materials: PowerPoint slide or flip chart to share information on the principle

Objectives:

- Introduce the "do no harm" principle in humanitarian aid.
- Emphasize the importance of being aware of the potential for unintended harm and taking efforts to prevent and mitigate it.

Instructions for the facilitator:

1. Present the following as a PowerPoint slide, or write it on a flip chart sheet:
    - Humanitarian aid and development actors use the "do no harm" principle to monitor the intended and unintended impact of their activities.
    - The "do no harm" principle is used to avoid exposing people to additional risks through our actions. "Do no harm" means taking a step back from an intervention to look at the broader context and mitigate potential negative effects on the social fabric.
2. Explain to the participants that "do no harm" is one of the key principles in humanitarian aid. Refer to the *Sphere Handbook* (5 minutes).[82]

82 Available at https://spherestandards.org/wp-content/uploads/Sphere-Glossary-2018.pdf.

3. Ask participants if they can think of examples (imaginary or from their own experiences) of how sexual violence and work to prevent and respond to sexual violence can cause harm, even unintentionally, for the survivor, their family, and their community. Ensure that you have examples of each of the different levels, including the individual level of the survivor, the level of the family, and the level of the community. List these examples on a flip chart (10 minutes).

   Examples include:

   - re-traumatization or re-experiencing for the survivor
   - shame by the survivor and/or among the family; and
   - condemnation by the family and/or community.

4. For every example, ask how this consequence can be prevented or mitigated. Add a few words to describe these strategies alongside the examples on the flip chart (10 minutes).

For the facilitator: To prevent unintended harm caused by work to prevent and respond to sexual violence, it is important to take a survivor-centered and holistic approach. Strategies include providing trauma-informed care and counseling to survivors, promoting a culture of respect and non-judgment, engaging community leaders to challenge harmful social norms, and offering support to family and community members impacted by the survivor's disclosure. By considering the broader social context and potential consequences of our actions, we can ensure that our interventions are effective and do not cause further harm.

5. Conclude by stating, *"There are often harmful consequences to sexual violence, some of which are unintended. We need to make conscious efforts to be aware of these consequences and do all we can to prevent and mitigate them"* (1 minute).

Session B: Psychological and emotional reactions to sexual violence by survivors

Summary description

This workshop session will explore how survivors, including ABMY, may react psychologically and emotionally to experiences of sexual violence. It will explore reactions, including re-traumatization, short-term reactions such as dissociation and derealization, and long-term reactions, including altered normality, depression, and the risk of suicide. The session will also discuss pathways for healing and the potential role of resilience in the recovery process.

Overall time needed: 160 minutes

Overall objectives:

- Explore psychological and emotional reactions to sexual violence in the short-term and the longer-term.
- Understand common pathways for healing for survivors of sexual violence.

Table 8. Overview of Session B

Step	Time estimated (minutes)	Materials
1: Brainstorming reactions to sexual violence	55	1 large paper per group of 4–6 participants, markers for each participant
2: Re-traumatization following sexual violence	15	None
3: Dissociation and derealization following sexual violence	20	Computer, projector, PowerPoint slides
Break	10	
4: Longer-term consequences of sexual violence	30	Computer, projector, PowerPoint slides
5: Possible phases in healing from sexual violence	20	3 plastic cups, Handout 4.B5 (1 copy per participant), tape (not clear)
6: Resiliency following sexual violence	10	None

Step 1: Brainstorming reactions to sexual violence

Time: 55 minutes

Materials: 1 large paper per group of 4–6 participants, markers for each participant

Objective: Use the experiences of the trainees as a starting point to explore reactions after sexual violence.

Instructions for the facilitator:

1. Start the exercise by stating, *"If we want to provide psychosocial assistance to adolescent boys and male youth (ABMY) survivors in all their diversity, we need to understand their inner worlds, including their psychological and emotional reactions to sexual violence and the impact of sexual violence on their development. Once we better understand their inner worlds, we can start developing and implementing strategies to provide them with relevant, appropriate support"* (2 minutes).
2. Divide the trainees into groups of four to six participants (2 minutes).
3. Provide each group with a large piece of paper, and ask them to list any reactions they have seen or would expect among survivors of sexual violence (10 minutes).

   Examples include:

   - shame
   - difficulties in having physical contact with others
   - loneliness
   - fear
4. Ask each group to share a few of their key reactions with all participants (2 minutes per group). If any of the examples noted above have not been brought up, be sure to do so.
5. Ask the groups to write "ST" beside every short-term reaction to sexual violence or "LT" beside every longer-term reaction to sexual violence that is listed on their paper (10 minutes). Short-term is defined here as the reaction in the immediate aftermath of the sexual violence, i.e., within the first week after sexual violence, while longer-term is defined here as the reaction that may occur beyond the first week after sexual violence.
6. Ask each group to present their reactions and the timeline for those reactions in plenary (2 minutes per group). Request that groups only explain those reactions and timelines that have not been mentioned by a previous group. Allow trainees to request clarifications, give examples, or make comments on each presentation.
7. Facilitate a discussion in plenary (10 minutes) using the following questions:

   - *"Why do survivors have these reactions?"*
   - *"What are some common signs or symptoms of these reactions?"*
   - *"Have you seen these reactions among ABMY survivors? How might social and cultural norms in their communities affect their reactions?"*

Notes for the facilitator—discussion points:

- **Reasons behind common reactions:** Participants can discuss the reasons behind common reactions such as shame, difficulties with physical contact, loneliness, and fear. They can explore how these reactions are related to the trauma experienced by the survivors and how they may differ based on the survivor's age, gender, and cultural background.
- **Survivor presentation:** Participants can discuss how survivors might present and what kind of behaviors or emotions they may exhibit as a result of the trauma they have experienced. They can explore how survivors may exhibit symptoms such as anger, depression, anxiety, or PTSD, and how these symptoms may manifest differently in ABMY survivors.

- **Impact of social and cultural norms:** Participants can discuss the ways in which social and cultural norms in their communities might impact survivors' reactions and make it more difficult for them to seek help and support. They can explore how gender norms, stigma, and shame associated with sexual violence can affect survivors' willingness to disclose and seek help.differently in ABMY survivors.

Step 2: Re-traumatization following sexual violence

Time: 15 minutes

Materials: None

Objective: Understand the concept of re-traumatization, and discuss possible scenarios that may trigger it.

Instructions for the facilitator:

1. Tell the participants that during the next few activities, we will further explore some of the consequences of sexual violence on survivors. Say, *"Re-traumatization happens when people with traumatic experiences are exposed to people, places, events, situations, or environments that cause them to re-experience past trauma as if it were fresh or new.*[83] *These triggers act as reminders of these experiences as they present similar sounds, smells, sights, touch, times of day or year, certain phrases, etc. While triggers can bring back unpleasant memories, or even provoke disturbing flashbacks, re-traumatizing events are especially powerful triggers that recreate the intense dynamics associated with the original traumatic encounters or episodes."*

   "Re-traumatization is also sometimes referred to as 're-experiencing'. It can include:

   - unwanted or intrusive thoughts related to the sexual violence
   - flashbacks and vivid recollections (either visual, emotional, or physical) of the sexual violence and the feelings associated with it, which can make it seem as though the violence is happening again
   - nightmares of the actual sexual violence or similar content
   - feeling emotional or agitated when reminded of the issue of sexual violence
   - anxiety that is either specifically related to the sexual violence or generalized" (5 minutes).

2. Ask participants to share some examples of re-traumatization and discuss what can be done to mitigate and/or avoid it (10 minutes).

   Examples can include:

   - Survivors being asked to explain their experience of sexual violence to journalists. Recalling details of their experience can trigger re-traumatization. The survivor has a right to decide when, to whom, and how they share their story. As a practitioner, you must protect the survivor's confidentiality and should never share a survivor's story on their behalf without their informed consent. It is good practice to stay with the survivor if they decide to explain painful events to the media. You can both keep the journalist at arm's length and provide emotional comfort to the survivor.
   - Survivors being asked (or required) to explain their experience of sexual violence to law enforcement agents. Specific protocols exist to minimize re-traumatization. Ensure that the agents are trained in this. Good practice in forensic interviewing is designed to cause minimum emotional pain to people who are being interviewed. This includes trauma-sensitive interviewing and avoiding having to repeat the story multiple times.[84]

83 See also https://store.samhsa.gov/sites/default/files/d7/priv/sma17-5047.pdf.

84 For resources on good practice, see: https://www.cfjnetwork.eu/.

Step 3: Dissociation and derealization following sexual violence

Time: 20 minutes

Materials: Computer, projector, PowerPoint slides

Objective: Understand the concepts of dissociation and derealization.

Instructions for the facilitator:

1. Explain that we will now focus on two ways that survivors of sexual violence often use to cope with sexual violence: dissociation and derealization. Following a traumatic event such as sexual violence, the body and mind adopt these coping methods implicitly. They help survivors to "escape" the overwhelming feelings that they may be experiencing following sexual violence. While we are not MHPSS providers and it is not our task to diagnose disorders following sexual violence, we do need to recognize and understand some key coping mechanisms that are not disorders (2 minutes).

2. Project the PowerPoint slide on dissociation and reiterate its key points (3 minutes), including:

    - Dissociation is a disconnection between a person's thoughts, memories, feelings, actions, or sense of who he or she is.
    - Examples of mild, common dissociation include daydreaming, highway hypnosis or "getting lost" in a book or movie, all of which involve "losing touch" with awareness of one's immediate surroundings.
    - During a traumatic experience such as an accident, disaster, or crime victimization, dissociation can help a person tolerate what might otherwise be too difficult to bear. In situations like these, a person may dissociate the memory of the place, circumstances, or feelings about the overwhelming event, mentally escaping from the fear, pain, and horror

3. Ask participants if they have witnessed or experienced dissociation. If they are comfortable, ask them to talk about that person's behaviors, how dissociation may affect an individual's relationships and daily life, and how dissociation may have helped them to cope (5 minutes).

4. Project the next PowerPoint slide and reiterate its key points (3 minutes), including:

    - Dissociation is healthy and good, as long as an individual does not stay dissociated for too long.
    - Dissociation also explains why some survivors can talk about their experience without breaking down emotionally.
    - If one stays in a strongly dissociated state, there is a danger of developing dissociative disorders. This is characterized by the existence of two or more distinct identities in one person. In that case, we have to refer to specialized services (i.e., psychologists, psychiatrists).

5. Project the next PowerPoint slide on derealization/depersonalization and reiterate its key points (2 minutes), including:

    - Depersonalization/derealization involves an individual having a persistent or recurring feeling of being detached from their body or mental processes, like an outside observer of their life (depersonalization), and/or a feeling of being detached from their surroundings (derealization).
    - If a high degree of depersonalization/derealization lasts longer than a month, we need to refer the individual to specialized services (i.e., psychologists, psychiatrists).
    - If one stays in a strongly dissociated state, there is a danger of developing dissociative disorders. This is characterized by the existence of two or more distinct identities in one person. In that case, we have to refer to specialized services (i.e., psychologists, psychiatrists).

6. Ask participants if they have witnessed or experienced derealization/depersonalization. If they are comfortable, ask them to talk about that person's behaviors, how derealization/depersonalization may affect someone's relationships and daily life, and how derealization/depersonalization may have helped them to cope (5 minutes).

7. Clarify any last questions.

Step 4: Longer-term consequences of sexual violence

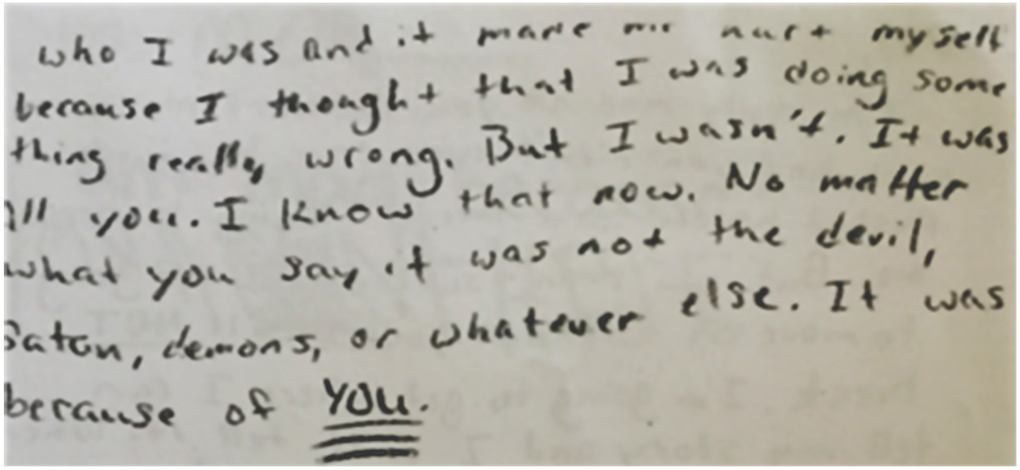
Time: 30 minutes

Materials: Computer, projector, PowerPoint slides

Objective: Understand the longer-term psychological consequences of sexual violencen.

Instructions for the facilitator:

1. Explain that we will now talk about frequently observed long-term consequences of sexual violence (1 minute). Show the slide of possible long-term consequences:
    - altered normality
    - depression
    - suicidal ideation and suicide
    - PTSD
2. Explain that some survivors, especially those who are or have been exploited and have survived more than one incident of sexual violence, may normalize sexual exploitation and violence. They may also have feelings of hopelessness and helplessness, all of which can be exacerbated through their interactions with those around them. Gaslighting is manipulating someone by psychological means into doubting their own sanity, e.g., people might try to convince the survivor that it was a normal sexual experience and no one was to blame (1 minute).
3. Show the slide with the fragment of a letter of an adolescent to an abusive father as an example (2 minutes).[85] Please feel free to make cultural adaptations as needed.



4. Ask the participants to think about and explain how gaslighting, possibly combined with feelings of hopelessness and helplessness, can alter reality for survivors of sexual violence (5 minutes).
5. Explain that another possible longer-term effect of sexual violence is depression. Show the slides on the signs of depression, making a note of the following key points (5 minutes):
    - To be diagnosed with clinical depression, you must present several of these symptoms for at least two weeks. The symptoms are serious enough to interfere with work, social life or family.
    - **Psychological symptoms** include continuous low mood or sadness/feeling hopeless and helpless/having low self-esteem/feeling tearful/feeling guilt-ridden/feeling irritable and intolerant of others/having no motivation or interest in things/finding it difficult to make decisions/not getting any enjoyment out of life/feeling anxious or worried/having suicidal thoughts or harming yourself.

85 There are many more harmful aspects of abuse. This letter illustrates just one of the possible psychological implications of abuse.

- **Physical symptoms** include moving or speaking more slowly than usual/changes in appetite or weight (usually decreased, but sometimes increased)/unexplained aches and pains/lack of energy/ disturbed sleep—for example, finding it difficult to fall asleep at night or waking up very early in the morning.

- **Social symptoms** include avoiding contact with friends and taking part in fewer social activities/ neglecting your hobbies and interests/having difficulties in your home, work, or family life.

6. Ask the participants if they have any questions or remarks on the slides. Ask if they have seen survivors with depression, and discuss some examples that they give (4 minutes).

7. Say that we should also pay special attention to suicide and suicidal ideation. Show the slide regarding suicide and say (2 minutes):

    - ***"Behavior that may indicate suicide and suicidal ideation includes*** *planning or researching ways to die, withdrawing from friends, saying goodbye, giving away important items, or making a will/taking dangerous risks such as driving extremely fast, displaying extreme mood swings, eating or sleeping more or less, using drugs or alcohol more often."*

8. Explain that suicide is the number one cause of death among adolescents. Although this training will not include training on suicide prevention and response, we will give some important guidelines later (1 minutes).

9. State that another long-term consequence that can be present among survivors is post-traumatic stress disorder (PTSD). While PTSD is talked about a lot, not many people actually develop PTSD. Everybody has a stress reaction, but it is not necessarily PTSD. PTSD is a diagnosis. As we are not MHPSS specialists, it is not our task (nor do we have the ability) to diagnose people with conditions such as PTSD. Instead, we can reference "stress reactions" or "reactions to critical incidents." The symptoms of PTSD that are described below should merely serve as background information to be presented on a PowerPoint slide or flip chart paper (3 minutes).

    - **PTSD symptoms** include flashbacks/nightmares/repetitive and distressing images or sensations/ physical sensations, such as pain, sweating, feeling sick or trembling/avoidance of social contact/ emotional numbing/hyperarousal.

    - Many people who are exposed to a traumatic event experience symptoms similar to those described above in the days following the event. For a person to be diagnosed with PTSD, however, symptoms must last for more than a month and must cause significant distress or problems in the individual's daily functioning. Many individuals develop symptoms within three months of the trauma, but symptoms may appear later and often persist for months and sometimes years.

10. Close by clarifying any last questions, and note that we will further discuss how to support survivors that face these and other issues in subsequent activities.

Step 5: Possible phases in healing from sexual violence

Time: 20 minutes

Materials: 3 plastic cups, tape (not clear), Handout 4.B5 (1 copy per participant)

Objective: Help trainees to understand the different phases in healing after sexual violence

Instructions for the facilitator:

1. Use the tape to make a timeline about 6 meters long on the floor in the middle of the room (2 minutes).

2. Explain that we will now talk about three general phases that might occur when healing from sexual assault. Ask participants to stand about one meter away from the timeline and on either side of it (2 minutes).

3. Say, *"This line symbolizes a timeline for healing following sexual violence. While every person is different, there are some phases in healing that we often observe."* Put the first plastic cup at one end of the timeline. Put the second cup one meter further down the line. Put the third cup 4 meters down the timeline (2 minutes).

- Point to the first cup. Note that this cup designates the moment that the sexual violence incident occurred. Next, point to the area between the first and second cup. Say, *"In the first phase of healing following sexual violence, there is often extreme active or extreme passive behavior. For example, the person might be lying*

in bed and looking at the wall, or the person might be hectically moving round. While every person is different, this phase typically takes about two weeks." Next, point to the area between the second and third cup. Say, *"Next, often survivors stay dissociated and give the impression that they are functioning normally. This phase takes typically around three months."* Point to the third cup. Say, *"After this period, often the dissociation ends, and the survivor enters a very difficult phase. They encounter feelings from the sexual violence incident again: they may have flashbacks, intrusive memories, nightmares, and panic attacks. This is a normal phase in healing, and often misunderstood by people surrounding the survivor. Only if the survivor gets sufficient emotional support can they continue their journey to healing. If there is no support, a repetition of sexual violence, or re-traumatization, the survivor will go back into dissociation and possibly develop dissociative disorders."* Ask if there are any questions or remarks (10 minutes).

4. Explain that most people can heal without professional, specialized interventions. The support of a caring and loving family and friends is mostly sufficient. Moreover, a non-requested intervention by psychologists or psychiatrist is often perceived as intrusive and can increase stigmatization (2 minutes). Ask participants if they have experience in observing that going to a psychologist or psychiatrist can stigmatize the client or patient.

5. Distribute Handout 4.B5 on "Common Reactions after Sexual Assault." Request that people read it in the evening. If they have questions, they can ask tomorrow (2 minutes).

Step 6: Resiliency following sexual violence

Time: 10 minutes

Materials: None

Objective: Understand the concept of resilience and its relation to healing following sexual violence.

Instructions for the facilitator:

1. Say to the participants, *"We have discussed a number of short- and longer-term consequences and effects of sexual violence on survivors. However, not all people are the same. For some, the negative impacts of a critical incident such as sexual violence can be more substantial than for others. This can be explained by many factors, but one of the key factors that explain this is a person's level of resilience. 'Resilience' is the capacity to withstand or recover from difficulties or tough situations or experiences. There are several factors that make up resilience, including a person's social support network, positive self-image, and problem-solving skills"* (2 minutes).

2. Ask participants to reflect for a moment about themselves and how they are able to withstand or recover from difficulties or tough situations or experiences. How does their ability to withstand or recover differ from their friends and family members? What factors support their resilience? How do they perceive the resilience of ABMY in their lives and communities? What factors support their resilience? (7 minutes).

3. Explain that people with lower levels of resilience are likely to need more support following a critical incident such as sexual violence. Tell participants that our next session will cover the impact of sexual violence on the socioemotional development of ABMY (1 minute).

Session C: Sexual violence and its impact on the developing adolescent or youth

Summary description

This session explores the impact of sexual violence on the socioemotional development of adolescents and youth, and provides training on pertinent resources and protocols that non-MHPSS specialists can use to support the needs of ABMY survivors of sexual violence.

Overall time needed: 75 minutes

Overall objectives:

- Participants understand the impact of sexual violence on the socioemotional development of adolescents and youth.
- Participants learn about pertinent resources and protocols that non-MHPSS specialists can use to support the needs of ABMY survivors of sexual violence.

Table 9. Overview of Session C

Step	Time estimated (minutes)	Materials
1: Introduction to the developing adolescent and youth	25	LCD projector, computer, PowerPoint slide, copies of the article "Suicide in the Context of Adolescent Development: What Humanitarian Actors Can Do" (1 per participant)
2: Group work on sexual violence and its impact on the developing adolescent and youth	50	Paper, pens, flip chart paper, markers

Step 1: Introduction to the developing adolescent and youth

Time: 25 minutes

Materials: LCD projector, computer, PowerPoint slide, copies of the article "Suicide in the Context of Adolescent Development: What Humanitarian Actors Can Do" (1 per participant)

Objective: Explore the socioemotional development of adolescents and youth.

Instructions for the facilitator:

1. Explain to the participants that in this session, we will review the socioemotional development trajectory of adolescents and youth. Note that this is a particularly fragile and complicated phase in life for many (2 minutes).

2. Project the slide "Development tasks of adolescents and youth" to the group, making note of the following key tasks that adolescents and youth take on in their journey to adulthood. Say that we will now read an article that defines each of these tasks (2 minutes):

    - mental review
    - the search for self
    - separation from parents or caregivers

3. Distribute copies of the article "Suicide in the Context of Adolescent Development: What Humanitarian Actors Can Do" to each participant. Ask participants to read about suicide in the context of adolescents up to the section "What Can Humanitarian Actors Do?"[86] (10 minutes).

4. After the participants have read the first part of the article, facilitate a discussion using the following questions (10 minutes):

    - *"Do you recognize these development tasks in your own life? In what ways did you find them difficult or challenging?"*
    - *"Can you share a story or reflection on the way that you or someone you know faced these development tasks?"*
    - *"What challenges or difficulties might ABMY in all their diversity face today in meeting these tasks in this context?"*

    If time allows, ask the participants to read the rest of the article.

5. Conclude the activity by stating that we will now work together to explore the ways in which sexual violence may impact the socioemotional development of adolescents and youth and the achievement of these development tasks (1 minute).

Step 2: Group work on sexual violence and its impact on the developing adolescent and youth

Time: 50 minutes

Materials: Paper, pens, flip chart paper, markers

Objective: Explore the impact of sexual violence on the socioemotional development of adolescents and youth.

Instructions for the facilitator:

1. Tell the participants that we will now do a group activity to explore the ways in which sexual violence may impact the development tasks that we discussed in the previous step (1 minute).

86 Koen Sevenants, "Suicide in the context of adolescent development: What humanitarian actors can do," *Intervention* 19, no. 2 (July–December 2021): pp. 266–270.

2. Divide the participants into groups of four to six participants. Hand each group pens and a piece of paper. Assign each group to work on one of the three development tasks (4 minutes).

3. Ask the groups to use their pen and paper to respond to the following question: “How does sexual violence interfere with your assigned development task?” (10 minutes)

    a. While the groups are working on their responses, put three flip chart sheets around the room and label each one with a development task.

4. Let each group present the outcomes of the discussion (5 minutes per group). Write any key points from their presentations on the appropriate flip chart sheet.

5. Facilitate a discussion after every group presentation (5 minutes each). Ensure that the following aspects are included for each development task:

    - **Mental review:** Many children who have been sexually abused in childhood did not realize that it was abuse. They come to realize this in adolescence, leading to confusion, anger, and a sense that their world is destroyed.

    - **The search for self:** One of the aspects in the search for identity is sexual orientation. This can become complex if sexual violence has taken place.

    - **Separation from parents or caregivers:** One of the consequences of having a child who is a survivor of sexual violence is overprotection of children, and as such not allowing the necessary separation from parents.

6. Conclude the session by summarizing key learnings and answering any last questions (5 minutes). Please note the following points for the participants:

    - *“Over the course of the last three sessions, we looked at the inner world of survivors of sexual violence, including ABMY survivors.”*

    - *“We discussed both short- and longer-term consequences, and the impact of sexual violence on the socioemotional development of adolescents and youth. We also talked about the role of resilience.”*

    - *“Key concepts and terms were dissociation, derealization, depression, suicide and suicidal ideation, PTSD, and the three tasks of socioemotional development.”*

    - *“In our next session, we will continue to explore how we can help young people who have survived sexual violence. But the reality is that by understanding better the inner world of survivors, we are already more than halfway in knowing what to do to help.”*

Session D: Assisting ABMY survivors

Summary description

Participants will be guided toward pertinent resources and protocols that non-MHPSS specialists can use to support the needs of ABMY survivors of sexual violence.

Overall time needed: 215 minutes

Overall objectives:

- Develop an understanding of different ways and strategies to help ABMY survivors of sexual violence.
- Explore pertinent resources and protocols that can be used by non-MHPSS specialists.

Table 10. Overview of Session D

Step	Time estimated (minutes)	Materials
1: Introduction to the developing adolescent and youth	45	Paper and pens, handout on resources (1 per participant), computer with internet connection, LCD projector, "Psychological First Aid (PFA) Pocket Guide" (Handout 4.D1), PPT slides
Break	10	
2: How to assist ABMY survivors with longer-term emotional distress	30	Computer with internet connection, LCD projector with audio output, SH+ Session 1 recording, printed copies of "Problem Management Plus (PM+)" (1 per participant), resources on longer-term emotional distress, "Self-Help Plus (SH+)" (1 per participant), PPT slides
3: Ensuring quality in psychological support	30	Computer with internet connection, LCD projector with video and sound capabilities, PPT slides
Break	10	
4: Guidelines for suicide prevention	70	Computer with internet connection, LCD projector with video and sound capabilities, PPT slides, "Suicide Prevention" handout for staff and volunteers (pages 14–33)
5: Mapping existing services and referral protocols	20	Computer with internet connection, LCD projector with video and sound capabilities, PPT slides

Step 1: How to assist ABMY survivors with acute stress

Time: 45 minutes

Materials: Paper and pens, handout on acute stress resources (1 per participant), computer with internet connection, LCD projector, "Psychological First Aid (PFA) Pocket Guide" (Handout 4.D1), PPT slides

Objective: Provide an overview of psychological first aid, and explore how to use it to address acute stress among survivors.

Instructions for the facilitator:

1. Before the step begins, print out copies of each resource to circulate among participants. Prepare and test audio equipment to listen to audio fragments.
2. Explain to the participants that in this session, we will provide the basics for supporting ABMY survivors of sexual violence. This session builds on what has been said in the previous sessions (1 minute).
3. Say, *"We will start the discussion by exploring how to assist ABMY with acute stress. Acute stress denotes 'a reaction that occurs no less than three days and no more than four weeks following a traumatic event'.*[87] *The methodology for assisting people with acute stress is referred to as 'psychological first aid' or PFA"*[88] (1 minute).
4. Present the slides on PFA and use them as a basis for training and discussion (3 minutes).

   What is PFA?

   Psychological first aid (PFA) describes a humane, supportive response to a fellow human being who is suffering and who may need support.

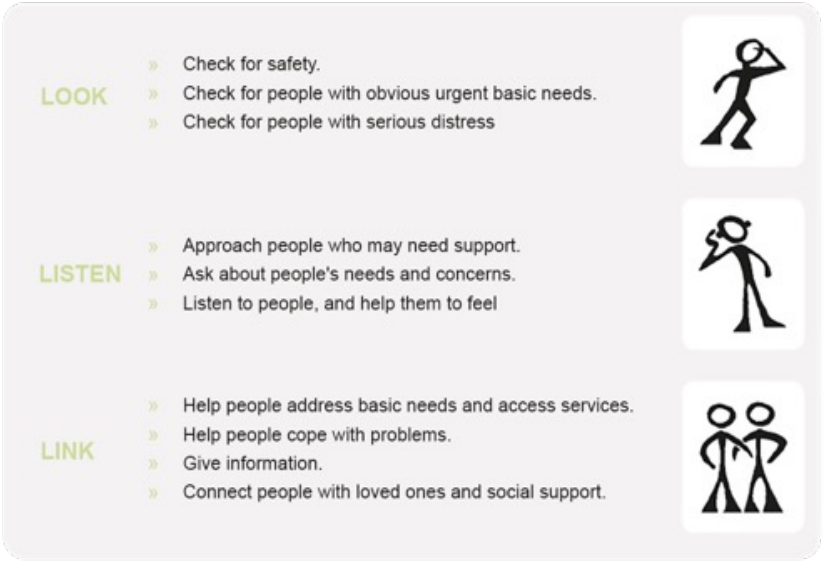
   Providing PFA responsibly means

   - respecting safety, dignity, and rights
     - e.g., being non-judgmental about sexual orientation;
   - adapting what you do to take the person's culture into account
     - e.g., being accepting if references are made to a religion that is not yours;
   - being aware of other emergency response measures
     - e.g., being aware that other sectors or people are also responding to the emergency, and building on synergies;
   - looking after yourself
     - e.g., accepting that you might be stressed and that you might have stress reactions afterwards.

87 Mehdi Fanai and Moien A.B. Khan, *Acute Stress Disorder*, July 2023, https://www.ncbi.nlm.nih.gov/books/NBK560815/.

88 World Health Organization, *Psychological First Aid: Facilitator's Manual for Orienting Field Workers* (2013). https://iris.who.int/bitstream/handle/10665/102380/9789241548618_eng.pdf?sequence=1.

Look ► listen ► link method



5. Tell participants that we will further discuss the provision of PFA through a group exercise. Ask participants to divide into groups of four to six people. Provide each group with one piece of paper and one pen (3 minutes).

6. Read aloud the following scenario to the participants. Ask groups to use their pen and paper to respond to the following questions. Give them 10 minutes to complete the exercise.

PFA case scenario

[Note: Review and adapt the following case scenario to your setting prior to the session]

You and your colleagues have traveled to a village after you received some alarming messages that sexual violence might have taken place. Upon arrival, you see an adolescent boy of about 17 years old in distress. He is panicked and seems to flee but without a clear direction. He is crying. His friend is also there, standing motionless without making any sound. It is clear that something happened very recently.

Discussion questions

Who needs assistance?

What needs to be done urgently?

How can you stay safe and help keep affected people safe from harm? What is important to LOOK for?

Who can help you?

As you make contact with the people involved, how can you best LISTEN and provide comfort?

What can you do to LINK affected people with information and practical support?

7. Ask each group to respond to one of the discussion questions. Once each group has done so, go around the groups again until all of the questions have been answered (10 minutes).

   The key learning element here is that all trainees start to use the "Look ► listen ► link method." Tell participants that more information on PFA can be found online.[89] Distribute Handout 4.D1 with resources.

89 See, for example, https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/pfapocket_guide.pdf.

8. Bring participants back to plenary, and remind them that over the course of this workshop, we have also talked about dissociation and derealization. Clarify to participants:

    - Dissociation is a healthy protection mechanism. It is not a pathology.
    - When people reconnect with their feelings again, it is progress in healing. Yet, it is also very painful. It is at this moment especially that they need support.
    - If people stay dissociated for several months, it is good to refer them to specialized services. However, this can only be done with the consent of the person.

Step 2: How to assist ABMY survivors with longer-term emotional distress

Time: 30 minutes

Materials: Computer with internet connection, LCD projector with audio output, printed copies of "Problem Management Plus (PM+)" (1 per participant), resources on longer-term emotional distress, "Self-Help Plus (SH+)" (1 per participant), SH+ Session 1 recording, PPT slides

Objective: Explore ways to support and assist the emotional distress of ABMY survivors in the longer-term, including through Problem Management Plus (PM+) and Self-Help Plus (SH+).

Instructions for the facilitator:

1. Tell participants that we will now talk about some protocols that non-specialists can use to support and address longer-term emotional distress among survivors, including ABMY. In humanitarian settings, the most commonly used approaches to support and address longer-term emotional distress among survivors include PM+ and SH+ (2 minutes).
2. Explain that (3 minutes):

    - Problem Management Plus (PM+)[90] is an evidence-based low-intensity psychological intervention developed by the World Health Organization (WHO) for adults and adolescents impaired by distress in communities exposed to adversity.
    - PM+ can be applied to improve aspects of mental health and psychosocial well-being, no matter how severe people's problems are.
    - In PM+, aspects of cognitive behavioral therapy (CBT) have been changed to make them feasible in communities that do not have many MHPSS specialists available.
    - To ensure maximum use, the intervention is developed in such a way that it can help people with depression, anxiety, and stress, whether or not exposure to adversity has caused these problems.

3. Distribute a copy of the structure of the different sessions of the PM+ intervention[91] (see pages 108–133) to each participant. Ask the participants to skim the structure and share their observations (10 minutes). Ensure that they mention the following observations:

    - The protocol is highly structured.
    - It requires five sessions, which can be challenging as sometimes people do not return for each session.

4. Share the slide on the materials available to learn more about PM+, including the PM+ manual,[92] the Community of Practice for PM+, and various trainings on PM+ (2 minutes).
5. Explain that another package that non-specialists can use to support and address longer-term emotional distress among survivors is Self-Help Plus (SH+). [93]

    - SH+ is a multimedia self-help package delivered by facilitators with minimal training.
    - Like PM+, SH+ is a structured five-session approach.

90 See https://iris.who.int/bitstream/handle/10665/206417/WHO_MSD_MER_16.2_eng.pdf
91 Ibid.
92 Ibid.
93 See https://www.who.int/publications/i/item/9789240035119.

6. Let the participants listen to the first 10 minutes of the first SH+ session.[94] Share a link to the manual.[95]

7. Ask participants about feelings or thoughts that came up while listening to the sound fragment.

8. Explain that different people use SH+, an evidenced-based intervention. Encourage the participants to explore SH+. It is a good idea to explore the package and try it out yourself before using it to help others.

Step 3: Ensuring quality in psychological support

Time: 30 minutes

Materials: Computer with internet connection, LCD projector with video and sound capabilities, PPT slides

Objective: Understand EQUIP and explore how it can improve service delivery for ABMY survivors.

Instructions for the facilitator:

1. Tell the participants that we will now explore Ensuring Quality in Psychosocial and Mental Health Care (EQUIP), as a method to improve lay counseling skills for survivors, including ABMY. Note the following points to participants using PPT slides (6 minutes):

    - EQUIP is a joint WHO/UNICEF project that aims to improve the quality of mental health and psychosocial helping skills of helpers, and improve the consistency and quality of training and service delivery.
    - EQUIP supports organizations, including NGOs, United Nations agencies, governments, and academic institutions, both in humanitarian and development settings, in training and supervising the workforce to deliver effective mental health and psychosocial support (MHPSS) to adults and children.
    - EQUIP makes freely available a package of resources, tools, and guidance for assessing and enhancing essential competencies. The EQUIP platform works on your computer, mobile device, and tablet.
    - EQUIP tools are available in multiple languages (including Arabic, English, French, Nepali, and Spanish).
    - In summation, EQUIP is a tool to improve the quality of the mental health and psychosocial helping skills of helpers. It
        - assesses real-time impact of helpers' observable skills and competence levels;
        - provides immediate visualizations and analysis of training and assessment results on trainees (individual and group level), which can be used to refine and improve training and for reporting purposes; and
        - helps identify concrete areas of improvement for helpers.

2. Show the overview video[96] on EQUIP (3 minutes).

3. Facilitate a discussion on initial reactions and questions on EQUIP (5 minutes).

4. Explore the tool on the website[97] using the projector.

5. Show participants the video:

    https://equipcompetency.org/sites/default/files/downloads/2022-08/02_unhelpful%20nonverbal_ENACT01.mp4.

6. Explain that the EQUIP method does not teach the basic skills. The basic skills are formulated in the ENACT guidance. ENACT represents a skill set for adults. You can download the ENACT skill set on the EQUIP home page. There are also other skill sets that you can download, e.g., for working with children. EQUIP is merely a tool that helps you to practice the skills formulated in ENACT or other packages.

94 Available at https://who.canto.global/s/RQK8B?viewIndex=0.
95 Available at https://www.who.int/publications/i/item/9789240035119.
96 Available at https://www.youtube.com/embed/CBU1chlUXsA.
97 See https://equipcompetency.org/

7. Ask the participants which group they can mobilize to jointly work with EQUIP. What precautions must they take when selecting participants?

    Answers: respect for each other, learning on an equal basis, creation of a safe environment in which weaknesses can be discussed

Step 4: Guidelines for suicide prevention

Time: 70 minutes

Materials: Computer with internet connection, LCD projector with video and sound capabilities, PPT slides, "Suicide Prevention" handout for staff and volunteers (pages 14–33)

Objective: Learn to identify and respond to ABMY who may be at risk of suicide or self-harm.

Instructions for the facilitator:

1. If possible, ensure that participants have the handout in advance of the training, and ask them to read it before this session. If not, distribute it now, and ask them to read it tonight.
2. Explain some key terms (5 min):
    - **Self-harm** is when someone hurts themselves on purpose, for example, by cutting or burning their skin and flesh, or through poisoning. It should be noted that not all self-harm is a suicidal behavior, so it is important to explore what the self-harming actions mean with the person affected. The most important distinction between self-harm and suicidal behavior is intent to take one's life.
    - **Suicide** is when someone intentionally takes their own life
    - **Suicidal** ideation is when someone is thinking about taking their own life. Suicidal behaviors are actions that a person might take to attempt to take their own life.
    - **Suicide attempt** is when someone actively attempts to take their own life. Language used to refer to suicide and self-harm should be carefully considered. Phrases such as "commit suicide" should be avoided, as it suggests a criminal or immoral element to the act, which may increase stigma and discourage people from seeking help. Language such as "attempted suicide", "took their own life", and "died by suicide" have been found to be most accepted among those affected by suicide.
3. Project the slide below and explain the different skills. Note: Explanations can be found on pages 15 and 16 of the guide (5 minutes).

    Essential communication skills:

    - communicate clear limits to confidentiality
    - respect service users
    - basic helping skills
    - verbal communication
    - ability to manage reactions
4. Explain that social support is an essential part of suicide prevention (25 minutes).

    Ask participants to practice, in pairs, the following sample questions. One person should act as the support provider and the other one the service user. Ask them to base it on real feelings, but only if people feel comfortable sharing their feelings. After 10 minutes, switch roles. After the exercise, ask if participants would like to share how they felt as a service user or as a service provider.

    Sample questions to explore social supports:

    - Can you think of a time when you were supported?
    - How did it feel to have that support? Are those people/that group still around? Are there ways for you to connect with them?

- Are there any types of supports you have found to be helpful in the past that maybe were not people? This could be activities or places you went to that helped you to feel calm and connected.
- How might you overcome these barriers?

5. Ask participants to check the risk factors and protective factors for youth on page 21. Discuss in plenary how you can do an assessment on the presence of these factors (10 minutes).
6. Project the following warning signs on a PowerPoint slide. Ask participants if they have come across people who had suicidal ideation, and who showed any of these warning signs or other signs (5 minutes).

   Warning signs that may indicate that a young person is thinking about or planning suicide include:

   - changes in sleeping and eating habits
   - loss of interest in activities that they previously enjoyed, such as sport or art
   - isolating themselves or withdrawing from family and friends
   - headaches, stomach aches, and other physical symptoms that cannot otherwise be explained by a medical condition
   - refusing to go to school or beginning to do poorly in school
   - talking about death often, asking questions about death
   - researching or looking up ways to die
7. Project the following on a PowerPoint slide and explain every point, as in the IFRC suicide prevention guidance page 25 (10 minutes).

   In emergency and imminent risk situations:

   - DO NOT leave the individual alone.
   - Call emergency services if medical attention is needed.
   - Remove any means of self-harm.
   - Bring the individual to a safe, supportive environment, if possible.
   - Include trusted supports of the individual (such as a friend or family member) if possible.
   - Consult with, and involve, the supervisor or a MHPSS specialist as soon as possible during the situation.
8. Finally, remind the participants that this is an introductory training, and insist that reading the handout provided is important and will save lives.

Step 5: Mapping existing services and referral protocols

Time: 20 minutes

Materials: Computer with internet connection, LCD projector with video and sound capabilities, PPT slides

Objective: Help participants understand their work to support ABMY survivors within a broader system, and the importance of service mapping and referrals.

Instructions for the facilitator:

1. Explain to the participants that we will now explore how our work to support ABMY survivors fits within a broader system (2 minutes).

   As you do so, be sure to note that:

   - We do not work in isolation but instead in cooperation with other services.

- We have our own limitations. Sometimes, we are not the right people to help others and rather should facilitate referral to other services. Call emergency services if medical attention is needed.

2. Ask the participants, *"When working with ABMY survivors, which other services and service providers might we want to work with and connect survivors to?*" (1 minute)

3. Facilitate a discussion on the question above and write participant answers on a flip chart at the front of the room (5 minutes). Make sure that the following services and service providers are included on the flip chart: mental health and psychologists, doctors, and psychiatrists. Other answers can include services and service providers related to shelter, livelihoods, and legal.

4. Explain to the participants that to be able to refer ABMY survivors to these and other services, we first need to have a clear understanding of what services are available, close by, accessible, and friendly to ABMY survivors. We thus must conduct a service mapping using our networks, the internet, and connections to existing coordination groups (e.g., a MHPSS technical working group, a child protection coordination group, and/or a GBV coordination group). A checklist can also be helpful in ensuring that these services are acceptable, equitable, appropriate, and effective—or in other words, friendly—to ABMY survivors (2 minutes).

5. Share and discuss the checklist (5 minutes).

6. Explain that it is also important that these other services are aware of what we're doing, so that they can connect and refer ABMY survivors to us as well (2 minutes).
   This means it is important that out work is visible, through for example:

   - visiting and connecting with these other services and providers to explain what we offer;
   - being a member of local coordination groups;
   - visiting school counselors; and
   - being a part of the service mapping exercises of other services.

7. Tell the participants that we want to refer ABMY survivors to services and service providers that promote safety and respect confidentiality. Therefore, it is important to visit the service providers to:

   - check their credentials;
   - verify the service(s) that they provide; and
   - verify how you can make referrals to them.

   It is also vital that after you have referred an ABMY survivor, you follow up on their services and progress (2 minutes).

8. Remind the participants that informed consent is needed to refer survivors and to share any information on them with these other services (2 minutes). Project the following slide and read aloud:

   "Individuals have the right to choose what information they disclose and to whom, and the right to withdraw their consent at any time. Any information disclosed should be shared onwards only with their informed consent.

   Informed consent means that information provided by or about someone is shared only if they understand what is to be shared, with whom, how the information will be used, and the risks and benefits of providing the information.

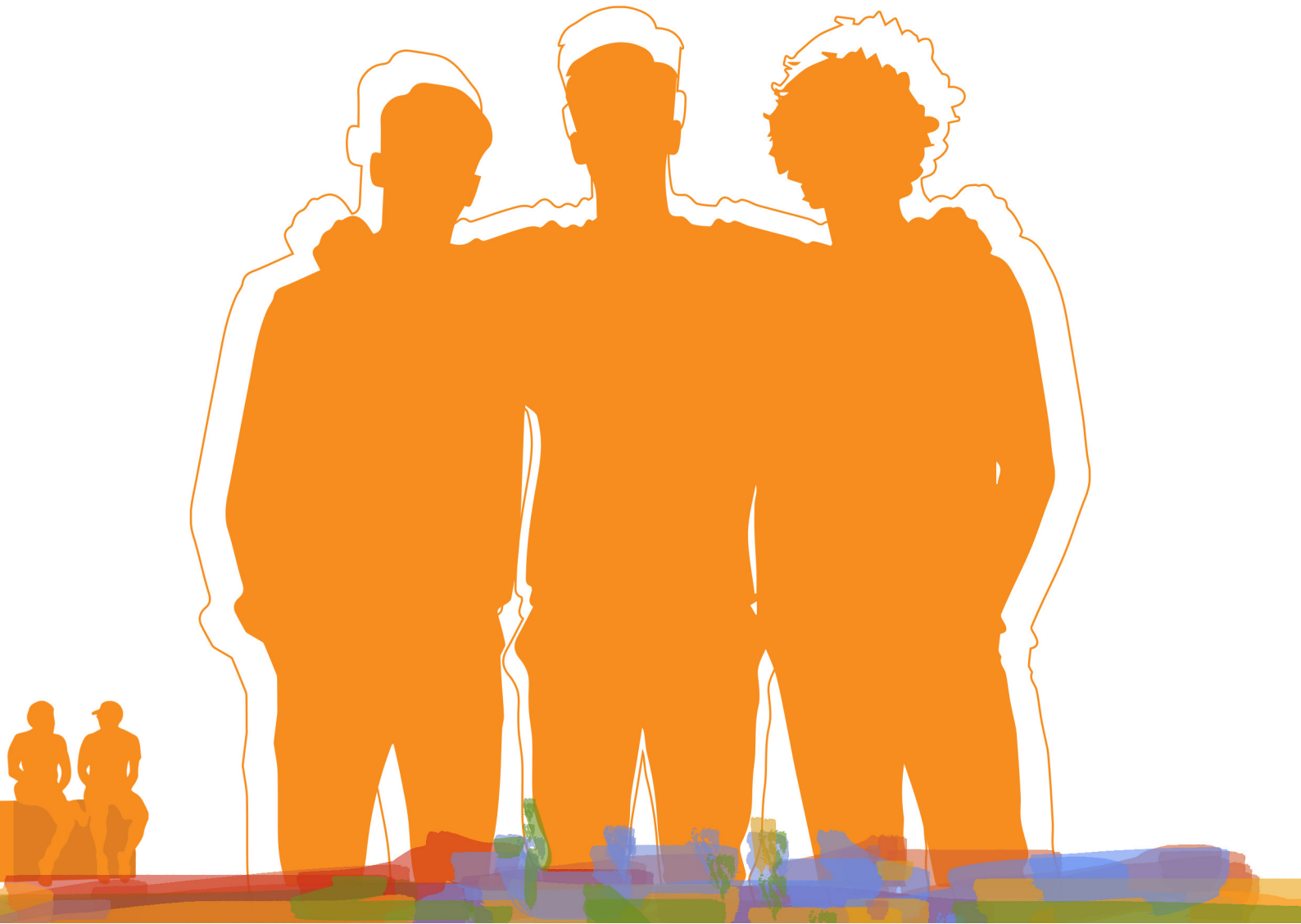
   Caregivers must provide consent for minors."[98]

9. Close the session by answering any last questions (2 minutes).

98 See also https://mhpssmsp.org/en/lesson/ensure-informed-consentassent-and-safe-information-sharing-practices?hl=Safe%20referrals#page-1.

MODULE 5

Adolescent Boy and Male Youth Survivors of Conflict-Related Sexual Violence



Module 5: Adolescent Boy and Male Youth Survivors of Conflict-Related Sexual Violence

Summary description

This module will define conflict-related sexual violence (CRSV) and differentiate it from sexual abuse. Participants will gain insight into the physical and mental health symptoms and effects of CRSV, including those that may arise from fear of and/or experiences of stigma and shame due to CRSV, as well as the unique mental and psychosocial-related needs of adolescent boy and male youth (ABMY) survivors of CRSV. The module will close with discussion and activities that will inform a survivor-centered approach to addressing CRSV, including among ABMY survivors.

Overall time needed: 200 minutes

Overall objectives:

- Define CRSV and learn about its gendered aspects, symptoms, and effects.
- Differentiate CRSV from sexual abuse, including that by family/community members.
- Explore the unique needs of survivors of CRSV, including ABMY, and the elements necessary to address their needs through a survivor-centered approach.

Table 11. Overview of Workshop on Adolescent Boy and Male Youth Survivors of Conflict-Related Sexual Violence

Step	Time estimated (minutes)	Materials
1: Introduction	30	2 or 4 large blank sheets of paper (depending on whether you form 2 or 4 groups), pens and colored pencils
2: Diving deeper	30	Handout 5.2, printed chosen article(s), pens, PowerPoint slides, projector, flip chart
Break	15	
3: Differentiating CRSV from sexual abuse, including that by family/community members	30	Handout 5.3.1, Handout 5.3.2, pens
4: Barriers and challenges for ABMY survivors of CRSV	30	Computer with internet and projector to show YouTube video and PowerPoint presentation, Handout 5.4.1
Break	15	
5: A survivor-centered approach to addressing CRSV	30	Handout 5.5, pens
Step 6: We are all in this together	20	Handout 5.6
Closing and post-test	36	Training evaluation form, Handout 5.7 (1 per participant), training certificates (1 per participant)

Step 1: Introduction

Time: 30 minutes

Materials: 2 or 4 large blank sheets of paper (depending on whether you form 2 or 4 groups), pens and colored pencils

Objective: Raise awareness among participants on CRSV.

Instructions for the facilitator:

1. Welcome the participants, and share with them that this module is going to focus on conflict-related sexual violence (CRSV), particularly its effect on adolescent boy and male youth (ABMY) survivors. State that this is a very sensitive topic and that they are encouraged to be kind to themselves and can leave the space at any time if they need to.

2. Define CRSV for the group:

   > *"The incidents or patterns of sexual violence that occur in conflict or post-conflict settings or other situations of concern. This includes rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, forced witnessing of sexual acts, forced stripping, or any other form of sexual violence of comparable gravity.*
   >
   > *CRSV may be directly or indirectly linked to conflict, and is intended to punish and/or shame people and communities. It is frequently carried out as part of abuses against civilian populations, who may be targeted as they are, or are perceived to be, members of the community's racial, ethnic, gender, religious, or political minority group. While women and girls are often targeted for CRSV, men, boys, and people with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC) are also survivors. Gender and social norms in these settings can pose barriers to survivors and witnesses of CRSV from coming forward, either to report the violence or to get help."*

3. Tell the participants that this first exercise will help us to explore the potential experiences of ABMY survivors of CRSV. In future exercises, we will dive deeper into the evidence and discuss the barriers and challenges that ABMY survivors face following CRSV, including in accessing services. We'll also discuss the elements necessary to address their needs using a survivor-centered approach.

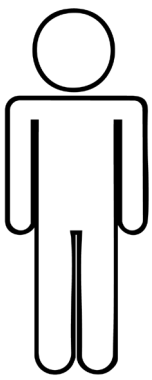
4. Ask participants to split into two groups. **Note**: If you think that your two groups are too large to enable broader participation, you can split participants into four groups. You'll then assign Character 1 to two groups and Character 2 to two groups.

5. Distribute a large, blank sheet of paper and pens and pencils to each group.

6. Ask each group to draw a person (outline only) and then assign each group either Character 1 or 2.

7. Read aloud the following character descriptions to their respective groups.

   Note: You are encouraged to assign names to each of these characters and adapt their stories as needed to better suit your setting.



- *"Character 1 is a 16-year-old male who lived in a small village in a conflict-affected region. He comes from a poor family and had limited access to education or resources before the conflict.*
- *Character 1 was sexually assaulted during a conflict and is coping with the psychological and emotional aftermath. He struggles with depression, anxiety, and flashbacks related to the trauma.*
- *Character 2 is a 19-year-old male who lived in a city that was under siege by armed groups. He was studying engineering at a local university before the conflict disrupted his studies.*
- *This character is coping with the physical and emotional consequences of being repeatedly raped by soldiers during a conflict. He struggles with severe physical pain and trauma-related depression."*

8. Tell the groups that their characters are survivors of CRSV and that their circumstances can impact the ways in which they and those around them perceive their experiences of CRSV and how they may address their needs. Ask them to take 10–15 minutes to respond to the following questions by discussing and then writing their group's responses within their respective person outlines. Note that sample responses are provided in Table 12.

- **What are your character's needs?** Prompt: Do they have particular physical and mental health needs, financial needs, etc.?
- **How can your character's needs be addressed?**

9. Give each group 3–5 minutes to present their character, their needs, and any ways they have identified that can address those needs.

10. Come back together as a group and take 10 minutes to discuss the characters from the activity. Use the table on the following page to guide the discussion. Some key questions and discussion points are provided below:

- *"What commonalities did you find between the characters? How are their needs similar and different?"*
- *"What common risk factors exist that affect ABMY survivors of CRSV?"*
- *"What common protective factors or existing coping mechanisms exist?"*

Table 12. Key points to include and discuss in Step 1 activity

Characters	**Character 1:** Character 1 is a 16-year-old male who lived in a small village in a conflict-affected region. He comes from a poor family and had limited access to education or resources before the conflict. Character 1 was sexually assaulted during a conflict and is coping with the psychological and emotional aftermath. He struggles with depression, anxiety, and flashbacks related to the trauma.	**Character 2:** Character 2 is a 19-year-old male who lived in a city that was under siege by armed groups. He was studying engineering at a local university before the conflict disrupted his studies. This character is coping with the physical and emotional consequences of being repeatedly raped by soldiers during a conflict. He struggles with severe physical pain and trauma-related depression.
What are their needs? Prompt: Do they have particular physical and mental health needs, financial needs, etc.?	This character is at risk of developing mental health problems, such as depression and post-traumatic stress disorder (PTSD), as a result of the trauma. He is also at risk of financial insecurity due to his limited resources and the economic impacts of the conflict. This character needs ongoing mental health support to address the psychological effects of the trauma. He also may need financial assistance to cover expenses related to his recovery, such as therapy.	This character is at risk of physical complications related to his injuries and developing mental health problems, such as depression and PTSD, as a result of the trauma. He is also at risk of financial insecurity due to his disrupted education and the economic impacts of the conflict This character needs medical treatment for his physical injuries and ongoing mental health support to address the trauma of the abuse. He also may need financial assistance to cover the cost of his medical care and to support himself.
How can your character's needs be addressed?	This character can be supported mentally through engaging with a therapist and his peers in a support group. He may also receive financial support from a local NGO that aids survivors of CRSV.	This character can be supported mentally through engaging with a therapist and his peers in a support group. He may also receive financial assistance from a government program that provides support to survivors of CRSV. He may also access physical therapy and other services/care for his physical health needs.

Step 2: Diving deeper

Time: 30 minutes

Materials: Handout 5.2, chosen article(s) printed (with enough copies for each participant), pens, PowerPoint slides, projector, flip chart

Objective: Learn more about CRSV and how it may affect ABMY in particular.

Notes for the facilitator: Choose one or two current news articles that discuss issues related to survivors of CRSV for your participants to read and reflect on. Links to some relevant articles are presented in Table 13. Some focus on ABMY specifically; others discuss survivors of different genders, including women and girls. **Your choice is not limited to this list. You are encouraged to find and use articles from your own setting for this activity.**

Table 13. News articles on CRSV

Article title	Setting/Population	Length	Source	Date published
"Justice Critical to Fighting Sexual Violence in Conflict"	Populations affected by CRSV (general)	Short	UN News	April 13, 2022
"Sexual Violence in Conflict 'Terrorizes Populations, Destroys Lives and Fractures Communities' "	Populations affected by CRSV (general)	Short	UN Women	June 17, 2022
"Media (Mis)representation of Conflicted-Related Sexual Violence"	Populations affected by CRSV (general)	Medium	London School of Economics	February 1, 2022
"New Study Calls for Reparations for Victims of Conflict-Related Sexual Violence in Uganda"	Survivors of CRSV in Uganda	Short	International Center for Transitional Justice	October 17, 2022
"There is Still Time to Stop Conflict-Related Sexual Violence from Happening in Ukraine"	Populations at risk of CRSV in Ukraine	Medium	Global Survivors Fund	March 22, 2022
"Ukraine Sets a World Precedent: Moving Forward on Holistic Care and Urgent Interim Reparation for Survivors of CRSV"	Survivors of CRSV in Ukraine	Short	Global Survivors Fund	November 2, 2022
"We Break the Silence to Help Survivors of Sexual Violence in our Fight for Justice"	Survivors of CRSV in Central African Republic	Short	Global Survivors Fund	June 20, 2022
"There is No Time to Lose to Ensure Victims' Right to Reparation in Colombia"	Survivors of CRSV in Colombia	Short	Global Survivors Fund	May 25, 2022

Once you have determined which articles you will use, print copies so that each participant can have their own during the activity.

Instructions for the facilitator:

1. Share with the participants that we are going to dive deeper into CRSV and how it may affect ABMY in particular. State that this is a very sensitive topic and that they are encouraged to be kind to themselves and can leave the space at any time.

2. Present the following information to the group.

    - **Slide 1: CRSV**
      Conflict-related sexual violence (CRSV) is defined as the incidents or patterns of sexual violence that occur in conflict or post-conflict settings or other situations of concern. This includes rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, forced witnessing of sexual acts, forced stripping, or any other form of sexual violence of comparable gravity.

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    - **Slide 2: Who are CRSV survivors?**
      Because of historical and structural inequalities, women and girls are more frequently targeted by CRSV than men and boys. However, CRSV also affects men, boys, and people who are sexually or gender diverse (SOGIESC). Internally displaced persons, widows, migrants, female heads of household, detainees, people with disabilities, and certain ethnic and minority groups are also more likely to be sexually abused than others during conflict.

    - **Slide 3: What are the effects of CRSV?**
      CRSV can cause severe physical injuries and long-term psychological trauma, as well as sexually transmitted infections (STIs) and, in some cases, death. Victims and survivors often may face shame and/or rejection from their communities and families, in addition to immediate and longer-term trauma and mental health difficulties..

      Some survivors of CRSV have unplanned pregnancies, and mothers of children from rape during conflict may face rejection from their own families and communities. These mothers may also have difficulty registering their children's births, legal names, or citizenship rights.

3. Hand out copies (one per person) of your chosen article to the participants. As you do so, ask participants to read it and reflect on what services and care the survivors of CRSV that are described need, as well as any barriers they face in receiving these services and care.

4. Give participants about 10–15 minutes to read the article. When they have finished, ask *"What services may the survivors of CRSV need?"* Probe around different aspects of the support such as MHPSS, health, shelter, livelihoods, and legal, among others. Write the responses on a flip chart.

5. Then ask, *"What barriers do they face in receiving these services and care?"* Write those responses on a different flip chart.

6. Thank the group for their participation and tell them that we will further discuss CRSV, and differentiate it from sexual abuse, in the next exercise.

Step 3: Differentiating CRSV from sexual abuse, including that by family/community members

Time: 30 minutes

Materials: Handout 5.3.1, Handout 5.3.2**, pens**

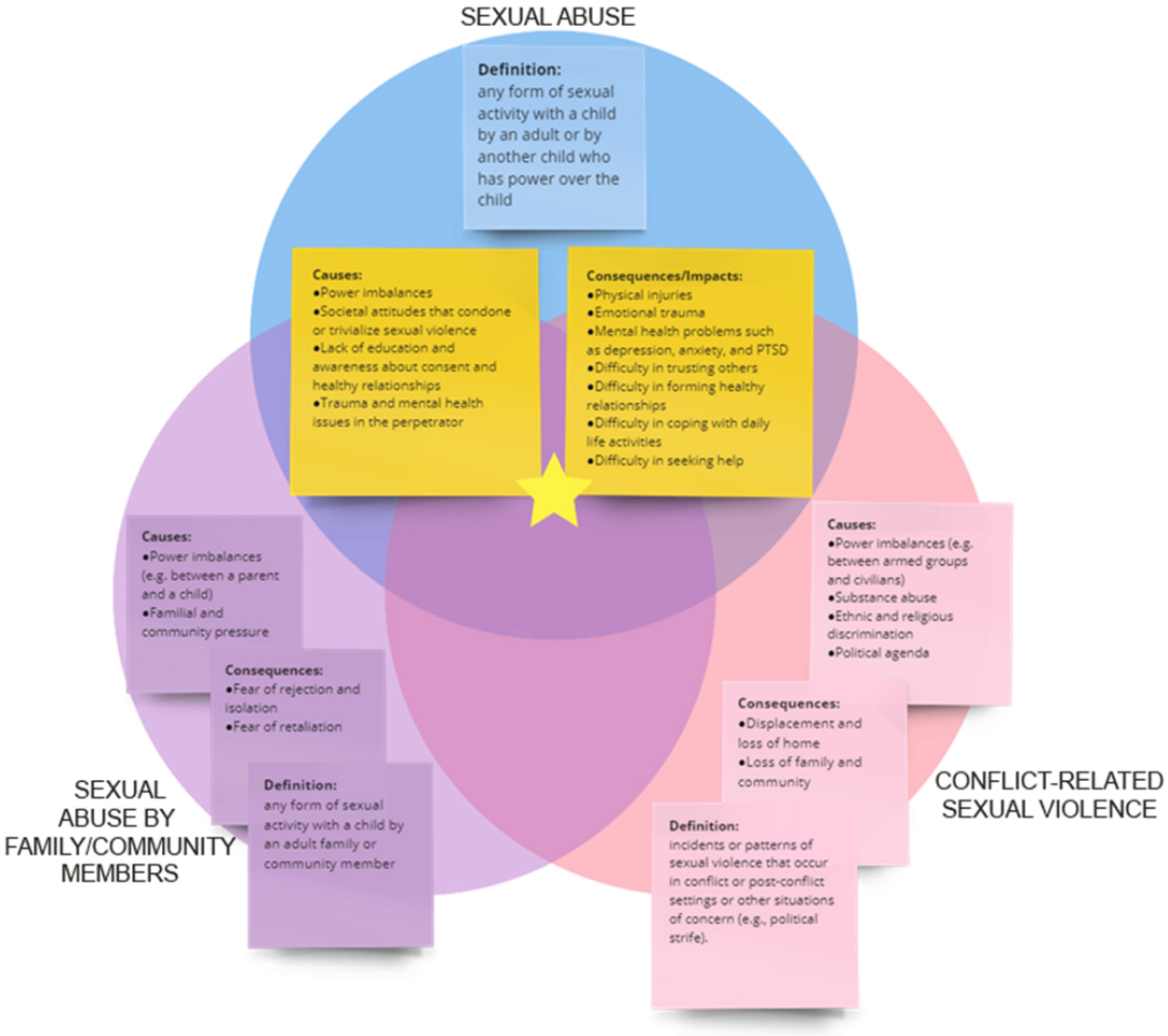
Objective: Increase understanding and awareness of the distinctions and similarities between CRSV and sexual abuse, including that by family/community members.

Instructions for the facilitator:

1. Welcome the participants, and share with them that this module is going to focus on conflict-related sexual violence (CRSV), particularly its effect on adolescent boy and male youth (ABMY) survivors. State that this is a very sensitive topic and that they are encouraged to be kind to themselves and can leave the space at any time if they need to.
2. Divide the participants into groups of three or four people.
3. Provide each group with a blank Venn diagram (Handout 5.3.1) and the handout that contains information on the causes, consequences/ impacts, and definitions of sexual abuse, CRSV, and sexual abuse by family/community members (Handout 5.3.2).

4. Ask each group to use the list in Handout 5.3.2 to complete the Venn diagram by writing the causes, consequences/impacts, and definitions of each type of violence in the appropriate sections to demonstrate the similarities and differences. They may of course add new ones.
5. Allow the groups 15–20 minutes to complete their Venn diagrams.
6. After the groups have finished, ask one representative from each group to share all the causes, consequences/ impacts, and definitions that they felt corresponded with sexual abuse. Discuss the differences and similarities between each group's responses, and share any key information with the group using the answers in Figure 2 below. Repeat the process with CRSV and sexual abuse by family/community members.
7. Conclude the activity by saying, *"It is important for us to emphasize the importance of understanding and addressing the distinctions between sexual abuse, conflict-related sexual violence, and sexual abuse by family/community members. Each form of violence has unique characteristics and impacts, and it is crucial to understand these distinctions in order to effectively support and empower adolescent boys and male youth (ABMY) who are affected by them. By understanding the underlying causes, scope, and consequences/ impacts of each type of violence, we can create more targeted and effective support systems for these youth and work towards preventing these forms of violence from happening in the first place."*

Figure 2: Similarities and differences between sexual abuse, conflict-related sexual violence, and sexual abuse by family and community members



Step 4: Barriers and challenges for ABMY survivors of CRSV

Time: 30 minutes

Materials: Computer with internet and projector to show YouTube video and PowerPoint presentation

Objective: Explore the barriers and challenges that ABMY survivors of CRSV face in accessing services.

Instructions for the facilitator:

1. Share with the participants that we are going to dive deeper into our discussion on ABMY survivors of CRSV. State that this is a very sensitive topic and that they are encouraged to be kind to themselves and may leave the space at any time.

2. Ask, *"How does CRSV affect ABMY?* Do they have unique needs and face unique barriers to services and care?" After receiving some responses, open the presentation and share the following information:

   Slide 1: CRSV against ABMY

   In conflict and post-conflict situations, men can be survivors, witnesses, and agents of change when it comes to CRSV. While CRSV mostly affects women and girls, men and boys can also be directly affected. Some examples of CRSV against ABMY are rape (including forced rape between victims), sexual torture, genital mutilation, sexual humiliation, and sexual enslavement. ABMY may also be forced to watch sexual violence being perpetrated, particularly that against their family members.

   Slide 2: Myths and misconceptions around CRSV against ABMY (Conduct optional Step 4.1)

   Misconceptions and stereotypes about CRSV that affect ABMY include:

   - Sex is the main reason for rape. (False—the real reason is domination, control, and misuse of power.)
   - Rape doesn't affect men. (False—there is a belief that men cannot be raped because "all men enjoy sexual encounters." This is of course wrong: sexual exploitation and CRSV are not sexual encounters, but violent acts.)
   - "Real" men can defend themselves against rape. (False—men are subjected to the same effects as women and girls in terms of being in shock during a traumatic event.)
   - Sexual assault by someone of the same sex causes homosexuality. (False—there is no relation between the two.)

   These ideas come from traditional masculine ideals that encourage being strong, sexual dominance, and being straight. On the other hand, these standards put homosexuality, especially homosexuality among men, in a lower position because it is linked to feminization, subjugation, and being a victim.

   Slide 3: How does CRSV affect ABMY?

   ABMY who experience CRSV face a range of physical and emotional effects. They may suffer physical consequences such as injury or STIs and struggle with emotional effects, including damaged self-esteem, fear, shame, and silence. These emotions can escalate to depression, anxiety, and PTSD, making it harder for ABMY survivors to seek help. Social and cultural norms and views on masculinity often prevent them from speaking out and seeking support. To effectively support ABMY survivors of CRSV, it is crucial to consider both the physical and emotional effects and the ways in which they may manifest. The "do no harm" principle must be considered when developing support strategies.

   Slide 4: Access to care

   Survivors of sexual violence, including ABMY and CRSV survivors, may have a hard time accessing and staying in services, including MHPSS services. Many ABMY do not get help or do not follow up with their treatment, including in humanitarian settings. Some possible reasons are not having enough time, going back to one's home country or community, being financially unstable, not being able to get transportation, not having enough money, or coping with various illnesses. However, there are also external barriers, such as a low number of resources offered to ABMY, inaccessibility (for example, difficulties in registering transgender individuals in certain institutions). Armed people and groups

often put MHPSS clients and survivors in danger. One of the stories we have heard a lot is that ABMY survivors (especially those with diverse SOGIESC) often do not access services due to shame and guilt, as they are often perceived as “outsiders” in the community.

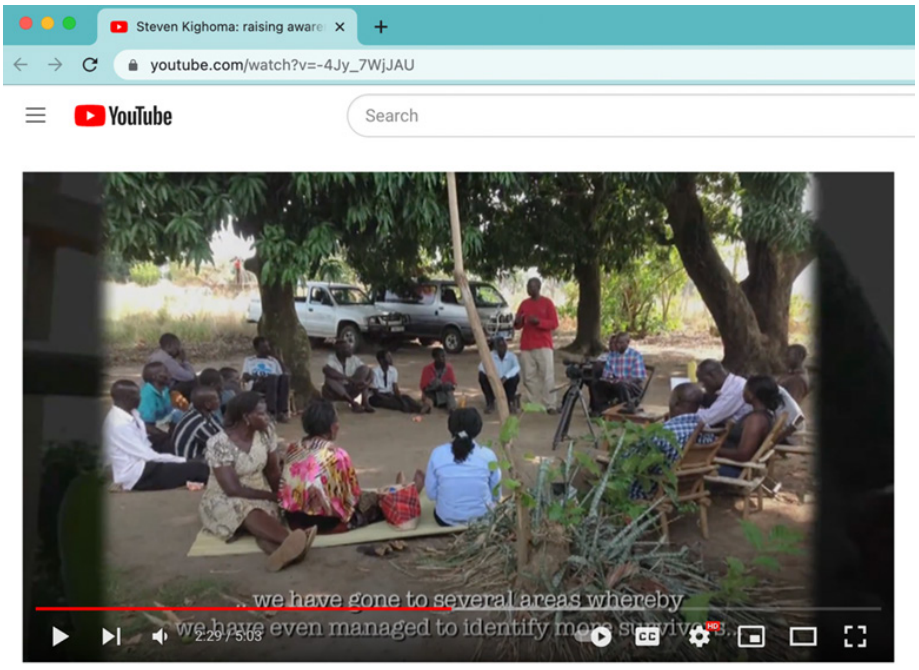
In addition, ABMY survivors may encounter barriers to care due to cultural or religious beliefs that influence their access to services. For example, some communities may prohibit or discourage individuals from seeking mental health care, viewing it as a sign of weakness or a form of Western influence. This can create a significant barrier to care for ABMY survivors who may be struggling with the psychological and emotional effects of sexual violence. It is important to recognize and address these barriers to care in order to ensure that ABMY survivors of sexual violence are able to access the support they need to heal and recover. This may involve creating safe and welcoming spaces for this population, providing education and training to service providers on how to support survivors with diverse SOGIESC, and working to create more inclusive and accepting communities.

Slide 5: What unique barriers may ABMY with diverse SOGIESC face in accessing and receiving services?

ABMY with diverse SOGIESC may face unique barriers to accessing services due to social and cultural norms that stigmatize or ostracize individuals with diverse SOGIESC. These norms may be deeply ingrained in the community and can create a sense of shame or guilt for survivors who do not conform to traditional gender roles or sexual orientations. As a result, they may be reluctant to seek help or disclose their experiences for fear of further marginalization or discrimination.

During interviews that were conducted by the WRC team with professionals who work with ABMY in Cox’s Bazar (Bangladesh), Lebanon and Colombia, a common denominator that was mentioned is that organizations and staff shy away from this topic and have a low level of understanding that ABMY can also be survivors of CRSV. Reasons cited are mostly a focus on CRSV against women and girls, cultural and religious sensitivities, as well as patriarchal attitudes and gendered perceptions of masculinity and ABMY’s vulnerabilities. For younger ABMY, there might be more understanding, but for older ABMY, being sexually violated is perceived as a threat to their masculinity. It is seen as something shameful.

3. Present the Institute of Development Studies’ video (5 minutes) from YouTube, during which a male survivor activist gives his perspective on responses to his experience of CRSV.



Steven Kighoma: raising awareness of conflict related sexual violence against men and boys.

4. Discuss the video as a group. Below are some questions to guide the discussion..

    - *"What challenges and barriers do ABMY survivors face in accessing and receiving services and care? What challenges and barriers do you see in your work? How can these challenges and barriers be addressed?"*
    - *"What challenges and barriers do providers and practitioners face in offering and delivering services and care? What challenges and barriers do you see in your work? How can these challenges and barriers be addressed?"*

Step 4.1: Exercise and handout on myths and facts related to male survivors of sexual violence and exploitation, including those with diverse SOGIESC

Time: 45 minutes

Materials: Two signs with "Myth" and "Fact" on, tape, printed Handout 5.4.1

Objective:

- Challenge commonly-held myths and misperceptions about male survivors of sexual violence and sexual exploitation, including those with diverse SOGIESC.
- Understand why these myths or misperceptions are wrong.

Exercise instructions:

1. Prepare two signs, "Myth" and "Fact", and place them on opposite sides of the room.
2. Tell the participants that you will be reading out statements about male survivors of sexual violence and sexual exploitation, including those with diverse SOGIESC. The participants will then need to decide whether each statement is a myth or a fact and move to the corresponding sign.
3. To begin, have the participants stand in the middle of the two signs. Read the first statement from the handout twice to ensure all participants have heard it. After the statement, tell the participants to choose "Myth" or "Fact." Ask two or three people why they are standing where they are. Probe further with additional questions if needed, e.g., on the first statement, ask participants "Do laws in this setting recognize male rape as a criminal act? Which law(s) exist related to sexual violence against men and boys?" Allow for a short discussion to take place.
4. Clarify and correct the points raised by the participants by using the explanation provided for each statement in Handout 5.4.1.
5. Repeat this process for each of the statements.
6. Distribute the handout to the participants.

Step 5: A survivor-centered approach to addressing CRSV

Time: 30 minutes

Materials: Handout 5.5, pens

Objective: Explore the barriers and challenges that ABMY survivors of CRSV face in accessing services.

Notes for the facilitator: A survivor-centered approach to CRSV puts the needs, wants, and rights of the survivor first in order to allow them to regain power. It entails working to ensure that the survivor has access to services such as MHPSS and that these services are appropriate, accessible, and high quality. It also means working to ensure that the survivor will be respected, believed, and supported by the community and services providers. This approach helps them to heal and makes it easier for them to choose between possible solutions (and if there are none, it provides them with a platform to say what they need).

Instructions for the facilitator:

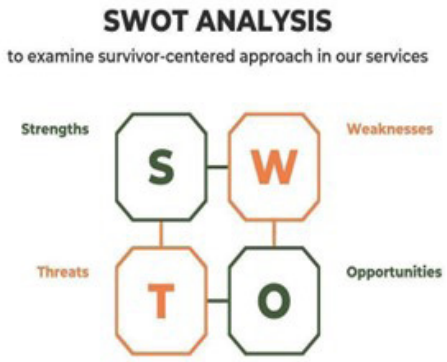
1. Define a survivor-centered approach for the participants by reading aloud the following:

   "A survivor-centered approach works to ensure that each survivor is treated with dignity and respect and that their rights are at the center of all decisions. This kind of approach gives the survivor more power and self-determination, helps them heal, and puts them at the center of the process. A survivor-centered approach can help a survivor by building trust and giving them back some control over their lives."[99]

2. Ask participants to reflect on this approach and discuss how it is (or isn't) used in their own work.

3. Explain SWOT analysis to the participants:

   "In this session, we will use the strengths, weaknesses, opportunities, and threats (SWOT) analysis to understand the factors that affect our services and strengthen or weaken their ability to provide a survivor-centered approach to ABMY survivors of CRSV. SWOT is a method used to examine programs and services, to understand how they can improve.[100] *Through its use, we will be able to advocate within our respective organizations and tackle any threats or weaknesses that we might recognize, while reinforcing the positive elements of our work. The SWOT analysis is divided into internal and external factors."*



4. Discuss internal and external factors with the participants:

   - Internal factors: Include the strengths and the weaknesses of our services.
     - **Strengths:** Things that our services do well, internal resources such as specialized community-based or grassroot organizations providing assistance, tangible assets such as human capital, culture etc.
     - **Weaknesses:** Things that our services lack, resource limitations, sociopolitical environment that prevents us from reaching potential service consumers.
   - External factors: Include the opportunities and threats of our services.
     - **Opportunities:** Current emerging need for our services, local initiatives or voices coming from the communities.
     - **Threats:** COVID-19 related regulations, changing community attitudes toward our services for and among ABMY survivors, bureaucracy, budget.

5. Pass out Handout 5.5 to the participants.

6. Give participants 15 minutes to fill out the handout. Encourage them to provide specific examples of their service and organization. You can also assist them by reminding them to think on the following levels:

   - individual (for example, what might affect the individual not to ask for help in your specific organization?)
   - systematic (for example, there is no coverage for ABMY to use certain facilities)
   - macro (for example, shame, guilt, stigma)

7. Reconvene the group and ask them to share some thoughts and reflections on their responses to the handout (10 minutes).

99 Klearchos A. Kryiakides and Andreas K. Demetriades, "Survivor-centered approaches to conflict-related sexual violence in international humanitarian and human rights law," *AMA Journal of Ethics* 24, no. 6 (June 2022): pp. E495–517.

100 Dac Teoli, Terrence Sanvictores, and Jason An, SWOT Analysis, 2019, https://www.ncbi.nlm.nih.gov/books/NBK537302/.

Step 6: Closing—We are all in this together

Time: 20 minutes

Materials: Handout 5.6

Objective: Motivate participants to make their service more friendly, accepting, and empowering for ABMY survivors of CRSV.

Notes for the facilitator: The purpose of delivering this poem (Handout 5.6) is to stress that CRSV is motivated by things that happen around us—it stems from gender power relations, from chauvinism, from homophobia, racism, and violence. If you feel that this poem would be useful to share with your participants, please do so. Otherwise, you are welcome to share another poem or art piece that may encourage reflection among your group.

Instructions for the facilitator:

1. Read the following poem out loud to the group. Preferably, you can ask one of the participants to read it or ask each participant to read a few lines.
2. Reflect on and discuss the poem. Some guiding questions are:
    - *"What is Szymborska talking about?"*
    - *"What does 'it's a political age' mean? Do you agree with this statement?"*
    - *"How does the 'political age' relate to ABMY survivors of CRSV?"*
3. End the session by stating: *"Often, ABMY survivors of CRSV internalize guilt and shame. This is common among ABMY who have been sexually violated. In the case of survivors of CRSV, it is important to remember that they have been subjected to cruel, unjust actions that arose from conflicts over politics and power. We should stand with them, protect them, and acknowledge that they might have complex reactions to the violence they have been through."*

Closing and post-test

Time: 36 minutes

Materials: Training evaluation form, Handout 5.7 (1 per participant), training certificates (1 per participant)

Objective: Close the workshop by thanking participants for their engagement, summarizing key learnings, answering any last questions, and providing an opportunity for participants to evaluate the workshop.

Instructions for the facilitator:

1. Thank the participants for their participation and dedication in this workshop (2 minutes).
2. Using a flip chart or PowerPoint slides, Summarize the topics that were covered throughout the training, and answer any last questions (3 minutes).
3. Provide contact details in case there are questions on the workshop content (1 minute).
4. Distribute the training evaluation form (20 minutes).
5. Distribute the training evaluation form (20 minutes).

Annex 1. Key findings that informed the evidence base of the training curriculum

Key findings from the literature review

There is limited evidence documenting adolescent boys and male youth's (ABMY)–especially people with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC)–experiences as victims or survivors of sexual violence. However, studies, articles, and guidelines/tool kits that address ABMY survivors recognize that understanding intersectionality is essential to addressing a whole range of topics, such as mental health and psychosocial support (MHPSS) outcomes, microaggressions, and coping with gender dysphoria or homophobia.

There is some discussion in the literature on the illustration of sexual violence against ABMY as an act that deconstructs relations of power and "masculine" performance (men as victims/survivors). This demonstrates that inhabiting a masculine body or masculine performance does not necessarily guarantee specific life experiences related to sexual violence. Deconstructing gender-inequitable power relations is an important objective for any MHPSS intervention—sexual violence can happen to anyone.

A lack of evidence exists on effective approaches, such as support groups and peer groups, to address the diverse needs of ABMY youth survivors of sexual violence (including lesbian, gay, bisexual, transgender, queer or questioning, intersex [LGBTQI+] individuals), especially in humanitarian settings. When the objectives of support groups are mentioned, they are usually included in the context of educational interventions in schools, such as leading an activist group, with little to no attention paid to MHPSS mechanisms.

Due to the lack of attention paid to ABMY survivors, including people with diverse SOGIESC, in humanitarian settings, most documents included in this literature review were produced through academic institutions or by individual researchers rather than via professional humanitarian organizations or service providers

Key findings from key informant interviews

The main issues that were recommended for discussion in relation to MHPSS were as follows:

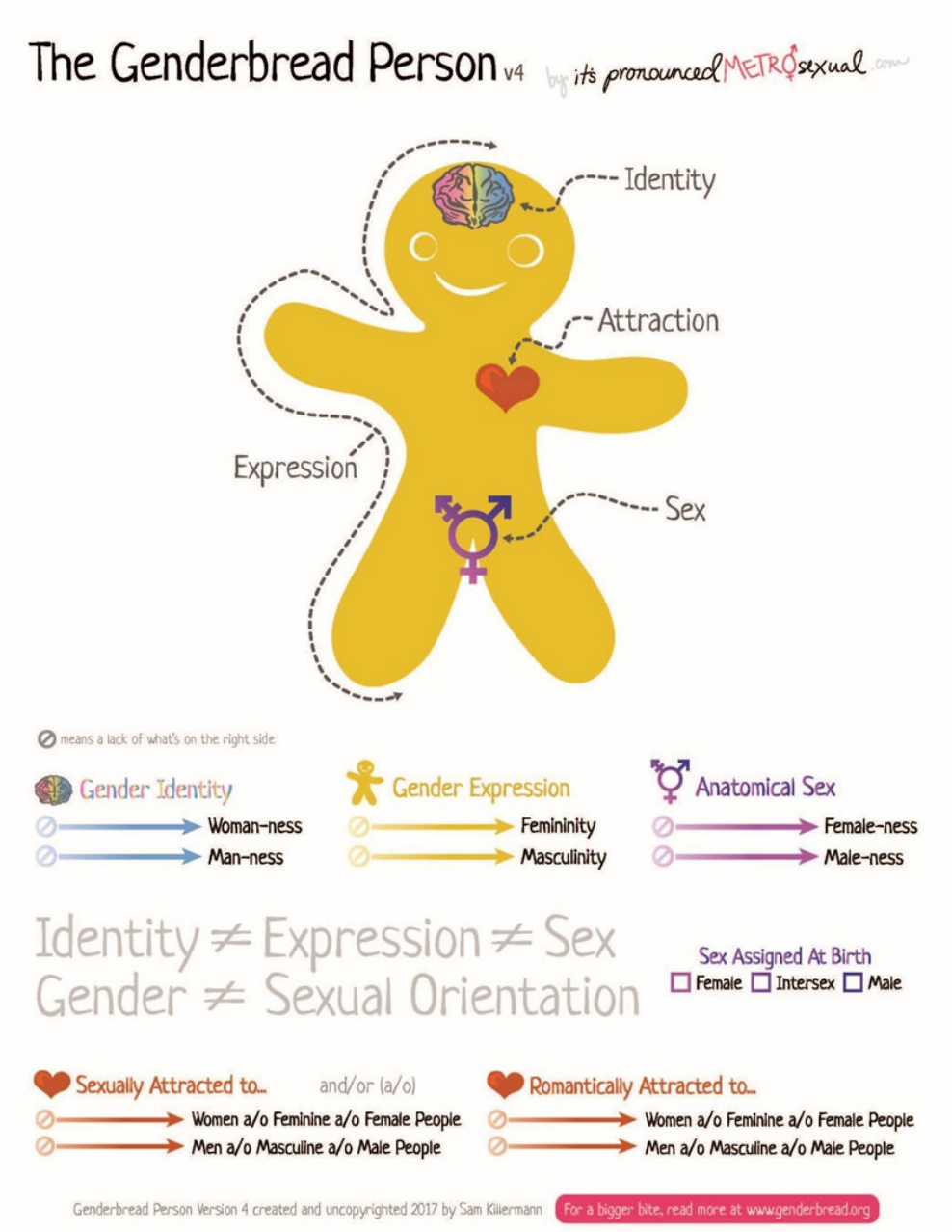
- Emotional, psychosocial, and cognitive issues:
    - anxiety, post-traumatic stress disorder (PTSD), depression, dissociation, complex trauma, personality disorders
    - alienation from family and community
    - substance use (drugs, alcohol)
    - risky sexual behaviors
    - attachment issues
- Youth emotional development, with a focus on SOGIESC and ABMY survivors:
    - The psychological effects of being queer among youth
    - Theories related to adolescence, and how they manifest in SOGIESC youth.

- Gender diversity training: Information and definitions about LGBTQI+ identities (gender, sexual orientation, transgender, performance or wearing clothes that identify with a different gender than the one assigned at birth), intersectionality, taboos and wrong assumptions, cultural awareness training
- Understanding that children must cope with ambiguous loss such as losing innocence at a young age; knowing or being related to their perpetrator; the effects of sexual violence on youth and how they manifest as risky behaviors
- Stigmas and biases on mental health
- Suicide prevention
- Normalization of physical contact with psychomotricity
- Naming feelings (related to cognitive behavioral therapy [CBT] and dialectical behavior therapy [DBT]) and ways to address them
- Cognitive review in adolescence
- Peer support groups, including guidelines and best practices
- Monitoring and evaluation of programs to detect impact

Handouts

Module 2 – Handout 2.2: Concepts and terms related to gender, sex, and sexual orientation

Note: This handout is optional. You can exclude this handout if you feel it is not context-specific.



Module 2 – Handout 2.5: Minority stress case studies

Note: **PRIOR** to implementing this activity, review the examples and adapt the descriptions to highlight minority groups in your context.

A Muslim woman experiences discrimination and prejudice because of her religion and culture, leading to increased stress and anxiety.
A transgender man faces challenges in accessing health care and employment due to discrimination, resulting in increased financial and emotional stress.
A person with a disability experiences social exclusion and limited access to public spaces, leading to feelings of isolation and loneliness.
A Black man experiences racial profiling and discrimination from law enforcement, causing increased fear and stress.
A lesbian couple faces discrimination and prejudice when seeking to adopt a child, causing additional stress and emotional distress.
A gay adolescent boy experiences bullying and social exclusion from his peers at school, resulting in feelings of shame and emotional distress.

Module 3 – Handout 3.2: Analyzing power dynamics

Note: This handout is only for the facilitator. It is recommended that the facilitator review each of the characters described below, and revise and adapt the names and characters to suit their particular setting. The facilitator should then cut out each character strip and provide one to each participant.

Ali is a transgender man who faces discrimination and harassment in a refugee camp.
Zara is a lesbian woman who is afraid to come out to her family and community due to fear of rejection and disappointing her parents, who are struggling with displacement.
Lilach is a gender-non-conforming woman who faces discrimination and prejudice from her family, friends, and coworkers.
Amira is a non-binary person who is frequently misgendered by the people around them.
Ravi is a closeted gay man who is married to a woman to conform to societal expectations.
Naima is a transgender woman who has been denied health care and employment due to discrimination; both due to her gender performance, and racial discrimination.
Maria is a bisexual woman who is constantly told that her identity is a phase or a choice, and that it is a result of the conflict-related sexual violence (CRSV) that she experienced.
Shmuel is a genderqueer person who is frequently misgendered and discriminated against by the health care system.
Samira is a young lesbian woman who is told by her family that she needs to be in a heterosexual relationship to be happy and fulfilled.
Ali is a gay man who is constantly told that he is not masculine enough and mocked by other men at the resettlement camp.
Aisha is an intersex person who has been subjected to unnecessary medical procedures without their consent.
Fatimah is a transgender woman who has been denied access to housing and public accommodation due to discrimination against people who are transgender.
Ahmed is a gay man who has been shunned and forced to leave his community due to his sexual orientation
Rania is a gender-non-conforming woman who has been denied access to education and employment due to societal norms and expectations of women
Leila is a woman who has been forced into marriage by her family and subjected to abuse and violence within the marriage.

Asma is a woman who has been denied access to education and employment due to her gender, lack of legal status and socioeconomic status.
Fatima is a woman who was subjected to female genital mutilation (FGM) as a child. She experiences physical and emotional pain and trauma as a result of the procedure.
Aisha is a woman who has been denied the right to vote and participate in political decisions due to her gender. She is unable to have a voice on the issues that affect her community.
Zainab is a woman who has been denied access to sexual and reproductive health services due to gender discrimination and sociocultural norms and beliefs.

Module 3 – Handout 3.3: Case studies

Note: This handout is only for the facilitator. It is recommended that the facilitator review each of the scenarios and characters described below, and revise and adapt them to suit their particular setting. The facilitator should then cut out each strip and provide one to each group of participants. The answer key for this handout is on the next page.

Caste study 1: Conflict-related sexual violence (CRSV) against male youth

Jorge (age 24) was a baker who lived at home with his parents and siblings in a small town. Then a war broke out in his country. One day, a group of armed soldiers came to Jorge's home and killed his family. He was able to hide for a while, but when he tried to escape through the woods, the soldiers found him. They held him hostage, and during that time, he was raped several times. He is highly traumatized and injured.

Case study 2: Sexual violence perpetrated against adolescent boys and male youth (ABMY) with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC)

Saida (age 18) identifies as a transgender woman. She started her transition (male-to-female) when she was 16, right after she escaped from home. She moved to the city and gained a large group of friends who support her. Because of discrimination in her community toward transgender people, it was difficult for her to find a job to finance herself. She is currently a sex worker and is waiting to get enough money so she can leave the country and build a new life. She is a very talented musician.

Case study 3: Forced witnessing as a form of sexual gender-based violence (SGBV)

Fazal (age 16) is a high school student, currently studying in the 11th grade. He is very good at science and would like to become a doctor. He is currently living with his parents and siblings in a refugee camp. One day, a group of armed militia attacks the refugee camp. Threatened, Fazal is forced to witness the armed militia sexually assault his female classmate. Fazal is extremely traumatized by the event and feels guilty for watching and not helping her. He joins a local group to fight the militia.

Effects	Case 1: Jorge	Case 2: Saida	Case 3: Fazal
Psychological	Jorge may experience symptoms of PTSD, such as flashbacks, nightmares, and anxiety. He may also feel a sense of shame, guilt, and self-blame for the rape. Jorge may struggle with depression, hopelessness, and suicidal thoughts.	Saida may experience symptoms of PTSD, depression, and anxiety. She may also struggle with feelings of shame, guilt, and self-blame due to societal stigma around her gender identity and sex work.	Fazal may experience symptoms of PTSD, depression, and anxiety. He may also struggle with guilt and self-blame for not being able to protect his classmate.
Social	Jorge may feel isolated and disconnected from others. He may have difficulty trusting others or forming relationships due to the trauma he experienced.	Saida may feel isolated and disconnected from her family and community. She may have difficulty finding employment or accessing services due to discrimination.	Fazal may have difficulty trusting others or forming relationships due to the trauma he experienced. He may also feel a sense of anger and resentment toward the armed militia and other perpetrators of sexual violence.
Physical	Jorge may have physical injuries from the rape, such as bruises and lacerations. He may also experience chronic pain, headaches, and gastrointestinal problems due to stress.	Saida may have physical injuries from the sexual violence, such as bruises and lacerations. She may also experience reproductive health problems, such as sexually transmitted infections (STIs) or unintended pregnancy.	Fazal may have physical symptoms related to stress and trauma, such as headaches and gastrointestinal problems.
Recommendations	Refer Jorge to trauma-focused therapy or medical care; coordinate the referral and ensure that it is respectful toward Jorge.	Provide psychoeducation and advocacy around the rights of transgender individuals, and work to reduce stigma and discrimination in the community. Also, if and when referring Saida to other services, ensure the service is transgender-friendly and respectful.	Refer Fazal to trauma-focused therapy; coordinate the referral and ensure that it is respectful toward Fazal.

Module 3 – Handout 3.4: Cards with scenarios using the terms “victim”, “patient”, and “survivor”

Note: This handout is only for the facilitator. It is recommended that the facilitator review each of the scenarios and characters described, and revise and adapt them to their particular setting. The facilitator should then cut out each strip and provide one to each group of participants.

Scenario 1:

A 15-year-old adolescent boy from a low-income neighborhood in Lebanon is sexually assaulted by a group of older boys from his school. He struggles to speak about the assault and is hesitant to seek help due to shame and fear of being stigmatized. He is referred to as a “victim” by health care professionals and is not given a choice in the type of support he receives.

Scenario 2:

A 17-year-old male youth from a rural community in Colombia is harassed and sexually assaulted by a group of armed actors. Over the course of the conflict, he is forced to flee his home and is displaced to a refugee camp. He is referred to as a “displaced person” and is not given any specific support for the sexual violence he experienced.

Scenario 3:

An 18-year-old adolescent boy from the Rohingya refugee community in Cox’s Bazar is raped by a group of men from the local host community. He is referred to as a “survivor” by the aid workers providing him with support and is involved in the decision-making process for the type of support he receives

Scenario 4:

A 16-year-old adolescent boy from Syria is kidnapped and physically and sexually abused by a group of armed men. He is referred to as a “patient” by health care professionals and is not given any information on the support services available to him, or how he can access them.

Module 4 – Handout 4.B5: Common reactions after sexual assault[101]

While each survivor is unique in their experience, many survivors are impacted in the following ways:

Flashbacks

Victims may re-experience the assault over and over again in their thoughts and/or in their dreams. When this happens, it is almost as though the assault is actually occurring again.

Fear

The most common victim reaction to sexual assault is fear. Fear responses associated with the assault (to certain sights, sounds, smells, thoughts, etc.) can persists for weeks, months, or even years. Some men and women become so fearful that they greatly restrict their activities, even to the point that they are unable to leave their homes or to be left alone.

Feeling dirty

Self-image frequently suffers as a result of the assault. Many victims report feeling “dirty” and may take frequent showers in an effort to feel clean.

Loss of interest in sex

After an assault, it is not unusual for the victim to experience a significant loss of interest in sexual relations. It is understandable that sexual assault trauma would lead to an avoidance of sexual activity.

Trouble concentrating

Sexual assault victims may find that they have trouble concentrating on things. They may struggle to keep their minds on what they are doing.

Depression

Another common reaction to sexual assault is a sense of sadness or depression. There may be feelings of hopelessness and despair, frequent crying spells, and sometimes even thoughts of suicide. A loss of interest in activities and things that previously were enjoyable often accompanies these feelings of sadness and despair. Nothing seems like it is fun anymore. This can also lead to disrupted relations.

101 Adapted from https://www.wcsap.org/help/about-sexual-assault/effects-sexual-assault ; https://www.amherstma.gov/1000/Common-Reactions-to-a-Sexual-Assault ; and https://www.loyola.edu/department/counseling-center/services/students/concerns

Module 4 – Handout 4.D1: Psychological first aid (PFA) pocket guide

Note: This handout is provided as a resource to participants. Click the link and print out one copy per participant:

https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/pfapocket_guide.pdf

LGBTQI+ mental health services safety checklist

Creating a checklist to assess the safety and inclusivity of mental health services for LGBTQI+ individuals, including gay people, is crucial to ensure that the services are supportive and respectful. You can use this checklist as a starting point. Adapt it based on specific organizational or regional needs:

Organizational policies and culture

1. Non-discrimination policies:
    - Ensure the mental health service provider has explicit non-discrimination policies that include sexual orientation and gender identity.
2. Inclusive language:
    - Assess whether the organization uses inclusive language in its materials, forms, and communication.
3. Training and sensitivity:
    - Check if staff members receive training on LGBTQI+ cultural competence and sensitivity.
4. Visible inclusivity:
    - Look for visible signs of LGBTQI+ inclusivity in the organization's physical space, such as posters, literature, or symbols.

Provider competency

5. Specialized training:
    - Confirm that mental health professionals have received specialized training in LGBTQI+ mental health.
6. Cultural competence:
    - Assess the provider's cultural competence in understanding and addressing the unique mental health needs of LGBTQI+ individuals.
7. Affirmative therapy:
    - Find out whether therapists practice affirmative therapy, which affirms the identities and experiences of LGBTQI+ individuals.

Accessibility and inclusivity

8. Appointment flexibility:
    - Check whether the organization offers flexible appointment scheduling to accommodate diverse needs.
9. Inclusive forms:
    - Ensure that intake forms include options for sexual orientation and gender identity, allowing individuals to self-identify.
10. Gender-inclusive facilities:
    - Confirm that facilities, including restrooms, are gender-inclusive and accommodating to diverse gender identities.

Privacy and confidentiality

11. Privacy policies:

- Review the organization's privacy policies and ensure that LGBTQI+ individuals' confidentiality is protected.

12. Outreach efforts:

- Check if the organization has mechanisms in place to reach out to LGBTQI+ communities and reduce potential stigma.

Feedback and continuous improvement

13. Feedback mechanisms:

- Ensure there are channels for clients to provide feedback on their experiences, including any concerns related to LGBTQI+ inclusivity.

14. Cultural competence audits:

- Periodically assess the organization's cultural competence through audits and feedback loops.

15. Continuous training:

- Confirm that staff members engage in ongoing training to stay informed about evolving LGBTQI+ mental health best practices.

Community partnerships

16. Community engagement:

- Ensure there are channels for clients to provide feedback on their experiences, including any concerns related to LGBTQI+ inclusivity.

17. Referral networks:

- Ensure there are channels for clients to provide feedback on their experiences, including any concerns related to LGBTQI+ inclusivity.

Legal compliance

18. Legal protections:

- Ensure that the mental health services adhere to local and national legal protections for LGBTQI+ individuals.

19. Confidentiality protections:

- Confirm that the organization complies with confidentiality laws, especially those protecting LGBTQI+ individuals.

Emergency protocols

20. Legal protections:

- Verify that the organization has protocols in place for LGBTQI+ individuals in crisis, including suicide prevention.

This checklist is a starting point, and it can be customized based on specific needs and regulations. There should be regular reviews and updates to ensure ongoing commitment to LGBTQI+ inclusivity and mental health support.

Module 5 – Handout 5.2: Diving deeper

Who are survivors of conflict-related sexual violence (CRSV)?

Because of historical and structural inequality, women and girls are more frequently targeted by CRSV than men and boys. However, CRSV also affects men, boys, and people who are sexually or gender diverse (SOGIESC). Internally displaced persons, widows, migrants, female heads of household, detainees, people with disabilities, and certain ethnic and minority groups are also more likely to be sexually abused than others during a conflict.[102]

CRSV can cause severe physical injuries and long-term psychological trauma, as well as sexually transmitted infections (STIs) and, in some cases, death. Survivors often may face shame and/or rejection from their communities and families, in addition to dangerous and long-term trauma and injuries.[103]

Some survivors of CRSV have unplanned pregnancies, and mothers of children born as a result of rape during wartime may face rejection from their own families and communities. They may also have difficulty registering their child's birth and legal name, or securing their citizenship rights.[104]

How does CRSV affect adolescent boys and male youth (ABMY)?

Men and boys may be hesitant to speak up because of the stigma and physical and mental consequences of being perceived as weak. CRSV mostly affects women and girls, but some men and boys can also be directly hurt by it. Even in places where women and girls are more likely to be the victims, men and boys may be forced to witness sexual violence. This is especially true when it is used as a common form of warfare.[105] Also, if women and young people don't have enough money or can't get in touch with their families and communities, they may be forced into prostitution or forced to trade sexual favors for money. In conflict and post-conflict situations, men can be perpetrators, victims, witnesses, and agents of change when it comes to CRSV. In this section, we will explore these four different groups, and try to understand what our most effective intervention can be when working with ABMY in those scenarios.

Some examples of sexual violence are rape, sexual torture, genital mutilation, sexual humiliation, sexual enslavement, and forcing a man to rape someone or masturbate. These horrible things are often done to keep ABMY in a weaker position than the aggressor, and make the power dynamic clear to all.

ABMY are often sexually abused in public. When sexual violence against men happens in public places, families, peers, and combatants see it as a sign of taking over a territory, which often leads to feelings of extreme shame and guilt.[106] Even though the numbers are lower than those for sexual violence against women and girls, less is known about sexual violence against men and boys. As already indicated, shame, humiliation, homophobia, fear of being judged as a male survivor, and the fact that men often don't get as much attention as women when they are victims of sexual violence all help explain why more men don't talk about it.

102 Nissou Ines Dossa et al., "Mental health disorders among women victims of conflict-related sexual violence in the Democratic Republic of Congo," *Journal of Interpersonal Violence* 30, no. 13 (August 2015): pp. 2199–2220.

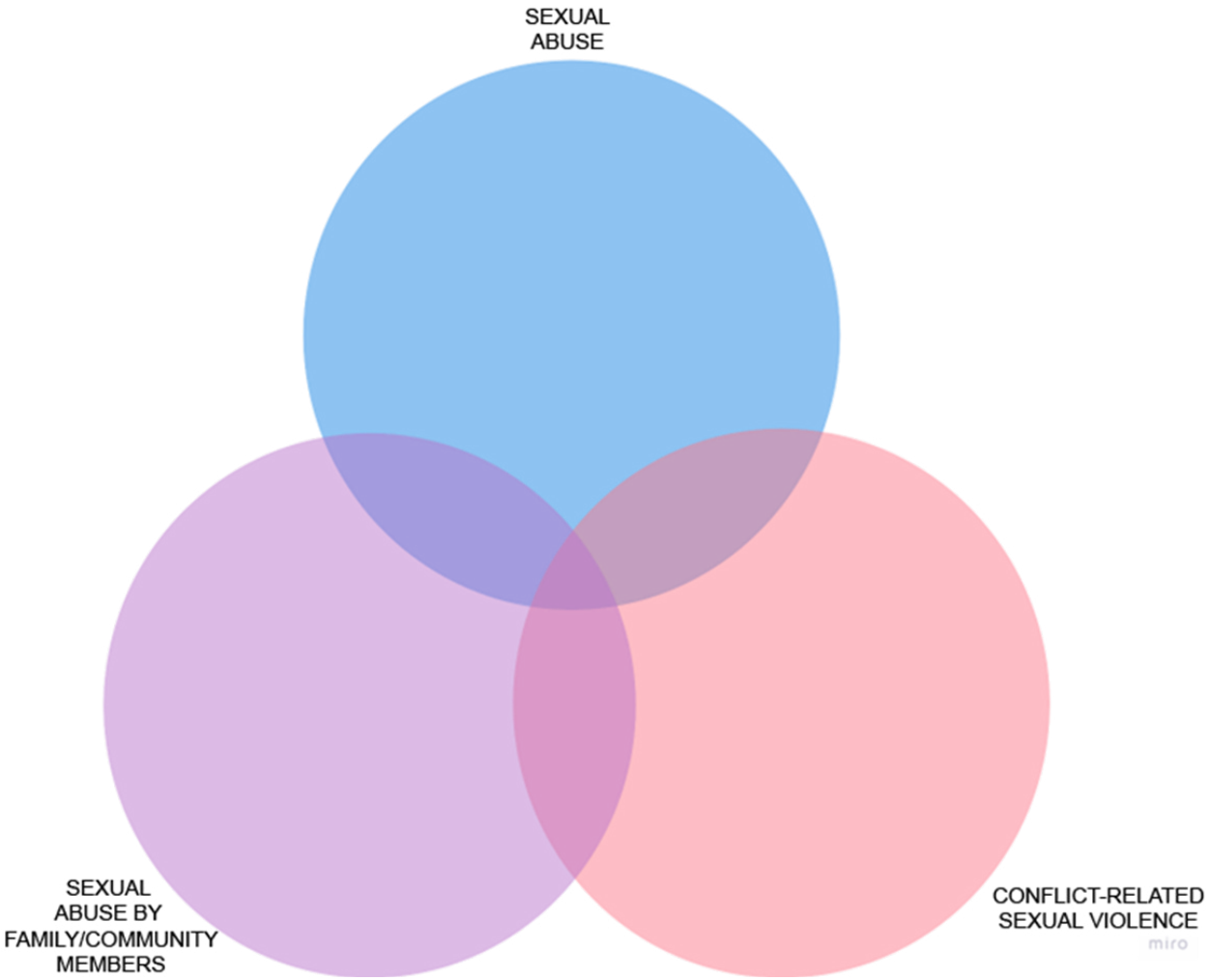
103 Louise Du Toit and Elisabet le Roux, "A feminist reflection on male victims of conflict-related sexual violence," *European Journal of Women's Studies* 28, no. 2 (February 2021): pp. 115–128.

104 Carlo Koos, "Decay or resilience? The long-term social consequences of conflict-related sexual violence in Sierra Leone," *World Politics* 70, no. 2 (April 2018): pp. 194–238

105 Emeka Thaddues Njoku and Isaac Dery, "Spiritual security: an explanatory framework for conflict-related sexual violence against men," *International Affairs* 97, no. 6 (November 2021): pp. 1785–1803.

106 Sara Meger, "The political economy of sexual violence against men and boys in armed conflict." In Marysia Zalewski et al. (eds), *Sexual Violence Against Men in Global Politics* (London: Routledge, 2018), pp. 102–116.

Module 5 – Handout 5.3.1: Distinction between sexual abuse, CRSV, and sexual abuse by family/community members (Venn diagram)



Module 5 – Handout 5.3.2: Distinction between sexual abuse, CRSV, sexual abuse by community/family members (List for Venn diagram activity)

Note: This handout is optional. You may adapt it according to the specific needs of your group and the context you are in.

Definitions:
1. Incidents or patterns of sexual violence that occur in conflict or post-conflict settings or other situations of concern (e.g., political strife).
2. Any form of sexual activity with a child by an adult or by another child who has power over the child
3. Any form of sexual activity with a child by an adult family or community member

Causes	Consequences/Impacts
• Ethnic and religious discrimination • Familial and community pressure • Lack of education and awareness about consent and healthy relationships • Political agenda • Power imbalances (e.g., between a parent and a child) • Power imbalances (e.g., between armed groups and civilians) • Power imbalances (e.g., between an adult and a child) • Substance abuse • Societal attitudes that condone or trivialize sexual violence • Trauma and mental health issues in the perpetrator	• Physical injuries • Difficulty in coping with daily life activities • Difficulty in forming healthy relationships • Difficulty in seeking help • Difficulty in trusting others • Displacement and loss of home • Emotional trauma • Fear of rejection and isolation • Fear of retaliation • Loss of family and community • Mental health problems such as depression, anxiety, and PTSD

Module 5 – Handout 5.4.1: Myths and facts related to male survivors of sexual violence and exploitation, including those with diverse SOGIESC

Myths

Statement	Explanation
Men cannot be raped.	Sexual violence can happen to anyone, regardless of their gender. Male survivors of sexual violence and exploitation do exist, and their experiences are just as valid and real as those of female survivors.
Men who experience sexual violence must be gay or must have wanted it.	Sexual violence is never the survivor's fault, and sexual orientation or sexual desire has nothing to do with it. Sexual violence is an act of power and control by the perpetrator, and it can happen to anyone.
Male survivors of sexual violence are only abused by other men.	Sexual violence against men can be perpetrated by people of any gender, including women. It is important to acknowledge and address all forms of sexual violence, regardless of the gender of the perpetrator.
Men can experience physical arousal during sexual violence, so it must mean they wanted it.	A survivor's physical response during sexual violence does not indicate that they wanted it or enjoyed it. It is a physiological response that can occur involuntarily and does not reflect the survivor's feelings or desires.
Men cannot experience emotional trauma from sexual violence.	Sexual violence can have long-lasting emotional effects on survivors, regardless of their gender. Survivors may experience symptoms of post-traumatic stress disorder (PTSD), anxiety, depression, and other mental health issues.

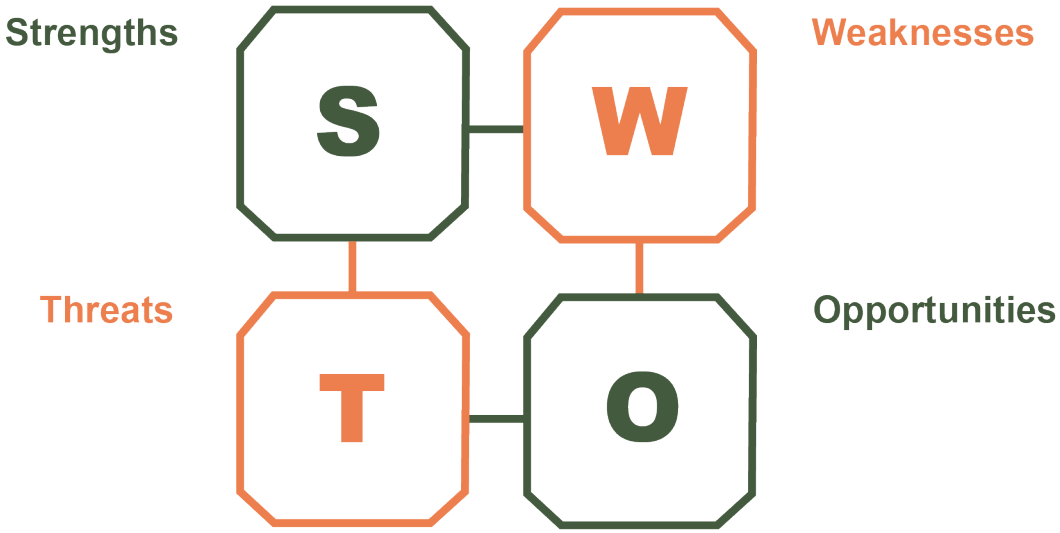
Facts

Statement	Explanation
Survivors may experience physical health effects.	Survivors of sexual violence may experience physical health effects, including STIs, chronic pain, and other medical issues related to their trauma.
Sexual violence is never the survivor's fault.	It is important to understand that sexual violence is always the responsibility of the perpetrator. No survivor should be blamed or shamed for what has happened to them.
Perpetrators can be of any gender.	It is important to understand that perpetrators of sexual violence can be of any gender, and survivors may experience violence from people of different genders than their own.
Male survivors face unique challenges in seeking help.	Due to societal stigma and a lack of understanding about male sexual victimization, male survivors may face additional barriers when seeking help and support.

Physical response does not indicate consent.	It is a common myth that a physical response, such as an erection, indicates consent. However, physical responses can occur involuntarily and do not indicate consent.

SWOT ANALYSIS

to examine a survivor-centered approach in our services



Module 5 – Handout 5.6: We are all in this together

Children of Our Age

By Wislawa Szymborska

We are children of our age,
it's a political age.

All day long, all through the night,
all affairs—yours, ours, theirs—
are political affairs.

Whether you like it or not,
your genes have a political past,
your skin, a political cast,
your eyes, a political slant.

Whatever you say reverberates,
whatever you don't say speaks for itself.
So either way you're talking politics.

Even when you take to the woods,
you're taking political steps
on political grounds.

Apolitical poems are also political,
and above us shines a moon
no longer purely lunar.
To be or not to be, that is the question
and though it troubles the digestion
it's a question, as always, of politics.

To acquire a political meaning
you don't even have to be human.
Raw material will do,
or protein feed, or crude oil,

or a conference table whose shape

was quarreled over for months:

Should we arbitrate life and death

at a round table or a square one.

Meanwhile, people perished,

animals died,

houses burned,

and the fields ran wild

just as in times immemorial

and less political.

Module 5 – Handout 5.7: Feedback form

Complete the following questions to share feedback on your experience of Part I: theoretical modules. The answers to the questions are anonymous. The facilitator will use the group's responses to improve future trainings. Thank you for your input!

1. Was the training content relevant to your work?
    a. Yes
    b. Somewhat
    c. No
2. How would you rate your overall learning experience?
    a. Excellent
    b. Not bad
    c. Poor
    d. Very poor
3. How could we improve the overall learning experience?

4. Please tell us which parts of this training you enjoyed the most.

5. How could we make the training materials more relevant to your work (e.g., provide an overview of statistics on sexual violence in your country, provide fluent native speakers)?

6. Is there anything else you'd like to share with us to help improve future trainings on this topic?

Thank you for participating in the [insert organization name] training. If you have any questions or would like more information, please contact [project lead name, position, and email].

Thank you!


WOMEN'S
REFUGEE
COMMISSION