

# FINAL REPORT

## Responding to the Psychosocial and Mental Health Needs of Sexual Violence Survivors in Conflict-Affected Settings

28-30 November 2011, Park & Suites Hotel, Ferney-Voltaire, France



## Executive summary

Sexual violence is an important documented correlate and consequence of conflict – an estimated 1.5 billion people live in countries affected by conflict. Sexual violence can have multiple health and social effects on survivors, their social networks, and their communities. High rates of psychological problems have been documented in survivors of sexual violence in areas of armed conflict. Reported mental health problems include psychological distress; some survivors will experience symptoms of mood and anxiety disorders, post-traumatic stress disorder (PTSD) and alcohol use disorders, amongst others. Frequent social effects include stigma and its consequences--including discrimination, rejection by family and community, and further poverty

In view of the increasing awareness of the need for action, WHO, with UNICEF and UNFPA, on behalf of UN Action against Sexual Violence in Conflict, convened a technical meeting on responding to the psychosocial and mental health needs of conflict-related sexual violence survivors. The meeting was held in Ferney-Voltaire (France) from 28-30 November 2011. Twenty-nine people from 16 countries attended, representing a range of multilateral agencies, academic institutions, international non- governmental agencies, and independent practitioners. The meeting aimed to review existing evidence and experiences and propose preliminary policy, programme and research recommendations.

Two systematic literature reviews commissioned for the meeting show that the amount of research on the effectiveness of mental health interventions (n=5 studies) and psychosocial supports (n=5 studies) for sexual violence survivors in conflict-affected settings is limited; the reviews showed that the existing literature has many methodological weaknesses. Most outcomes-based research focuses on a narrow range of clinical consequences, mainly PTSD or depression. A large base of studies exists on mental health in general which has relevance for some survivors of sexual violence who experience mental health problems. The evidence tentatively suggests that a number of individual and group interventions if safely implemented may be successful in treating common mental disorders, particularly PTSD. In addition, the qualitative social science literature and various widely endorsed consensus documents (such as IASC, 2005; IASC, 2007; Sphere, 2011) on good humanitarian practice emphasize the value of community-based psychosocial programming and the importance of interventions promoting psychosocial well-being of the wider population, in addition to providing services for identified persons with specific problems.

Despite the weakness of the evidence base, there is growing intervention experience. Six intervention experiences were presented during the meeting, covering Afghanistan, the Democratic Republic of the Congo (DRC), Nepal, Sri Lanka, Syria, Liberia, Rwanda, Uganda, and Sierra Leone. In light of the available information on programming experiences, the meeting outlined a number of better practices:

- Mental health and psychosocial support interventions are essential components of the comprehensive package of care that aim to protect or promote psychosocial well-being and/or prevent or treat mental disorders among sexual violence survivors.
- Interventions should be rights-based, survivor-centered, and contextualize violence against women and girls.
- There is a need for integrated and linked community-focused and person-focused interventions. Community-focused psychosocial interventions generally seek to enhance survivor well-being by improving the overall recovery environment. Person-focused interventions concentrate on the individual survivor. They include case-focused psychosocial care (such as psychological first aid and

linking survivors with other services), psychological interventions (such as group and individual talking therapies), and, where indicated, clinical interventions.

- Interventions must be conducted in accordance with existing humanitarian guidance. All interventions and supports should be based on participatory principles and implemented, to the extent possible, together with communities. They should be based on assessment of capacities and needs, and build and strengthen existing resources and helpful practices.
- Mental health and psychosocial support programming for survivors of conflict-related sexual violence should be integrated into general health and a range of other services. While the needs of sexual violence survivors must be addressed by programmes, specific targeting of sexual violence survivors should be avoided; doing so risks a range of further problems such as stigma, discrimination, and violence.
- Mental health and psychosocial support planners should ensure that programmes do no harm. This requires alertness to possible adverse effects during programme planning, and measuring and recording unintended negative consequences through monitoring and evaluation.

Meeting participants agreed on key areas for action, categorized into community-focused and person-focused interventions, and prioritized according to commonly understood stages of humanitarian response. Participants agreed that activities can be selectively introduced in the acute emergency and strengthened as the situation stabilizes.

In terms of community-focused interventions:

- Community-based psychosocial programming is an important element of the mental health and psychosocial response to sexual violence in most conflict-affected settings.
- Interventions should aim to be socially inclusive and address stigma and its negative consequences; members of the stigmatized group must be involved in design, delivery, and evaluation.
- Community-focused interventions in the acute emergency can include community mobilization activities and establishment of safe social spaces for women and children.
- As the situation stabilizes, these interventions need to be expanded and socio-economic empowerment activities for women, such as village savings and loans associations, may be introduced.

In terms of person-focused interventions:

- Psychosocial interventions in the acute emergency include incorporation of psychological first aid into a standard package of post-rape care offered by a (locally determined) first point of contact and linking survivors with economic and other social supports. Training and supervising care coordinators (also known as case managers) to link people – in a safe manner – to relevant services and community supports is important. Links to available social services, general health services and mental health services care must be facilitated.
- Culturally appropriate services should be available for severe mental health problems. As the situation stabilizes, activities can be strengthened and expanded by training and supervising non-specialized health workers (including primary health care staff) to provide support for mental and substance use problems.
- As the situation stabilizes, individual and group psychological interventions can be introduced. The meeting suggested that development and utilization of manualized, highly structured, brief, evidence-based, culturally validated and problem-oriented talk therapies is warranted. Current evidence suggests inclusion of cognitive behavioural therapeutic approaches, interpersonal therapy

for depression, and brief intervention for hazardous or harmful alcohol use problems. Safe implementation is a major concern: programmes should be carefully designed, independently evaluated, and findings disseminated.

To aid in improved programming, participants agreed that two guidance documents should be developed based on current evidence and resources: 1) Do's and don'ts for community based psychosocial programming for sexual violence in conflict affected settings; and 2) Adaptation of the evidence-based WHO Mental Health Gap Action Programme Intervention Guide (mhGAP, WHO, 2010) for non-specialized settings to conflict-affected settings, incorporating working with sexual violence survivors. Guidance is required to address acute stress reactions, bereavement, depression, psychosis, PTSD behavioural and developmental disorders, alcohol and drugs-related problems, and psychosomatic complaints, and should include guidance on talk therapies. Guidance should also include minimum requirements for training, supervision, skills, attitudes, and need for follow-up, as well as discuss additional safety and security concerns for intervening on psychological and social issues in remote or insecure settings.

Participants further prioritized areas for on-going research. These are given below.

Community-focused research areas include:

- The outcomes of community-focused interventions such as community mobilization, socio-economic empowerment and safe spaces on the psychosocial well-being and mental health of survivors of sexual violence.
- Identification of factors promoting psychosocial resilience among survivors of sexual violence.
- Evidence for communal cultural, spiritual and religious healing practices and support mechanisms that promote functioning, psychosocial well-being and mental health and are consistent with international human rights standards.
- Incorporation of rapid ethnographic assessment to improve culturally appropriate programming.

Person-focused research areas include:

- The role of the community-based care worker and the place of supportive counseling in person-focused care.
- Development and local validation of person-focused assessment tools and measures of functioning.
- Better understanding of how to support children and adolescents;
- Exploration of which psychological techniques are safe and work best with survivors of sexual violence in general and which specific cognitive behavioural techniques are feasible, safe and effective in this population.
- Evaluation of single-session counseling (with no follow-up) as well as evaluation of different traditional and spiritual practices.

Although the evidence-base is weak, the need for action is very strong. This imperfect situation demands urgent intervention – following accepted best practice – in tandem with a scaling up of research and evaluation.

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## Acronyms

CBT	Cognitive behavioural therapy
DRC	The Democratic Republic of the Congo
EMDR	Eye Movement Desensitization and Reprocessing
IASC	Interagency Standing Committee
PHC	Primary health care
PTSD	Post-traumatic stress disorder
WHO	World Health Organization
UNOCHA	United Nations Office for the Coordination of Human Affairs (UNOCHA),
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund

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Special thanks to UN Action for their financial support to the meeting and for initiating discussions on this important yet neglected area for intervention to support survivors of conflict-related sexual violence.

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## Background and rationale

Sexual violence is a documented part of many armed conflicts. Sexual violence is defined as “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, including but not limited to home and work.” (Jewkes, Sen, & Garcia-Moreno, 2002, p149). Conflict-related sexual violence includes “rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity, against women, men, girls or boys. Such incidents or patterns occur in conflict or post-conflict settings or other situations of concern (e.g., political strife). They also have a direct or indirect nexus with the conflict or political strife itself, i.e. a temporal, geographical and/or causal link.’ (UN Action, 2011, p3).

The World Bank estimates that 1.5 billion people live in countries affected by armed conflict (World Bank, 2011). More than 40 million people are displaced by armed conflict (IDMC, 2011; UNHCR, 2011). In 2009, armed conflicts occurred in 36 locations across 27 territories, mostly in Africa and Asia (Harbom & Wallensteen, 2010). Sexual violence is perpetrated primarily by males; the majority of survivors of sexual violence are women and girls.

There is great variation in the extent, scale, type of violence, targeting, intent, profile of perpetrator, and population impact of wartime sexual violence. Commonly reported events include rape by a single male perpetrator and male gang rape, conducted both privately and publicly, as well as the taking of women and girls as sex slaves by male military and government personnel (Wood, 2004). Militarized sexual violence characterized by gang rape and extreme brutality by males against females has been documented from South Kivu, the Democratic Republic of the Congo (DRC; Kelly, et al., 2009). Sexual violence has been reported as a systematic part of armed conflict in Darfur, Sudan (Physicians for Human Rights, 2009). Reported rates of intimate partner violence by men against women are also high in conflict-affected populations, sometimes higher than rates of wartime sexual violence and sexual violence perpetrated by individuals outside of the home (Stark & Ager, 2011). According to the United Nations Office for the Coordination of Human Affairs (UNOCHA), understanding conflict-related sexual violence as either ‘opportunistic’ or only as a ‘method of warfare’ is too simplistic. Rather, perpetration of sexual violence is motivated and sustained by a complex set of individual and collective factors (UNOCHA, 2008), including gender.

Sexual violence can have multiple health and social consequences for survivors, their social networks and communities. Reported social consequences include rejection by family and community, strain on marital relations, impaired parenting skills, children born as a result of rape, exclusion from schools and jobs, being perceived as unfit for marriage, more violence, repeated assault, isolation, inability to function in society and stigmatization by (and of) family members (Josse, 2010). Health consequences include sexually transmitted infections (including HIV), unwanted pregnancies, gynecological problems, physical injuries, and higher maternal mortality (Cottingham, et al., 2008; Kinyanda, et al., 2010).

High prevalence of psychological distress and mental disorders has been documented in survivors of sexual violence in areas of armed conflict (Johnson et al., 2008). Reported mental health problems include psychological distress (such as anger, self-blame, shame, or feelings of insecurity), anxiety disorders (including post-traumatic stress disorder, PTSD), major depressive disorder, medically unexplained somatic complaints, as well as alcohol and other substance use disorders and suicidal

ideation and self-harm. For example, in a population-based survey in Liberia, Johnson and colleagues found higher rates of PTSD, depression, and suicidal ideation in a sample of former combatants who experienced sexual violence (both male and female) compared to those who did not experience sexual violence (Johnson, et al., 2008). These findings mirror studies conducted with survivors of sexual abuse in non-conflict settings. A recent rigorous systematic review and meta-analysis found higher rates in survivors of anxiety disorder, depression, eating disorders, PTSD, sleep disorders, and suicide attempts. (Chen, et al., 2010).

Despite the enormous scale of the problem, little is known about mental health and psychosocial supports for populations surviving sexual violence in areas of armed conflict. There is evidence that sexual assault survivors may have higher initial levels of mental health symptoms and psychosocial distress than the general population and other people who have experienced armed conflict (Vickerman, et al., 2009; Johnson et al., 2008). Furthermore, survivors of sexual violence may have a slower pattern of recovery than other conflict-affected people in the population (Foa & Meadows, 1997).

In view of the limited evidence-base for action, WHO, with UNICEF and UNFPA, on behalf of UN Action against Sexual Violence in Conflict, convened a technical meeting on responding to the psychosocial and mental health needs of conflict-related sexual violence survivors. This meeting begins to address the evidence gap by reviewing existing evidence and experiences.

The meeting aimed to propose recommendations on interventions to address the psychosocial and mental health needs of survivors of sexual violence in conflicted affected settings. Specifically, the meeting objectives were to:

- Review the current body of literature and level of evidence supporting different approaches to the mental health and psychosocial needs of survivors of sexual violence.
- Share experiences of and lessons learned from innovative approaches being tried out in the field in conflict affected settings, particularly experiences that have been evaluated.
- Suggest preliminary policy and programmatic recommendations to inform donors and programmes.
- Develop an agenda for future programme development, evaluation and research efforts.

The meeting brought together practitioners from the field, representatives of key UN agencies and international non-governmental organizations working on sexual violence in conflict and academic experts to review existing evidence and experience. (See Annex 1 for list of participants.) The meeting was held over three days near Geneva (November 28-30 2011, Ferney-Voltaire, France (see Annex 2 for agenda).

## **Intervention framework**

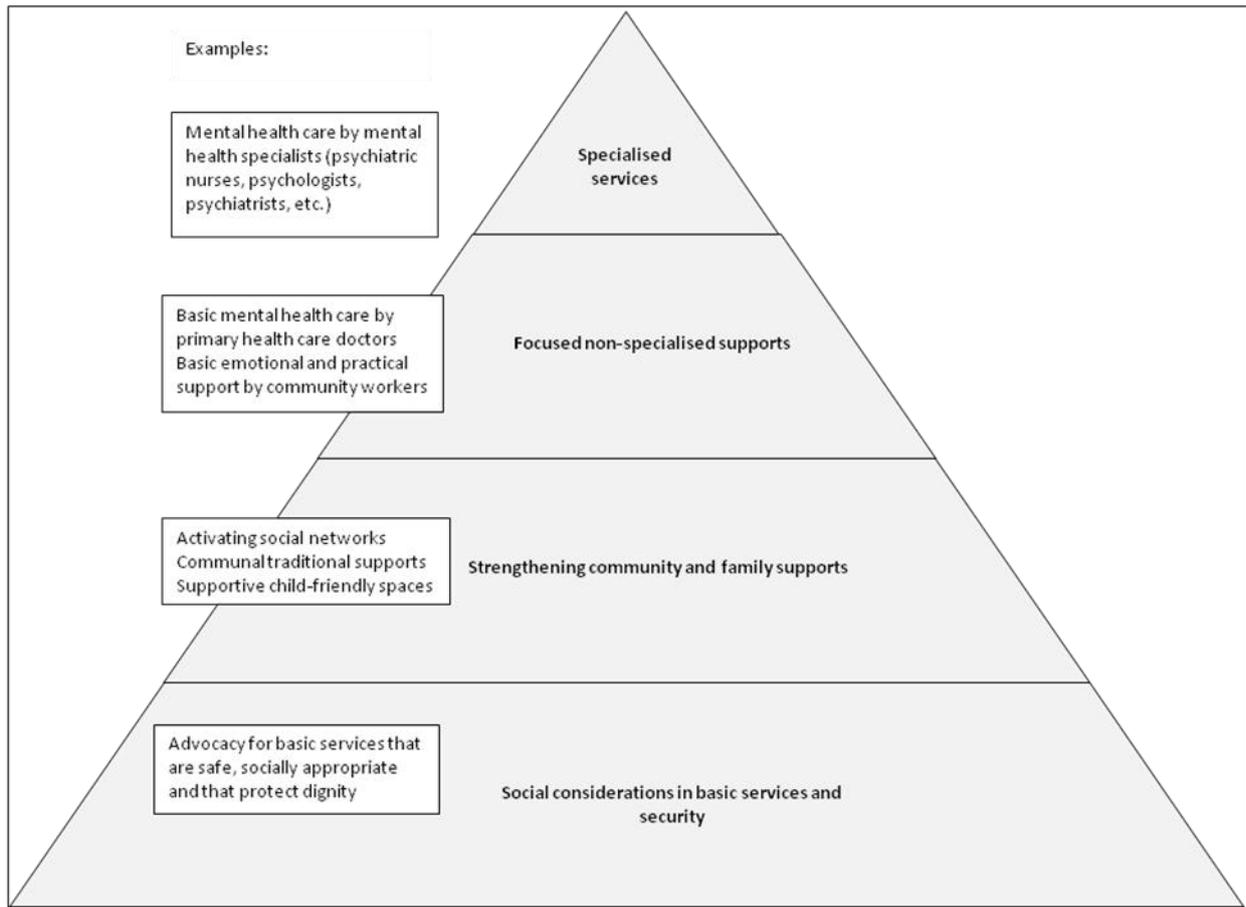
The meeting builds on work conducted by the Interagency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support and its consensus Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC 2007). The terms mental health and psychosocial support are closely related and overlap. The terms are used in different ways by different actors, agencies, disciplines and in different countries. Thus this report uses the composite term mental health and psychosocial support to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. The term mental health and

psychosocial support serves to unite different approaches and highlight the need for diverse and complementary supports in conflict-affected settings.

The Guidelines outline six principles for humanitarian action:

1. Promote **human rights** and protect affected populations from human rights violations; humanitarian actors should promote **equity** and **non-discrimination**.
2. Maximize **participation** of the affected population in the humanitarian response.
3. **Do no harm**.
4. **Build on existing capacities** and resources.
5. **Integrate support systems** to improve coordination, sustainability, and reach and minimize stigma. Stand-alone services such as for rape survivors are not recommended, and should be integrated into existing community support mechanisms and services.
6. Provide **multi-layered supports** targeted to identified persons and their families, as well as to the community more broadly. Figure 1 represents this concept using an intervention pyramid. At the bottom of the pyramid, population well-being is protected and promoted through socially inclusive security, governance, and services that address basic needs while protecting dignity. The next layer includes additional family and community supports such as strengthening supportive social networks in the community. Above this layer, non-specialized supports are provided to targeted persons, groups of persons or families in need of additional support. Non-specialized supports may be provided by people without years of specialist training, such as community health workers providing psychological first aid or nurses and health officers offering basic mental health care. At the top of the pyramid, specialized services are provided by people with advanced training in mental health care. Comprehensive service delivery for survivors of sexual violence requires access to complementary activities across all layers of supports.

**Figure 1. Mental health and psychosocial support in emergency settings intervention pyramid**



Source: Adaptation of IASC (2007), previously published in Sphere (2011)

The IASC Reference Group has developed a tool for mapping mental health and psychosocial supports that have been implemented in conflict-affected settings. This tool is called the 'Who is Where, When and doing What (4W) for mental health and psychosocial support matrix' (IASC, in press). For the purpose of this meeting and report, this 4Ws tool has been adapted for mental health and psychosocial support for survivors of sexual violence in conflict-affected settings (Table 1). This Table serves to define 'community-focused' and 'person-focused' interventions. Supports aimed at working with communities as a whole (or entire segments thereof) are called 'community-focused' interventions (see categories 1-6 in Table 1). Activities that focus on identified individuals or families are called 'person-focused' interventions (see categories 7-10 in Table 1).

**Table 1. Examples of community and person-focused interventions for mental health and psychosocial support for survivors of sexual violence in conflict-affected settings, categorized according to mental health and psychosocial support 4W activity code.**

MHPSS 4W activity code		Examples of supports for conflict-related sexual violence
COMMUNITY-FOCUSED	1. Information dissemination to the community at large	<ul style="list-style-type: none"> <li>• Information on sexual violence, protection efforts, or available services and supports</li> <li>• Messages on positive coping</li> </ul>
	2. Facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general	<ul style="list-style-type: none"> <li>• Support for sexual violence response that is initiated by the community</li> <li>• Support for communal spaces/meetings to discuss, problem-solve and plan action by community members to respond to problems, including sexual violence</li> <li>• Community mobilization to build protective environment</li> <li>• Anti-stigma community mobilization</li> </ul>
	3. Strengthening of community and family support	<ul style="list-style-type: none"> <li>• Support for social support activities that are initiated by the community</li> <li>• Strengthening of parenting/family supports</li> <li>• Facilitation of community supports to vulnerable persons, including sexual violence survivors</li> <li>• Structured social activities (e.g. group activities)</li> <li>• Structured recreational or creative activities</li> <li>• Early childhood development (ECD) activities</li> <li>• Facilitation of conditions for indigenous traditional, spiritual or religious supports, including communal healing practices</li> </ul>
	4. Safe spaces	<ul style="list-style-type: none"> <li>• Child friendly spaces</li> <li>• Safe houses</li> <li>• Other safe spaces</li> </ul>
	5. Psychosocial support in education	<ul style="list-style-type: none"> <li>• Sexual violence-related psychosocial support to teachers / other personnel at schools/learning places</li> <li>• Sexual violence-related psychosocial support to classes/groups of children at schools/learning places</li> </ul>
	6. Supporting the inclusion of social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation	<ul style="list-style-type: none"> <li>• Orientation of or advocacy with aid workers/agencies on including social/ psychosocial considerations in sexual violence programming</li> <li>• Orientation of or advocacy with aid workers/agencies on sexual violence considerations in aid programming</li> </ul>
PERSON –FOCUSED	7.(Person-focused) psychosocial work	<ul style="list-style-type: none"> <li>• Psychological first aid</li> <li>• Linking vulnerable individuals, including sexual violence survivors and their families, to resources (e.g., health services, livelihoods assistance, community resources, legal assistance etc) and follow-up to see if support is provided</li> </ul>
	8.Psychological intervention	<ul style="list-style-type: none"> <li>• Basic counselling for individuals</li> <li>• Basic counselling for groups or families</li> <li>• Interventions for alcohol/substance use problems (e.g., Brief Intervention)</li> <li>• Psychotherapy (e.g., Cognitive Behavioural Therapy, Interpersonal Therapy)</li> </ul>
	9.Clinical management of mental disorders in sexual violence survivors by non-specialized health care providers (e.g. PHC, post-surgery wards, women's wellness centres)	<ul style="list-style-type: none"> <li>• Non-pharmacological management of mental disorder by non-specialized health care providers</li> <li>• Pharmacological management of mental disorder by non-specialized health care providers</li> <li>• Action by community workers to identify and refer people with mental disorders and to follow-up on them to ensure adherence to clinical treatment</li> </ul>
	10. Clinical management of mental disorders in sexual violence survivors by specialized mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/general health facilities/mental health/women's wellness facilities)	<ul style="list-style-type: none"> <li>• Non-pharmacological management of mental disorder by specialized mental health care providers</li> <li>• Pharmacological management of mental disorder by specialized health care</li> <li>• In-patient mental health care</li> </ul>

Source: Adapted from IASC Reference Group on Mental Health and Psychosocial Support (2012). PHC = Primary Health Care

## **State of the evidence**

### **1. Mental health interventions and psychosocial support for survivors of sexual violence, humanitarian settings in low and middle income countries**

Two systematic reviews were commissioned for the meeting to describe literature on the two complementary aspects of mental health and psychosocial support for survivors of conflict-affected sexual violence. One review was concerned with interventions aimed to prevent and clinically diagnosed mental health problems, defined according to formal diagnostic criteria and tools (such as the International Classification of Diseases). A separate review was concerned with interventions aimed to promote psychosocial wellbeing of survivors and their communities. Both reviews found only a limited number of studies.

Five studies met the inclusion criteria for the review on clinical mental health problems (Tol, et al., 2011a), two of which were single case reports of counselling for PTSD in refugees resettled to USA (Schultz, et al., 2006; Vickers, 2005). Hustache et al (2009) reported post-intervention improvement in functioning among 70 women survivors of 'sexual violence by unknown perpetrator wearing military clothes' in the Republic of the Congo. The intervention consisted of between one and four individual consultations as part of medical service delivery. The study's methodology was severely limited by a high proportion of loss to follow up (60%) and no comparison group. Leskes, van Hooren and Beus (2007) reported that PTSD scores decreased for a trauma counselling intervention (eight sessions of individual trauma counselling over three months) but increased for income generation and waitlist controls among 66 women (68% survivors of sexual violence). The study was limited by large numbers of drop outs and marked difference in PTSD scores at baseline. In an uncontrolled study by Plester (2007) improvement occurred in PTSD symptoms, depression, anxiety, somatic concerns and empowerment among 39 women in Albania (most of whom were sexual violence survivors) who received group counselling (9 sessions over 12 weeks) of a combination of cognitive behavioural therapy (CBT), psychodrama, imagination exercises and relaxation techniques; those with highest PTSD scores improved the most.

The author of the review concludes that this very small body of evidence tentatively suggests that individual and group interventions, with a particular emphasis on nonspecific trauma counselling and cognitive behavioral therapies, may be successful in treating mental disorders, particularly PTSD. However, the identified studies suffered serious methodological limitations that make conclusions based on these evaluations tenuous at best (Tol, et al., 2011a). Particularly, it is premature to recommend nonspecific trauma counselling given that studies in other contexts have not provided evidence for this intervention (Tol, et al., 2011b). Similarly, only five studies met the inclusion criteria for a systematic review of psychosocial interventions (Stavrou, 2011). In addition to the three studies identified by the Tol, et al., review outlined above, two additional studies were identified. The first study was by Ager et al (2010) conducted among women who were formerly abducted and held by an armed group in Sierra Leone. The study showed that although girls and young women in both intervention and comparison communities made progress towards integration, the intervention was associated with improved mental health outcomes. For those who had found the greatest challenges in reintegrating, the intervention additionally appeared to support community acceptance. The intervention combined traditional healing, economic strengthening, outreach and education, medical

care, and micro-credit (n=142). The study was subject to a number of methodological challenges, including lack of baseline data. Moreover, Bolton (2009) demonstrated post-intervention improvement in functioning and indices of psychological distress among 65 women sexual violence survivors in the DRC. The intervention programme mixed support to service providers (health, psychosocial and legal) and grassroots women's projects with interagency mechanisms for service delivery and referral; conclusions regarding programme effectiveness are hampered by lack of comparison group.

Although evidence is extremely limited, the author of the literature review concludes that the retained articles possibly represent what is considered 'best practice' (Stavrou, 2011):

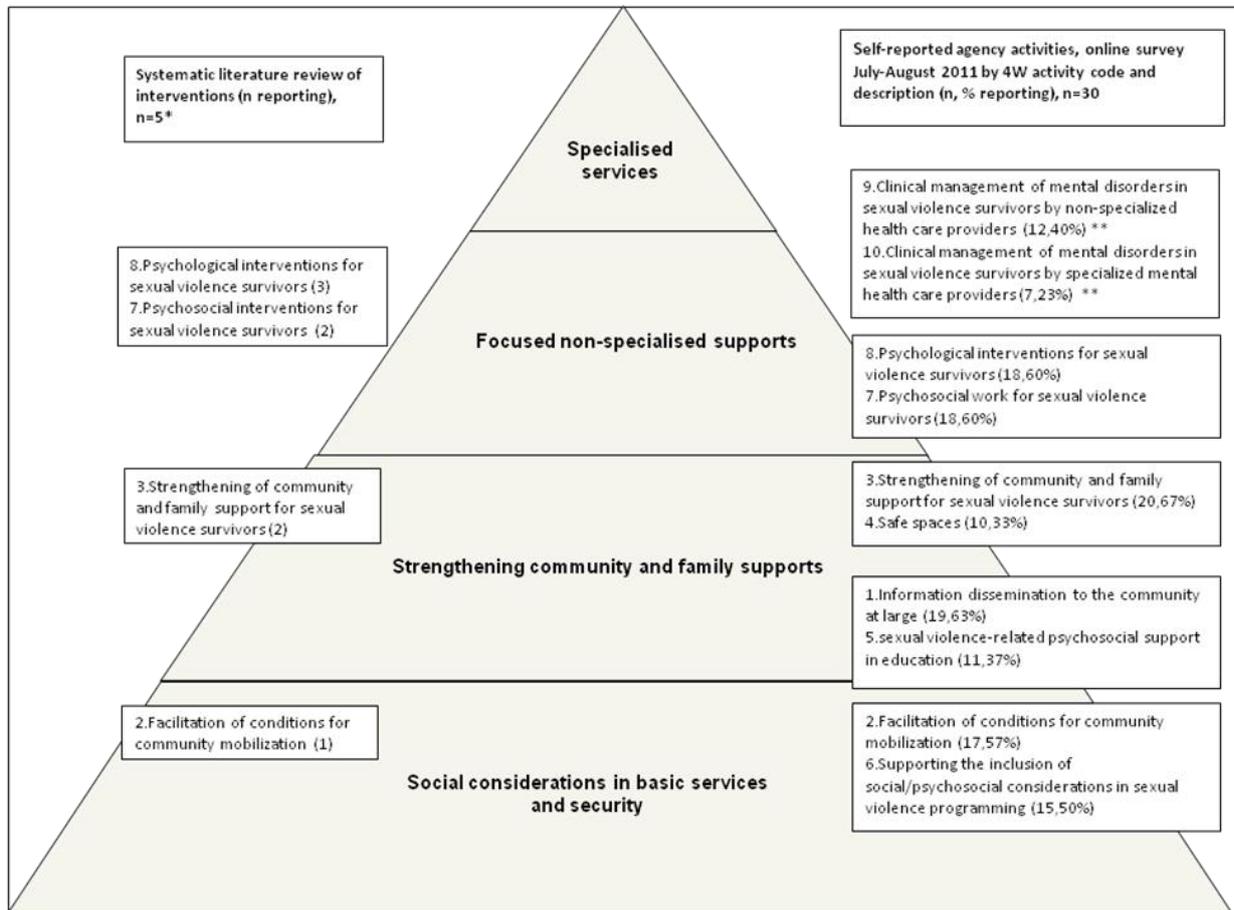
- An integrated approach to psychosocial interventions for survivors of conflict related sexual violence.
- Community-based, primary care, low cost approaches.
- Linking psychosocial support with access to medical care and economic strengthening activities.
- Short-term, context and culturally adapted individual and group counselling
- Ongoing community engagement.

To complement the background information from the literature on mental health and psychosocial support interventions for conflict-related sexual violence for the meeting the department of Reproductive Health Research of the World Health Organization conducted an online survey of international humanitarian actors and their conflict-related sexual violence programming (Bauer, 2011). Thirty agencies responded. The four most commonly reported categories of activity were:

- Psychological interventions for sexual violence survivors.
- Case-focused psychosocial work for sexual violence survivors.
- Strengthening of community and family support for sexual violence survivors.
- Facilitation of conditions for community mobilization.

These four areas are also the areas of activity in which the few published evaluations have been made. Figure 2 shows the evaluations and the intervention reports mapped onto the IASC intervention pyramid, by 4W code.

**Figure 2. Published data and self-reported agency activities for mental health and psychosocial support (2011), organized by level of activity**



\* The two single case reports from refugees in the USA were excluded

\*\*1 agency reported pharmacotherapy (by non-specialized providers), 1 agency provided psychotherapy, 2 agencies provided non-pharmacological management of mental disorder by non-specialized providers and 5 by specialized providers, and 4 agencies conducted interventions for alcohol or substance use problems.

Source: Stavrou (2011); Tol, et al. (2011a); Bauer (2011)

### Field experiences

In addition to the published data, participants described a range of mental health and psychosocial programmes to the meeting. Interventions included the following:

- Individual psychological and psychosocial care plus community-level economic and social mobilization activities in two provinces, partnering with local non-governmental and community-based organisations (by the International Rescue Committee (IRC), DRC; Cetinoglu), CBT and village savings and loans components currently under formal evaluation (by Johns Hopkins University; Skavenski, et al.).
- Individual psychosocial and community mobilization, 14 districts (by Transcultural Psychiatry Organisation, Nepal; Koroila).

- Training of trainers of lay counselors to deliver trauma-focused psychotherapy based on CBT principles (by Vivo International, DRC Rwanda and Sri Lanka; Maedl).
- Psychosocial group counselling with women sexual violence survivors (by medica mondiale, Afghanistan; Mannerschmidt & Griese).
- Participatory Action Research with young women with children formerly associated with fighting forces (by multiple organizations and researchers, Liberia, Sierra Leone and northern Uganda; McKay et al.; Onyango).
- Multi-level mental health and psychosocial support programme – specialized services and case management, community outreach, capacity building and training – including for sexual violence survivors among refugee population (by UNHCR, Syria; Quosh).

## **2. General mental health interventions and psychosocial supports, humanitarian settings, low and middle income countries**

A recent meta-analysis of 32 controlled studies of mental health and psychosocial support interventions in humanitarian settings in low and middle income countries identified three studies on strengthening community and family supports, 20 studies of focused (person-to person) supports and 9 studies involving specialized providers. Results showed that, overall, psychological interventions were efficacious in reducing PTSD symptoms among adults (n=9) and internalizing symptoms (anxiety or depression) among children and adolescents (n=8) but not PTSD (n=5) among children and adolescents, although results varied (Tol, et al, 2011b). In addition, from a systematic analysis of 160 field reports, the authors conclude that the majority of mental health and psychosocial support actions cluster around delivery of basic counselling and community supports, whereas the growing evidence base for mental health interventions among conflict-affected populations is concentrated on more complex psychological interventions. While there is some observational evidence to support context-specific social interventions (Batniji, et al., 2006), more work is required on complex evaluations of community-focused interventions.

## **3. General mental health interventions and psychosocial supports, non-humanitarian settings, high income countries**

Current global guidelines for mental health interventions of general populations may be of relevance to working with sexual violence survivors globally. These guidelines are based on systematic review of evidence and cover depression (Dua, et al., 2011; WHO, 2010), PTSD and acute stress (WHO, in preparation) . These recommendations are shown in Table 2 . In addition, the current global evidence-based guidelines suggest brief intervention for harmful and hazardous alcohol use, benzodiazepines for alcohol withdrawal, and structured psychosocial interventions and pharmacotherapy for alcohol dependence (Dua et al 2011; WHO, 2010).

**Table 2. Current and anticipated WHO recommendations for mental health interventions in general populations**

<i>Diagnostic category</i>	<i>Severity</i>	<i>Intervention</i>	<i>Conclusions</i>	<i>Source</i>
<b>Depression</b>	Any severity	CBT or interpersonal therapy	Well studied, effective, recommended	Dua et al (2011)
	Moderate and severe	Antidepressants	Well studied, effective, recommended for adults	Dua et al (2011)
	Mild or sub-threshold	Antidepressants, benzodiazepines	Ineffective/not recommended	Dua et al (2011)
<b>PTSD</b>	Any severity	Antidepressants	Many studies, inconsistent findings	Forbes et al (2010) ; Bisson et al (in press)
	Any severity	CBT	Well studied, effective, likely recommendable (adults and children)	Forbes et al (2010) ; Bisson et al (in press) WHO (in preparation)
	Any severity	EMDR	Well studied, effective, likely recommendable	NICE (2005); Bisson et al (in press)
	Any severity	Relaxation and stress management	Some studies, effective (but less than CBT and EMDR)	NICE (2005); Bisson et al (in press)
	Any severity	Universal interventions (including debriefing)	Some studies, ineffective, not recommendable	Roberts et al (2009)
<b>Acute stress</b>	Any severity	Psychological first aid	Not well-studied but likely recommended based on consensus	Dua et al (2011)
	Any severity	CBT	Well studied, effective and likely recommendable	Roberts et al (2010)
	Any severity	Benzodiazepines and antidepressants	Not well studied and unlikely recommendable	Ongoing work by the mhGAP Guidelines Development Group (WHO, in preparation)
	Any severity			

*CBT=Cognitive Behavioural Therapy; EMDR=Eye Movement Desensitisation and Reprocessing*

#### **4. Mental health interventions and psychosocial supports for survivors of sexual violence, high income countries**

The literature on trials on interventions for sexual violence survivors in high-income countries is more limited, but shows similar results. Recent systematic review data (n=8) showed overall improvement in PTSD and depression (but not fear and anxiety) from a range of CBT treatments and Eye Movement Desensitisation and Reprocessing (EMDR) (Martin., et al., 2011). A previous meta-analysis has suggested individual treatment was associated with better results than group treatments, and semi-structured approaches and home-work techniques are associated with better treatment outcomes (Taylor & Harvey, 2009).

#### **5. Anti-stigma actions**

Anti-stigma actions should be an integral part of work to address sexual violence: stigma is an important consequence of sexual violence in many settings, and can act as a barrier to seeking support. A review paper on stigma was commissioned for the meeting (Semrau, et al., 2011). Stigma may include three elements: problems of knowledge (ignorance or misinformation); problems of attitudes (prejudice); and problems of behaviour (discrimination). Anti-stigma interventions may be developed to address at least one of these three elements. There are some examples of anti-stigma work for survivors of sexual violence in humanitarian settings, but they have not been rigorously evaluated and the key ingredient of the programs is difficult to identify. There is no available evidence on how to prevent stigmatizing consequences of interventions to address sexual violence but much has been

learned from stigma studies in other populations. Strategies that have been used to reduce stigma and discrimination amongst members of the public for various health concerns, such as mental health problems and HIV and AIDS, mainly in high income settings, include social contact, education and protest. There is a positive evidence base for social contact interventions (such as direct contact with affected persons, or indirect contact such as through role playing). However, these interventions must be done in a safe way as to prevent inadvertently increasing stigma: there is evidence that some types of anti-stigma messages have led to negative outcomes. Furthermore, contact interventions have been shown to be effective only when particular conditions have been met, such as equal status among members of different groups. Interventions with affected individuals and their families have also been employed. Protest is less likely to be useful; the evidence base for its effectiveness is unclear, and the feasibility and applicability of this intervention is likely to be limited in humanitarian situations.

In summary, there is big evidence gap for mental health and psychosocial support for sexual violence in conflict. Although there are a number of gender-based violence mental health and psychosocial support programmes being implemented, practitioners agree that many good practices as outlined in existing consensus-based documents (such as IASC, 2005; IASC, 2007; Sphere, 2011) are often not effectively implemented. We do not know enough about how effective – or potentially harmful – a variety of interventions are, and monitoring for adverse consequences and outcome evaluations are far from routine. In light of the available evidence and experience, the meeting participants proposed a number of preliminary policy, programme and research recommendations, which are outlined below.

### **Preliminary general recommendations**

Mental health and psychosocial support interventions are essential components of the comprehensive package of care that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders among sexual violence survivors. Interventions must address the particular vulnerabilities and related needs of women and girls who are risk of/have experienced sexual violence. Mental health and psychosocial supports include both interventions and services for individuals and families with identified problems as well as for entire communities or segments thereof.

Interventions must be conducted in accordance with existing humanitarian guidance. The first Core Standard outlined in the first chapter of the Sphere Handbook (Sphere Project, 2011) sets out the importance of people-centered humanitarian response. This core standard describes the type of key actions that are essential to promote the well-being and protect the dignity of members of affected populations, such as recommendations to:

- Support local capacity by identifying community groups and social networks at the earliest opportunity and build on community-based and self-help initiatives.
- Ensure a balanced representation of vulnerable people in discussions with the affected population.
- Provide the affected population with access to safe and appropriate spaces for community meetings and information-sharing at the earliest opportunity.
- Design projects, wherever possible, to accommodate and respect helpful cultural, spiritual and traditional practices regarded as important by local people.
- Progressively increase affected people's decision-making power and ownership of programmes during the course of a response.

Mental health and psychosocial support is best organized as part of an integrated, holistic, community-based multi-disciplinary approach, coordinated across all sectors (including protection; shelter; health; nutrition; water, sanitation and hygiene; and education) as called for in the Interagency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) and the Interagency Standing Committee Guidelines on Gender Based Violence (2005) in addition to relevant Sphere Project standards (2011). Additionally, IASC (2007) guidance recommends that agencies aim to concurrently implement specialized services, focused non-specialized supports, strengthened community and family supports, and social considerations in basic services and security.

Good practice – as outlined in the documents above – demands that design of programmes is informed by assessment of the situation and the needs. Design of mental health and psychosocial support programmes should be informed by an assessment of the cultural context, including at least an understanding of attitudes around different forms of sexual violence and existing supports for survivors. Aims, methods and procedures of assessment will vary according to available information, security situation, phase of the assessment (such as acute emergency, stabilisation, or early recovery), capacities and mandates of agencies, available resources and time pressures. Ideally, initial assessments should be integrated between agencies and sectors (such as water, sanitation and hygiene, food, nutrition, protection, shelter). Later assessments can aim to fill identified gaps in information, such as ethnographic data on cultural norms around sexual violence. Good programming includes continuous learning and re-assessment, particularly on power dynamics within communities, pre-existing ('traditional') community psychosocial support resources, and risks for harmful psychosocial and mental health consequences of sexual violence.

A key consideration in organizing mental health and psychosocial support is to do no harm. Unintended consequences of programmes include cultural, economic, political, psychological, security, and social aspects. Some avoidable causes of harmful outcomes of particular relevance to sexual violence programming are given in Box 1.

Box 1. Potential harmful practices relevant to sexual violence programming (from Wessells, 2009).

- Poor coordination;
- discrimination and excessive targeting;
- too much or too little attention to severe problems;
- undermining of existing supports;
- services that heighten vulnerability or revictimize;
- stigmatizing labeling;
- emphasis on pathology and deficits;
- medicalising of complex problems;
- aggressive questioning;
- fragmentation of systems; and
- poor quality counselling with little training and supervision.

A range of supports for improved mental health and well-being should be inclusive of – and not exclusively target – survivors of sexual violence. At the same time, supports should be designed to ensure that the needs of all survivors of sexual violence and other forms of gender-based violence are met. (Sexual violence by armed groups and armed perpetrators specifically is recognised as one of a range of gender based and other forms of violence experienced by conflict-affected populations.)

Interventions should be rights-based, survivor centred, and contextualise violence against women and girls.

Because the evidence base regarding the effectiveness and sustainability of diverse interventions is weak, it is a priority to strengthen intervention research, evaluation, and collaborative learning that can help to strengthen practice in this important area. All data collection efforts must follow existing safety and ethical standards for researching, documenting and monitoring sexual violence in emergencies (WHO, 2007). The interest of the survivor and respect for her or his decisions is of primary importance; all actions must always be guided by a survivor-centered approach and the principles of confidentiality, safety and security, respect and non-discrimination.

## **Preliminary programme recommendations**

The meeting made a number of preliminary recommendations which are discussed in more detail in the following sections.

### **Community-focused interventions**

Community-based psychosocial programming is an essential element of the mental health and psychosocial response to sexual violence. Context specific interventions need to be developed, keeping in mind good practice recommendations as outlined above in the first core standard in Sphere.

Additional points to consider include:

- Interventions should be socially inclusive, not over-targeted to sexual violence survivors. Sexual violence services should be integrated into broader health, mental health, psychosocial and legal services. At the same time, the sexual-violence specific needs of survivors (as well as the specific needs of child survivors and children born of sexual violence) need to be recognized and addressed.
- Community-focused psychosocial supports respond to identified needs, as well as potentially playing a role in protecting dignity, promoting psychosocial well-being and preventing mental health problems associated with sexual violence.
- Anti-stigma actions include educational interventions to address misconceptions. Interventions with people and families affected by sexual violence may be useful when combined with interventions aimed at reducing social stigma, and negative feelings by the affected individuals and families themselves. Care must be taken when designing social contact interventions to ensure that harmful outcomes do not arise, such as increased stigma. Members of the stigmatized group must be involved in design, delivery, and evaluation. Supporting socio-economic opportunities which improve daily functioning of affected persons have also been noted as being potentially beneficial in reducing stigma.

Monitoring and evaluation is essential. Much of practice is unevaluated; it is important to determine the benefits and possible harms of interventions. Participatory processes should be used. Locally identified outcome indicators should be developed, including locally defined measures of acceptance at individual, family, and community levels. For example, Steiner, et al. (2009) measured change in proportion of women being expelled from home after experiencing sexual violence. Other indicators may include women's psychosocial well-being and functioning in the community.

Three programming areas were discussed in detail during the meeting: safe spaces, promoting socio-economic opportunities and community mobilization. These areas may be considered to have high relevance in many conflict-affected settings; they are discussed in more detail below.

### **1. Safe spaces**

There is growing experience of supporting safe spaces in conflict-affected populations (Williamson, 2008); more research is required into their impact on the mental health and psychosocial well-being of sexual violence survivors. A safe spaces is a safe social space, which can be organized around a physical space such as a community centre or a women's centre or can be an *ad hoc* social space. They are places where women, adolescent girls and (other) child survivors can go to receive compassionate, caring, appropriate and confidential assistance. Examples include women's activity groups, wellness centres, support groups, drop-in centres, and child-friendly spaces. They are thus not limited to women's shelters, which in some settings have been observed to increase protection risks for women (such as reported anecdotally in Afghanistan).

Safe spaces can be implemented in all phases of humanitarian response, provided security concerns can be addressed (which may be particularly relevant in the emergency phase). They can be implemented in urban and rural settings, as well as camp and non-camp settings. Safe spaces have been established for women, for the elderly, and, most often, for children. Safe spaces for children are important as children may be survivors of sexual violence and at-risk of sexual violence; children publicly known to be born of sexual violence may be vulnerable to a range of health, mental health, and psychosocial problems resulting from exclusion and stigma. As with adults, children's safe spaces should be age and gender sensitive in order to effectively address the needs of different groups, particularly adolescent girls. Adults and children will usually require different approaches to programming: attention must be paid to ensuring that spaces are relevant and accessible to adult women as well as adolescent girls.

Core features for programme implementation include an adequate degree of safety and security, and community buy-in and ownership. Programmes should be culturally appropriate, accessible to all community members who need the service, and ensure confidentiality. Safe spaces should also be tailored so as to address the specific needs of particular sub-groups. For example, girls who have been recruited into armed groups may be survivors of sexual violence. Where communities fear or seek reprisal against such girls, additional intervention components may be needed to promote nonviolent conflict management and transformation. Safe spaces aim to promote trust, social cohesion and solidarity among group members. Services should be established so as to be inclusive of all vulnerable women and children: careful consideration should be made of possible adverse effects such as increased stigma when considering targeting a group of at-risk sexual violence survivors

### **2. Promoting socio-economic opportunities**

There is growing experience of gender and socio-economic empowerment initiatives in conflict-affected populations (SEEP, 2009) – for example village savings and loans associations which rely on collective pooling and sharing of financial resources – which may support the mental health and psychosocial well-being of sexual violence survivors. Socio-economic initiatives can be implemented in all post-emergency phases of humanitarian response, and if present prior to the crisis can be supported to continue during the emergency phase. They can be implemented in urban and rural, as well as camp and non-camp settings.

Core considerations for programme implementation include: initiatives by women and children themselves; socially-inclusive self-selection of group members; and commitment by group members to a collective (joint) process of decision making and ownership, which is sensitive to the power dynamics within groups and promotes trust among group members. External support includes training on methodology, and ongoing technical assistance and support. Support from partners, other family members and the broader community is considered important for programme success.

### **3. Community mobilization**

Supporting and promoting community mobilization efforts in populations affected by conflict is an accepted part of good humanitarian response (Sphere, 2011). Relevant community mobilization activities include women's and men's support groups, dialogue groups, and community education and advocacy. Community mobilization can be supported in a range of settings – urban and rural, camp and non-camp. Activities are usually begun in the acute phase (provided security is adequate) and are built on, expanded and strengthened throughout post-emergency, protracted, and recovery phases. The type of community mobilization will vary according to the phase of the emergency: as the situation stabilizes, more complex processes can be supported.

An understanding of community norms and power dynamics, and potential obstacles to mobilization, is a prerequisite for intervention development. Community mobilization is a process, not a 'one-off' intervention. Outside agencies need to continuously reflect and engage in ongoing dialogue with community members around their role and possible adverse effects. Supports should be socially inclusive and engage local leadership (women, men, and young people). Recognizing social networks as profound assets, and building on them, is essential for effective community mobilization. Efforts should be sensitive to existing social norms, both positive and negative.

Possible aspects of mental health and psychosocial support for sexual violence survivors include: building a protective environment; addressing stigma; and changing norms around gender-based violence and promoting existing protective norms. Community mobilization may not initially be explicitly concerned with sexual violence by armed groups. Further research is required into the impact of community mobilization on specific outcome measures related to sexual violence, and key elements responsible for programme effectiveness.

#### **Person-focused interventions**

There is a recognition that while many survivors of sexual violence will recover with no or limited support, there are those for whom focused and clinical interventions could be of benefit. Access to clinical services, including specialized care if needed, is currently limited in most settings. The meeting recommended a number of person-focused interventions. These are summarized in Table 3.

**Table 3. Programme response matrix, person-focused interventions**

Activity	Proposed supports for conflict-related sexual violence	
	Acute emergency	Post-acute emergency
Psychosocial care with help-seeking survivors	<p>Incorporation of psychological first aid into standard package of post-rape care offered by (locally determined) first point of contact.</p> <p>Train in more depth a specific group of trained psychological first aid focal points as points of first contact.</p> <p>Train care coordinators in established protocols for help-seeking survivors of sexual violence to link to relevant services and supports , including provision of survivor-centred information (including what to expect from a medical examination and step-by-step guide to seeking legal assistance).</p> <p>Link to available community supports, social services, general health services and mental health care, according to identified need and referral.</p>	<p>Continue to implement and strengthen psychological first aid delivery and linking with services and supports.</p> <p>Strengthen social networks .</p>
Psychological intervention with help-seeking survivors, integrated into wider systems, such as health, educational or nutrition care.	<p>Research needed into potential value (potential benefits and harms) of adding a psychological intervention (such as supportive brief counselling or cognitive behavioural techniques) to case management (which is coordination of care for individual persons).</p> <p>Research needed into potential value of single-session psychological care including psycho-education, coping skill building, and safety planning.</p>	<p>Safe implementation of manualized evidence-based psychological talk therapies for people who are not functioning well because of their symptoms. The current evidence base favours adaptation of:</p> <ul style="list-style-type: none"> <li>Culturally validated cognitive-behavioural (CB) approaches for PTSD and depression and alcohol dependence</li> <li>Interpersonal therapy (IPT) for moderate-severe depression (which is depression affecting daily functioning)</li> <li>Brief intervention for harmful or hazardous alcohol use.</li> </ul> <p>Research needed into interventions without evidence base such as: supportive counselling as a stand-alone form of support; and traditional, spiritual and religious healing practices.</p>
Clinical management of mental disorders in sexual violence survivors by general health care providers (e.g., general nurses, health officers and doctors in primary health centres, post-surgery wards, women's wellness centres).	<p>Clinical care with follow-up for severe mental disorder (adapted to the local context and monitored for adverse effects, and accessible to all who require care).</p>	<p>Clinical care and follow-up for both severe and common mental disorders</p> <p>Safe implementation of manualised psychological talk therapies (as above).</p>
Clinical management of mental disorders in sexual violence survivors by specialized mental health care providers (e.g., psychiatrists, psychiatric nurses and psychologists).		<p>Clinical care (adapted to the local context and monitored for adverse effects) provided by specialists with advanced knowledge in mental health care of sexual violence survivors.</p> <p>Safe implementation of manualised psychological talk therapies (as above).</p>

Building clinical capacity requires a systems approach, and should be integrated into health and social care delivery in a sustainable manner from the outset. There should be an emphasis on building the capacity of local staff (primary health care workers, social workers, others), lay workers, and other professionals who can carry this on in subsequent phases. Clear guidance needs to be provided on minimum skills, training, supervision and resources, as well as limits to interventions that can be delivered by non-professionals. Training needs to focus on sexual abuse and sexuality, as well as skills in self-care and stress management for help providers. Training should also incorporate communications skills, and self-reflection on own experiences and attitudes (particularly towards gender-based violence and women’s empowerment). Ongoing supervision, including technical and emotional support, should be provided. Linkages between mental health, primary health, social services, protection and gender-based violence services should be developed and strengthened.

A stepped care approach should be taken, so that as a minimum, all survivors of sexual violence have access to psychological first aid even in the emergency phase of response. In addition, some may require further psychological and specialized mental health care (depending on time since event and severity of symptoms and degree of functioning) as indicated below.

In accordance with good practice, interventions should be monitored and evaluated. Some suggested indicator domains – which are particularly relevant to health services - are given in Table 4. Data should be sex and age-group disaggregated (e.g. child, adolescent, and adult).

**Table 4. Suggested programme indicator domains**

<b>Category</b>	<b>Indicator domain, examples</b>
Process indicator	Utilization rate (new visits/population)
	Frequency of follow-up visits
	Coverage / reach
	Accessibility
	Adherence to any treatment
	Number of people receiving services; % men, women, boys, girls, adolescent girls, adolescent boys
	Number and proportion of workers using manualized psychological treatments
	Number and proportion of workers receiving training and supervision
	Number and proportion of health workers receiving support
	Outcome indicator
Presence of disorder	
Functioning	
Well-being	
Side effects of treatment	
Suicide thoughts and plans	
(Recurrence of) sexual violence	

Three programming areas were discussed in detail during the meeting: psychological first aid as a component of psychosocial care, psychological care, and clinical management of mental disorders related to sexual violence. These are discussed in more detail below.

**1. Person-focused psychosocial care for help seeking survivors**

Person-focused psychosocial care includes linking survivors to social supports, and identification of a care coordinator (see Table 3). Psychological first aid provision is a key element of person-focused psychosocial care. Psychological first aid can begin in the acute emergency phase, but may also be provided after the acute emergency, as new incidents of violence may continue to happen.

Psychological first aid involves providing practical, non-intrusive, care and support to a person in acute distress. It includes: assessing needs and concerns; helping people to address basic needs; listening to people, but not pressuring them to talk; comforting people and helping them to feel calm; helping people to connect to information, services and social support; and protecting people from further harm (Sphere, 2011).

Psychological first aid should be provided by the first point of contact. The first point of contact will need to be oriented to psychological first aid, assessment (including how to ask about needs and concerns and how to manage disclosure of sexual violence) and referral. Identifying the likely first point of contact and referral will require mapping of services for orientation in psychological first aid. The first point of contact is context specific and will need to be identified locally and as broadly as possible: it could be primary health care, legal services or nutrition centre staff.

In addition to orienting a broad range of potential first points of contact in psychological first aid, a specific subset of workers should be identified locally, trained and supervised more thoroughly in psychological first aid. As the situation stabilizes, information and community awareness programmes can be developed to enhance utilization of services and expand linkages with community networks.

## ***2. Person-focused psychological care***

More research is required for feasibility, effectiveness and potential harms of psychological interventions in the acute phase (such as single-session care). Once the emergency situation stabilizes, capacity can be built for including culturally appropriate individual or group talk therapy (monitored carefully for possible adverse consequences) for people with mental disorder that impacts on functioning. Interventions should be integrated into other services (such as general health, reproductive health, education, and nutrition). Guidance should include minimum requirements for training, supervision, skills, attitudes, and resources, as well as clear limits on what should and should not be included by each level of worker, and should be child sensitive. Community and individual level assessment tools and procedures need to be developed that include level of functioning and both universal and locally determined measures of distress and mental health problems.

All counselling techniques and psychotherapies must be carefully defined so as to be transparent and replicable, following a manualised treatment, care and support protocol. Care should be survivor-centred, trauma-sensitive (in order to avoid re-traumatization) and integrate cultural knowledge. Interventions need to be tailored depending on whether the care is started soon after the (last) event or whether there has been a delay (months or years). Interventions need to be specified for both adults and children.

Interventions should be evidence-based, as far as is possible. Current research from non-conflict settings favours that it is worthwhile to develop manualised culturally validated cognitive behavioural therapy (CBT) approaches (both individual and group), offer Interpersonal Therapy for moderate-severe depression (i.e., depression that impacts on daily functioning) and to offer brief intervention for harmful and hazardous alcohol use. Further research is required into a number of elements of CBT such as: individual versus group activities; provision by lay versus specialized workers; CBT proper versus therapy based on cognitive behavioural principles; therapy with exposure versus therapy without exposure for sexual violence survivors. Safety and follow-up issues related to implementing exposure treatment in unstable environments are of central concern. Interventions must be well-monitored and supervised, accompanied by protocols to ensure safe implementation. At present, the indication is that potential intrusive talk therapies should only be commenced where there is the opportunity for further

review and follow-up with the person. There is a need for research into the potential of single-session psychological intervention without follow-up for emergency phase. Supportive counselling and promotion of various forms of traditional and spiritual healing are popular interventions that need to be unpacked, defined and subjected to further research.

More guidance is required on effective supports for children and adolescents, such as support to early childhood development and involvement of parents in interventions. Linkages need to be made with other social support programmes, such as livelihood support. A systems approach should be used, guided by policies and protocols.

### ***3. Clinical management of mental disorders related to sexual violence***

In the acute emergency phase, clinical care should be assured – whether by non-specialized or specialized practitioners where available and supported by external practitioners where necessary – to ensure that people with severe mental disorders have access to treatment. In accordance with norms of good practice, these interventions should be culturally appropriate and monitored for inadvertent harmful outcomes. Once the situation stabilizes, primary health providers should be trained and supervised to address the major or most common mental health problems, as described in mhGAP Intervention Guide (WHO, 2010). The feasibility of successfully integrating mental health care for survivors of sexual violence into primary health care will depend on existing primary and secondary care services, infrastructure, and human resources available.

## **Recommendations for development of global technical guidance documents**

To aid in improved programming, the development of two technical guidance documents is recommended:

1. Do's and don'ts for community based psychosocial programming for sexual violence in conflict affected settings
2. Adaptation of mhGAP Intervention Guide for use in conflict-affected settings (WHO, 2010) that incorporates working with sexual violence survivors. This document should link with guidance on talk therapy by non-specialized mental health workers (such as nurses and community health workers), possibly with locally validated assessment protocols that include assessment of level of functioning; and guidance on cognitive behavioural techniques, interpersonal psychotherapy for depression, brief intervention for alcohol and other substance use. It should clearly spell out the minimum requirements in terms of training and supervision, skills, and resources.

## **Research recommendations**

The meeting concluded with a discussion around research priorities. Participants agreed that research is needed on how to adapt interventions with evidence of safety and effectiveness for low-resource and conflict affected settings. In addition, more documented experience is required to understand how best to target particularly at-risk populations, such as adolescent girls. Finally, local context specific information is essential: while some forms of local or traditional or spiritual supports may be helpful, there are others that may be harmful, and better understanding of how to link externally derived interventions with local interventions is indicated. Although a number of areas requiring further research arose during the meeting (see for example Table 3, above), meeting participants generated and prioritized a list of key research questions. Questions which were considered to be important or

very important, practice-oriented, and feasible by the majority of group members are given below, in order of ranking.

Meeting participants argued for independent research. In other words, interventions should not be studied only by those who developed them or those who have a close affinity with them. For unbiased research to occur, interventions and supports require independent evaluation.

### **Community-focused interventions**

1. What factors promote **psychosocial resilience** among survivors of sexual violence, and what do survivors themselves identify as additional psychosocial stressors and helpful mechanisms that aid resilience?
2. Are there any evaluated examples of **communal cultural, spiritual and religious healing practices and support mechanisms** that promote functioning, psychosocial well-being and mental health of conflict-related sexual violence survivors, and how can they be strengthened and rebuilt in (post-)conflict settings?
3. How can **rapid ethnographic assessment** improve culturally appropriate programming? Can rapid ethnographic methods be used to successfully inform conflict-related sexual violence mental health and psychosocial support programme design, implementation, monitoring, and evaluation?
4. What **socio-economic interventions** are effective to improve psychosocial well-being and mental health of survivors of sexual violence in conflict settings?
5. What are the elements of **safe spaces** that work to promote psychosocial well-being and mental health related to sexual violence?
6. Which community-based culturally appropriate mental health and psychosocial support programmes for **adolescent girl** survivors of conflict-related sexual violence are effective?

### **Person-focused interventions**

1. What is the role, place, function, advantages, and risks of engaging an **individual care coordinator** to coordinate the care of individuals seeking mental health and psychosocial support. (The care coordinator is also known as core psychosocial worker, lay resource person, community social worker, case manager, or care coordinator.) In particular, can this intervention improve continuity and quality of psychosocial support and mental health care or help prevent symptoms or distress in the future? What additional programme components, such as outreach and community mobilization, could strengthen linkages between person-focused and community-focused interventions?
2. What is the definition and role, if any, of **supportive counselling**? What is its purpose, goal, target, aims, effects, and how can it be described (duration, for what mental health and psychosocial concerns, content, techniques, training, service delivery, supervision, providers, minimum skills, cultural relevance, scope, and quality)?
3. What **assessment** tools (including measures of functioning, well-being and distress) can be used in primary health care settings and more specialized mental health settings to identify the mental health support needs of survivors and how can these be locally validated and ethically applied? Answering this question involves a critical review of existing scales and other measurement tools in terms of validity and reliability.

4. What interventions are effective for working with **children** and adolescents who have experienced sexual violence, and how can risk behaviours be prevented? Do existing databases have intervention information on child sexual abuse?
5. What type of conditions need to be in place for CBT to be offered safely in terms of the safety and stability of the person's living environment and in terms of opportunity for follow-up? Which **CBT techniques** work best and are safe for sexual violence survivors in low-income settings in conflict-affected settings? For example, formal CBT versus intervention based on cognitive behavioural principles ("CBT light"), individual versus group CBT, and incorporation or not of exposure elements.
6. In addition, two research questions were generated on practices that are often done in the field and that need evidence or consensus before they can be recommended:
  - a. Can **single-session counselling** (with no follow-up) be effective in reducing symptoms of mental health problems and distress and improving function among sexual violence survivors in conflict-affected settings, and for whom (those with identified mental health issues such as depression or PTSD)? What socio-cultural variables (e.g. concept of self, expression of distress, help-seeking patterns, and treatment expectations) influence the extent to which findings can be generalized?
  - b. When and for whom are **traditional healing and spiritual practices** helpful or harmful, and how can they best be integrated with externally provided services?

## Conclusions

Sexual violence in conflict-affected settings has far-reaching mental health and psychosocial effects on the individual survivor and her social networks. The urgency for intervention is hampered by marked limitations in evidence for action.

The meeting recommended strongly that action, evaluation and research be conducted in accordance with the well-established principles of humanitarian best practice (IASC, 2005; IASC, 2007; Sphere, 2011). They must be conducted in a participatory manner, in a way that builds on and strengthens existing community supports and helpful practices, and does no harm. This requires attention to possible adverse effects during programme planning, and measuring and recording unintended negative consequences through monitoring and evaluation. Key to the implementation of supports to sexual violence survivors is to avoid increasing stigma, discrimination and exclusion. Establishing services that specifically target sexual violence survivors should be avoided; instead services should be designed to be inclusive of all affected and vulnerable women. Addressing gender and other structural inequities is considered crucial to the success of any programme that aims to strengthen mental health and psychosocial well-being related to gender-based violence.

Multi-level interventions are indicated: there is a need for both community-focused interventions that promote self-help and improve the recovery environment as well as a need for person-focused interventions such as care coordination (e.g. case management), psychological first aid, linking individuals with economic opportunities, and clinical interventions. Mental health and psychosocial support programming for survivors of conflict-related sexual violence should be integrated into general health and other services.

Although the information base is weak, the demand for action is very strong. This imperfect situation demands action to intervene. The humanitarian community should scale up mental health and psychosocial supports for conflict-related sexual violence – following accepted best practice – while simultaneously conducting research and programme evaluations.

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## Annex 2: Agenda

### Day 1 – Monday 28 November 2011

#### Introduction and background

09:00–09:30	Welcome and Opening Remarks	<i>M. Mbizvo and S. Saxena</i>
	Introduction to the meeting	<i>C. Garcia-Moreno</i>
09:30–11:00	Background - current state of the evidence	
	Mental health and psychosocial support for sexual violence in conflict	<i>V. Stavrou</i>
	Mental health and psychosocial support in humanitarian crises	<i>M. van Ommeren</i>
	Reducing stigma in humanitarian crises	<i>M. Marsh</i>
	<i>Discussion</i>	
11:00–11:30	<i>Coffee/Tea Break</i>	
11:30–12:30	Findings from an online practitioner survey of interventions	<i>T. Bauer</i>
	Do no harm: contextually appropriate psychosocial support in emergencies	<i>M. Wessells</i>
	Methodological approach to addressing violence: example from eastern DRC	<i>S. Skavenski</i>
	<i>Discussion</i>	
12:30–14:00	<i>Lunch break</i>	
14:00–15:30	Intervention experiences (1)	<i>Chair: E. Kenny</i>
	○ IRC, DRC	<i>D. Cetinoglu</i>
	○ Vivo, DRC	<i>A. Mädl</i>
	○ World Vision, northern Uganda	<i>G. Onyango</i>
	<i>Discussion</i>	
15:30–16:00	<i>Tea break</i>	
16:00–17:00	Intervention experiences (2)	
	○ TPO, Nepal	<i>S. Koirala</i>
	<i>Discussion</i>	
17:00–17:30	Group work introduction	
	○ Expected outcomes	<i>C. Garcia-Moreno</i>
	○ Method of work	<i>N. Ezard</i>
	<i>Discussion</i>	
18:00	<i>Cocktail</i>	

### Day 2 – Tuesday 29 November 2011

#### Recommendations for psychosocial and mental health support

09:00–10:00	Intervention experiences (3)	<i>Chair: M. van Ommeren</i>
	○ UNHCR, Syria	<i>C. Quosh</i>
	○ medical mondiale, Afghanistan	<i>S. Mannes Schmidt / K. Griese</i>
	<i>Discussion</i>	
10:00–10:30	Group work (1): Programmatic recommendations for community-focused and case-focused interventions.	
	<i>Community: E. Kenny facilitator, M. Wessells rapporteur, C. Quosh note-taker</i>	
	<i>Identified persons: J. Ward facilitator, S. Skavenski rapporteur/note-taker</i>	
10:30–11:00	<i>Coffee/Tea Break</i>	
11:00–12:00	Group work (1) continues	
12:30–14:00	<i>Lunch break</i>	
14:00–15:30	Feedback session and discussion, programmatic recommendations	
15:30–16:00	<i>Tea break</i>	
16:00–17:30	Group work (2): Policy and research recommendations for community-focused and case-focused interventions	

### Day 3 – Wednesday 30 November 2011

#### Future agenda

09:30-10:30	Feedback session and discussion, policy and research	<i>Chair: M. Wessells</i>
10:30–11:00	<i>Coffee/Tea Break</i>	
11:00–12:30	Presentation and discussion programmatic recommendations	<i>N.Ezard</i>
12:30–13:30	<i>Lunch break</i>	
13:30–15:00	Final session	<i>Chair: C. Garcia-Moreno</i>
	○ Consensus agenda for programme development, evaluation and research	
	○ Next steps	
15:00	Close	