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How to Integrate Mental Health and Psychosocial Interventions in Gender-Based Violence Programs in Low-Resource Settings

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How to Integrate Mental Health and Psychosocial Interventions in Gender-Based Violence Programs in Low-Resource Settings

Overview

Around the world, there is an increasing awareness about the importance of mental health and psychosocial support (MHPSS) as part of gender-based violence (GBV) prevention and response programming. This how-to note describes MHPSS interventions and how USAID and implementing partners can integrate them into programs and activities. The note defines important terminology and provides a rationale for why MHPSS interventions are important in GBV programming. It also provides a framework to guide the design and implementation of GBV MHPSS interventions, program considerations, illustrative activities, a case study, and succinct "dos and don'ts" for MHPSS programming. While this how-to note offers an introduction to MHPSS in GBV programming, it should not be viewed as an exhaustive resource and should be paired with accompanying resources provided at the end of this note.

Why MHPSS in GBV Programs?

MHPSS is an essential component of a multisectoral response to GBV, and MHPSS outcomes should be integrated into health, justice, education, social services, and other sectoral initiatives that address GBV. While survivors' experiences vary, the impacts of GBV on mental health and psychosocial well-being can have far-reaching consequences for individuals, families, and communities. Psychological effects of GBV can include feelings of fear, sadness, guilt, and anger, as well as anxiety, depression, self-harm, suicidal ideation, and addiction. Alongside social consequences, such as stigma, isolation, and discrimination, these effects can contribute to difficulties in maintaining or establishing relationships and disruptions to work, caregiving, and education. Addressing the mental health and psychosocial needs of survivors and those disproportionately at risk of GBV is critical to promoting healing, empowerment, and meaningful participation in education, economic, and civic activities. This work amplifies positive outcomes across development.

Ensuring Well-Being in GBV Prevention Programming

"Even programs focused on violence prevention will touch the lives of many women who have already experienced abuse. If 20 percent of women in a setting experience intimate partner violence, for example, at least one in every five female staff, facilitators, and workshop participants will have, too. For some, discussing violence may cause earlier trauma to resurface; others may need immediate support to cope with ongoing abuse. Organizations must train staff to respond appropriately to disclosures of abuse, including any legal requirements to report the abuse of children or vulnerable adults, and establish referral pathways to professional health, legal, and psychosocial services."

– Prevention Collaborative

Table 1. Key definitions

Mental health	Mental health encompasses dynamic states of emotional, psychological, and social well-being. These states affect how individuals think, feel, act, respond to stress, and relate to others.[1] When in a state of mental wellness, individuals can cope with adversity and experience a full range of emotions but return to a place of emotional equilibrium.[2] Mental health is culturally defined; reactions to adversity and a functioning state of well-being look different across the world.
Psychosocial	The term "psychosocial" reflects the interaction between psychological dimensions of an individual (such as thoughts, emotions, feelings, and reactions) and their social context (including their environment, relationships with others, community, and culture).[3] Psychosocial well-being is context-specific and culturally defined. The terms "mental health" and "psychosocial well-being" are often used interchangeably.[4]
Mental health and psychosocial support (MHPSS)	A holistic approach to programming includes both mental health and psychosocial support. These two aspects of programming are closely linked, and the term MHPSS is used to reflect the interrelated nature of these types of programming and their impact on well-being. • Mental health programming seeks to address specific mental health, neurological, and substance abuse conditions. Community- and systems-level approaches may include policy work, capacity strengthening, or social and behavior change communications. Interventions focused on addressing mental health conditions of individuals or small groups may include psychotherapy, psychoeducation, and psychopharmacology. These interventions are often delivered by doctors, psychologists, or other formally trained mental health providers, including those with expertise in cultural practices of healing. • Psychosocial support is a continuum of programming that works at different layers of care, including with individuals, families, groups, and communities.[5] Interventions focus on coping and stress reduction; building interpersonal connections; and addressing psychological, social, and spiritual needs of individuals and communities through respectful and caring relationships. These approaches strengthen collective care mechanisms across families, communities, and cultures to affect both individual and collective well-being.
Trauma	Trauma results from events or circumstances that are experienced as deeply distressing. These experiences are often associated with a sense of overwhelm or powerlessness and may adversely affect the functioning and well-being of individuals and groups in many ways, from minor disruptions to debilitating and severe impacts.[6,7]

There is also increasing evidence around the role that MHPSS can play in preventing violence. While poor mental health and psychosocial well-being are not causes of GBV, promoting protective factors[a] at individual, relationship, and community levels—such as empathy, communication skills, coping, emotional regulation, and nurturing family environments—has been shown to be effective in reducing forms of GBV, such as intimate partner violence.[8,9] When driven by the needs and priorities of survivors and those at risk of GBV, MHPSS can complement and bolster gender-transformative prevention approaches that address root causes of violence such as gender inequality and power imbalances.[10,11]

[a] Protective factors are conditions or attributes with a lower likelihood of an individual perpetrating or experiencing violence. These factors occur at the individual, relationship, community, and societal levels.

Foundational Approaches

Foundational approaches that support MHPSS interventions in GBV programming include MHPSS intervention layers, and survivor-centered, do-no-harm, and trauma-informed approaches.

MHPSS Intervention Layers

Adapted from the Inter-Agency Standing Committee MHPSS Intervention Pyramid,[12] Figure 1 illustrates four complementary layers of support that together form a continuum of care for mental health and psychosocial needs. Examples of GBV programming approaches and interventions at each layer are outlined below.

LAYER 1: SOCIAL CONSIDERATIONS IN BASIC SERVICES AND SECURITY

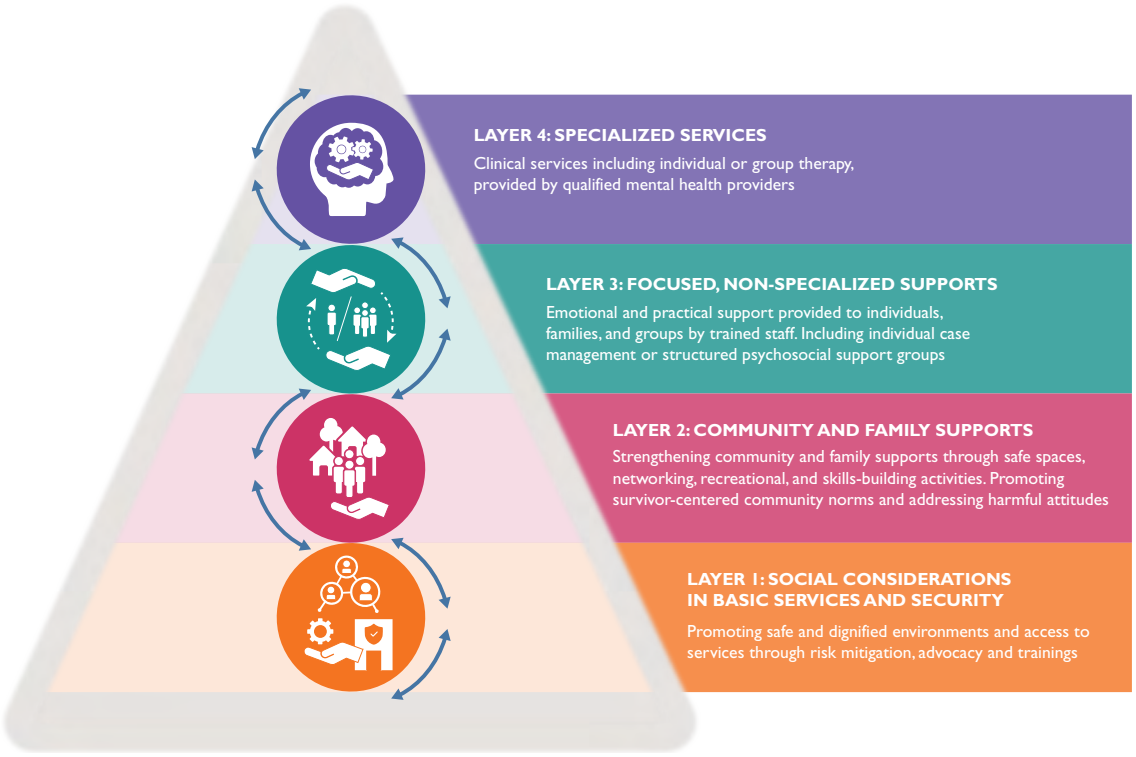
Interventions at layer 1 focus on promoting safe environments and access to a range of quality services to meet the needs of survivors and those at risk of GBV. Examples include reducing threats of violence in public spaces[13] and promoting access to safe, dignified, quality services to minimize the risk of exacerbating a survivor's distress as they seek these services.

Activities at this layer may include training service providers on rights-based and survivor-centered care; conducting safety audits or mapping to identify GBV risks and mitigation strategies; creating and enforcing a code of conduct for project staff related to sexual harassment and sexual exploitation and abuse; and policy and advocacy efforts to strengthen systems of care.

LAYER 2: COMMUNITY AND FAMILY SUPPORTS

At layer 2, GBV programs promote mental health and psychosocial well-being by strengthening access to community and family supports. Activities may include establishing peer networks or community safe spaces for groups at higher risk of GBV, such as women, girls, and people with diverse sexual orientation, gender identity and expression, and sex characteristics (SOGIESC); leading skills-building and recreation groups; or conducting community outreach and awareness-raising to reduce biases and harmful attitudes toward survivors and to promote survivor-centered attitudes and practices.

Figure 1. The four complementary layers of support that together form a continuum of care for mental health and psychosocial needs



Adapted from the Inter-Agency Standing Committee MHPSS Intervention Pyramid.

LAYER 3: FOCUSED, NON-SPECIALIZED SUPPORT

Layer 3 interventions are focused on providing emotional and practical support to survivors of GBV, those at risk, or their family members, in individual or group settings. These activities may include individual GBV case management, counseling services, body-based practices (such as trauma-informed yoga), curriculum-based groups, or other culturally appropriate measures that focus on building or strengthening resiliencies, coping strategies, supportive relationships, and self and collective care.

LAYER 4: SPECIALIZED SERVICES

Layer 4 includes clinical psychological, psychiatric, or social services to support survivors of GBV who are experiencing disruptions to their basic functioning or mental health. When staff have appropriate backgrounds and training, GBV programs can provide direct services including individual therapy, group therapy, and other specialized services. Evidence-based interventions include Common Elements Treatment Approach (CETA),[14,15] Interpersonal Psychotherapy,[16] and Cognitive Processing Therapy.[17] If staff are not equipped to provide these services directly, they should be trained to identify severe signs of distress and make appropriate referrals to services, where they exist.

Traumatic and stressful events affect people in different ways, so the types of support needed will vary. A holistic response requires links between services at every layer. While programs do not need to directly implement interventions at each level, they must map and assess the safety of existing services, identify gaps that they may have the capacity to address, and develop mechanisms to safely link survivors to existing services.

Survivor-centered approach

For GBV programs, any MHPSS intervention must be grounded in a survivor-centered approach. This approach focuses on the empowerment of survivors by creating a supportive environment for healing and places the rights of survivors and their unique experiences, needs, strengths, wishes, and challenges at the center of their recovery. A survivor-centered approach starts with recognizing that survivors' experiences of violence and recovery are shaped by their intersectional identities and focuses on restoring power to each unique individual.[18] This includes taking into account and addressing the MHPSS needs of women and girls, in all their diversity, as well as those of individuals with diverse SOGIESC, whether they have experienced violence or self-identified as survivors.

In addition, systemic factors—including patriarchy and misogyny—that perpetuate overlapping forms of oppression and compound adverse experiences, including experiences of violence, also create environments that can affect individuals' mental health and psychosocial well-being. MHPSS services

Trauma-Informed Care

People who experience traumatic events often express feelings of powerlessness, shame, helplessness, and intense fear. These feelings may linger long after the event has passed and contribute to difficulties in cognitive functioning, coping with normal day-to-day stressors, or building and maintaining trusting relationships. The Chemonics Trauma-Informed Approaches to Development Checklist provides guidance on applying key principles in trauma-informed care across development contexts that can help restore safety, power, and connection for individuals, families, and communities. Trauma-informed care can look like:

- Providing services in secure, welcoming, and comfortable environments
- Validating feelings and concerns and avoiding judgmental language
- Communicating clearly and avoiding surprises
- Providing information and options to support individuals and families in making their own choices
- Offering opportunities for peer support and community reintegration

to individuals and small groups must be coupled with interventions and work to shift and dismantle systems of oppression.[19] While MHPSS interventions can support the capacity to manage the effects of these structural stressors in everyday life, efforts to push for systemic change and address the structural roots of distress are critical to the survivor-centered approach. These efforts can include activism and the support of social movements.

Do-no-harm approach

A do-no-harm approach in GBV programming focuses on making sure that programming objectives, actions, and interventions do not—intentionally or unintentionally—compromise the physical and emotional safety of program participants, community members, or staff. To apply this specifically to MHPSS interventions in GBV programming requires an understanding of local practices, existing networks of support, and gendered and cultural aspects of mental health and psychosocial well-being. Interventions must undertake a detailed risk-analysis of programming to assess for the potential to damage local support networks, exacerbate or create mental or psychosocial distress rather than alleviate it, or introduce other risks to safety. Assessments should occur throughout the program cycle and be used to inform and update strategies to mitigate risks of harm.

Trauma-informed approaches

Trauma-informed approaches respond to both primary and vicarious trauma[21] with policies, procedures, and practices that promote safe, healing, and empowering environments for all staff and program participants, including survivors of GBV. A basic trauma-informed approach follows four key principles:[14]

- **Realize:** Everyone, at all levels of the agency or organization, should be trained to have a basic understanding of how trauma can affect individuals, families, groups, and communities.
- **Recognize:** Everyone, at all levels of the agency or organization, should be able to recognize signs of trauma. These signs will be contextually and culturally specific to local meanings and understandings of trauma and can differ based on social identity and the presence of protective and risk factors.
- **Respond:** Those interacting with individuals, groups, or communities who have experienced traumatic events should receive dedicated training and develop strategies to build institutional capacity so they can respond with culturally appropriate, trauma-informed behaviors and actions. This includes developing and working to increase survivor-centered attitudes and practices among staff through opportunities that promote self-awareness of unconscious biases and attitudes.
- **Resist re-traumatization:** Organizations and staff should be trained and evaluated on their ability to operate in ways that reduce the risk of re-traumatizing clients and staff. Agencies should address staff wellness, reduce stressful work environments, and foster an environment dedicated to collective care. Agencies should examine policies and standard practices directed at clients for the risks of re-traumatization.

[b.] Vicarious trauma refers to trauma that is experienced from listening to, learning about, and/or witnessing traumatic events affecting others. It is sometimes referred to as secondary trauma.

Program Considerations

Four critical elements to consider when designing or strengthening MHPSS services in GBV programming are context, co-creation, confidentiality, and staffing.

Context

Interventions must be firmly rooted in an understanding of local needs, priorities, beliefs, and practices surrounding mental health and psychosocial well-being. Different survivors have different needs, and one program or agency may not be able to appropriately respond to the needs of all survivors. Contextualized MHPSS programming requires community-informed and intersectional approaches that seek to identify, analyze, and determine strategies to safely meet the needs of specific groups of survivors and those at risk of GBV, including individuals with multiple intersecting and marginalized identities (e.g., girls with disabilities, transgender women, women with HIV/AIDs, lesbian women).

Co-creation with people at risk of GBV

Throughout the program cycle, consult with diverse groups of people at risk of GBV, recognizing that survivors of GBV and individuals with lived experiences of mental and psychosocial distress will be among these groups. Programs should also engage locally led women's rights organizations and other groups working on GBV, human rights, and MHPSS, including diverse SOGIESC and disability rights organizations, religious leaders, traditional healers, and men and boys. These consultations should inform which types of MHPSS activities are prioritized and how they are designed, implemented, monitored, and evaluated so that they are safe, inclusive, and responsive.

Confidentiality and informed consent

Interventions should be designed and implemented in ways that do not identify survivors to the wider community and that protect the right of survivors to control their own information. At minimum, data protection and information-sharing protocols must be in place, and individual and group interventions should be provided in locations that offer privacy. Programs must establish appropriate monitoring, evaluation, and learning (MEL) structures for GBV MHPSS programming to protect confidential data. This includes protocols to protect the confidentiality of records and having all reports include aggregated data rather than specifics about reported incidents.

Culture, Gender, and Mental Health

Cultural expressions of mental health are often gendered. It is important to recognize that appropriate and acceptable ways of expressing mental well-being and mental distress often vary significantly across cultures for men, women, and individuals of diverse gender identity and expression. Therefore, it is important to be aware of the local and culturally specific understandings of mental health and well-being, as well as of the culturally specific gender expressions of mental health and well-being.

In many settings, group activities that exclusively focus on survivors of GBV may be stigmatizing, jeopardize confidentiality, and place survivors at risk. Mixed-group interventions that include survivors and nonsurvivors with similar identities and experiences (e.g., adolescent girls) can support safety and confidentiality for survivors, offer an opportunity for participation by survivors who have chosen not to disclose their experience, and promote connections between survivors of violence and individuals who have not experienced GBV.

Staffing

Qualified staff are essential to MHPSS programming; they should have appropriate levels of organizational support and supervision and meaningful familiarity with local practices and understandings of well-being. Assessments of local workforce capacity should inform the design of realistic interventions and the development of staff training packages that build core competencies. Staff safety and well-being are promoted through opportunities for capacity strengthening, debriefing, and support through training, coaching, and supervision practices. These opportunities also increase the ability of staff members to deliver, monitor, and evaluate quality services. Interventions should not be implemented unless training and ongoing technical or clinical supervision can be guaranteed. For additional guidance on staff care, see How to Embed Self- and Collective-Care in Organizations Addressing Gender-Based Violence.

Illustrative MHPSS Activities for GBV Programming

Table 2 describes illustrative activities, mapped to each layer of the MHPSS pyramid.

Table 2. Illustrative activities for GBV programs for each layer of the MHPSS pyramid.

Pyramid Layer	Illustrative Activities for GBV Programs
Layer 4: Specialized services	• Group or individual therapy by a qualified mental health provider • Mapping specialized mental health services and establishing referral pathways among and between health, safety, shelter, economic assistance, justice, and MHPSS services • Trainings for project staff on recognizing signs of severe distress and making safe referrals to specialized services • Trainings for specialized mental health providers on basic GBV concepts and survivor-centered approaches • Capacity and systems strengthening on survivor-centered mental health approaches and interventions for local communities and government agencies
Layer 3: Focused, non-specialized support	• Individual case management for survivors of GBV • Life skills curricula for adolescent girls and their caregivers[c, 20] • Positive parenting or partnership skill-building approaches[21] • Women's village savings and loan associations (VSLAs) or other livelihood approaches that embed psychosocial components • Establishing GBV help lines
Layer 2: Community and family supports	• Safe spaces for women and girls[22] • Peer networks or support groups for men and boy survivors, or survivors with diverse[23] SOGIESC • Recreational, skills-building, or educational activities that foster relationships and social connection • Community-level campaigns that address harmful norms and behaviors (e.g., victim-blaming, stigmatization)
Layer 1: Social considerations in basic services and security	• Safety audits to inform GBV risk mitigation strategies • Trainings for service providers, such as police and health care providers, on trauma-informed and survivor-centered approaches and basic psychosocial support • Developing and enforcing codes of conduct related to sexual harassment and sexual exploitation and abuse • Work with governments and communities to build capacity to strengthen systems of care, including credentialing programs

[c.] As defined by UNICEF, life skills education seeks to equip young people to negotiate and mediate challenges and risks in their lives, and to enable productive participation in society.

Case Study: Indashyikirwa Program

The Indashyikirwa program was designed to reduce intimate partner violence (IPV) and improve the response to and well-being of survivors in rural Rwanda. Drawing on global evidence and promising practices, the Rwanda Women's Network, CARE Rwanda, and Rwandan Men's Network collaborated to develop the program, which features four major components:

1. Couples' curriculum[24] to promote equitable, non-violent relationships

- Married or cohabitating heterosexual couples with at least one partner participating in CARE Rwanda micro-finance VSLAs were invited to join 21 weekly sessions over the course of five months during which the couples' curriculum was delivered. Couples were not recruited based on known experiences of IPV because of concerns that this approach would be stigmatizing and place survivors at risk.

2. Community activism to shift harmful norms and build positive skills, attitudes, and behaviors

- A smaller cohort of couples who completed the couples' curriculum received a 10-day training on community activism and committed to conducting at least three activism activities per month. These activities aimed to encourage reflection and action around power, violence, and healthy relationships through community conversations and dramas.[25]

3. Women's safe spaces to support survivors of IPV and link to additional services

- Women's safe spaces were established in each intervention community and offered networking, skills-sharing, and livelihood activities, as well as a place for survivors of IPV to seek support and referrals. Female facilitators were recruited from the community and received training and support.

4. Training and engagement of opinion leaders and service providers to promote an enabling environment for IPV prevention and response

- Local authorities, religious leaders, police, and health care providers received training on gender, power, IPV, and supportive actions for prevention and response. Program staff also engaged opinion leaders on a quarterly basis to plan and reflect on commitments to prevent and respond to GBV.[26]

Figure 2. The MHPSS components of the Indashyikirwa program in Rwanda

Program impact on mental health and psychosocial well-being in Indashyikirwa program case study

An external evaluation of the Indashyikirwa program was conducted through a community randomized controlled trial and qualitative research. The principal finding of the evaluation was a significant reduction in experiences and perpetration of violence among women and men participating in the couples' curriculum. In addition, insights into the program's impact on mental health and psychosocial well-being are highlighted below.

- Women and men who participated in the couples' curriculum reported significant improvements in mental health, including reduced symptoms of depression.[d, 27]
- Women's safe spaces improved women's social supports and enhanced both formal and informal response services for survivors of IPV, including referral pathways.

  "Many women noted that the solidarity at the safe spaces helped reduce their sense of loneliness and anxiety and meant they could draw on others for emotional and sometimes financial support. Several attendees noted that the quality of the support and care received at the spaces developed their sense of self-worth and strength, which helps to counter the emotional legacy of IPV."[28]

More information on Indashyikirwa can be found on the Prevention Collaboration's Knowledge Hub.

[d] Authors note caution in interpreting reported reductions in depression, as the CES-D 10 scale used is indicative, not diagnostic.

Dos and Don'ts for MHPSS Programming

Table 3 provides key considerations for MHPSS programming at each step of the USAID program cycle.

Table 3. "Dos and don'ts" for MHPSS programming at each step of the USAID program cycle.

Do	Don't
Assessment	
Consult with diverse populations at risk of GBV about the way they think about mental health and their MHPSS needs and priorities.	Assume needs, priorities, symptoms, and help-seeking behaviors will be the same for all groups and survivors.
Map existing MHPSS services and assess for safety—harmful attitudes, bias, ability to be survivor centered.	Assume all MHPSS services will be safe for diverse survivors.
Train assessment teams in survivor-centered principles, responding to disclosures, and ethical and safety considerations for data collection.	Ask questions that are distressing or will put respondents at risk of further violence.
Program Design	
Design interventions to address gaps in services.	Duplicate existing services.
Co-create programming with communities and those at risk of GBV.	Actively seek to identify survivors in the community to inform your programming.
Contextualize program models to meet identified needs and align with cultural definitions of mental health, psychosocial well-being, etc.	Assume services will be appropriate across contexts without consultation about relevant cultural definitions.
Set up services that seek to identify and increase strengths and resiliencies of individuals, families, and communities.	Focus on identifying specific mental health conditions, particularly if not a psychologist or other mental health provider trained to do so.
Design interventions that align with trauma-informed and survivor-centered principles (safety, confidentiality, respect, nondiscrimination).	Set up MHPSS services that are stigmatizing or that identify survivors to the wider community.
Ensure appropriate funding and staffing for program activities.	Implement individual or group MHPSS interventions without high-quality technical supervision, training, and support to staff.
Identify and address critical barriers to and enablers of sustainability (e.g., equitable pay, staffing shortages, professional development, organizational care policies).	Provide short-term, stand-alone interventions when additional MHPSS services to support continued therapeutic work with individuals do not exist or are inaccessible.

Do	Don't
Implementation	
Seek to provide programming through appropriately trained and supervised staff from the local community.	Provide programming without assessing whether staff have the necessary qualifications and capacity to deliver interventions.
Provide technical supervision and ongoing capacity-building relevant to the services being provided.	Equate program line management with technical or clinical supervision
Establish clear protocols for responding to disclosures of GBV—including from men, boys, and people with diverse SOGIESC—and vet all services to which survivors are referred.	Assume that services will be safe, appropriate, accessible, and survivor-centered for all groups of survivors.
Train staff to recognize signs of mental distress, including trauma reactions, and link survivors to appropriate services.	Focus solely on trauma and post-traumatic stress disorder in understanding mental health.
Monitoring, Evaluation, Adapting, and Learning	
Set up appropriate MEL structures for GBV MHPSS programming that include protecting confidential data.	Implement MEL systems without appropriate training and supervision.
Use existing MEL data to inform advocacy work, technical support to governments, and information and awareness campaigns.	Make assumptions that are not contextualized with local data.

Resources

- United States Strategy to Prevent and Respond to Gender-Based Violence Globally
- IASC Minimum Standards for Gender-Based Violence in Emergencies Programming
- How to Implement a Survivor-Centered Approach in GBV Programming
- How to Embed Self- and Collective Care within Organizations Addressing Gender-Based Violence
- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
- Chemonics Trauma-Informed Approaches to Development Checklist
- Women Rise: A GBV Psychosocial Support Framework and Toolkit
- Interagency Gender-Based Violence Case Management Guidelines
- Addressing Sexual Violence against Men, Boys, and LGBTQI+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector
- Women and Girls Safe Spaces: A Toolkit for Advancing Women's and Girls' Empowerment in Humanitarian Settings
- Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit
- Common Elements Treatment Approach
- Interpersonal Psychotherapy
- Cognitive Processing Therapy
- WHO | Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-care Providers
- IASC Reference Group Mental Health and Psychosocial Support Assessment Guide
- IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

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The goal of the Collective Action to Reduce Gender-Based Violence (CARE-GBV) activity is to strengthen USAID's collective prevention and response, or "collective action" in gender-based violence (GBV) development programming across USAID. For more information about CARE-GBV, click here.

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