Summary

Mental health and pyschosocial support for conflict-related sexual violence: principles and interventions[1]

Sexual violence and armed conflict

- Sexual violence is an important problem associated with armed conflict (see Box 1 for definition).
- There are great variations in the extent, scale, type, targeting, intent, profile of perpetrator and population impact of conflict-related sexual violence.

Box 1. Definition of conflict-related sexual violence

Conflict-related sexual violence includes "rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence . . . 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 against Sexual Violence in Conflict. *Analytical and conceptual framing of conflict-related sexual violence*, p. 3).

- Sexual violence is perpetrated in the context of men's power over women. Sexual violence is perpetrated primarily by men against women and girls. In conflict, however, boys and men are also targeted. Sexual violence may be commanded or condoned as a tactic of war.

[1] This is a summary of the report from a meeting on *Responding to the psychosocial and mental health needs of sexual violence survivors in conflict-affected settings,* organized by the World Health Organization (WHO), with United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF), on behalf of United Nations Action against Sexual Violence in Conflict (UNAction), on 28–30 November 2011 in Ferney-Voltaire, France.

UNFPA unicef

STOP RAPE NOW
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Health and social consequences

- Sexual violence can have multiple physical, psychological and social effects on survivors, their social networks and their communities.
- Sexual and reproductive health consequences include sexually transmitted infections, including HIV, unwanted pregnancies, unsafe abortions, gynaecological problems and physical injuries.
- Psychological/mental health consequences include non-pathological distress (such as fear, sadness, anger, self-blame, shame, sadness or guilt), anxiety disorders (including post-traumatic stress disorder, PTSD), depression, medically unexplained somatic complaints, and alcohol and other substance use disorders, as well as suicidal ideation and self-harm.
- Social consequences include stigma and its sequelae – including social exclusion, discrimination, rejection by family and community, and further poverty.

General principles of humanitarian programming

- Mental health and psychosocial supports are essential components of the comprehensive package of care and aim to protect or promote psychosocial well-being and/or prevent or treat mental disorders among survivors of sexual violence.
- Interventions must be conducted in accordance with existing humanitarian guidance. All interventions and supports should be based on participatory principles and implemented together with communities. They should be based on assessment of capacities and needs, and build and strengthen existing resources and helpful practices. They should promote human rights and protect affected populations from violations of human rights; humanitarian actors should promote equity and non-discrimination.
- 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. 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 presented in Box 2.

Box 2. Potential harmful humanitarian 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 labelling
- Emphasis on pathology and deficits
- Medicalization of complex problems
- Aggressive questioning
- Fragmentation of systems
- Poor-quality counselling, with little training and supervision

General principles of conflict-related sexual violence programming

- A range of supports for improved mental health and psychosocial well-being should be inclusive of – and not exclusively target – survivors of sexual violence. While the needs of survivors of sexual violence must be addressed by programmes, specific targeting of survivors of sexual violence should be avoided as it risks a range of further problems such as stigma, discrimination and violence.
- Mental health and psychosocial support programming for survivors of conflict-related sexual violence should, as far as possible, be integrated into general health services, as well as a range of other services and community supports, including reproductive health, antenatal care, infant and young child nutrition, gender-based violence prevention and response, child protection, microfinance initiatives, and existing community-support mechanisms.
- Interventions should be rights based and contextualize violence against women and girls. 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-centred approach and the principles of confidentiality, safety and security, respect and non-discrimination.

Box 3. Key principles for conflict-related sexual violence programming

- Avoid specific targeting of survivors of sexual violence
- Integrate supports into wider systems (e.g. general health services; existing community support mechanisms)
- Adhere to the principles of confidentiality, safety and security, respect and non-discrimination

Multilevel supports for conflict-related sexual violence

Supports should be multilevel, in other words, they should target both persons and communities (or segments thereof). 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 and the survivor's immediate family and social network. They include psychological first aid and linking survivors with other services, psychological interventions (such as talking therapies), and, where indicated, specialist mental health care. Types of interventions by level are shown in Figure 1.

Community-focused interventions

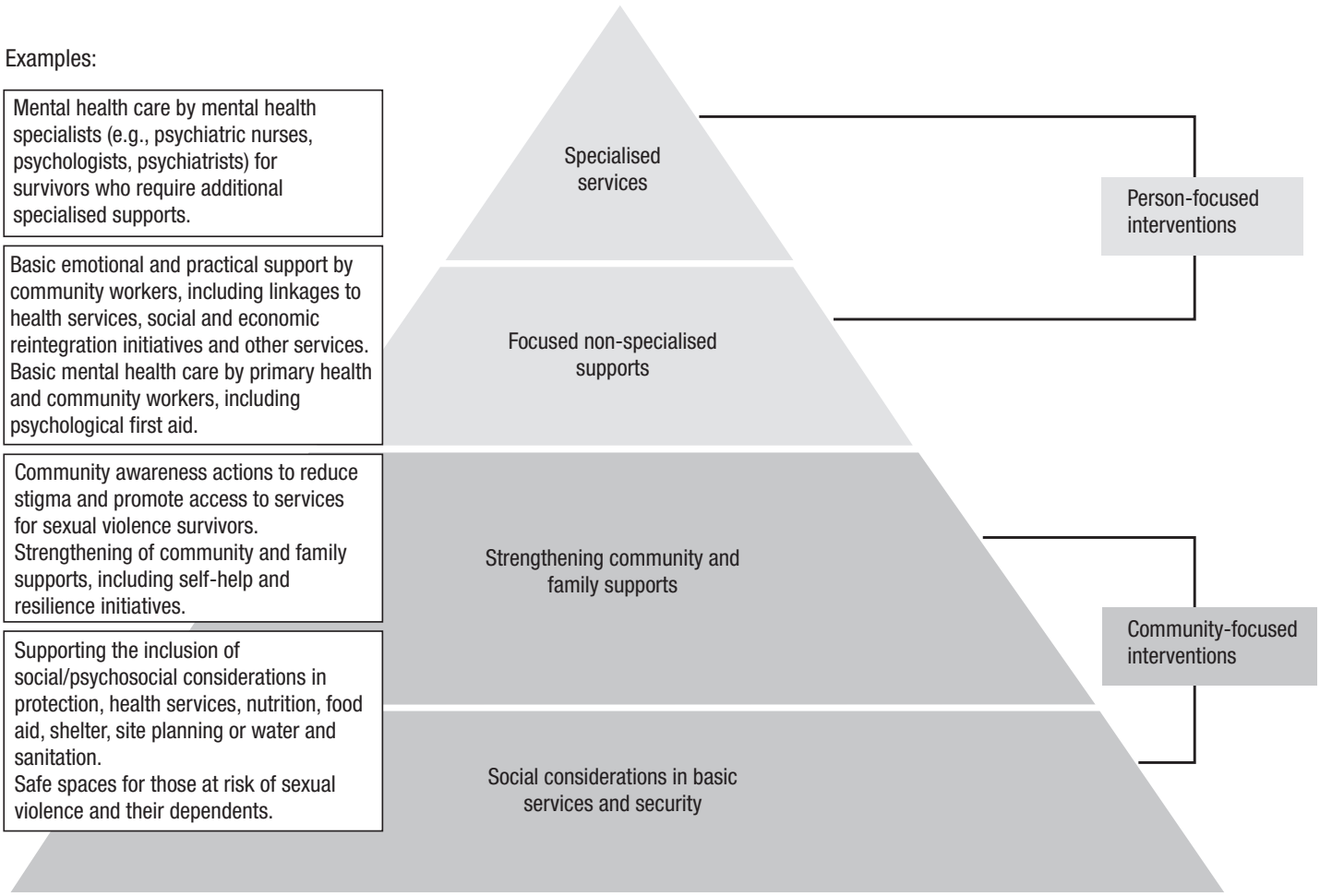
- Community-focused psychosocial supports seek to respond to identified needs, as well as to potentially play a role in protecting dignity, promoting psychosocial well-being and preventing mental health problems associated with sexual violence (see Box 4).
- Interventions should aim to be socially inclusive and address stigma and its negative consequences; members of the stigmatized group must be involved in design, delivery and evaluation. Anti-stigma actions include educational interventions to address misconceptions. Care must be taken when designing interventions, to ensure that harmful outcomes, such as increased stigma do not arise.

Box 4. 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.
- 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 socioeconomic-empowerment activities for women, such as village savings and loans associations, may be introduced.

Figure 1

Different levels of psychosocial and mental health intervention for survivors of conflict-related sexual violence. (Adapted from Inter-Agency Standing Committee, 2007).



- Safe social spaces can be organized around a physical space such as a community centre or a women's centre, or can be an adhoc social space. Safe spaces 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 not limited to women's shelters, which may increase risks for women.
- Relevant community-mobilization activities include women's and men's support groups, dialogue groups and community education and advocacy. Supports should be socially inclusive and engage local leadership (women, men and young people). Possible aspects of psychosocial support for survivors of sexual violence include: building a protective environment; addressing stigma; and changing norms around gender-based violence and promoting existing protective norms. Community mobilization may initially not be concerned explicitly with sexual violence by armed groups.
- Socioeconomic-empowerment initiatives can be implemented in all post-acute emergency phases of humanitarian response, and, if present prior to the crisis, can be supported to continue during the emergency phase. Examples include village savings and loans associations that rely on collective pooling and sharing of financial resources, which may support the mental health and psychosocial well-being of survivors of sexual violence and potentially reduce stigma.

Person-focused interventions

- There should be an emphasis on building the capacity of local staff (such as primary health-care workers or social workers), lay workers and other professionals who can sustainably carry this on in subsequent phases. Clear guidance needs to be provided on minimum skills, training, supervision and resources, as well as the type of interventions that can be delivered by workers with no professional experience (such as psychological first aid and basic referral).
- Training should be participatory and based on active learning principles; it should be well designed and 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 the provider's own experiences and attitudes (particularly towards gender-based violence and women's empowerment). Training needs to be modified to the level of education and skills of trainees and the operational context. Ongoing structured supervision, including technical and emotional support, should be provided by skilled mental health workers. Linkages between mental health, primary health, social services, protection and gender-based violence services should be developed and strengthened.
- A phased approach to delivering person-focused interventions is recommended, so that, as a minimum, all survivors of sexual violence have access to psychological first aid, even in the initial phase of response. In addition, some may require further psychological and specialized mental health care (depending on the time since the event, the severity of symptoms and degree of functioning). As the situation stabilizes and the response matures, more complex interventions can be delivered. These interventions are shown in Table 1.

Monitoring, evaluation, research and collaborative learning

- 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 improve practice in this important area.
- It is important to determine the benefits and possible harms of interventions. Participatory processes should be used to evaluate programming. Outcome indicators should be developed, including locally defined measures of acceptance at individual, family and community levels.
- All data-collection efforts must follow existing WHO (2007) safety and ethical standards for researching, documenting and monitoring sexual violence in emergencies.

References

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Table 1. Programme response (and research) matrix for person-focused interventions

<table>
<tr><th rowspan="2">Activity</th><th colspan="2">Proposed supports for conflict-related sexual violence</th></tr>
<tr><th>Acute-phase response</th><th>Post-acute-phase response</th></tr>
<tr><td>Psychosocial care with help-seeking survivors</td><td>Incorporate psychological first aid into a standard package of post-rape care offered by (locally determined) first point of contact.

Provide in-depth training on psychological first aid to a selected group of focal points (as points of first contact).

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).

Provide linkages to available community supports, social services, general health services and mental health care, according to identified need and referral.</td><td>Continue to implement and strengthen delivery of psychological first aid and linkages with services and supports.

Strengthen social networks.</td></tr>
<tr><td>Psychological intervention with help-seeking survivors, integrated into wider systems, such as health, educational or nutrition care</td><td>Research 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).

Research the potential value of single-session psychological care, including psychoeducation, building coping skills, and safety planning.</td><td>Safely implement manualized psychological talking therapies for people who are not functioning well because of their symptoms. The current evidence base favours culturally validated adaptation of:
• cognitive-behavioural approaches for PTSD and depression and alcohol dependence
• interpersonal therapy for moderate–severe depression (which is depression affecting daily functioning)
• brief intervention for harmful or hazardous substance use
Research into interventions without an evidence base, such as: supportive counselling as a stand-alone form of support, and traditional, spiritual and religious healing practices.</td></tr>
<tr><td>Clinical management of mental disorders in survivors of sexual violence. By general health-care providers (e.g. general nurses, health officers and doctors in primary health centres, post-surgery wards, women's wellness centres)</td><td rowspan="2">Provide clinical care with follow-up for severe mental disorders (adapted to the local context and monitored for adverse effects, and accessible to all who require care).</td><td>Provide clinical care with follow-up for both severe and common mental disorders.

Safely implement manualized psychological talking therapies (as above).</td></tr>
<tr><td>Clinical management of mental disorders in survivors of sexual violence. By specialized mental health-care providers (e.g. psychiatrists, psychiatric nurses and psychologists)</td><td>Provide clinical care with follow-up for both severe and common mental disorders (by mental health-care providers with advanced knowledge in mental health care of survivors of sexual violence).

Safely implement manualized psychological talking therapies (as above).</td></tr>
</table>

Key resources

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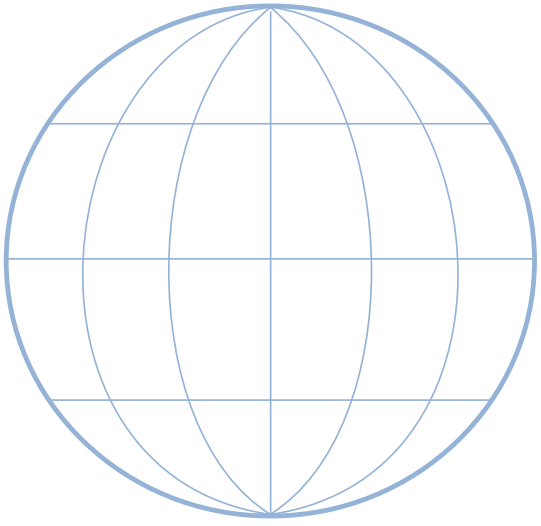

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