Guidance to support the mental health and psychosocial well-being of GBV and SRH service users in humanitarian settings

UNFPA

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Executive summary

This guidance document provides a comprehensive framework to support the **mental health and psychosocial well-being of gender-based violence (GBV) and sexual and reproductive health (SRH) service users in humanitarian settings**. Recognizing the heightened vulnerabilities caused by conflicts and disasters, the guidance emphasizes the critical need for integrated, gender-responsive and survivor-centred approaches that bridge mental health and psychosocial support (MHPSS) with SRH and GBV programming.

Humanitarian crises expose individuals to multifaceted risks including violence, restricted access to services, and social isolation, which significantly impact mental health and psychosocial well-being. This guidance aims to equip humanitarian actors, front-line service providers and community organizations with the knowledge and tools to identify and address these complex needs effectively. It underscores the imperative of coordination among MHPSS, SRH and GBV actors to ensure holistic care, reduce retraumatization and improve access to support for all survivors, including women, girls, men, boys, and people of diverse sexual orientations, gender identities, gender expression and sex characteristics (SOGIESC).

Key intervention strategies include joint situation analyses that capture gender-specific barriers, capacity-building of front-line workers on psychosocial support and trauma-informed care, and the establishment of safe, accessible and confidential service environments. Community engagement is promoted through support to women-led organizations and group-based psychosocial activities to strengthen resilience. Additionally, the guidance advocates for robust monitoring and evaluation frameworks that use gender-responsive and survivor-centred indicators to measure the effectiveness and integration of MHPSS within GBV and SRH services.

The mental health and well-being of front-line workers are also recognized as essential components, with recommendations to address their unique risks and provide supportive supervision.

Ultimately, this guidance sets a foundation for humanitarian programmes to deliver respectful, effective and integrated MHPSS that not only addresses immediate mental health needs, but also empowers survivors to advocate for their rights and fosters recovery in crisis-affected populations.

1. Introduction

Conflicts and disasters affect millions of people each year, leading to tremendous loss and suffering. Heightened exposure to violence both within and outside their communities, increased domestic and financial burdens, restricted freedom of movement, and diminished social support can reduce access to life-saving services, including sexual and reproductive health (SRH) and protection services, mental health and psychosocial support (MHPSS), and other humanitarian interventions.[1]

The risk of gender-based violence (GBV) is increased in these contexts, with serious consequences for the mental health and psychosocial well-being of survivors. While sexual violence disproportionately affects women and girls, men, boys, people of diverse sexual orientations, gender identities, gender expression and sex characteristics (SOGIESC), and other marginalized groups are also affected, increasing their MHPSS needs.

The impacts, needs and barriers to accessing MHPSS care often differ based on gender identity and sexual orientation. People who develop severe mental health conditions in the context of crisis[2] may be vulnerable to further abuse of their human rights, including violations of their reproductive rights and additional barriers to their right to gender equality.

In emergency settings, survivors of GBV or other traumatic events may present for SRH or protection services. It is important that front-line SRH and GBV service providers are able to identify and address the MHPSS needs of these survivors, and make appropriate referrals for their continued care and support, in order to ensure that ***the SRH, GBV, and mental health and psychosocial needs of survivors are addressed in a timely and integrated manner***.[3]

The development of this guidance has been informed by the following documents:

- Inter-Agency Standing Committee (IASC), The Mental Health and Psychosocial Support Minimum Service Package (Geneva, 2022) (MHPSS MSP).
- Gender-Based Violence AoR and Global Protection Cluster, The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming (Geneva, 2019) (GBV Minimum Standards).
- Inter-Agency Working Group on Reproductive Health in Crises, Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (New York, 2020)
- World Health Organization, Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings (Geneva, 2020)

1 Further information on stressors faced by SRH and GBV service users in humanitarian contexts can be found in Annex 1.

2 Approximately 22 per cent of crisis-affected individuals develop a mental health condition, including 4 per cent who experience severe mental health conditions. Left untreated, these mental health conditions may persist for months and years. See Fiona Charlson and others, "New WHO prevalence estimates of mental disorders in conflict settings: A systematic review and meta-analysis", *The Lancet*, vol. 394, No. 10194 (July 2019), pp. 240–248.

3 The term ***service users*** is used in this guidance to refer to the diverse populations accessing SRH and GBV services in humanitarian contexts, including women and girls, men and boys, people of diverse SOGIESC, adolescents and youth, and other marginalized groups within the affected population.

Intended audience

This guidance aims to support SRH, GBV and other humanitarian actors to ensure that SRH and GBV programmes address the MHPSS needs of service users in crisis situations:

- Front-line SRH and GBV service providers working in humanitarian contexts, particularly as part of integrated SRH-GBV programmes.
- SRH and GBV programme managers working in humanitarian contexts.
- MHPSS technical staff who support strengthening and/or integration of MHPSS responses into SRH-GBV programming in humanitarian contexts.
- Actors implementing MHPSS interventions through other sectors.

How to use this guidance

This guidance is designed to complement the IASC MHPSS Minimum Service Package (MHPSS MSP). SRH and GBV service providers should have a basic familiarity and understanding of the MSP. Specific sections of the MHPSS MSP are linked as references throughout the document and will be tagged with this icon: MHPSS MSP

Recognizing that there are multiple entry points for survivors to seek access to or be referred to MHPSS services through the health and protection systems, ***separate guidance is provided by the type of service provider***, with the understanding that MHPSS services are not stand-alone, but rather form part of a broader package of integrated SRH and GBV services.

Finally, it is important to note that this guidance is not intended to replace capacity-building on MHPSS in humanitarian settings, which is strongly encouraged as the guidance supports staff to apply their knowledge and integrate MHPSS into SRH and GBV service provision.

2. Mental health and psychosocial support needs of SRH and GBV service users in humanitarian settings

MHPSS in SRH and GBV programming

GBV and SRH programmes target the same populations, addressing different but closely linked needs,[4] and these sectors must collaborate closely to improve the overall health, well-being and safety outcomes of the people they serve.

MHPSS is integral to GBV and SRH programming and directly affects the quality of SRH-GBV services. Poor SRH or GBV outcomes can lead to poor mental health and psychosocial outcomes, and vice versa. A survivor whose protection and SRH needs have not been met, for example, may experience higher levels of psychological distress which, in turn, would make it difficult for them to recover, build on their strengths and make decisions on how to protect themselves. Integrating MHPSS into SRH and GBV programming supports survivor- and patient-centred approaches and contributes to improved health and mental health outcomes, enhanced safety and realization of the rights of SRH and GBV service users. These services are thus not only complementary, but are inseparable.

There are multiple entry points where the mental health and psychosocial well-being of GBV and SRH services users can be addressed. This, along with the resource constraints that are often seen in humanitarian contexts, and the complex challenges faced by GBV, SRH and MHPSS actors, highlights the importance of coordinating and integrating approaches. While humanitarian interventions cannot directly address the root causes of gender inequality and discrimination, collaboration and integration between GBV and SRH can help mitigate their consequences and ensure more effective and holistic support.

Figure 1 illustrates the integration of GBV and SRH needs and services with MHPSS.

GBV and SRH service users entry points for MHPSS support

GBV programming

- Women and girls safe spaces (WGSS)
- Psychosocial support groups
- GBV prevention and risk mitigation activities (safety audits, awareness session on GBV)
- GBV case management
- Economic empowerment and livelihoods activities
- Distribution of dignity kits

SRH programming

- Emergency obstetric and newborn care (EmONC) services
- Family planning and contraception activities
- Clinical management of rape

Survivors' entry points for MHPSS support through other areas of work

- Integrated mental health services within health care (mhGAP)
- Psychological interventions provided by health and protection actors
- Group-based MHPSS activities within protection services
- Caregivers' MHPSS group-based activities
- Child protection/protection case management
- Early childhood development activities
- MHPSS activities integrated through nutrition activities

Challenges/risks for safe provision of MHPSS support to GBV and SRH users, including survivors:

- Misconception that MHPSS is limited to provision of focused support for psychological distress or mental health conditions or what is often label as "specialized support"
- Diversity on the quality of implementation of MHPSS activities and on the MHPSS components incorporated within GBV and SRH programming
- Confusion around the use of MHPSS as composite term: Who is an MHPSS actor? Who provides MHPSS support?
- Challenges in coordination among all actors involved in supporting the MHPSS well-being of GBV and SRH service users
- Poor integration of GBV considerations in the provision of MHPSS activities by other sectors, particularly when it comes to support for psychological distress and mental health conditions
- Lack of consistency in integrating MHPSS for SRH users that is not only limited to survivors of rape
- Availability of human resources trained on the three areas of work (MHPSS, SRH and/or GBV)
- Limited availability of research on impact of MHPSS interventions through GBV programming in humanitarian settings

4 See Annex 2.

Key principles of safely promoting the mental health and psychosocial well-being of SRH and GBV service users

All humanitarian actors should ensure that MHPSS interventions adhere to the following principles:

Gender responsiveness: Service providers should understand how gender shapes the experience of individuals, and apply this information across all aspects of programming. Examples of this include gender inequality, which contributes to violence, discrimination and barriers to accessing services or to participating in public life. Psychological distress may manifest differently based on one's gender identity or expectations of how a person of their gender should react to a situation. Coping mechanisms may also differ by gender.

Intersectionality: In all situations, it is important to recognize that people experience overlapping forms of oppression, discrimination and marginalization, and that because of this, a service user may have diverse MHPSS needs. In humanitarian contexts, the additional factors of violence, fear, loss, displacement, etc. can also contribute to these intersectional needs.

Situating distress in context: The social determinants of psychological distress (gender inequality, intersectionality, systematic oppression suffered by women and girls and people of diverse SOGIESC) must be considered when responding to the mental health and psychosocial needs of GBV and SRH service users. Be aware that medicalized approaches to MHPSS may ignore these social determinants, and even use diagnoses as a way to perpetuate gender inequality and oppression.

Focus on empowerment: Following the survivor- and patient-centred care models, MHPSS service provision should reflect the collaborative nature of emergency programming, rather than an "expert-beneficiary" model of care. In practical terms, this means supporting GBV and SRH service users to understand how the violence and discrimination stemming from gender inequality impacts their life, mental health and well-being, and supporting them to challenge those situations safely, while restoring a sense of agency and supporting self-efficacy.

3. Essential components of all MHPSS programmes

Note: The actions in the following tables complement the actions and considerations outlined in MHPSS MSP Section 2.

3.1 Design, plan and coordinate programmes to promote and protect the mental health and psychosocial well-being of GBV and SRH service users

Coordination

Ensure cross representation at MHPSS, SRH and GBV coordination meetings

Cross representation ensures that MHPSS, SRH and GBV planning and interventions are linked, leading to improved coordination among sectors and engagement, with all actors integrating MHPSS in their sectors. This ensures that MHPSS, SRH and GBV actors are aware of GBV- and SRH-related MHPSS needs, so they can integrate these considerations in the design of their activities.

Example: Designated SRH and GBV focal points can attend MHPSS technical working group (TWG) meetings and MHPSS representatives participate in the Health Cluster / SRH Working Group and GBV coordination meetings. Through these forums, they can share relevant information related to crisis-related stressors, vulnerable groups among the affected population, observations from service providers about mental health and psychosocial needs among service users, and barriers to accessing MHPSS services.

Coordination bodies should conduct joint SRH-GBV needs assessments and situation analyses that incorporate mental health and psychosocial risks and needs. This will foster development of integrated responses, and also allows for increased sensitization and collaboration across sectors, and integration of services.

This can also facilitate the development of referral pathways and standard operating procedures for the referral of women, girls and survivors to and from MHPSS and GBV and SRH services.

Promote coordinated approaches to GBV and SRH service delivery during programme design:

This can be achieved by setting clear channels of communication; supporting joint situation analysis; and joint capacity-building efforts when possible, and integrated GBV/SRH services[5] based on their feedback.

Integrating SRH and GBV services reduces mental health and psychosocial risks for SRH and GBV service users by promoting a holistic approach to care that is more effective in protecting and promoting the mental health and psychosocial well-being of SRH and GBV service users.

Integrated services reduce security risks related to moving to different places to receive care; reduce retraumatization of survivors who would otherwise have to tell their stories multiple times; makes GBV services more accessible to survivors of sexual violence, including men, boys and people of diverse SOGIESC, who may not otherwise be able to access GBV services for fear of retaliation or stigma.

Example:

- Consultation with SRH and GBV services users before deciding on MHPSS activities.
- Advocate with MHPSS actors to incorporate specific information addressing GBV and SRH service users as described here.

5 An example of a GBV/SRH integrated service is a WGSS, where midwives provide regular SRH consultations.

- Jointly establish SRH-GBV protocols and referral pathways, including MHPSS specialized services to reduce risks of retraumatization of survivors.
- Conduct joint trainings for GBV and SRH front-line workers on relevant MHPSS.

Planning: Situation analyses/assessments[6]

Assess for gender-specific barriers to accessing services and gendered drivers of mental health and psychosocial needs and capacities

Incorporate questions that capture gender-specific information in consultations, situation analyses or needs assessments conducted with affected communities to inform project planning.

Examples may include:

- Cultural norms around masculinity that discourage men and boys from accessing MHPSS-integrated services.
- Restrictions on women's and girls' movement that limits their access to GBV or SRH services.
- Restrictions on women's and girls' ability to make decisions that may affect their access to treatment options, e.g. facility-based hospital delivery, consent to emergency Caesarean section, access to contraception.
- Competing demands on women's and girls' time due to caregiving or household labour expectations.
- Lack of trust in front-line workers to provide respectful care, e.g. during deliveries and among gender minorities, linked to experiences of discrimination and violence.
- Fear or experience of judgment, misgendering or outright refusal of care among people of diverse SOGIESC.

Examples of gendered drivers of mental health and psychosocial needs and capacities:

- Cultural norms on expression of emotion, participation in grieving rituals and observance of religious practices, which differ by gender.
- Uneven gender distribution of caretaking and domestic labour.
- Coping mechanisms and help-seeking behaviours.
- How distress is expressed, based on norms and culture.

Suicidality:[7]

- Life events linked to suicidality often vary by gender: unintended pregnancy, miscarriages and GBV are associated with increased risk of suicidality among women and girls.
- Means of suicide may differ based on gender, and thus suicide risk assessments should include questions about access to different means of suicide.

Social support

- Women, girls and people of diverse SOGIESC may face limitations in accessing social support linked to restrictions on their movement directly imposed by society or indirectly imposed by gender-specific safety risks in the local environment.
- Many of the circumstances under which women, girls and people of diverse SOGIESC are likely to need social support are the same circumstances which expose them to stigmatization and social isolation: GBV, abortion, HIV-positive status, obstetric fistula, etc. Communities should be consulted on what avenues for social support are still available to people facing these specific risks.

6 Please align with the IASC, "Multi-sectoral MHPSS needs and resources assessments toolkit" (Geneva, 2024) and available GBV assessments.

7 Please see IASC, Guidance: Addressing Suicide in Humanitarian Settings (Geneva, 2022).

Assesses service providers' knowledge about the survivor-centred approach as part of MHPSS mapping

To establish a comprehensive understanding of the capacity-building needs of MHPSS service providers, use questions that capture whether there is a basic understanding of the survivor-centred approach without naming it. These questions help to explore blaming attitudes, knowledge about safety measures, understanding of the needs of GBV survivors, and stigma associated with male survivors and judgments about masculinity.

Example:

- What would you do if a woman/man accessing your services disclosed that they are experiencing or have experienced GBV?
- How do you feel about providing support to GBV survivors, including men and boys? Do you know where to refer a survivor? Do you know if there is a GBV coordination group?

Other information that can help assess knowledge about the survivor-centred approach includes:

- Presence of specific protocols in case of GBV disclosures.
- Knowledge of laws and regulations regarding GBV.
- Specific measures taken to provide support to men and boy survivors.

Note: This applies to all MHPSS activities yet is of crucial importance to prevent harm when providing MHPSS-focused support for survivors.

Programme design

Ensure that MHPSS activities described in the GBV Minimum Standards 5 and 8 (on WGSS), have clear MHPSS goals

Tools can be found in the MHPSS MSP and the Women Rise GBV PSS Programming to define clear MHPSS objectives for WGSS.

Before planning new MHPSS activities, assess existing MHPSS interventions,[8] assess the activities and skills of front-line workers[9]

Ensure that pre-existing mental health and psychosocial aspects of services and activities are aligned with the core actions within MHPSS MSP section 2 and the additional considerations laid out in this guidance. Assist programme staff to **identify gaps** in MHPSS skills and activities. Provide **actionable guidance** on how to strengthen MHPSS skills and activities.

When incorporating MHPSS activities in maternal and child health services, ensure that design and planning are aligned with identified needs and available resources

When incorporating protocols on detection/screening for psychological distress and/or mental conditions through SRH services, ensure that they are relevant and adapted to the context and existing services and human resources

Note: Screening should only be done IF providers are trained on how to ask about psychological distress and mental conditions, if a first-line response protocol is in place, and if referral pathways are functional. Investing in basic psychosocial skills of SRH front-line workers to identify, refer or provide first-line support might be better than routine screening.

8 "MHPSS components" refers to aspects of/activities on MHPSS that have already been partially or fully integrated but may benefit from better design, such as LIVES, psychological first aid, orientation of basic psychosocial support skills, GBV case management (without supervision on the skills of GBV workers) and group psychosocial support activities within the WGSS.

9 See subsection 1.4, "Support MHPSS competencies of staff and volunteers".

Establish a clear protocol for the identification and safe, survivor-centred referrals of GBV survivors

Strengthen the capacities of front-line SRH and GBV service providers to identify the mental health impacts of GBV and provide first-line response. Ensure that they have the skills to do no harm when identifying and referring survivors.

Support women-led organizations (WLOs) to provide MHPSS to GBV and SRH service users

Because of their knowledge, experience and trusted position within communities, WLOs are well-placed to support the mental health and psychosocial needs of GBV and SRH service users in humanitarian contexts.

Depending on the type of MHPSS activity you are planning to integrate, consider different types of support to WLOs:

- In-kind support to refurbish their spaces so they can provide MHPSS activities.
- Technical support to strengthen activities they may already be providing, adapted to the intensity, frequency and duration that is appropriate to the capacity of the WLO.
- Strengthen their knowledge and capacities on specific MHPSS topics.
- Strengthen their capacities to deliver scalable, low-intensity interventions by non-specialized MHPSS actors at the community level.

Establish gender-specific recruitment practices to mitigate barriers for women, men and boy survivors, and people of diverse SOGIESC, and enable the organization to staff according to the needs of the affected population

- Prioritize same-sex service providers to ensure accessible services to women and girls (e.g. preferentially hiring female medical staff to provide maternity care, same-sex providers for clinical management of rape [CMR] services).
- Consider hiring male staff in contexts where men and boy survivors of conflict-related sexual violence (CRSV) are reported.
- Assess barriers that prevent women from applying to or being selected for posted positions, and take proactive steps to make hiring processes more gender-equitable.
- Set gender hiring targets to match the gender ratio of front-line workers with the gender ratio of those accessing services (for example, if 80 per cent of people accessing a community centre are women and girls, a hiring target could be set of 80 per cent female front-line workers at the community centre).

During recruitment processes, assess for judgmental and/or discriminatory attitudes during recruitment processes

Create scenarios such as “What would you do if…” that incorporate elements to capture specific attitudes around GBV, gender inequality, abortion care, HIV and sexually transmitted infection (STI) treatment, family planning, towards mothers who may be displaying mental health conditions associated with birth and have difficulties in caring for their infants. Negative attitudes of health care providers reinforce stigmatization and can lead to poor health care and denial of service.

Additional considerations for the plan and design of activities providing focused support for psychological distress or mental health conditions

Incorporate training topics that help front-line workers to understand SRH-related issues that can have mental health and psychosocial implications

Consider integrating the following topics, as relevant, into training sessions:

- Perinatal mental health (e.g. depression, grief).
- Post-partum mental health (e.g. depression, psychosis).

- Perimenopause and menopause mental health (e.g. depression, anxiety).
- Impact of obstetric violence, abortion, miscarriage, stillbirth.
- Impact of unwanted/forced pregnancy on mental health.
- Impact of HIV/AIDS and STIs on mental health.

When using syndromic/diagnosis-based tools within the focused SRH or GBV interventions, consider this from a gender-responsive perspective.

It is important to consider that mental health diagnoses may be used to stigmatize and disempower people in distress, at times rationalizing the restriction or removal of their rights, and their forced separation from communities.

- You should refrain to share mental health diagnoses with the people around the person (family, friends, wider community, etc.) to respect their confidentiality and avoid putting them at further risk.[10]

Example: Counsel the service user (and whomever they have designated as a trusted person) so that they understand their condition and can make their own treatment decisions. Carefully share information in a way that is not stigmatizing and helps them to understand their current suffering. You might decide not to use a "diagnosis-name", that might be used to control or harm the service user. A "depression diagnosis" could be used to lock down a woman, send her back to her parents, or separate her from her children, with these claimed as protection measures.

Ensure that MHPSS services are safe to access and that MHPSS staff are trained to maintain safety of survivors

Before initiating focused MHPSS support or specialized MHPSS services outside of GBV case management, take steps to establish clear minimum safety conditions:

- Conduct a safety assessment in collaboration with the survivor/community and SRH service providers and GBV case management.
- Evaluate the accessibility of SRH and GBV services, including GBV case management.
- Assess the timing and duration of the intervention and whether the violence is ongoing.
- Ensure that interventions are not stigmatizing or identified by the community as only for GBV survivors, which may place survivors at further risk.

Do not initiate MHPSS interventions unless you are prepared!

- Ensure all case files and records adhere to the GBV information management system.
- Design and locate facilities to enhance physical security and safety and accessibility to GBV and SRH services users in consultation with the population, in particular, women, adolescents, people living with disability and other marginalized populations.
- Whenever possible, coordinate, ask for any safety audits done by GBV partners to provide information on possible barriers to access for GBV and SRH services users.
- Based on available information, integrate GBV prevention strategies to reduce the risk of GBV for people who participate in or access the programme's activities and services.
- Build capacity of service providers on how to conduct basic safety planning (see below "Support MHPSS competencies of staff and volunteers")

10 This is very important, particularly if there is any chance a mental health diagnosis may be used as a means to justify restricting freedom of movement or violence against the individual (note that this risk is particularly high for adolescent girls and survivors of IPV).

Ensure that all relevant protocols explicitly protect and promote the mental health and psychosocial well-being of survivors

Protocols should include:

- Cross referrals between services providing MHPSS support, including GBV, SRH, CMR-intimate partner violence (IPV), including protocols for ensuring referrals for survivors identified during MHPSS, SRH or other services.
- Interventions for high-risk situations like suicide attempts (roles and responsibilities between SRH, GBV and MHPSS providers; clarity on which survivor-centred MHPSS services are available; clarity on who can be involved without putting the survivor at further risk, etc.).
- Steps to take if a perpetrator threatens a survivor or front-line staff during service delivery.

3.2 Develop and implement a monitoring and evaluation system

Include process indicators that capture MHPSS integration

The MHPSS MSP M&E Indicator Bank[11] pages 21–22 provides process indicators for each MHPSS MSP activity.

Examples:

- Number of GBV and SRH front-line workers and volunteers oriented on gender-responsive basic psychosocial support/first-line basic psychosocial support (disaggregated by type of staff).
- Number and percentage of GBV services and SRH facilities with staff trained and supervised to identify and manage psychological distress and mental health conditions in a gender-responsive way (disaggregated by type of service/facility and type of staff).
- Number of GBV or SRH needs assessments conducted that include a specific focus on mental health and psychosocial well-being.
- Number and percentage of GBV and SRH programmes that have established and functional cross-sectoral referral networks that incorporate referrals to mental health services.

Select indicators measuring the six key mental health and psychosocial well-being domains and adapt them to SRH-GBV programming

The MHPSS MSP Indicator Bank outlines six domains of mental health and psychosocial well-being:

- Functioning
- Subjective well-being
- Extent of prolonged disabling distress and/or presence of mental, neurological and substance use (MNS) disorders
- Coping
- Social behaviour
- Social connectedness

Adapted SRH-GBV indicators could measure:

- Functioning:
  - Survivors of GBV receiving GBV case management with integrated MHPSS.
  - Pregnant women receiving psychological interventions integrated into SRH services.

11 IASC, "MHPSS MSP Monitoring & Evaluation Indicator Bank" (Geneva, 2022).

- Subjective well-being:
  - Post-menopausal women attending group-based MHPSS activities for older women.
  - Adolescent girls attending group activities for girls.
- Distress/MNS disorders for:
  - Women receiving focused or specialized support for postnatal depression.
  - Survivors of GBV receiving clinical care with integrated MHPSS.
- Coping:
  - Women who access post-abortion care and participate in group-based MHPSS activities.
  - Adolescent girls attending WGSS with integrated MHPSS activities.
- Social behaviour:
  - SRH service providers and WGSS service providers trained in responding to the mental health and psychosocial needs of girls and women.
- Social connectedness:
  - Pregnant women at risk of perinatal depression attending activities through WGSS or other women-led initiatives.
  - Mothers attending parenting programming within SRH services.

Select indicators that assess the uptake of survivor-centred approaches and attitudes of the staff, as well as service users' satisfaction and feelings of safety

Indicators and tools may be adapted from the GBV Minimum Standards M&E framework.[12]

Assess uptake of survivor-centred approaches and attitudes among providers:

- Number and percentage of SRH/GBV programme staff, including volunteers and community workers trained on the GBV Guiding Principles and demonstrating improved survivor- or patient-centred attitudes, knowledge and skills after training.

Assess feelings of safety and security among SRH-GBV service users (feedback measured through exit interviews, satisfaction surveys):

- Number and percentage of SRH or GBV service users who report they felt safe and were treated with respect and dignity during SRH or GBV services.
- Number and percentage of women and girls report feeling safe while at WGSS.

Qualitative measures, such as focus group discussions, can be used to get more detailed information on service users' satisfaction with services.

- How safe do GBV and SRH services users feel when accessing services? (0–5)
  - What could be done to make accessing services safer?
- How easy is it for women, girls and gender minorities to access services? (0–5)
  - What could be done to make accessing services easier?
- Is it considered "acceptable" within the community for you to be seen accessing these services?
  - If not, what could the programme do to increase community acceptance?
  -

12 Maureen Murphy, Alina Potts and Fiona Shanahan, *The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming: Monitoring and Evaluation Framework* (Washington, D.C. and Maynooth, Global Women's Institute and Trócaire, 2023).

3.3 Care for personnel providing MHPSS to GBV and SRH service users

During recruitment, be sure that prospective staff are aware of the specific mental health and safety risks they may face in the course of their work with SRH and GBV service users

Risks to mental health and psychosocial well-being that front-line workers may face in the course of their work include:

- Demands, pressure, harassment or security risks as a result of the sensitive work associated with GBV and SRH challenges related to working in a humanitarian context.
- Challenges related to the content of their work.
- Situations that may not be possible to "solve", including ongoing risk of violence, abusive situations, which often create frustration, anger and "compassion fatigue" for the service provider.
- Disconnect between personal values and professional responsibilities.
- Exposure to difficult, distressing and/or traumatic material in the course of performing work duties (e.g. witnessing or hearing about obstetric violence, perinatal psychosis, unsafe abortions, grief related to pregnancy loss, GBV).

3.4 Support MHPSS competencies of staff and volunteers

Promote joint training for GBV and SRH staff on relevant MHPSS topics

Design orientations and trainings that accommodate GBV and SRH workers, e.g. training on basic psychosocial support skills for GBV and SRH front-line workers to use the LIVES approach; psychological first aid; the GBV Pocket Guide on GBV disclosures; and managing suicide for GBV case workers and SRH staff providing CMR.

This will help in:

- Building common understanding of the synergies between both programmes.
- Support better integration and collaboration.
- Better use of limited resources.

The MHPSS MSP provides a list of relevant training topics that can help in designing these joint training sessions.

Promote joint supervision of GBV/SRH staff on basic and more advanced MHPSS skills to facilitate progressive capacity-building

- Incorporating biweekly/monthly sessions integrated with other supervision activities linked with the SRH activities, e.g. within clinical case discussions.
- When possible, GBV and SRH teams coordinate on initiatives aiming to support capacity-building on MHPSS skills to support service users.
- Support GBV case managers supervising GBV case workers in acquiring skills and tools to integrate within their supervision.
- Identify opportunities for collaboration and joint supervision with other health actors providing MHPSS activities. Always ensure that supervisees are clear on their role and responsibilities, and on the objectives and conditions of the joint supervision.

Ensure front-line workers providing MHPSS through other sectors are trained in the survivor-centred approach, have a basic familiarity with GBV case management and know how to refer survivors to GBV services

Support front-line staff to develop an understanding of mental health and psychosocial

well-being that incorporates social determinants as explanatory factors and is non-stigmatizing

Routinely monitor front-line workers' interactions with service users and community members to confirm they are treating people with dignity and respect

Observe for:

- Use of non-discriminatory, non-judgmental language.
- Provision of services in a manner that is fair, equitable and follows established guidance or protocols.
- Procedures that are fully explained to service users and for which consent is obtained prior to proceeding.
- Maintaining appropriate eye contact and an open posture.
- Explaining the concept of confidentiality.

Additional considerations when planning and designing activities providing focused support for psychological distress or mental health conditions (*to be introduced only if the above considerations are in place*)

Build skills and knowledge of all front-line workers intervening with GBV and SRH service users to manage risk factors that impact their mental health and psychosocial well-being

Women and girls and people of diverse SOGIESC accessing GBV and SRH services often face immediate threats to their mental health and psychosocial well-being. Specific psychosocial and mental health risks include suicidality, ongoing and/or heightened risk of GBV, and impaired functioning linked to distress.

Front-line workers can help support service users' mental health and psychosocial well-being risk factors by:

- Assisting them to identify these threats.
- Assessing the severity and immediacy of these threats.
- Collaboratively developing a safety plan to mitigate risks.
- Providing additional MHPSS services, or offering referral to further support where needed.

Front-line service providers supporting service users should have:

- Problem solving and decision-making skills.
- Action planning and goal setting skills.
- Knowledge about how to develop a safety plan for IPV, assess for suicidality.
- Knowledge about the impact of GBV on the mental health and psychosocial well-being of a survivor, and the cycle of violence.
- Skills and techniques to support emotional containment.

To assess these risks or threats without adopting a syndrome-based approach or immediate intervention, front-line workers can ask questions[13] such as:

- What has happened to you/is happening to you? (What violence or types of violence to which the person is exposed.)
- How is it affecting you? (What kind of risks are posed to the person.)

13 These questions are adapted from the "power threat meaning" framework, which seeks to move away from models of intervention based on diagnosis, while facilitating an analysis of emotional distress based on contextual factors and the biographies of the persons. Lucy Johnstone and Mary Boyle, *The Power Threat Meaning Framework: Towards the Identification of Patterns in Emotional Distress, Unusual Experiences and Troubled or Troubling Behaviour, as an Alternative to Functional Psychiatric Diagnosis* (Leicester, British Psychological Society, 2018).

- What things are you doing to survive? (To assess coping mechanisms, own safety measures.)
- What are your strengths? (To build on positive coping skills and resilience.)
- Is there anyone you can confide in/trust?

Prepare front-line workers to recognize the effects of traumatic events, normalize stress reactions, destigmatize these effects, and adapt the support they provide according to the needs of the service user

Train front-line service providers to meet the unique needs of each individual survivor of traumatic events. Topics to include are:

- What is the fight/flight/freeze response, and practice in addressing this response, in particular tonic immobility in relation to GBV.
- Ways in which traumatic experiences can impact memory.
- Principles of trauma-informed care, reinforcing their overlap with the survivor- and patient-centred approaches.
- How to be trauma-aware, identifying possible responses to traumatic events, and how trauma may play a role in the psychological distress expressed by the service user.
- Understanding how and when to refer persons with possible mental health conditions (e.g. post-traumatic stress disorder [PTSD]) to appropriate mental health providers.

4. Integrating new MHPSS activities within GBV and SRH programming

This section will assist GBV and SRH actors to identify entry points, based on the GBV Minimum Standards and the Minimum Initial Service Package for SRH in Crisis Situations to integrate new MHPSS activities, as described in the MHPSS MSP. The table shows the MHPSS MSP programme activities that each sector is best placed to implement, and the entry points for each of those activities within the sector. **The sections above in this guidance should be taken into account when implementing any of the MHPSS MSP activities detailed here, together with the core actions described under all the MHPSS MSP activities.**

The following should be considered when selecting new MHPSS activities to integrate into GBV and SRH programming:

- Whenever possible, **GBV and SRH teams should collaborate to incorporate MHPSS activities into integrated SRH/GBV services**. This can be an opportunity to strengthen the SRH-GBV integration.
- Activities should be selected based on the situation analysis, client feedback, resources available, and the current staff capacity versus capacity required to implement the activity and opportunities to build on existing MHPSS capacities of the teams.
- MHPSS interventions integrated into SRH or GBV programming should be complementary and support integrated referrals (e.g. psychosocial support groups for pregnant women taking place in WGSS; creating joint MHPSS key messages that incorporate GBV and SRH issues).
- Before integrating new MHPSS MSP activities, check on the **quality of the ongoing activities** with an MHPSS focus.
- Initial steps to strengthen and or integrate MHPSS within GBV and SRH programming may require additional human resources with knowledge on MHPSS programming to assess the level of integration and quality, and develop/contextualize specific resources on MHPSS/SRH/GBV-related topics.
- When integrating MHPSS activities into GBV or SRH programming, front-line providers should be trained to meet the unique needs of each individual survivor of traumatic events. Topics to include are:
  - The **fight/flight/freeze response**, and practice in addressing this response.
  - Ways in which **traumatic experiences can impact memory**.
  - Principles of **trauma-informed care**, reinforcing their overlap with the survivor- and patient-centred approaches.
  - **How to be trauma-aware**, identifying possible responses to traumatic events, and how trauma may play a role in the psychological distress expressed by the service user.
  - Understanding **how and when to refer** persons with possible mental health conditions (e.g. PTSD) to appropriate mental health providers.

If the aim of integrating MHPSS activities is to provide support for psychological distress or mental health conditions, ensure that:

- You have qualified MHPSS staff who can provide continued supervision and support to trained workers.
- The considerations under the above heading "**Additional considerations for the plan and design of activities providing focused support for psychological distress or mental health conditions**" are implemented from the start.

4.1 MHPSS MSP programme activities that can be integrated in GBV programming

This table draws from the Quick Start guide found in the MHPSS MSP for GBV survivors.

MHPSS MSP programme activities	Entry points within GBV programming Note: GBV Minimum Standard 5, "Psychosocial support", is considered a key entry point for all MHPSS MSP activities. For this reason, it is not included in this table.	
Objective: *Humanitarian actors (including GBV and SRH actors) and community members (volunteers, WLOs…) are oriented for the MHPSS needs of GBV service users (including survivors), and are equipped with basic psychosocial support skills.*[14]		
3.1: Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions	Standard 9: Safety and risk mitigation Standard 10: Legal justice and aid Standard 15: GBV coordination	Orienting key stakeholders on **gender-responsive and survivor-centred** MHPSS and interlinkages between GBV and MHPSS programming. Advocating to **address social** determinants of mental health and psychosocial well-being (e.g. levels of social support, exclusion, deprivation, poverty) among women and girls, including addressing risks and promoting protective factors. Ensuring that GBV activities are accessible and meet the needs of people with **mental health conditions**. All are actions that can be incorporated through regular GBV coordination with GBV service providers. Integrating this information with legal justice and aid actors can help in reducing risks of revictimization through understanding the mental health and psychosocial impact on survivors. Safety audits give **information** that can help other actors in understanding the **stressors** to which **women and girls** at risk are exposed.
3.2: Orient frontline workers and community leaders in basic psychosocial support skills	Standard 4: Health care for GBV survivors Standard 6: GBV case management Standard 7: Referral systems Standard 8: Women and girls safe spaces Standard 9: Safety and risk mitigation Standard 10: Legal justice and aid Standard 11: Dignity kits, cash and voucher assistance Standard 12: Economic empowerment and livelihoods Standard 13: Transforming legal systems and social norms	Orienting front-line GBV staff on **basic psychosocial support skills**, from WGSS facilitators to GBV case workers to people distributing dignity kits. GBV assessment staff and those conducting safety audits should also be oriented to ensure they are prepared to cope with the most vulnerable women and girls. These skills can also be **transferred to WLOs**. Through **GBV coordination**, or when establishing referral systems, collaborate (and help) with MHPSS TWGs and other clusters to ensure that orientations in basic psychosocial skills for front-line workers from other sectors are survivor-centred and include training on what to do in cases of GBV disclosure.

14 Objectives contextualized for the purpose of this guidance based on the MHPSS MSP M&E Indicator Bank.

Objective: *GBV service users have access to information and activities to promote their mental health and psychosocial well-being.*		
3.3: Disseminate key messages to promote mental health and psychosocial well-being	Standard 8: Women and girls safe spaces Standard 11: Dignity kits, cash and voucher assistance	Identifying and incorporating **key MHPSS messages** into GBV activities and informational materials. As part of WGSS activities, MHPSS key messages are adjusted to the specific MHPSS needs of women and girls accessing these activities. The key messages developed can be part of any **GBV awareness-raising** activity, or when distributing dignity kits.
3.4: Support new and pre-existing group-based community MHPSS activities	Standard 8: Women and girls safe spaces	Supporting **pre-existing community initiatives** and **facilitating new group-based community initiatives** that promote the mental health and psychosocial well-being of community members, particularly women and girls. Ensure that **WLOs are equipped with MHPSS skills** and interventions for women and girls to the level of their capacity. Identify other relevant groups for women that can also be supported at community level to provide basic psychosocial support.
3.7: Promote caregivers' mental health and psychosocial well-being and strengthen their capacity to support children[15]	Standard 7: Referral systems Standard 8: Women and girls safe spaces Standard 9: Safety and risk mitigation	Supporting **caregivers** affected by GBV to look after their own physical and **mental health needs**, and promote **positive caregiving skills**. When conducting safety and risk mitigation activities, information on the impact caregiving has on women and girls can be gathered and shared with actors providing such activities. When establishing **referral pathways, connect GBV survivors** to these groups that may be delivered through child protection activities. Finally, within **WGSS, MHPSS gender-responsive support** can be provided to groups of women and girls by incorporating curricula that support them in dealing with the difficulties they may experience associated with their roles as caregivers.
3.9: Provide MHPSS through women and girls safe spaces	Standard 8: Women and girls safe spaces Standard 12: Economic empowerment and livelihoods	Providing **MHPSS activities for all women and adolescent girls, including survivors of GBV,** for example, individual and/or group activities that promote the mental health and psychosocial well-being of women and girls. Additionally, through economic and empowerment activities for women and girls in WGSS, it can include curricula targeting the development of emotional regulation or skills to positively cope with stressors associated with these activities.
Objective: *GBV service users, including survivors, impaired by distress or mental health conditions, have access to care, protection and support.*		

15 International Rescue Committee, "Girl Shine Caregiver Curriculum: Part 3" (New York, 2018).

3.11: Provide MHPSS as part of clinical care for survivors of sexual violence and intimate partner violence	Standard 4: Health care for GBV survivors	Building the capacity of healthcare providers (including those offering sexual and reproductive services) on **aspects of MHPSS specific to sexual violence and IPV**, e.g. mental health and psychosocial needs of GBV survivors and individuals at risk of GBV, providing first-line support to survivors, managing disclosure, survivor-centred approach, facilitating links and referrals to additional services.
3.12: Initiate or strengthen the provision of psychological interventions[16]	Standard 6: GBV case management Standard 8: Women and girls safe spaces	Delivering **scalable psychological interventions** to address impairment due to **psychological distress** and **mental health conditions** for women and girls, including survivors, accessing GBV case management services and WGSS activities.
3.13: Provide MHPSS through case management services	Standard 6: GBV case management	**Training GBV case managers** and their supervisors on relevant MHPSS topics. **Adapting GBV case management tools, templates and referral protocols** to include MHPSS.
3.14: Protect and care for people in psychiatric hospitals and other institutions	Standard 7: Referral systems Standard 9: Safety and risk mitigation Standard 10: Legal justice and aid Standard 15: GBV coordination	Ensure that **GBV service providers and coordinators** are aware of these interventions, so that other actors working in these environments are aware of the specific mental health and psychosocial needs of women and girls, including survivors. These actors can also be helped to increase their understanding of GBV principles. Finally, GBV actors could be called upon when survivors are identified.
4.2: Provide mental health and psychosocial support to persons deprived of their liberty	Standard 9: Safety and risk mitigation Standard 15: GBV coordination	Providing **access to MHPSS** for women, girls and survivors of GBV **deprived of their liberty**, and advocating for gender-responsive MHPSS considerations in detention facilities.

16 International Rescue Committee, "Women Rise: A gender-based violence psychosocial support framework and toolkit" (New York, 2021).

4.2: MHPSS MSP programme activities that can be integrated in SRH programming

Access the complete details of each activity within the MHPSS MSP listed on the left side of the table by clicking its name.

MHPSS MSP programme activities	Entry points within GBV programming	
Objective: *Humanitarian actors and community members are oriented on the MHPSS needs of SRH service users, and are equipped with basic psychosocial support skills.*		
3.1: Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions	SRH coordination meetings. Health cluster coordination.	**Advocating** for the MHPSS needs of SRH services users **within key coordination forums** to create a common understanding and facilitate increasing coverage of responses to the MHPSS needs of the SRH service users. Increase awareness of SRH service providers on the specific MHPSS needs SRH service users may have. Help other actors in understanding **how to identify MHPSS needs associated with SRH**, such as perinatal depression and psychological distress associated with miscarriage or stillbirths. **Identify the MHPSS impact on men and boy survivors**. Orient on an understanding of MHPSS that is **away from medicalized models** and takes into consideration social determinants of MHPSS associated with SRH needs with a gender lens.
3.2: Orient frontline workers and community leaders in basic psychosocial support skills	CMR and IPV. Obstetric and newborn care (EmONC, basic emergency obstetric and newborn care [BEmONC] and comprehensive emergency obstetric and newborn care [CEmONC]). Contraceptive, HIV and STI counselling. Condom distribution. Adolescent-friendly SRH services. Comprehensive abortion care. Outreach activities/SRH promotion activities not related to MHPSS, e.g. SRH awareness-raising sessions on various SRH-relevant topics, e.g. unintended pregnancies, safe delivery in different spaces (health clinics, maternity wards). Values clarification and attitude transformation (VCAT). Birth attendant/midwifery training. One-stop centres, WGSS.	Provide training and/or orientation sessions on **basic psychosocial support skills** for SRH **front-line workers** providing any of the activities described to equip them to provide first-line support to SRH service users. Provide training and/or orientation sessions on basic psychosocial support skills for **SRH community partners**, e.g. traditional birth attendants, to equip them with basic skills in recognizing and responding to the mental health and psychosocial needs of women and girls and people with diverse SOGIESC in the community. Provide training to community health workers in basic psychosocial support skills.

Objective: *Humanitarian actors (including GBV and SRH actors) and community members (volunteers, WLOs, etc.) are oriented for the MHPSS needs of GBV service users (including survivors), and are equipped with basic psychosocial support skills.*[17]		
3.3: Disseminate key messages to promote mental health and psychosocial well-being	Contraceptive, HIV and STI counselling. Condom distribution. Comprehensive abortion care. Through any activity taking place in mother and baby-friendly areas/corners. Through adolescent SRH services (ASRH). Through services for GBV survivors.	**Develop and adapt key messages** that promote an understanding and normalization of the impact of SRH needs on mental health and psychosocial well-being, and provide information on **positive coping** with these needs.
3.4: Support new and pre-existing group-based community MHPSS activities	Actions to support traditional birth attendants. Any women's group that has a role in supporting mothers during perinatal period or other group that support women (e.g. older women groups) and SOGIESC on SRH-related topics.	**Integrate** this activity into groups identified in SRH needs assessments. This can include groups providing support to women and girls through the perinatal period, e.g. traditional birth attendants, mothers' groups. Integrate MHPSS activities addressing mental health and psychosocial needs related to pregnancy, perinatal depression, post-partum depression, social isolation and protective factors that may be disrupted in conflict settings. Integrate MHPSS activities related to perimenopause and menopause impact on mental health and psychosocial well-being, social isolation and people with diverse SOGIESC. Integrate MHPSS activities addressing social isolation, discrimination and stigmatization, mental health and psychosocial needs related to gender-affirming care, etc.
Objective: *SRH service users, including survivors impaired by distress or mental health conditions, have access to care, protection and support.*		
3.10: Provide mental health care as part of general health services	One-stop centres, WGSS (where relevant). Maternity ward centres. Antenatal care clinics. Postnatal care clinics. Family planning clinics. Adolescent-friendly SRH clinics.	This activity can be integrated through these SRH service delivery points. Health staff providing different SRH services can be trained in **basic psychosocial skills**, responding to disclosures of sexual violence, IPV or GBV, referral mechanisms, and mhGAP, to support SRH service users experiencing psychological distress and mental health conditions, depending on their role, access to supportive supervision and clinical background.

17 Objectives contextualized for the purpose of this guidance based on the MHPSS MSP M&E Indicator Bank.

3.11: Provide MHPSS as part of clinical care for survivors of sexual violence and intimate partner violence	CMR and IPV. Health centres, WGSS (as relevant).	**Build the capacity of SRH staff providing CMR services** to address the mental health and psychosocial needs of survivors through training on the LIVES component of CMR, and on basic psychosocial support. They can be trained alongside GBV staff to address the MHPSS needs associated with sexual violence, rape and IPV. This activity can also be used to strengthen the quality of MHPSS services provided within one-stop centres or other GBV services, for all staff involved in the centre.
3.12: Initiate or strengthen the provision of psychological interventions	CMR. Maternity wards. One-stop centres.	Provide **competency-based training and supervision** of scalable psychological interventions, relevant to the needs of SRH service users, to SRH staff working in these service points. This may entail hiring new staff assigned to deliver these interventions.
3.13: Provide MHPSS through case management services	Any type of case management delivery mode within SRH-related areas/issues (unplanned pregnancy; stillbirth; STI/HIV services; obstetric fistula). One-stop centres.	**Build capacity of SRH staff providing case management** to address the mental health and psychosocial needs for any of the SRH-related topics described. **Adapt case management tools** to support the mental health and psychosocial needs of SRH service users accessing case management services.
4.1: Integrate MHPSS considerations and support into clinical management of infectious diseases	Any type of SRH service provided during infectious diseases responses.	This activity can help to continue integrating MHPSS within SRH services, when these are also adapted as a consequence of an infectious disease.

Annexes

Annex 1: Key concepts

Gender-based violence (GBV): An umbrella term for any harmful act that is perpetrated against a person and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. The term GBV is most commonly used to underscore how systemic inequality between males and females, which exists in every society in the world, acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. GBV also includes sexual violence committed with the explicit purpose of reinforcing gender-inequitable norms of masculinity and femininity.[18]

Mental health and psychosocial support (MHPSS): "The composite term 'mental health and psychosocial support' is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental health conditions."[19]

The term MHPSS brings together a broad range of interventions/activities and actors in both mental health and psychosocial support that complement one another. It also underlines the need for diverse approaches to different needs to provide appropriate support.

In addition, a unified concept of MHPSS recognizes that everyone is susceptible to changes in their mental health in response to a range of factors (psychological, social and environmental), and may benefit from a range of services and supports at different levels, from community support to specialized care, over the course of their lives.

Services at all levels of the MHPSS intervention pyramid[20] must recognize and respond to both internal individual (mental or psychological) factors and external social and environmental factors (e.g. relationships, economic stressors) that impact well-being.

MHPSS activity: An activity that has the explicit and primary goal of impacting the mental health and psychosocial well-being of individuals. The MHPSS MSP outlines a set of MHPSS activities considered to be of the highest priority in meeting the immediate critical MHPSS needs of emergency-affected populations. These can be implemented by different sectors (health, protection, GBV, education, etc.).[21]

MHPSS actor: An organization (e.g. working in health, nutrition, protection, child protection, GBV) which is well-placed to implement MHPSS activities and/or strengthen MHPSS components laid out in their existing guidelines and standards.

MHPSS needs: For the purpose of this document, it is important to emphasize that MHPSS needs are not equivalent to mental health conditions.[22] Mental health needs assessments and situation analysis[23] include aspects such as stressors to which specific groups are exposed: help-seeking behaviours; positive and negative coping mechanisms; understanding of what mental health and psychosocial well-being mean among different groups; cultural and gendered

18 *The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming* (Geneva, 2019).

19 IASC, IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Geneva, 2007), p. 11.

20 IASC, The Mental Health and Psychosocial Support Minimum Service Package (Geneva, 2022), p. 12.

21 Ibid., p. 5.

22 IASC, "1.2 Assess MHPSS needs and resources to guide programming. Key consideration: Assessments showing prevalence estimates of mental health conditions in humanitarian settings are not essential to initiate services". https://www.mhpssmsp.org/en/activity/key-consideration-prevalence-estimates-mental-health-conditions#page-1 (accessed 26 March 2025).

23 IASC, "Multi-sectoral MHPSS needs and resources assessments toolkit" (Geneva, 2024).

expressions of distress;[24] and the resources available to address the different needs of MHPSS (e.g. social and health services, human resources).

Mental health condition: A broad term describing a significant disturbance in an individual's cognition, emotional regulation or behaviour that is often associated with distress and impairment in functioning. Psychosocial disabilities fall under this umbrella term, being disabilities that arise when a person with a mental health condition faces barriers in their social environment that limit full access to their rights.

Psychological distress: Refers to the presence of a broad group of indicators (e.g. worry, shame, guilt, sadness, physical aches and pains, sleep problems, fatigue, anger) that can impact the mental health and psychosocial well-being of an individual. Most people affected by humanitarian emergencies experience psychological distress.

Sexual and reproductive health (SRH): SRH is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the ability to choose one's sexual partner, and the freedom to decide if, when and how often to reproduce, free from violence or coercion. To maintain one's SRH, people need access to accurate and evidence-based information and safe, effective, affordable and acceptable SRH services. They must be informed and empowered to protect themselves from STIs, and able to access timely and compassionate health services if they experience GBV (such as sexual assault/rape or IPV). In addition, all individuals should have information about and access to SRH services to delay or space pregnancies with the contraceptive method of their choice. When they decide to have children, women must have access to skilled healthcare providers and services that can help them have a healthy pregnancy, safe delivery/birth and a healthy baby. Every individual has the right to make their own choices about their SRH.[25]

24 IASC, "Multi-sectoral mental health and psychosocial support assessment toolkit: Draft version for field testing" (Geneva, 2024).

25 UNFPA, "Sexual & reproductive health". https://www.unfpa.org/sexual-reproductive-health (accessed 26 March 2025).

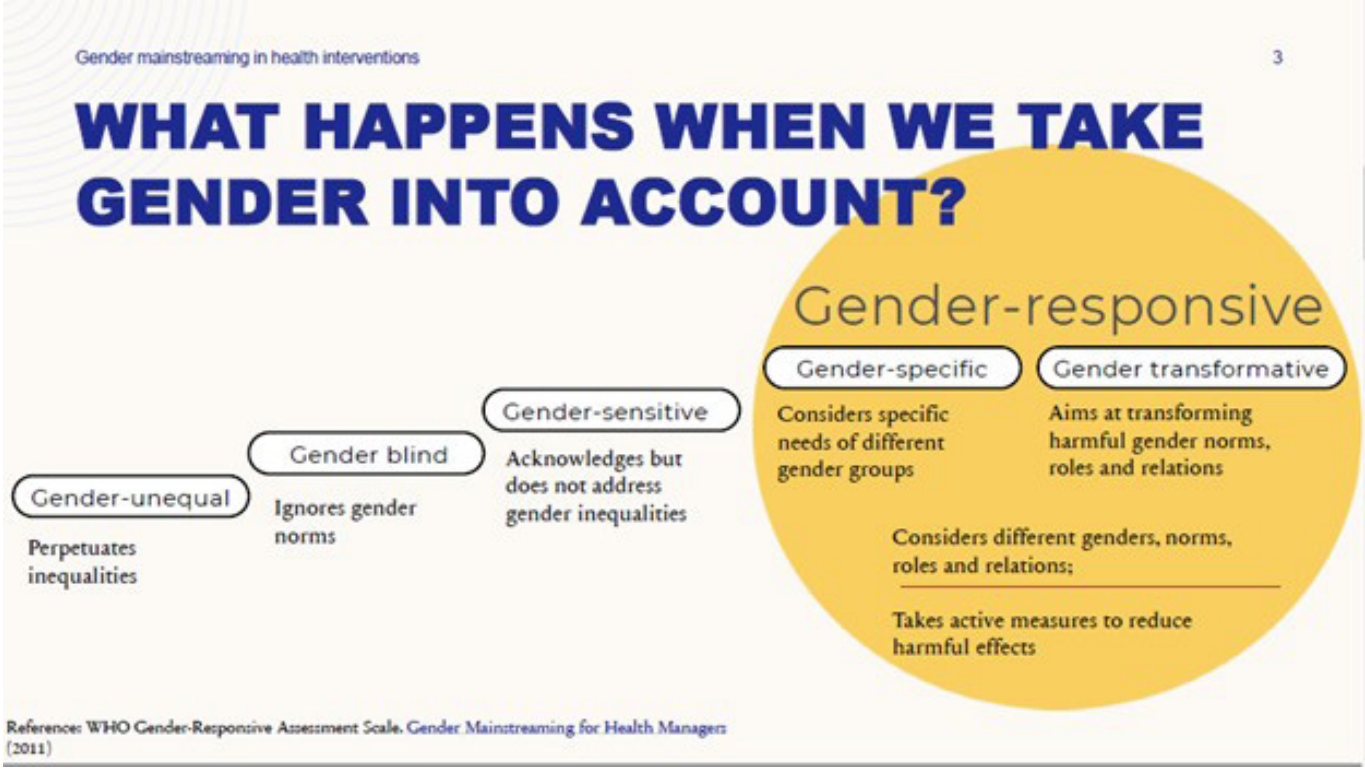
Annex 2: Stressors and associated mental health conditions for GBV and SRH service users

The table below outlines a list of stressors. Considering the specificity of these stressors, it is essential to identify the different MHPSS needs of these groups. Please note that this is not a comprehensive list.

Women and girls, people of diverse SOGIESC in humanitarian settings	Youth	SRH service users	Survivors of GBV including CRSV
Stressors associated with risks of GBV: Restriction of movement; being blamed or made responsible for their protection without acknowledging gender inequality; limited access to basic services; risk of sexual exploitation and abuse by humanitarian actors; exacerbation of power dynamics; community control over behaviour; limited or no acceptable gender-specific emotional responses. **Stressors associated with living in a humanitarian setting:** Displacement; loss of loved ones; limited or lack of access to basic services; limited opportunities for livelihoods; uncertainty about future; limited opportunities for education of children; unclear legal status in countries of asylum; higher risk for mental health conditions such as depression and PTSD.	**Stressors associated with youth in humanitarian settings:** Uncertainty about the future; pressure to take on adult responsibilities (caring for siblings, providing for family); feelings of isolation or lack of belonging; disrupted social networks (friends scattered, community lost); disrupted learning and loss of academic progress/limited access to education; misinformation or lack of access to accurate information; unemployment; risk of arbitrary detention and imprisonment; Internet blackouts and restrictions on communication. **Stressors associated with youth/SRH/GBV:** Shame, stigma or fear around discussing SRH issues; misinformation or lack of knowledge about reproductive health (e.g. menstruation, contraception, STIs); risk of unintended pregnancy due to lack of access to contraception; lack of confidential spaces to discuss SRH concerns; limited access to accurate SRH education (leading to myths and misconceptions); increased risk of STIs and HIV due to lack of testing and prevention services; dangers of unsafe abortions in restrictive settings; complications from early pregnancy; early marriage.	**Stressors associated with SRH:** Lack of family planning options; lack of post-abortion care; inadequate birth support; obstetric violence; caring responsibilities; barriers to access services due to gender and sexual orientation. **Associated mental health conditions/ impacts linked to SRH needs:** Perinatal depression; post-partum psychosis; perinatal grief; grief; guilt and distress as a result of stressors such as abortion or stillbirth; impact on mental well-being due to HIV/AIDS and other STIs; mood changes due to perimenopause and menopause; guilt, distress and anxiety over unwanted pregnancies; suicidal ideation due to stressors such as unwanted pregnancy as a result of rape; miscarriage.	**Stressors associated with GBV and CRSV experience:** Stigmatization; discrimination; fear of retaliation; continued exposure to GBV; lack of safety and protection and/or ability to leave the abusive relationship as a result of the disruption of social fabric due to the humanitarian context; lack of gender-responsive services; isolation; blaming attitudes; health problems; lack of awareness about GBV; revictimization as result of services that perpetrated victim blaming attitudes; attachment to the perpetrator; missed identification of GBV due to concomitant severe mental health conditions; coercion by perpetrator for accessing basic services including SRH services; vicarious violence with children; impact on SRH health (e.g. increased risk of miscarriage; and other associated SRH issues).

Associated mental health conditions/ impacts linked to GBV/living in humanitarian settings: Depression; PTSD; grief; substance abuse; guilt and shame arising from stigma; suicidality; previous mental health conditions exacerbated by risk of GBV and living in humanitarian settings.	**Associated mental health conditions/ impacts linked to youth:** Grief due to loss of home, community or stability; hopelessness due to uncertainty; suicidality.	**Associated mental health conditions/ impacts linked to SRH needs:** Perinatal depression; post-partum psychosis; perinatal grief; grief; guilt and distress as a result of stressors such as abortion or stillbirth; impact on mental well-being due to HIV/AIDS or other STIs; mood changes due to perimenopause and menopause; guilt, distress and anxiety over unwanted pregnancies; suicidal ideation due to stressors such as unwanted pregnancy as a result of rape; miscarriage.	**Associated mental health conditions/ impacts linked to GBV needs:** Experience of psychological distress; increased risk of mental health conditions such as depression, PTSD, psychosis, and suicidal ideation or suicide and self-harm attempts.

Annex 3: Visualization – gender mainstreaming in health interventions



Annex 4: Road map for MHPSS strengthening/integration

Use the table below to create a road map based on the results of revising considerations laid out here, and the essential components/activities within the MHPSS MSP.

Actions for strengthening/integration…				
Essential component (design, monitoring, care for staff, competencies and supervision)	**Description**	**Required resources**	**Responsible person**	**Time frame**
1.				
2.				
3.				
4.				
5.				
6.				

Guidance to support the mental health and psychosocial well-being of GBV and SRH service users in humanitarian settings

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