

Systematic inclusion of Gender-Based Violence in Mental Health and psychosocial services at primary health care level in emergency contexts

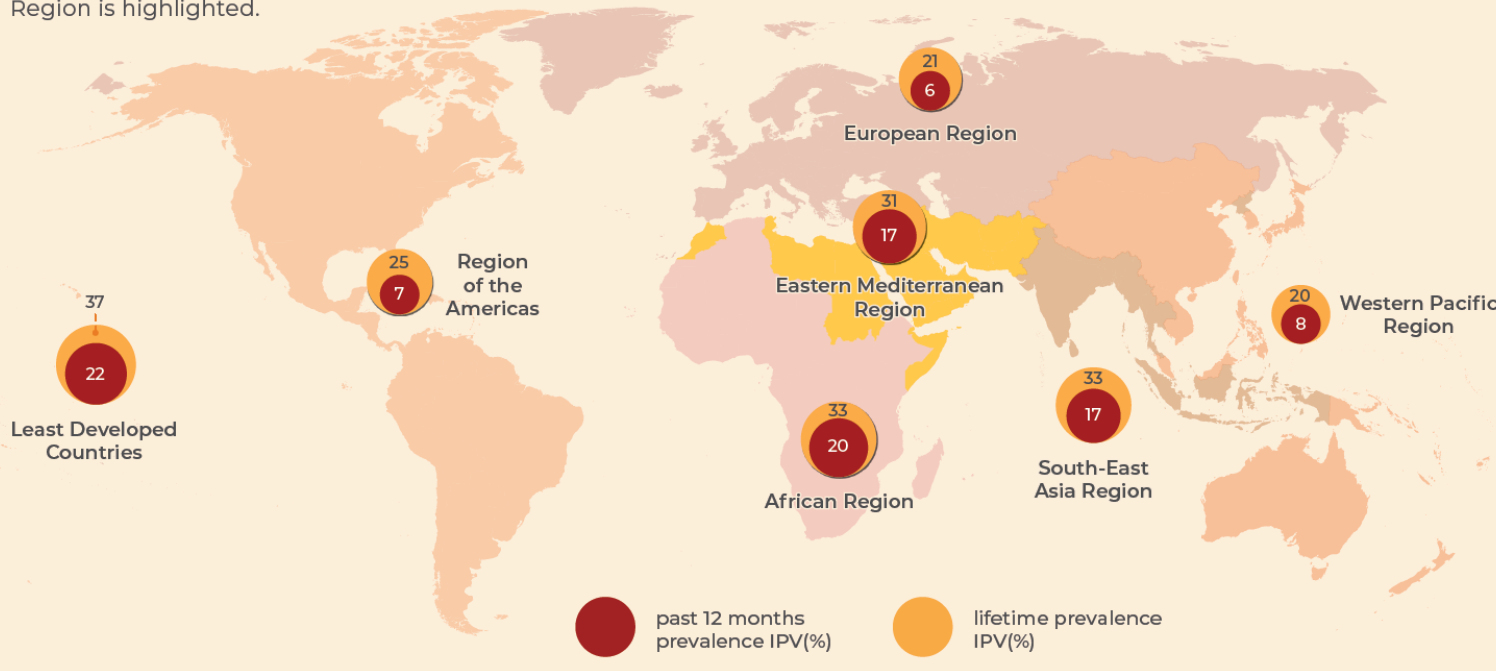
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Background

REGIONAL PREVALENCE ESTIMATES OF INTIMATE PARTNER VIOLENCE

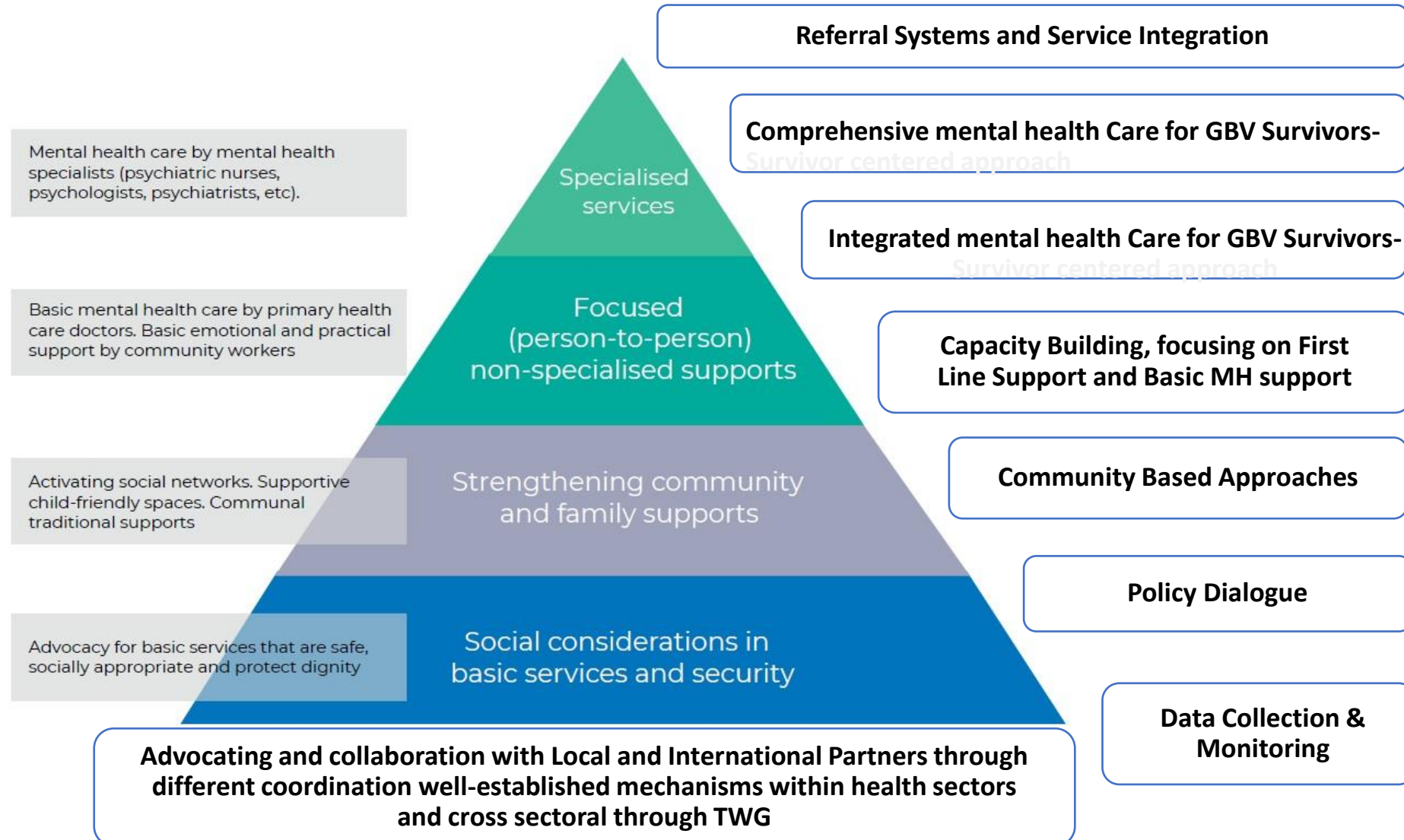
This map shows global and regional (by WHO region) prevalence estimates of lifetime and past 12 months physical and/or sexual intimate partner violence (IPV) among ever-married/partnered women aged 15–49. The WHO Eastern Mediterranean Region is highlighted.

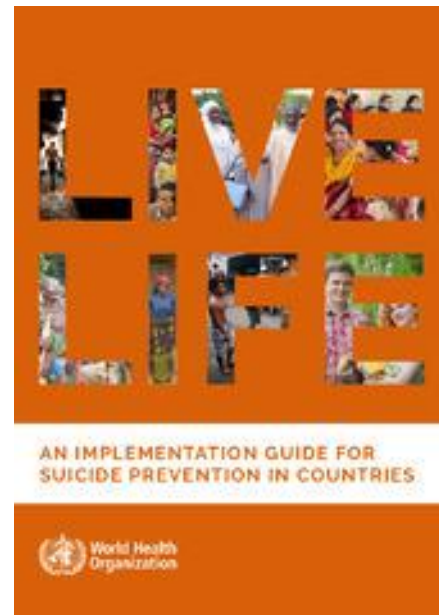
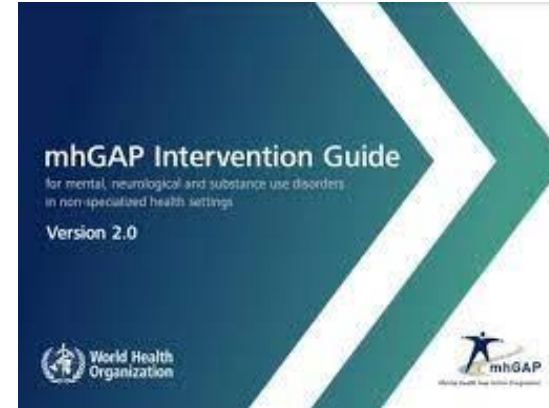
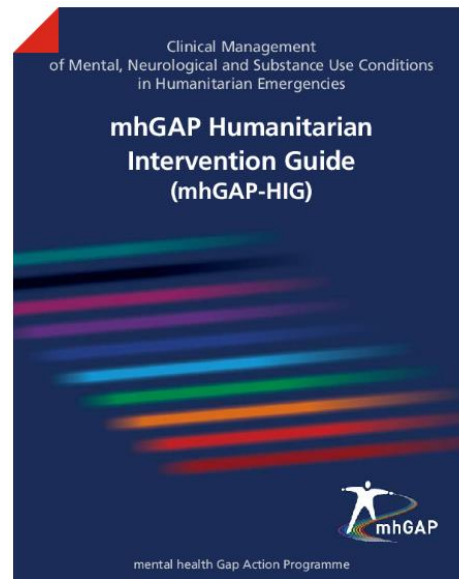


- The EMR has the 3rd highest prevalence of IPV worldwide
- GBV survivors can experience depression and other MH conditions like PTSD, and anxiety
- Survivors of GBV, especially sexual violence, have a higher risk of attempting suicide.
- Children of survivors also experience health consequences, including for MH

The WHO Response according to IASC MHPSS Pyramid of interventions

- Addressing GBV and Mental Health in emergency response
- Pioneering the integration of GBV services with MHPSS
- Strategic and culturally acceptable
- Delivering health and community based GBV services integrated into MHPSS





Technical tools and guidance

Systematic inclusion of GBV in MHPSS at primary health care level in emergency contexts

Aim: Identify lessons learned for integrating care for GBV survivors in mental health services in humanitarian settings

Methodology

- 861 PHCCs selected (215 in Iraq, 30 in Libya and 616 in Syria) over a 2-year period for systematic inclusion of GBV response in MHPSS services.
- 2540 MHPSS providers trained to identify survivors through clinical inquiry, provide first-line support and referrals as part of WHO's MHPSS training programs (mHGAP, Problem Management Plus, and suicide prevention).
- Key informant assessment interviews conducted 3 to 6 months



Results



HEALTH PROVIDERS

- **IDENTIFICATION**: reported ability to identify GBV cases, and history child abuse based on patients' complaints of conditions and help survivors to regain control over the lives.
- **SERVICE PROVISION**: All 861 PHCCs reported provision of services for 13,572 survivors over a period of 2 years.
- **ATTITUDE**: improved attitude in dealing with survivors (willingness to identify, empathize and do not blame).

SURVIVORS

- **ACCESSIBILITY**: Integration of GBV within the MHPSS services gave the best results in service accessibility and reduced stigma
- **SELF-AWARENESS** and **DISCLOSURE**: GBV survivors more willing to acknowledge their experience, open up and seek for support in a MH clinic with integrated GBV services rather than in other stand-alone GBV centers.



Impact

- 100% increased provision of services for GBV survivors
- Positive change in the attitudes of mental health care providers in dealing with survivors
- Enhanced health and well-being of GBV survivors, contributing to long-term systemic change and resilience.

Lessons learned & conclusion

Integration of MHPSS and GBV response

- Acceptable
- Cost effective
- Feasible

When should we integrate MHPSS and GBV interventions?

- Capacity building
- Service provision
- Supportive supervision

Conclusion:

- The linkage between GBV and MHPSS services at primary and secondary prevention level is key to fill a crucial gap in healthcare of GBV amidst the humanitarian crisis and beyond.
- Increased integration of mental health in GBV research and program is needed for lasting benefits to survivors and contributing to systemic change.

THANK YOU

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