Intersections of Gender-based Violence and Common Mental Health Problems:

Understanding the Evidence and Strengthening Integrated Action

UK International Development

Partnership | Progress | Prosperity

WhatWorks

TO PREVENT VIOLENCE

Acknowledgements

This report was produced by the Ending Violence Against Women and Children (VAWC) Helpdesk, as part of the What Works to Prevent Violence: Impact at Scale (What Works II) initiative. The report was written by Veronica Ahlenback, Erin Stern and Erika Fraser of Social Development Direct, with support from Kate Bishop, Veronica Martinez Tamayo, Onyeka Nneli, and Naomi Clugston also of Social Development Direct. The consultations for this report would not have been possible without the support of Hope Harriet (independent consultant), Agnes Nabachwa (independent consultant), Poonam Rishal (independent consultant) and Bimala Gurung (Mitini Nepal), who also contributed with their expertise and inputs on case studies and recommendations. We would like to express our deep gratitude to everyone who generously shared their expertise and insights in key informant interviews and roundtable discussions which helped shape the report and its recommendations.

About the What Works to Prevent Violence: Impact at Scale initiative (What Works II)

What Works to Prevent Violence: Impact at Scale (What Works II) is a seven-year initiative (2021- 2028) funded by the UK's Foreign, Commonwealth and Development Office (FCDO) to scale up global evidence-based and practice-informed efforts to prevent violence against women and girls (VAWG).

As part of it, the Ending Violence Against Women and Children (VAWC) Helpdesk is a high-quality, tailored research and programming advice service that feeds learning from research and practice, including from our project partners, directly to FCDO and other government departments. Helpdesk staff support UK Government colleagues to use evidence and practice-based lessons to design and implement cutting-edge violence prevention policy and programming. The Ending VAWC Helpdesk is delivered by Social Development Direct.

Suggested citation Ahlenback, V., Stern, E., and Fraser, E. (2026) Intersections of Gender-based Violence and Common Mental Health Problems: Understanding the Evidence and Strengthening Integrated Action, What Works to Prevent Violence: London UK

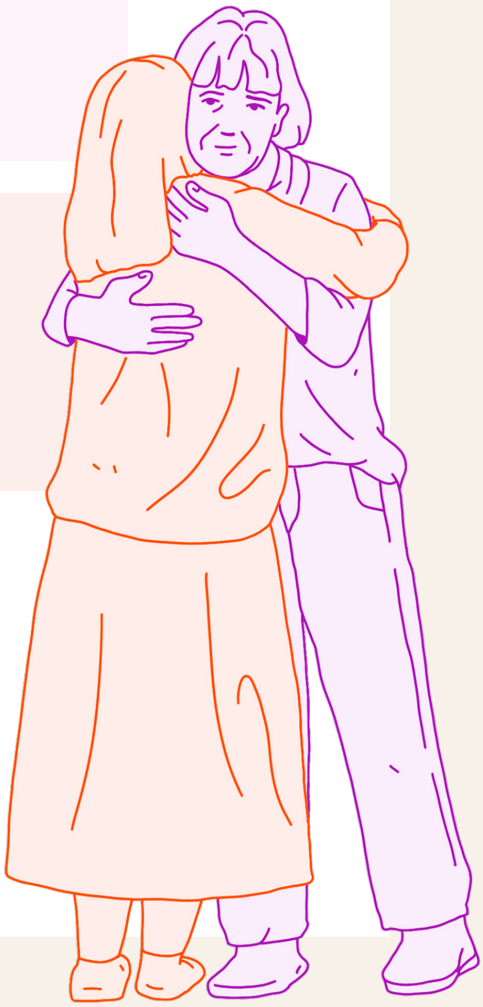
Design Meg Therese Del Castillo

Are you or someone you know in need of help, or need someone to talk to?

This report contains reference to and descriptions of gender-based violence (GBV) and mental health problems, including suicide ideation and attempts. If you or someone you know needs support, please contact your local GBV support (such as a helpline, a women's shelter or a local women's- or LGBTQI+ rights organisation) or your local mental health service providers (such as a helpline, your local healthcare facility, or mental health charities and support groups).

These resources may be helpful for finding out information about services available:

- Visit lila.help for information about GBV support services available in your area.
- On findahelpline, you can find information about free, confidential helplines for mental health problems and other issues that may affect your wellbeing.
- ILGA World is an umbrella organisation of LGBTQI+ organisations, representing more than 2,000 member organisations from over 170 countries and territories. This list of their member organisations might help you identify an organisation in your country.



Disclaimer: This independent report was funded by UK aid via the What Works to Prevent Violence Against Women and Girls: Impact at Scale Programme. The funds were managed by the International Rescue Committee (IRC). The views expressed and recommendations made in this publication are the authors' alone and are not necessarily the views or intentions of the UK Government.

Contents

Acronyms

ACT	Acceptance and commitment therapy
AI	Artificial intelligence
AIR	The African Institute for Integrated Responses to Violence Against Women and HIV/AIDS
CBT	Cognitive behavioural therapy
CETA	Common elements treatment approach
CPT	Cognitive processing therapy
CSO	Civil society organisation
DRC	The Democratic Republic of Congo
EMDR	Eye Movement Desensitisation Reprocessing
FCDO	The UK's Foreign, Commonwealth and Development Office
GBV	Gender-based violence
HaRT	The Healing and Resilience after Trauma Programme
HICs	High income countries
INGO	International non-governmental organisation
IPV	Intimate partner violence
IRC	International Rescue Committee
ITP	Interpersonal psychotherapy
ITP-A	Interpersonal psychotherapy for depressed adolescents
ITP-C	IPT for couples
LBQ	Lesbian, bisexual, queer
LGBTQI+	Lesbian, gay, bisexual, transgender, queer (or questioning), and intersex people +

LMICs	Low-and middle-income countries
MBI	Mindfulness-based interventions
MHPSS	Mental health and psychosocial support
NET	Narrative exposure therapy
NGO	Non-governmental organisation
NPSV	Non-partner sexual violence
OSMC	One-stop crisis management centre
PFA	Psychological first aid
PSVI	Preventing Sexual Violence in Conflict Initiative
PTSD	Post-traumatic stress disorder
PTSS	Post-traumatic stress symptoms
RCT	Randomised controlled trial
SOGIESC	Sexual orientation, gender identity and expression, and sex characteristics
TFGBV	Technology-facilitated gender based violence
TF-CBT	Trauma-focused CBT
TRR	Trauma recovery rubric
UNHCR	United Nations High Commissioner for Refugees
USAID	USAID
VAWC	Violence against women and children
VAWG	Violence against women and girls
WHO	The World Health Organisation
WRO	Women's rights organisation

Glossary

This glossary explains key terms used in the report to help readers from both the GBV and mental health fields understand key concepts from each discipline. Where relevant, we note variations in terminology and explain why certain terms were chosen.

Child maltreatment

Includes violent punishment, physical, sexual, emotional violence and neglect of infants, children, and adolescents by parents and caregivers.[1]

Common mental health problems

The most common mental health problems include depression, anxiety, and trauma-related symptoms including post-traumatic stress disorder (PTSD).

- **Depression** involves persistent sadness, loss of interest, low self-worth, fatigue, poor concentration, and changes in sleep or appetite. It can last a long time, affect daily functioning, and, in severe cases, lead to suicide.
- **Anxiety** causes recurring worry and may involve physical symptoms like restlessness, rapid heartbeat, sweating, and trouble sleeping. People may avoid situations that trigger anxiety.
- **PTSD** can develop after highly distressing events. However, not all people who go through traumatic events subsequently develop PTSD. It includes three primary symptom groups: 1) re-experiencing the traumatic event (e.g. through flashbacks or nightmares), 2) avoidance and emotional numbness (e.g. avoiding reminders, shutting down feelings), and 3) hyperarousal (e.g. feeling on edge or overreacting to sounds or stimuli).

Gender-based violence (GBV)

This report understands GBV as “any harmful threat or act directed at an individual or group based on actual or perceived sex, gender, gender identity or expression, sex characteristics, or sexual orientation, and/or lack of adherence to varying socially constructed norms around masculinity and femininity. Although individuals of all gender identities may experience GBV, women, girls, and LGBTQI+ individuals face a disproportionate risk of GBV across every context due to their unequal status in society“.[2]

GBV in and around schools	Gender-based violence in and around schools encompasses physical, sexual, and psychological violence affecting girls, young women, and LGBTQI+ learners. This includes verbal abuse, bullying, peer violence, sexual harassment, coercion, and assault perpetrated by peers, teachers, or others in the school environment.
Intersectionality	Coined by Kimberlé Crenshaw in 1989, intersectionality explains how overlapping systems of oppression, such as gender inequality and racism, shape lived experiences. It is used to understand how discrimination linked to multiple factors like identity, socioeconomic status, health, location, and migration status interact to influence inequality and subsequent risk of violence. While all women, girls, and gender-diverse people experience gender inequality, these experiences are not the same; they vary depending on these intersecting factors.
Intimate Partner Violence (IPV)	is a pattern of harmful behaviour where an intimate partner, whether current or former, inflicts violence or harm upon another. IPV encompasses various forms, including physical, emotional, sexual and economic violence. Like other forms of GBV, IPV causes serious harm to survivors, families, and communities, highlighting the urgent need for prevention and support.[3]
LGBTQI+	This acronym stands for lesbian, gay, bisexual, transgender, intersex and queer, with the plus sign acknowledging that there are many other identities that cannot be captured by an acronym. Variations like LGBT, LGBTI, and LGBTQIA+ are well known and widely used in a range of contexts, however, LGBTQI+ terminology is largely rooted in a Western framework which may not capture the diversity of SOGIESC identities and experiences (see 'SOGIESC' below). This report uses both LGBTQI+ and SOGIESC terminology. When citing research, the report uses the original terms (unless they conflict with a rights-based approach) to accurately reflect the study population. When synthesising and discussing findings, this report will use LGBTQI+ and SOGIESC terminology for consistency.

Mental health	Mental health encompasses emotional, cognitive, psychological, and social well-being. It affects how humans think, feel, learn, work, make decisions, and build relationships.[4]
Mental health and psychosocial support (MHPSS)	According to UNHCR's Emergency Handbook, MHPSS refers to "any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental health conditions. MHPSS is not confined to a single sector but requires a multi-sectoral approach with involvement of partners in health, education and protection (community-based protection, child protection and GBV)".[5]
Minority stress	Minority stress is a concept for understanding the mental and physical health disparities experienced by LGBTQI+ people, including the high levels of mental health issues and suicide ideation among LGBTQI+ people. Minority stress is different from the types of stress faced by people in their everyday life – it specifically originates from the excess stress that sexual and gender minorities may experience due to prejudice, discrimination and violence.
Psychosocial aspects	The term 'psychosocial' captures the interaction "between psychological dimensions of an individual (such as thoughts, emotions, feelings, and reactions) and their social context (including their environment, relationships with others, community, and culture)".[6]
Sexual harassment	of women, girls, and LGBTQI+ persons occurs across public spaces, workplaces, educational institutions, and online, rooted in systemic gender inequality and power hierarchies. It includes unwanted sexual attention or behaviours such as verbal harassment, unwanted touching, sexual messages or requests, and suggestive remarks.[7]
Sexual violence	The WHO defines sexual violence as *"any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting"*.[8] Numerous studies have examined its impacts on survivors' mental health. However, existing systematic reviews and meta-analyses provide little or no gender-disaggregated analysis of how these impacts differ across genders.

SOGIESC

SOGIESC stands for sexual orientation, gender identity and expression, and sex characteristics. Everyone has a SOGIESC, but people who do not conform to heteronormative or gender-binary norms often face discrimination and violence. SOGIESC terminology recognises that there are people and experiences across the world which cannot be neatly labelled or captured by LGBTQI+ terminology – for instance, non-binary people or third gender groups who may not identify within a LGBTQI+ framework. This report uses both LGBTQI+ and SOGIESC terminology. When citing research, the report uses the original terms (unless they conflict with a rights-based approach) to accurately reflect the study population. When synthesising and discussing findings, this report will use LGBTQI+ and SOGIESC terminology for consistency.

TFGBV

UN Women and the WHO define technology-facilitated gender based violence (TFGBV) as *"any act that is committed, assisted, aggravated, or amplified by the use of information communication technologies or other digital tools, that results in or is likely to result in physical, sexual, psychological, social, political, or economic harm, or other infringements of rights and freedoms"*.[9] Conceptualisations of this form of violence stress that TFGBV is part of the wider continuum of violence experienced by women, girls and LGBTQI+ persons and can intensify offline violence. For example, research with LGBTQI+ survivors of online hate crime and hate speech shows substantial overlap between online and offline abuse, with incidents often occurring simultaneously or moving between the two spaces.[10]

Trauma

Trauma comes from experiences that feel deeply distressing and overwhelming, often leaving people feeling powerless. These experiences may affect the functioning and well-being of individuals and groups in many ways, from minor disruptions to debilitating and severe impacts.[11]

Executive summary

Background

Gender based violence (GBV) and common mental health problems are deeply interconnected global challenges that disproportionately affect women, girls, and LGBTIQ+ people. These linkages are complex, shaped by intersecting social, structural and individual factors, and cannot be understood as causal or one-directional. A 2026 Global Burden of Disease study estimates that 608 million women globally have experienced intimate partner violence (IPV) and over one billion people have experienced childhood sexual violence.[12] These forms of violence rank as the fourth and fifth leading risk factors for disability among women aged 15-49 worldwide. Mental health conditions, particularly anxiety, depression, and self-harm, account for the largest share of the health burden experienced by survivors. This evidence underscores the urgent need to integrate GBV prevention and response with mental health strategies, an opportunity that remains underutilised.

Methodology

This report synthesises findings from two evidence reviews commissioned by the Ending Violence Against Women and Children (VAWC) Helpdesk. The first review examined the relationship between GBV and mental health, including the mental health impacts of experiencing GBV and evidence on common mental health problems as risk factors for experiencing or perpetrating violence. The second reviewed interventions across the prevention–response continuum that address both GBV and mental health.

Priority was given to systematic and meta-reviews while making deliberate efforts to identify evidence and programme examples from low- and middle-income countries (LMICs). To complement the literature, consultations were conducted with 22 stakeholders across women's rights organisations (WROs), mental health NGOs, LGBTQI+ organisations, INGOs, UN agencies, and universities, alongside in-person roundtables in Nepal and Uganda. These consultations added contextual insight, surfaced practice-based evidence, and strongly informed recommendations.

Key findings

Mental health impacts of GBV

The mental health consequences of GBV are well established. Survivors commonly experience depression, anxiety, post-traumatic stress, and thoughts of self-harm or suicide, alongside profound psychosocial impacts such as shame, self-blame, social withdrawal, and diminished self-worth. Stigma and victim-blaming often compound these harms. LGBTQI+ survivors may face additional mental health stressors linked to discrimination, internalised stigma, and exclusion from services.

Significant evidence gaps remain on the mental health impacts of specific forms of violence –including child, early and forced marriage; technology-facilitated GBV, as well as on the non-clinical psychosocial impacts that shape survivors' wellbeing and recovery across

all forms of GBV. Evidence also suggests that common mental health problems may increase risk of experiencing or perpetrating GBV, particularly when intersecting with other risk factors such as harmful alcohol use, economic stress, or histories of childhood abuse. However, this evidence base is limited and requires careful, survivor-centred interpretation to avoid reinforcing stigma.

Response and prevention interventions

Comprehensive survivor support remains foundational. GBV case management, mental health and psychosocial support (MHPSS), and access to specialised mental health care are essential for recovery in both development and humanitarian settings. A range of therapeutic, psychosocial, and body-based approaches have demonstrated effectiveness in reducing common mental health problems among survivors, though many were not originally designed for GBV contexts and lack clear guidance for adaptation. Evidence gaps remain on how to tailor interventions to diverse survivors, including LGBTQI+ survivors, and on overcoming barriers to access.

Evidence and consultations demonstrate that both **GBV prevention programmes and mental health interventions can deliver mutual benefits,** even when integration is not an explicit objective. In low-resource and humanitarian settings, many effective interventions have been delivered by trained lay providers, demonstrating feasibility where specialist services are scarce. However, quality and safety depend on sustained training, supervision, referral pathways, and functioning health systems to support survivors with more complex mental health needs. Interventions addressing structural drivers of both GBV and poor mental health show promise. Economic empowerment programmes have significant potential to improve mental health outcomes and reduce GBV, while social support – especially group-based interventions – emerged as a key mechanism for healing and collective resilience, described by practitioners as “the power of social contact.”

Recommendations

CROSS-CUTTING

- **Centre women, girls, and gender-diverse people** with lived experience, supporting survivor-led and locally grounded approaches and recognising lived experience and community knowledge as critical forms of expertise.
- **Strengthen collaboration** across GBV, mental health, broader public health, social protection and economic sectors and better link research, policy, and practice.
- Invest in approaches that **actively reduce stigma** around both GBV and mental health, at individual, community and structural levels.
- Prioritise the **mental health, wellbeing, and collective care** of staff, activists, and researchers to sustain safe and effective programming.

DONORS AND GOVERNMENTS

- Invest in **integrated, multi-sectoral approaches** that address mental health and GBV together across prevention and response, including through mainstreaming in health, education, and livelihoods programmes.
- Support **national mental health and GBV systems strengthening,** including workforce development, supervision, and referral pathways.
- Fund **research alongside programming,** including practice-based knowledge, research on culturally relevant adaptation, implementation quality in LMICs, and ethical scaling.
- Provide **long-term, flexible funding** to local WROs, CSOs, and survivor-led groups as core delivery and accountability actors.
- Apply a **twin-track approach** to reach structurally marginalised groups – embedding inclusion within mainstream services while supporting targeted interventions for those facing heightened GBV and mental health risks.
- Use **diplomatic, policy and convening influence** to advance trauma-informed, survivor-centred approaches and to elevate promising, locally-led models.

MENTAL HEALTH AND GBV PRACTITIONERS

- Systematically **integrate attention to GBV–mental health linkages** within programme design, delivery, and monitoring.
- Apply **survivor-centred, trauma-informed approaches** and tailor support to diverse needs, identities, and healing pathways.
- Invest in **sustained training, supervision, referral** mechanisms, and adaptive learning to ensure quality and safety, particularly when employing non-specialist or lay providers.

RESEARCHERS

- Address **key evidence gaps** on the mental health and psychosocial impacts of diverse forms of GBV and on poor mental health as a risk factor for GBV perpetration or victimisation.
- Examine how programmes **address social and structural determinants** of mental health and their intersections with GBV.
- Strengthen **intervention and implementation science** to improve adaptation, dosing, and tailoring of interventions in LMICs.
- Ensure **survivor and practitioner engagement,** intersectional analysis, and disaggregated data across all research priorities.

1. Introduction

1.1 Gender-based violence and mental health: A global snapshot

Gender-based violence (GBV) and common mental health problems are two deeply connected global challenges. Women and girls face GBV due to systemic gender inequality and power imbalances that perpetuate and normalise violence, with serious consequences for survivors, families and communities. New prevalence estimates from the World Health Organisation (WHO) confirms that nearly one in three women have suffered physical and/or sexual intimate partner violence (IPV) or non-partner sexual violence (NPSV) at least once in their lifetime – a figure that has barely changed in the last two decades.[13] Past year IPV also remains high – 13.7% of ever married/-partnered women and girls aged 15-49 years (around 1 in 7) – were subjected to physical or sexual violence by an intimate partner in the past 12 months.[14] Women, girls and gender-diverse people who experience multiple forms of inequalities, such as those linked to disability, ethnicity, age, and sexual orientation, gender identity and expression, and sex characteristics (SOGIESC), are often at higher risk of GBV.

1 in 7 women and girls experienced physical and/or sexual intimate partner violence in the last year.[15]

1 in 8 people are living with a mental health condition.[16]

TERMINOLOGY

Common mental health problems

This report uses 'common mental health problems' to refer to depression, anxiety and trauma, including post-traumatic stress disorder (PTSD), as defined by the WHO.[17] Terms such as 'mental illness' or 'mental health disorders' are only used when the evidence is referring to a clinical diagnosis. The report furthermore takes a broad view of mental health, recognising diverse expressions, symptoms, and lived experiences. This approach provides more context and moves away from the narrow, medicalised perspective often seen in global mental health research.

Like GBV, common mental health problems are widespread. In 2019, 1 in every 8 people, around 970 million globally, were living with a mental health condition, with anxiety and depressive disorders being the most common.[18] A study based on data from 29 countries estimates that around half of all people will meet the criteria for a mental health condition at some point in their life.[19] The COVID-19 pandemic exacerbated this crisis, which continues to

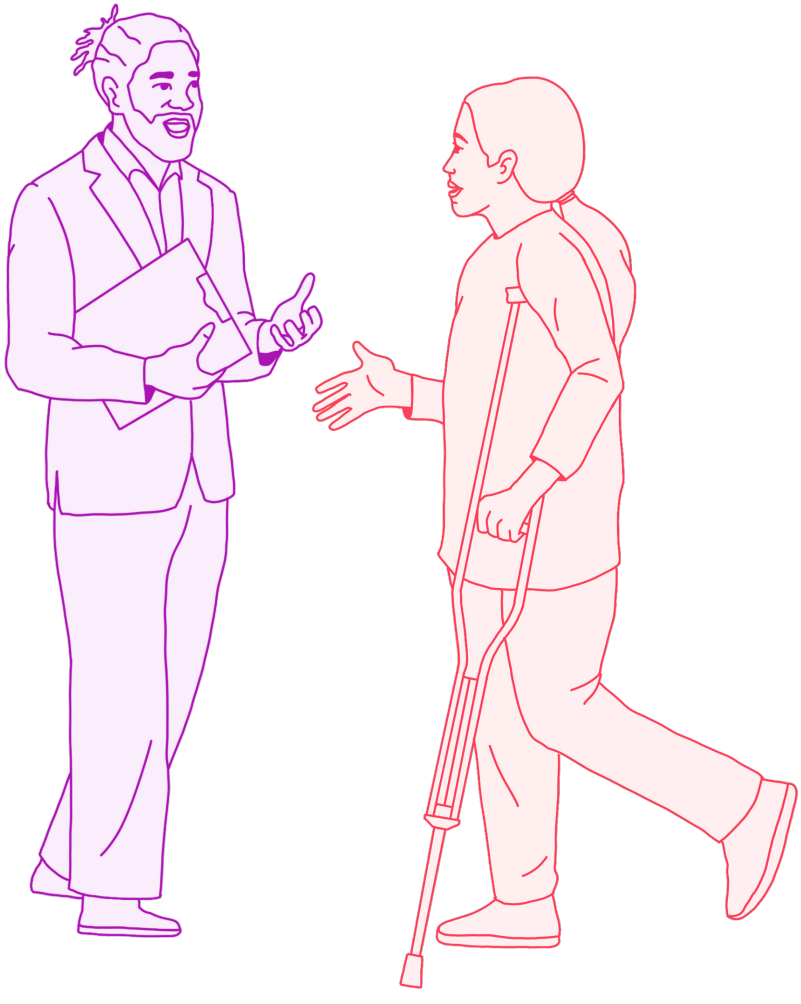
be driven by conflict, climate change, economic instability, geopolitical events, and human rights violations.[20] [21] Almost everyone affected by emergencies experiences some level of psychological distress, including sadness, hopelessness, sleep difficulties, fatigue, irritability or anger.[22] While many recover over time, over one in five people (22%) who have lived through war or conflict in the past decade will develop common mental health problems including depression, anxiety and PTSD, or more complex mental health disorders, such as bipolar disorder and schizophrenia.[23]

Globally, women and girls are more likely than men and boys to experience common mental health problems, including depression and anxiety.[24] This gender gap is partly linked to systemic inequalities, including the risk of GBV faced by women, girls and LGBTQI+ people.[25] [26] Gender norms also shape coping strategies. Men are less likely to seek formal or informal support due to traditional notions of masculinity and lower mental health literacy[27], and are more likely to use alcohol and drugs as coping strategies for emotional distress,[28] behaviours that can worsen mental health outcomes.[29] In conflict-affected settings, the prevalence of common mental problems tends to be similar for women and men.[30]

The mental health impacts of GBV are well documented, with studies showing how experiencing GBV can lead to anxiety, depression, PTSD, and elevated risks of suicidality. These effects often emerge immediately after violence but can persist long-term. Survivors also face profound psychosocial impacts, including social isolation, social stigma and ostracisation from families and communities, which further harm mental health and well-being.

1.2 Understanding GBV and mental health: Why context matters

Both GBV and common mental health problems are driven by multiple, interacting risk factors. Common mental health problems can increase the risk of experiencing or perpetrating GBV, but these dynamics must be understood within a socio-ecological framework that considers how factors operate across **societal, community, interpersonal and individual levels** to influence the risk of GBV. These factors can vary by context and type of GBV. For example, conflict and crisis settings often introduce new risks while worsening existing ones. The infographic summarises common risk factors for GBV, many of which also increase vulnerability to common mental health problems. In addition, levels and types of GBV and common mental health problems are shaped by intersectional factors, including ethnicity, class, sexual and gender identity, disability, age, and migrant status.



Risk Factors

- Discriminatory laws on property ownership, marriage, divorce and child custody
- Low levels of women's employment and education
- Absence or lack or enforcement of laws addressing violence against women
- Gender discrimination in institutions (e.g. police, health)

SOCIETAL

- Harmful gender norms that uphold male privilege and limit women's autonomy
- High levels of poverty and unemployment
- High rates of violence and crime
- Availability of drugs, alcohol and weapons

COMMUNITY

- High levels of inequality in relationships/ male-controlled relationships/ dependence on partner
- Men's multiple sexual relationships

INTERPERSONAL

- Childhood experience of violence and/or exposure to violence in the family
- Common mental health problems
- Attitudes condoning or justifying violence as normal or acceptable
- Men's use of drugs and harmful use of alcohol

INDIVIDUAL

Figure 1: Socio-ecological model of GBV. Adapted from the RESPECT Framework.

Framing GBV and mental health carefully: Why it matters

This report examines linkages between GBV and mental health, including how common mental health problems can contribute to GBV risk within broader social and environmental contexts. Considering mental health as a risk factor for GBV can be sensitive given historical debates between feminist perspectives and traditional mental health approaches. Mental health has often been treated in a highly medicalised way, raising concerns about how these linkages are framed.

WHY IS THIS CONTENTIOUS? KEY DEBATES TO CONSIDER:

- **Risk of victim-blaming:** Mental health has previously been misused to blame survivors of violence. For example, in the US during the 1960s-70s, women experiencing IPV were often portrayed as having psychological problems, reinforcing stigma and dismissing the violence itself.[31] These patterns persist, and mental health diagnoses can be weaponised by abusive partners to justify abuse and exercise control – a form of psychological abuse.[32]

- **Risk of downplaying perpetrator accountability:** Focusing narrowly on mental health in GBV perpetration can unintentionally reduce accountability if mental health is treated as a casual factor rather than one of multiple interacting risks. It is critical to situate mental health within the broader socio-ecological framework to avoid interpretations that justify or excuse violence.[33]

- **Limitations of diagnostic frameworks:** Standard diagnostic frameworks may not capture the full experiences of GBV survivors, such as how trauma, comorbidities, environmental factors, or other circumstances shape a survivor's mental health.[34] For example, severe PTSD from IPV can cause symptoms that resemble psychosis, leading to misdiagnosis or fragmented care where providers focus on one set of symptoms for treatment rather than survivors' holistic needs.[35]

- **Risk of reinforcing stigma:** Discussing mental health and GBV perpetration may unintentionally heighten stigma around mental health – especially among men and boys – further discouraging those experiencing mental health problems from seeking help and deepening barriers to care.

Given these concerns, it is essential to apply a **survivor-centred, feminist approach** when exploring GBV–mental health linkages. This includes maintaining perpetrator accountability, avoiding individualised explanations that ignore structural drivers, and situating linkages within broader structural drivers such as gender inequality, patriarchal norms, poverty, food insecurity, childhood trauma, conflict and humanitarian emergencies, and substance abuse.[36] [37]

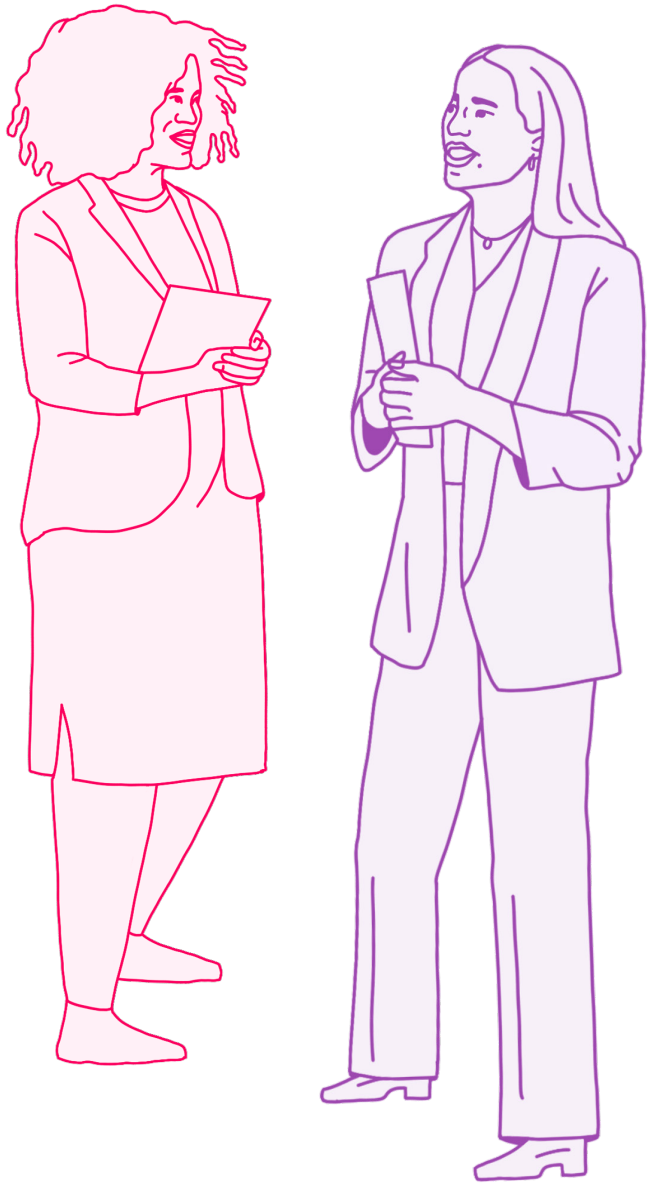
A clearer understanding of these intersections can ultimately **strengthen prevention and response efforts across both fields.** A recent *Lancet Global Health* viewpoint emphasises that exposure to violence affects the mental health of both women and men, albeit within the context of unequal power dynamics. Crucially, these mental health impacts are modifiable; by addressing them, programmes can support the universal right to mental wellbeing while simultaneously mitigating the risk of future IPV. [38]

1.3 GBV and mental health: Bridging the gap between two fields

Links between GBV and mental health are receiving increased attention. However, most research originates from high income countries (HICs) and relies heavily on Western, medicalised conceptualisations of mental health. These approaches often focus on individual clinical treatment and overlook local, cultural, and contextual understandings of mental health and wellbeing.

There is growing critique of this imbalance, with calls to decolonise global mental health research and adopt approaches rooted in local knowledge and historical context.[39] Mental health encompasses more than clinical symptoms, including social and spiritual wellbeing, community connections, and interpersonal relationships. These factors are especially relevant for GBV survivors, who often face stigma, isolation, and discrimination that profoundly affect psychosocial health.

This review draws on evidence from both the mental health and GBV field, prioritising evidence from humanitarian and development settings in LMICs, especially those that consider local understandings and approaches to mental health. However, much of the available evidence still reflects Western medical models, highlighting the need for more contextualised, locally led research to understand how GBV-mental health linkages manifest in different contexts, through which pathways, and what is needed to address them.



The report integrates knowledge and insights from GBV and mental health researchers and practitioners, organisations led by and for groups who are disproportionately affected by GBV and common mental health problems, and service user and survivor networks. These consultations provided a wider range of perspectives than the published evidence alone, surfacing emerging practices and innovative examples that demonstrate the potential of integrated, locally informed approaches to address GBV and mental health together.

GBV and mental health problems are deeply interconnected and disproportionately affect women, girls, and gender-diverse people worldwide. Supporting survivors' mental health is central to effective GBV response, yet integrating efforts to strengthen mental health into GBV prevention remains underexplored. This report offers recommendations for donors, policymakers, practitioners and researchers working in the GBV and mental health fields to bridge these gaps and advance integrated, survivor-centered approaches.

How was this report developed?

GLOBAL EVIDENCE REVIEW

Two rigorous evidence reviews were conducted to examine:

- Mental health impacts of GBV, and how common mental health problems act as risk factors for experiencing or perpetrating GBV
- Approaches used to address the linkages between mental health and GBV

KEY INFORMANT INTERVIEWS

Remote interviews with 22 key informants

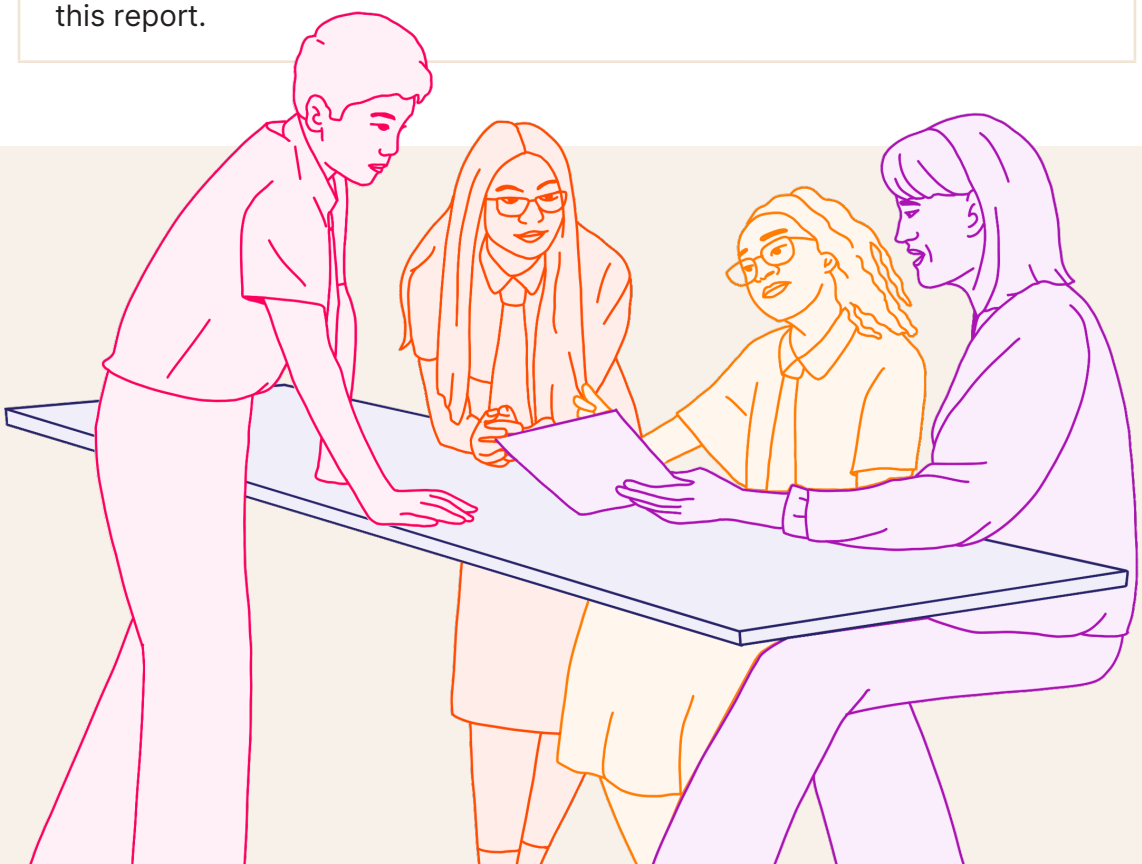
ROUNDTABLE DISCUSSIONS

Two in-person roundtables in Nepal and Uganda with 34 participants

CONSULTATIONS INCLUDED:

- Individuals from women's rights organisations (WROs), mental health NGOs, service-user associations, LGBTQI+ civil society organisations (CSOs), international NGOs (INGOs), UN agencies, universities, and government officials (in Nepal).
- Key informants and roundtable participants were based in 11 countries: the Democratic Republic of Congo (DRC), Ethiopia, Nepal, Pakistan, Uganda, Ireland, Australia, Egypt, South Africa, Nigeria and the US.

A detailed description of the methodology can be found in the annex of this report.



2. What are the linkages between GBV and mental health?

2.1 Mental health impacts of experiencing different forms of GBV

The mental health consequences of experiencing GBV are well recognised. However, much of the research focuses on clinical diagnoses, which can narrowly 'medicalise' survivors' experiences and overlook broader psychosocial impacts.[40] These include changes in interpersonal relationships, connections to community, and spiritual or religious well-being. Participants in the roundtable in Uganda highlighted the importance of looking beyond diagnoses to understand survivors' lived realities. This report seeks to integrate these broader perspectives into its analysis.

"We need to ask, 'what are people going through?' when trying to understand the impacts of GBV on survivors"

- Uganda roundtable participant

Re-thinking Trauma: Beyond PTSD in the context of GBV and structural inequalities

PTSD as a diagnosis was originally developed to describe the experiences of male soldiers returning from war and has since been applied to a wider range of traumatic events, including GBV.[41] While PTSD is useful in recognising that survivors' mental health reactions are responses to trauma for which perpetrators – never survivors – are responsible, feminists have critiqued the overwhelming focus on PTSD in research on GBV and trauma.

For instance, 'Towards a Transformative, Feminist Approach to Trauma in Africa: Perspectives from Practice' argues that trauma must be understood in the broader social and political context of women's and girl's lives. In many settings, this context includes ongoing and multiple forms of trauma, linked to structural oppression.[42] As a result, the concept of 'post-trauma' may not fully capture experiences in contexts where structural inequalities, such as gender-based discrimination, expose women and girls to persistent violence and related mental health impacts. Such experiences may be better understood as complex, ongoing trauma rather than a response to a single event.

This section brings together global evidence on the impacts of GBV on survivors' mental health and psychosocial wellbeing. Different forms of GBV are considered separately to outline their specific mental health and psychosocial impacts, while recognizing that forms of GBV often overlap. For example, technology-facilitated gender-based violence (TFGBV) may occur alongside IPV – which can lead to more complex trauma and more severe mental health impacts.[43] Emerging evidence suggests that participation in misogynist online communities – often referred to as the manosphere – can further normalise these behaviors, as these spaces often provide an ideological justification for coercive control and offline violence.[44]

A following sub-section summarises the available evidence on the mental health and psychosocial impacts of GBV among LGBTQI+ survivors, an area that remains under-researched despite well-documented risks and severe consequences. While the evidence helps illuminate possible pathways between experiencing GBV and common mental health problems, survivors respond to trauma in diverse ways. Responses are shaped by context, available support systems, and individual factors. The severity, frequency and type of GBV also influence mental health outcomes, though these patterns remain under-documented and require further research.

Understanding limitations and biases in the global evidence base

Several limitations should be considered when interpreting this evidence:

- **'Global' evidence often represents a small number of countries:** Most systematic reviews and meta-reviews still draw heavily on research from the Global North. As a result, the so-called 'global' evidence base is not truly global. To address this gap, this report also draws on country-focused and qualitative studies from the Global South, particularly in development and humanitarian settings, to capture a broader range of experiences and contexts.

- **Dominant mental health frameworks shape what we know:** Much of the evidence relies on diagnostic categories rooted in Western mental health practice. While understanding common conditions is important for service provision, a narrow biomedical focus – which views mental health symptoms primarily as internal "disorders" to be treated – can risk pathologising survivors' responses rather than recognising them as meaningful, adaptive reactions to violence and trauma.[45] Survivors of GBV have also critiqued the biomedical model for emphasising symptoms without exploring underlying causes.[46] Shifting toward more holistic psychosocial or socio-ecological frameworks allows a move beyond clinical symptoms to address the environmental and social roots and profound forms of distress that impact survivors, including stigma, fear, shame, social isolation, economic hardship, and concern for children.

- **Inconsistent definitions and measurements:** Studies vary in how they define GBV (e.g. for sexual assault or technology-facilitated GBV) and in how they measure common mental health problems. For example, PTSD is often diagnosed using different methods,[47] and some studies combine depression and anxiety into a single measure.[48] These inconsistencies limit comparability and mean findings should be interpreted with caution.

- **Limited intersectional evidence:** While this report highlights available evidence on women, girls and LGBTQI+ individuals, intersectional analyses remain scarce. Many datasets are not gender-disaggregated, despite clear gendered patterns in both GBV and common mental health problems. As a result, research often misses how overlapping forms of gender inequalities and other forms of oppression shape experiences of GBV and mental health.

INTIMATE PARTNER VIOLENCE (IPV)

Research consistently shows that experiencing IPV is strongly linked to negative mental health outcomes.[49] A 2024 systematic review of 201 studies from diverse countries – though many from the US[50] – found that IPV significantly increases the risk of depression, suicidal thoughts and attempts, anxiety, PTSD, and psychological distress. Among survivors, depression was the most common (70%), followed by PTSD (29%) and anxiety (17%).[51]

Evidence from the first *What Works to Prevent Violence against Women and Girls programme* (2015-2019) further highlights these impacts.[53] In South Africa, research from this global programme showed that the frequency and severity of IPV were positively associated with mental health consequences.[54] Emotional and economic IPV also contributed to significant mental health impacts for women, extending beyond the effects of physical and/or sexual IPV alone.

Evidence from the What Works programme across five Global South settings showed that women who had experienced IPV in the past 12 months had **2.5 times higher odds** *of experiencing depressive symptoms compared with those who had not.*[52]

IPV increases during conflict and humanitarian crises[55], with some studies reporting rates as high as 70%,[56] which in turn heightens the risk of poor mental health in these settings. For example, among Somali women in a Kenyan refugee camp, 47% reported past-year IPV, and 39% reported past-year non-partner violence. More than half of these women exhibited symptoms of PTSD and/or moderate to severe depression or anxiety, and those experiencing IPV were more likely to report symptoms of depression than those experiencing non-partner violence alone.[57]

Ample evidence indicates that women living with disabilities are at higher risk of IPV than women without disabilities and face greater barriers to seeking help or accessing appropriate health and mental health services[58], which increases their likelihood of adverse mental health outcomes. For example, a cross-sectional study in informal settlements in India[59] found that women with disabilities had more than 50% higher odds of experiencing physical, sexual, or emotional IPV than non-disabled women, and women with disabilities and those who had experienced IPV were more likely to report **anxiety, depression, and suicidal thinking.** Importantly, women with disabilities had more mental health concerns than women without disabilities even after controlling for socioeconomic conditions and experiences of violence.

IN FOCUS

Children witnessing IPV at home

GBV and violence against children (VAC) are closely linked, including through shared risk factors and overlapping patterns of violence. IPV and child maltreatment frequently co-occur within the same household.[60] Children who witness their mother experiencing IPV face an elevated risk of both perpetrating and experiencing IPV in adulthood-a pattern often described as the 'intergenerational cycle' of violence.[61]

A 2023 systematic review found that nearly all included studies[62] reported negative mental health effects among children exposed to IPV at home, including stress, depression, anxiety, PTSD, and negative and overwhelming emotional responses.[63] Although variations in measurement methods that limits precise prevalence estimates, the review consistently shows that these children face higher risks of common mental health problems alongside broader psychosocial and behavioural difficulties, including problems forming relationships and aggressive behaviours.

Evidence from Cambodia, Malawi, and Nigeria provides additional context from LMIC settings. Analysis of VAC surveys found that between 22% and 34% of children and young people (aged 13-24) had witnessed IPV between caregivers during childhood.[64] Witnessing IPV was associated with higher odds of mental distress in Cambodia and Malawi, while in Nigeria this association was observed only among boys and young men.[65] Across all three countries, between one third and one half of respondents also reported experiencing physical violence by a parent, caregiver, or adult relative, highlighting the frequent co-occurrence of IPV and VAC.

Further insight comes from a recent randomised controlled trial (RCT) with adolescents in South Africa, which found that exposure to family violence and poor parent–child relationships contributed significantly to poor mental health, behavioral problems, and violence in early adolescence, with distinct gendered pathways.[66] Among girls, exposure to family violence was associated with depression through reduced parent–child connection, delinquent behaviour, negative school attitudes, and bullying. Among boys, family violence indirectly predicted violence through depression, substance use, and delinquent behaviour, with depression also having a direct impact on substance use. Together, these findings underscore the central role of common mental health problems in shaping behavioural outcomes and suggest a potential cycle of violence across generations, mediated by trauma and diminished psychosocial wellbeing.

SEXUAL VIOLENCE

Global evidence shows that sexual violence is strongly associated with common mental health problems and profound psychosocial impacts.[67] [68] A systematic meta review[69] found that between 25% and 75% of survivors of sexual violence report symptoms of PTSD. Sexual violence is also associated with anxiety and specific fears, such as fear of leaving home or of the violence recurring. Up to two thirds of survivors report depressive symptoms, and nearly two in five report suicidal ideation and attempts.[70] This review also identified clear gendered

patterns in mental health outcomes. Female survivors were more likely to experience PTSD, depression, anxiety, substance use, and eating disorders, while male survivors showed higher rates of distress, paranoia, hypomania,[71] schizophrenia, substance use disorders, and suicidal behaviour. The review also highlights social and relational consequences of sexual violence: around 20% of survivors withdrew from social activities, 10%-60% experienced social dysfunction, and up to 75% reported distrust of others. Substance abuse was reported by up to half of survivors.

Another systematic review[72] focused on young survivors of sexual assault found that 58-60% met PTSD diagnostic criteria one year after the assault.[73] While most survivors initially reported moderate depressive symptoms (74%), these symptoms had shifted to mild depression for many at one-year follow-up. This review did not provide gender-disaggregated analysis, although the majority of participants were female.[74]

IN FOCUS

Evidence from conflict and humanitarian emergencies

Women and girls in humanitarian and conflict settings face particularly high levels of sexual violence perpetrated by multiple actors, including intimate partners, although research has predominantly focused on non-partner sexual violence. Across such settings, evidence consistently demonstrates severe and enduring psychological and social consequences for survivors.[75]

A qualitative systematic review found survivors of non-partner sexual violence in conflict settings commonly experience PTSD, anxiety, depression, eating disorders, thoughts of self-harm, and suicide attempts.[76] Survivors frequently reported shame, fear of re-victimisation, low self-esteem, flashbacks, nightmares, poor concentration and memory, feeling detached from their former self, and loss of motivation. These impacts often disrupted survivors' ability to work, care for children, and participate in daily life. Some survivors reported using alcohol as a coping strategy for distress. Reported social harms of sexual violence in these settings include stigma, rejection by partners and families, isolation, and in some cases leaving their communities to escape shame.[77] When sexual violence resulted in pregnancy, survivors reported hopelessness, anxiety, suicidal thoughts alongside fear of rejection and pressure to terminate pregnancies.

Evidence from a violence against children (VAC) survey in Ugandan refugee settlements reflects similar patterns. Girls and young women who experienced sexual violence in childhood were significantly more likely to report recent mental distress (81.6% compared with 70.4%) and suicidal ideation (14.5% compared with 7.4%) than those who had not experienced sexual violence.[78]

CHILD, EARLY AND FORCED MARRIAGE

Child, early and forced marriage[79] disproportionally affects girls and is associated with heightened risks of IPV, adolescent pregnancy, and a range of adverse health and social outcomes.[80] Evidence links child marriage to common mental health problems, psychological distress, and suicidal ideation. A 2022 narrative review identified depression as the most frequently examined and consistently associated mental health outcome.[81] The review also highlighted intersecting drivers of distress, including exposure to IPV, poverty, challenges related to childbirth, and social isolation. Additional studies report psychosocial harms linked to loss of education, self-confidence, and childhood, alongside stress associated with early pregnancy, childbirth, and parenting responsibilities.[82]

Although the evidence base remains limited, a few studies have examined associations between suicidal thoughts and attempts and child marriage.[83] For example, a study in Ethiopia found that girls who had been promised in marriage or had received marriage proposals were twice as likely to report suicidal thoughts compared with girls who had not.[84]

Roundtable participants in Uganda reinforced these findings. Participants reported increases in child marriage during COVID-19, which led to more adolescent pregnancies. They observed that many girls and young women were living with trauma and mental health concerns linked to early and forced marriage, underscoring the long-term psychosocial consequences.

TECHNOLOGY-FACILITATED GBV

Evidence on the mental health impacts of TFGBV in LMICs remains limited. However, emerging research indicates substantial mental health and psychosocial consequences for women and girls.[85] A survey of girls and young women aged 15-26 across 22 countries found that 42% reported mental or emotional stress from online harassment, and a further 42% reported reduced self-esteem or confidence.[86]

Most existing evidence on TFGBV and mental health comes from HICs. A systematic review examining non-consensual sharing of intimate images (NCII) among youth in five countries[87] in the Global North found consistent associations with depression, anxiety, and suicidal ideation. Survivors also reported bullying, harassment, and victim-blaming, which intensified mental distress and undermined self-worth.[88]

Studies focusing on adults show similar impacts. A survey of women aged 18-55 in across eight countries[89] in the Global North found that 54% of survivors of online abuse reported panic attacks, anxiety, or stress.[90] Similarly, a systematic review of cyberstalking and harassment (largely drawing on Global North studies) reported adverse mental health outcomes across nearly all studies, including depression, anxiety, PTSD, panic attacks, self-harm, and physical stress-related symptoms such as heart palpitations.[91] Depression was the most frequently cited impact, followed by anxiety, stress, and PTSD. While women comprised the majority of study participants, the review did not provide detailed gender-disaggregated analyses.

A recent systematic review examining the psychological and political consequences of online harassment among politically active women found that 81% of studies reported psychological distress, anxiety, and fear among targeted women, while 31% identified

online harassment as a trigger for re-traumatisation.[92] This review notably included evidence from several LMICs including Bangladesh, Brazil, Namibia, Nepal, Nigeria, Pakistan, Philippines, Paraguay, and Uganda.

GBV IN AND AROUND SCHOOLS

Although harmful gender norms, misogyny, and homo-, bi- and transphobia are widely recognised as drivers of violence in and around schools,[93] existing systematic reviews provide limited gender-disaggregated analysis of the associated mental health impacts. A 2018 systematic review found that school violence victimisation is consistently associated with poorer mental health outcomes and predicts higher levels of depression.[94] A substantial body of evidence links bullying to adverse mental health outcomes among children and adolescents. A 2023 meta-analysis found that children and adolescents who had experienced bullying in the past year had a 2.77-fold higher risk of depression. [95] Similarly, a 2017 review reported that bullying victimisation increased the likelihood of suicide attempts among both girls and boys, with risk escalating as the frequency of victimisation increased.[96] Bullying has also been strongly associated with anxiety, including social anxiety, as well as PTSD.

SEXUAL HARASSMENT

Global evidence on the mental health impacts of sexual harassment rarely provides gender-disaggregated analysis. A systematic review of sexual harassment in workplaces, educational institutions, and public spaces in LMICs found significant associations between experiences of sexual harassment and depressive symptoms, however, only three studies examined this relationship, underscoring the need for more rigorous research.[97] A subsequent qualitative review identified a range of common psychological and emotional consequences of sexual harassment including anger, sleep difficulties, nightmares, anxiety, humiliation, fear, lowered self-confidence, depression, hopelessness, and suicidal ideation.[98] Both reviews included samples of women and men survivors and did not provide gender disaggregated findings.

Additional context-specific evidence comes from a mixed-methods study in rural India examining ‘eve teasing’- a common form of sexual harassment in South Asia encompassing staring, stalking, verbal comments, and inappropriate touching. Girls and young women described significant mental health and psychosocial impacts including depression and suicide risk. Among the 36 participants who had experienced eve teasing, 61% reported anger, 47% shame or humiliation, and more than one-third reported fear, worry, or tension.[99]

Mental health impacts of GBV among LGBTQI+ survivors

LGBTQI+ people experience both common forms of GBV and forms of violence rooted specifically in intersecting gender-based and SOGIESC-based oppression, including so-called "conversion" practices. Experiences of violence and associated mental health impact are not homogenous within LGBTIQ+ populations; intersecting identities, social status, and broader social determinants of health shape patterns of risk, harm, and access to support.

INTIMATE PARTNER VIOLENCE

Evidence suggests particularly high levels of IPV among sexual and gender minorities. A survey in Fiji found that 83% of LBT women and non-binary respondents had experienced physical and/or sexual IPV, and 35% had experienced emotional IPV. Nearly one-quarter (23%) of respondents reported feeling stressed, depressed and suicidal as a result of the abuse.[100]

SEXUAL VIOLENCE

Research on the mental health impacts of sexual violence among LGBTQI+ survivors remains limited, but available studies indicate severe psychological and social consequences, similar to, and often compounded beyond, those experienced by other survivors. A 2019 survey of nearly 140,000 LGBTI people across the EU, North Macedonia, and Serbia found that psychological impacts – such as depression, anxiety, and fear of leaving home – were the most commonly reported consequences of sexual violence, affecting 49% of respondents.[101] In sub-Saharan Africa, a multi-country study across nine countries[102] found high levels of PTSD symptoms among sexual and gender minority survivors of sexual and physical violence, with 44% reporting all three PTSD indicators[103] measured.[104] Another multi-country study with lesbian and bisexual women in Zimbabwe, Botswana, and Namibia linked experiences of sexual violence to mental distress, problematic alcohol and drug use, and reduced sense of belonging within LGBT communities.[105]

CHILD, EARLY AND FORCED MARRIAGE

Emerging evidence suggests that some LGBTQI+ individuals are forced into marriage by family members as a means of concealing or attempting to 'convert' their SOGIESC, increasing risks of violence and serious mental health harms. A survey of sexual and gender minorities in nine African countries[106] found that 18% were in a forced marriage at the time of the study, which was strongly associated with higher lifetime and past-year experiences of violence.[107] A qualitative study in Cambodia examining family violence against lesbian and bisexual women and trans men found that forced marriage was one of several strategies used by parents to conceal or 'convert' their child's sexual orientation or gender identity. Survivors described depression, suicidal thoughts, and suicide attempts as consequences of forced marriage.[108]

TECHNOLOGY-FACILITATED GBV

Despite high rates of victimisation, evidence on the mental health impacts of TFGBV among LGBTQI+ survivors remains scarce.[109] A UK survey found 78% of LGBTQI+ respondents had experienced online anti-LGBT+ hate crime or hate speech in the past five years, with even higher rates among transgender individuals.[110] 67% of respondents reported anxiety, 62% stress, and 40% depression following the most serious incident. Many also reported feelings of guilt related to their sexual orientation or gender identity, contributing to internalised homophobia, biphobia, or transphobia. Respondents also reported self-harm, suicidal thoughts and attempts, with transgender respondents experiencing more severe mental health impacts than cisgender respondents.

GBV IN AND AROUND SCHOOLS

Globally, an estimated 45% of LGBT students experience bullying, including name-calling, threats, exclusion, and being 'outed'.[111] A 2023 evidence review found that school-based victimisation is strongly associated with depression, anxiety, PTSD, substance use, self-harm, and suicidal thoughts or attempts, with more severe outcomes when multiple forms of victimisation co-occur.[112] Additional systematic review evidence[113] [114] confirms that school-based bullying is a major contributor to the disproportionally high rates of suicide ideation or attempts[115] and self-harm among LGBTQI+ adolescents.

SEXUAL HARASSMENT

Evidence also points to significant mental health impacts of sexual harassment among LGBTQI+ people in workplaces and other public settings. A UK survey found that 65% of LGBT respondents had experienced harassment at work – rates were highest among LGBT women –with 16% reporting negative mental health impacts such as stress, anxiety, and depression.[116] A US study documented widespread 'covering' behaviours among LGBT employees, including altering appearance, hiding personal information or avoiding bathrooms to reduce harassment risk.[117] While mental health outcomes were not measured directly, broader evidence links such concealment of one's SOGIESC to minority stress and poorer mental health outcomes.[118]

So-called 'conversion' practices: So-called "conversion" practices are associated with some of the most severe mental health harms documented among LGBTQI+ populations. A global survey[119] of LGBTQI+ rights experts and survivors identified profound mental health impacts of such practices, including depression, suicidality, self-hatred, feelings of shame, humiliation, hopelessness, and internalised homo-, bi- and transphobia.[120]

When perpetrated by religious actors, conversion practices often result in additional spiritual and relational harms. An Australian qualitative study found that survivors experienced severe anxiety, depression, suicidal ideation, moral injury and grief linked to ruptured relationships with faith communities and a damaged sense of self.[121]

So-called "corrective" rape – documented primarily against lesbians, bisexual women, and trans men – particularly in Sub-Saharan Africa, though increasingly reported elsewhere[122] is another form of "conversion" practice involving sexual violence intended to punish or

forcibly "correct" a person's sexual orientation or gender identity. Lesbian, bisexual women, trans men, and gender non-conforming survivors in South Africa describe severe mental health consequences including flashbacks, low self-esteem, suicidal ideation or attempts, concentration difficulties, and persistent fear of recuring sexual violence.[123] Many also reported behavioural changes such as social isolation, avoiding certain places, or restricting movement to reduce perceived risk of further violence.

A NOTE ON TERMINOLOGY

This report uses *so-called "conversion" practices* to describe efforts intended to change or suppress the SOGIESC of LGBTQI+ people. The prefix "so-called" signals that these are not therapeutic or evidence-based interventions, but harmful practices that constitute serious human rights violations, and in some cases, may amount to torture, as recognised by the UN Independent Expert on SOGI.[124] The term "practices" is used in place of "therapies" to reflect their abusive nature.

So-called "conversion" practices encompass a wide range of harmful acts – perpetrated by religious leaders, medical and mental health professionals, traditional healers, self-help groups, families, and community members – aimed at "curing," "treating," or "converting" LGBTQI+ individuals to cisgender and/or heterosexual identities.

IN FOCUS

Experiences of GBV and mental health among LBQ women in sub-Saharan Africa

Across studies with LBQ women in Kenya, Uganda and Rwanda, consistent patterns emerge linking lifetime experiences of GBV, the ongoing risks of targeted violence and discrimination, and high levels of common mental health problems. These experiences are shaped by criminalisation, social exclusion, and limited access to supportive and affirming services.

In Kenya, qualitative interviews with 18 LBQ women highlighted high levels of stress associated with everyday violence and discrimination, with participants describing depression, anxiety and insomnia.[125] Discussion of mental health was constrained by strong stigma and taboo, with distress often understood through beliefs related to witchcraft, curses, or religious non-conformity. Women also reported that cumulative stress and limited access to support contributed to patterns of heavy alcohol use among LBQ women in urban settings.

In Uganda, a study involving 220 LBQ women found that nearly all participants reported experiencing mental health problems.[126] Women attributed this to lifelong violence, including childhood neglect and abuse, IPV, unsafe sex or abortions. Many reported self-harm, suicidal ideation, and the use of alcohol and other substances as coping mechanisms.

In Rwanda, interviews with 20 lesbian and bisexual women revealed frequent exposure to multiple traumatic and violent events, including harassment, forced or pressured marriage to male partners, and physical and sexual violence. Participants described chronic stress, sadness, hopelessness, depression, and suicidal thoughts.[127]

2.2 Mental health as a potential risk factor for GBV

In the GBV field, attention to mental health has largely focused on the impacts of experiencing violence and the role of GBV response services. Far less emphasis has been placed on understanding how common mental health problems may act as risk factors for both experiencing and perpetrating GBV. These linkages are complex and sensitive, as outlined in the introduction, but integrating mental health considerations into both GBV response and prevention is critical for more comprehensive and effective approaches.

Understanding current limitations in the global evidence base

Several key limitations should be noted when interpreting evidence on common mental health problems as potential risks factor for perpetrating and experiencing GBV:

- **Narrow focus on IPV perpetration:** Most research on poor mental health as a risk factor for GBV perpetration is concentrated on IPV, with little evidence examining other forms of GBV.
- **Limited and uneven evidence on men's mental health:** Studies addressing men's mental health and IPV perpetration are predominantly from HICs, often with military or offender populations, and tend to focus on PTSD rather than other common mental health problems. Variation in sample types, measurement approaches, and study designs further complicates conclusions.[128]
- **Poorly described pathways for women and LGBTQI+ populations:** Existing research largely examines women's depression as a risk factor for IPV, with very limited research on other mental health problems or on LGBTQI+ populations' experiences.[129]
- **Challenges in establishing causality:** Many studies cannot determine whether mental health symptoms preceded or followed GBV. Common mental health problems can be both a consequence of, and a potential risk factor for, GBV, creating what researchers describe as a "cycle of reciprocal causality."[130] As one expert observed: *"I don't think we know what comes first… Where in the life course does abuse come first and poor mental health come second?"* This uncertainty complicates interpretation across the evidence base.

This section first examines common mental health problems as a potential risk factor for GBV perpetration, before exploring the linkages between common mental health problems and the risk of experiencing GBV. As outlined in the introduction, these relationships cannot be understood in isolation from the broader socio-ecological model of GBV (see Figure 1), which highlights how individual, interpersonal, community and societal factors shape both the likelihood of experiencing and perpetrating GBV.

Understanding these linkages also requires situating common mental health problems within wider social and structural contexts. Research on the social determinants of mental health emphasises that mental health is fundamentally a matter of social justice. Factors such as education, income, employment, housing, social support, exposure to childhood adversity and discrimination shape mental health across the life course.[131] Common mental health problems therefore often stem from underlying inequalities and structural injustices that drive disparities within and between populations.

GBV and common mental health problems share several drivers, including systemic gender inequality, patriarchal norms, poverty and food insecurity, childhood trauma, social isolation, conflict and humanitarian crises, and substance abuse.[132] [133] Paying closer attention to how these two global challenges intersect can help both fields address shared root causes, contributing to GBV prevention while strengthening mental health outcomes.

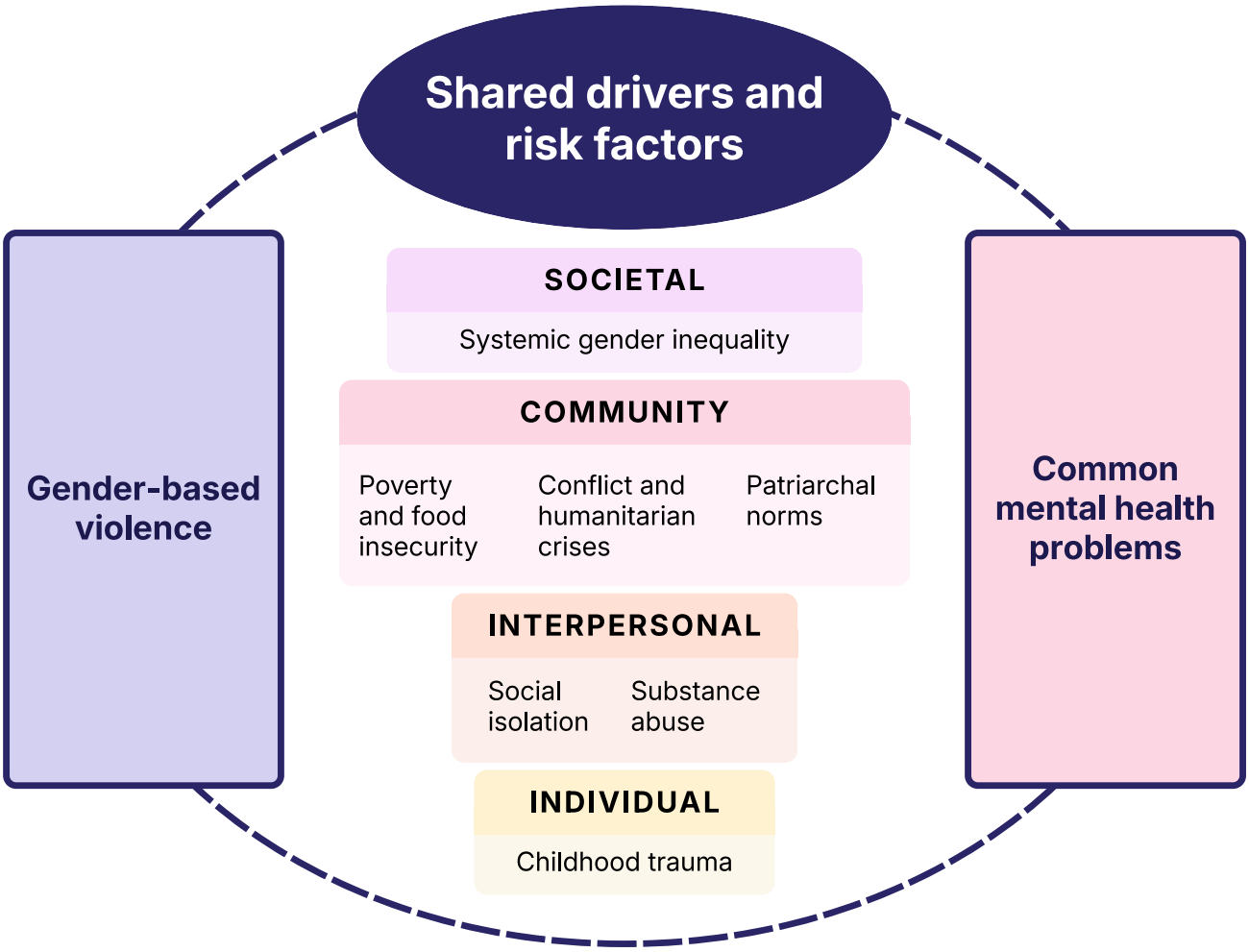


Figure 2: Shared drivers of GBV and common mental health problems

Mental health as a risk factor for perpetrating GBV

Poor mental health as a risk factor for GBV perpetration has primarily been studied in relation to men who have perpetrated IPV. Evidence on how common mental health challenges may contribute to other forms of GBV is more limited.

INTIMATE PARTNER VIOLENCE PERPETRATION

A pooled analysis from five countries[134] in the Global South found a consistent link between men's common mental health problems and physical IPV perpetration, with associations observed in four of the five country-level analyses. Men reporting PTSD had nearly double the odds of perpetrating physical IPV in the past year, while those with depressive symptoms had more than twice the odds compared with men who did not report poor mental health. These findings align with other studies in both the Global South and North, including a UN multi-country study[135] in Asia and the Pacific, which found that men's depression was associated with physical and/or sexual IPV perpetration in Bangladesh, Cambodia and China.[136]

NON-PARTNER SEXUAL VIOLENCE PERPETRATION

Evidence on links between men's poor mental health to NPSV perpetration is limited, particularly in the Global South. The same pooled analysis from five countries cited above examined NPSV in three contexts – two in South Africa and one in Ghana[137] and found that men's common mental health problems were associated with higher odds of NPSV perpetration. In South Africa, men reporting more depression symptoms had over 50% higher odds of perpetrating NPSV compared to those with fewer depression symptoms. Across all three studies, men with PTSD were more than twice as likely to perpetrate NPSV compared to men without PTSD.

TECHNOLOGY-FACILITATED GBV PERPETRATION

For TFGBV, only one systematic review was identified which included some evidence on risk factors. This review found that adverse mental health and social outcomes may not only be a consequence of TFGBV victimisation, but also appear among young perpetrators of this type of abuse.[138] All studies included in this review were from HICs and the authors noted limitations around the use of unvalidated tools for measuring mental health in some studies, highlighting the need for more robust and geographically diverse evidence. A separate study among 520 Lebanese adolescents aged 13-16 found that perpetrators of sexual cyberbullying or and posted malicious or embarrassing content reported significantly higher levels of anxiety and depression than non-perpetrators.[139]

PERPETRATION OF GBV IN AND AROUND SCHOOLS

Some evidence suggests depression may contribute to school violence and bullying, with systematic reviews showing higher depression levels among children and adolescents who engage in these behaviours.[140] However, this evidence is not gender-disaggregated and does not specifically examine the gendered dimensions of this violence.

What are the possible pathways between common mental health problems and GBV perpetration?

More research is needed on how men's experiences of common mental health problems contribute to GBV perpetration. Current evidence points to two main pathways: men's harmful alcohol use and childhood experiences of trauma, violence, and maltreatment.

HARMFUL ALCOHOL USE

Depression often co-occurs with harmful alcohol use, which can be strongly linked with IPV and NPSV perpetration.[141] For example, the first What Works to Prevent Violence programme found high levels of harmful alcohol use among male perpetrators of past year physical and/ or sexual IPV and NPSV in South Africa and Ghana. Harmful alcohol use was reported by 43% of perpetrators of violence against women in one South African study; 39% in another South African study, and 26% in Ghana. The two South African studies also found that poverty and childhood abuse or neglect increased men's depressive symptoms and harmful alcohol, which in turn were associated with higher IPV perpetration.[142]

CHILDHOOD EXPERIENCES OF TRAUMA, VIOLENCE AND MALTREATMENT

Exposure to adverse childhood experiences including physical, sexual, and emotional violence is consistently linked with men's adult IPV perpetration.[143] Childhood maltreatment also increases the risk of major depression and alcohol use later in life.[144] A UN multi-country study[145] in Asia and the Pacific found that men's depression linked to IPV perpetration in three out of six countries (Bangladesh, Cambodia and China), and that childhood violence, especially emotional abuse and witnessing IPV at home, significantly influenced adult IPV perpetration.[146]

In South Africa, analysis of data from 416 men found that those who were physically or sexually abused as children were more likely to perpetrate physical IPV (though not sexual IPV) than men who had not been victimised as children.[147] Men with PTSD or depressive symptoms were more likely to perpetrate sexual or physical IPV at least once in their lifetime. The study identified a direct pathway from men's childhood trauma to IPV perpetration, mediated by PTSD.

Importantly, research also shows childhood victimisation does not lead inevitably to later violence but depends on factors such as severity of abuse and the support received afterwards, which influence recovery from trauma and the likelihood of perpetrating GBV later in life.[148]

IN FOCUS

Intersections of poor parental and caregiver health and child maltreatment

A review by the Prevention Collaborative shows that poor parental/caregiver mental health, particularly depression, increases the risk of child maltreatment, especially when combined with IPV, harmful alcohol use, and socio-economic stressors.[149] Studies indicate that IPV can worsen caregivers' mental health, which in turn increases the likelihood of harsh and punitive parenting.[150] [151] Together, this evidence shows how mental health, IPV and violence against children are closely linked and can reinforce cycles of harm across generations.[152] [153]

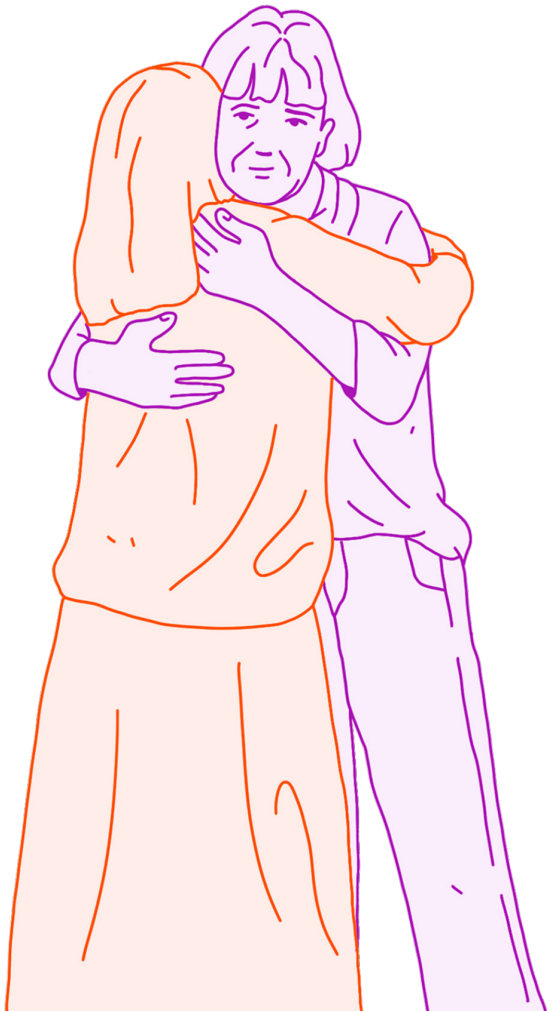
Mental health as a risk factor for experiencing GBV

THE IMPORTANCE OF FRAMING

A reminder before reading this section

A survivors' mental health is never a causal driver of GBV and exploring mental health as a risk factor – alongside other elements of the socioecological model – **does not** shift attention away from the fundamental role of power and control that underpins all GBV (see page 7 for a detailed discussion on the importance of this framing).

Evidence on how women's and LGBTQI+ people's mental health may influence the risk of experiencing different forms of GBV is limited. Where research exists, it has largely focused on the mental health of women who have experienced IPV. This evidence suggests that women's experiences of common mental health problems – most notably depression – can increase the risk of exposure to controlling behaviours and IPV or contribute to remaining in abusive relationships.[154] The pathways through which this occur are not yet fully understood, but emerging research highlights several few possible mechanisms and interrelated factors.



Mental health impacts on relationship dynamics

SHARED RISK FACTORS

One explanation for the association between poor mental health and experiences of IPV is the presence of common, co-occurring risk factors, including childhood trauma, poverty, and substance use. These factors often intersect and can undermine individuals' capacity to engage in emotionally connected and trusted relationships.[155]

THE IMPACTS OF LIVING WITH COMMON MENTAL HEALTH PROBLEMS

Evidence also points to the ways in which living with common mental health problems may increase vulnerability to IPV. An evidence review by the Prevention Collaborative highlights that symptoms of depression – such as feelings of worthlessness, low motivation, hopelessness, and persistent sadness – can affect a person's ability to manage disagreements and arguments in relationships, triggers of violence, and to leave abusive relationships.[156]

Women living with severe mental illness face substantially higher risks of IPV. A 2016 systematic review and meta-analysis found that between 15 and 22% of women with severe mental illness (defined as having a diagnosed psychotic disorder or receiving secondary mental health care) had experienced domestic violence in the past three years.[157] Evidence from the UK indicates even higher levels of risk: 27% of women with severe mental illness reported experiencing past-year IPV compared to 9% among women in the general population.[158]

Higher risks for women living with severe mental illness extend to sexual violence. A systematic review and meta-analysis found a median prevalence of 10% for recent sexual violence (within the past three years) among women with severe mental illness.[159] Where comparisons were possible, prevalence was consistently higher than among women without serious mental illness.[160] It is important to note that all but one of the studies include in this meta-analysis were conducted in HICs.

Women with mental health conditions may face heightened risks of GBV in inpatient units and psychiatric hospitals, arising from institutional conditions and power imbalances within care relationships. Research indicates that women residing in mental health inpatient units are at risk of experiencing GBV perpetrated by both other patients and staff, particularly in under-resourced health systems. A study from Australia observed that GBV risks are exacerbated by mixed-gender spaces (including lounges, dining rooms and bathrooms) and by bed shortages that result in women being placed in men's wards, increasing exposure to threats, harassment, and sexual or physical violence.[161] Although published research remains limited, a small number of studies have documented a pattern of sexual exploitation and abuse perpetrated by mental health professionals. For example, a qualitative study of women living with severe mental illness in Uganda described a case in which a woman was sexually exploited by a clinician treating her bipolar affective disorder, who used his control over access to psychiatric medication to initiate and sustain a sexual relationship.[162]

3. How can the linkages between GBV and mental health be addressed?

Given the complex and multiple linkages between different forms of GBV and common mental health problems, no single approach or sector can address these challenges in isolation. Multi-level, multi-sectoral strategies are needed to support GBV survivors' mental health and wellbeing, disrupt pathways linking common mental health problems with GBV perpetration and victimisation, and address the shared root causes of both GBV and common mental health problems – many of which overlap.

The evidence review identified interventions that address these linkages through a range of approaches. Consultations with GBV and mental health researchers, women's rights and LGBTQI+ rights organisations, and survivor-led groups provided additional insights grounded in practice and lived experience. Evidence in this section is organised across three sections:

1. **Response interventions** that strengthen survivors' mental health and well-being through survivor-centered, trauma-informed GBV response services and mental health support.
2. **Prevention and risk reduction interventions** that interrupt pathways between mental health problems and GBV by integrating mental health considerations into GBV prevention programming.
3. **Structural and enabling approaches** that address shared root causes, including gender inequality, stigma, poverty, social exclusion, weak systems and services that shape both GBV and mental health outcomes.

The interventions and examples included in this section span different levels of the socioecological model for GBV. These include individual-level approaches focused on supporting GBV survivors' healing and recovery; interpersonal approaches that address GBV and mental health linkages through relationships-focused strategies; community-based approaches that strengthen the social environment surrounding survivors; and structural and societal approaches that seek to tackle root causes through systems-level change.

All levels play a critical role and require sustained multi-sectoral investment and coordination. However, most of the available evidence focuses on individual and interpersonal level interventions. Consultations emphasised the importance of community-level strategies to address pervasive stigma and taboo surrounding GBV and common mental health problems, which are critical to the acceptability and uptake of interventions at other levels. Evidence on structural approaches remains limited, although there are growing calls to address the social determinants of mental health and GBV, as discussed later in this section.

Addressing GBV and mental health linkages across the socioecological model

INDIVIDUAL APPROACHES	INTERPERSONAL APPROACHES	COMMUNITY APPROACHES	STRUCTURAL AND SOCIETAL APPROACHES
• Mental health and psychosocial support • GBV case management • Psychotherapy • Mindfulness and body focused approaches • Livelihoods and mental health approaches	• Couples' interventions • Family focused interventions • Parenting interventions • Peer-led mental health support	• Addressing stigma and taboo around GBV and common mental health problems • Strengthening community-based services, support structures and safe spaces	• Cash transfers • Social protection • School-based approaches • Strengthening health infrastructure

The examples included in this report provide an overview of the types of approaches that have been implemented, the results achieved, the contexts in which they have been applied (including humanitarian and development settings) and the populations reached. The aim is to highlight promising practices and recurring challenges in order to distil lessons from a limited and uneven evidence base. Findings should therefore be interpreted with caution: approaches that demonstrate positive results in one context may not be directly transferable to another. Any adaptation should be carefully tailored to local contexts and populations, drawing on the expertise of local practitioners and affected communities.

Understanding current limitations and biases in the global evidence base

Several limitations and considerations should be kept in mind when interpreting the evidence presented in this section:

- **Limited evidence of mental health interventions for GBV survivors:** Across the broader evidence on treating common mental health problems, relatively few studies examine the effectiveness of these interventions among GBV survivors – especially in development and humanitarian contexts. Psychotherapy-based approaches are somewhat more represented, but overall evidence remains sparse across intervention types.

- **Limited gender-sensitive, transformative, and intersectional approaches:** Few mental health interventions explicitly integrate gender-sensitive or gender-transformative components, or account for how intersecting identities shape survivors' experiences, risks, and needs.

- **Variation in definitions and outcome measures:** Differences in how studies define and measure effectiveness limit comparability across interventions. GBV and mental health fields also use different criteria for judging effectiveness, complicating synthesis.

- **Limited evidence on sustainability of impacts:** While some studies include follow-up periods of six months or longer, there remains limited evidence of whether observed impacts are sustained over time.

- **Limited analysis of core intervention components:** Research rarely identifies which components of an intervention drive observed impacts, such as dosage or intensity, delivery modality, provider characteristics, or the relative effectiveness of group vs individual-based approaches for different populations.

- **Evidence dominated by small-scale trials and pilots:** Most available research is drawn from small-scale trials or pilot studies. There is very limited evidence on population-level or systems-level approaches to addressing GBV and common mental health problems.

- **Scarce evidence from conflict-affected settings:** Evidence on the use of mental health interventions to prevent or reduce different forms of GBV in conflict-affected settings remains limited.[163] This represents a significant gap, given the high burden of poor mental health in such settings and the potential for mental health interventions to contribute to violence reduction.

3.1 Response approaches to support GBV survivors' mental health

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

Growing evidence shows that survivors' mental health can improve within short timeframes, even in resource-limited contexts. Brief interventions delivered by trained lay providers – rather than mental health specialists – are emerging as a promising approach for lower resource settings.[164] [165] At the same time, survivors of GBV heal and adapt in diverse ways following trauma. There is no single or linear pathway to recovery, and survivors draw on a range of strategies to process and manage the impacts of violence over time.[166] Understanding this diversity of healing experiences is essential for designing mental health responses that are survivor-centred, flexible, and tailored to individual needs.

IN FOCUS

Mapping Pathways to Healing from GBV – The Trauma Recovery Rubric

The Trauma Recovery Rubric (TRR) was developed to better understand pathways of trauma recovery following experiences of GBV, using participatory methods including social network mapping, body mapping, lifelines, and card-based exercises. These tools supported women survivors of GBV to map feelings of distress, experiences of trauma, and their healing journeys over time.[167] The study identified seven broad recovery pathways:

1. Normalisation
2. Minimising
3. Consumed/ trapped
4. Shutdown/ frozen
5. Surviving
6. Seeking and fighting for integration
7. Finding integration/ equanimity

Drawing on survivor narratives from four countries (the US, Japan, Greece and Turkey), the TRR provides insights into the healing processes and the ways in which mental health care can be better tailored to GBV survivors' needs. Consultations with one of the researchers involved in developing the TRR highlighted its potential value as a reflective tool, enabling survivors themselves to understand and track changes in their healing and recovery over time.

This section begins with an overview of **mental health and psychosocial support (MHPSS)** and **GBV case management** – two core approaches for supporting survivors' mental health and well-being in development and humanitarian settings. It then examines **psychotherapy-based approaches, mindfulness and body-focused approaches,** and **livelihoods and empowerment strategies.** The focus is on interventions that have been specifically developed for use with GBV survivors or adapted in promising ways to respond to their needs. Interventions that lack sufficient evidence of appropriateness or effectiveness – particularly those that do not adequately address survivors' safety, ethical considerations, or the specific impacts of GBV– are briefly noted but not explored in depth.

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

Mental health and psychosocial support

Mental health and psychosocial support (MHPSS) refers to a range of local or external services that aim to promote psychosocial wellbeing or prevent and treat mental health conditions.[168] Effective MHPSS requires a multi-sectoral approach, involving coordination across health, education, and protection sectors. Actors providing MHPSS- whether GBV specialists or practitioners delivering mental health focused interventions- need to be aware of the specific experiences of GBV survivors, including their healing and recovery goals, and their diverse needs, priorities and safety considerations.

The MHPSS intervention pyramid (figure 3) provides a widely used framework for organising MHPSS in emergency settings. It emphasises the importance of layered support, ranging from basic services and security for the broader population affected by an emergency, to community-led approaches and non-specialist mental health support, and finally to specialised mental health services for those with more severe needs.

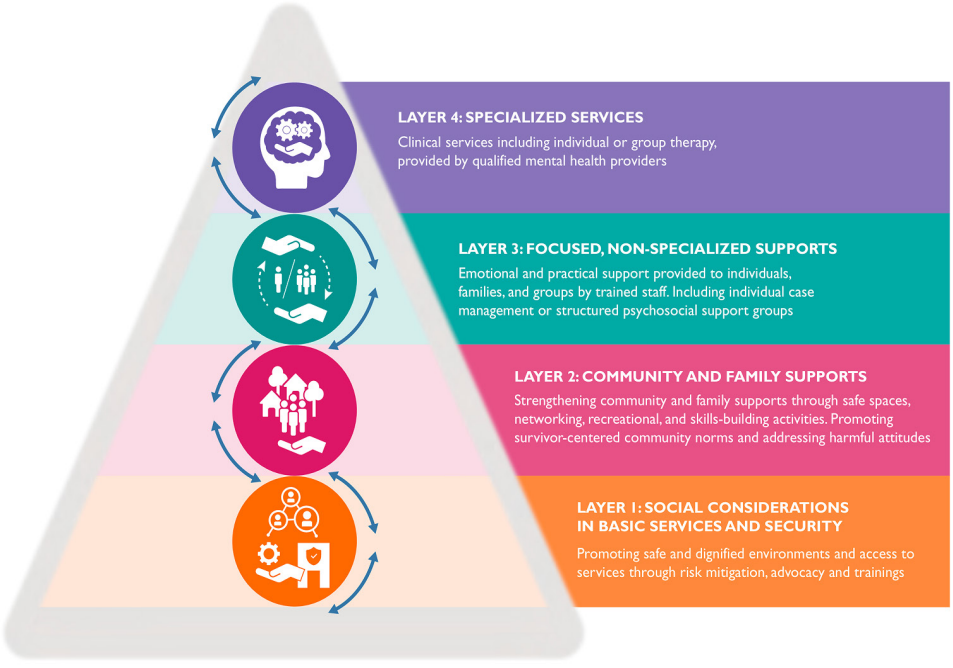


Figure 3: MHPSS intervention layers. Source: USAID (2022) USAID's Collective Action to Reduce Gender-Based Violence (CARE-GBV) – How to Integrate Mental Health and Psychosocial Interventions in Gender-Based Violence Programming in Low-Resource Settings.

GBV survivors may access support through different levels of the MHPSS pyramid, including through general services and specialised GBV services such as GBV case management, women's and girls' safe spaces, and reintegration and empowerment activities. This report highlights examples of interventions operating across these different levels.

Given the high prevalence of violence against women, girls and LGBTQI+ people, MHPSS actors and service providers whose work does not explicitly focus on GBV will nevertheless encounter survivors, whether or not these experiences of violence are disclosed. All actors providing MHPSS should therefore adopt safe, confidential, non-discriminatory practices grounded in **survivor-centred** and **trauma-informed principles.**

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

SURVIVOR-CENTRED APPROACH

The survivor-centred approach – a core GBV Guiding Principle – aims to create a supportive environment where survivors' rights and wishes are respected, their safety is ensured, and they are treated with dignity.[169] The approach is based on four key principles:

- **Safety:** The safety of the survivor and their children is the top priority.
- **Confidentiality:** Survivors have the right to control who hears their story and information is only shared with their informed consent.
- **Respect:** All actions honour the survivor's choices, wishes, rights and dignity.
- **Non-discrimination:** Survivors receive equal treatment regardless of age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or other characteristics.

TRAUMA-INFORMED APPROACH

A trauma-informed approach can be applied at organisational, systems, or programme levels. It involves taking intentional steps to understand the potential impacts of trauma on individuals, families and communities and committing to deliver programmes and services in ways that are safe, inclusive, respectful and compassionate.

Taking a trauma-informed approach does not require identifying who may have experienced trauma; rather, it focuses on creating inclusive and safe environments and practices that minimise the risk of re-traumatisation and further harm.

A project led by the Global Women's Institute at George Washington University and Trócaire found that, despite many shared principles across the MHPSS and GBV fields, there has been limited consensus on how to best design and deliver MHPSS for GBV survivors.[170] Through consultations with local, national, and regional stakeholders, the project worked to develop shared guiding principles and best practices for survivor-centred approaches across both fields. The

resulting resources aim to support the delivery of safe, effective, and survivor-centered MHPSS for GBV survivors, particularly in humanitarian settings where GBV and MHPSS actors often operate under significant constraints, including weak health systems and limited services. While some guidance is specific to crisis contexts, the core principles and practices are applicable across a range of low-resource settings.

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

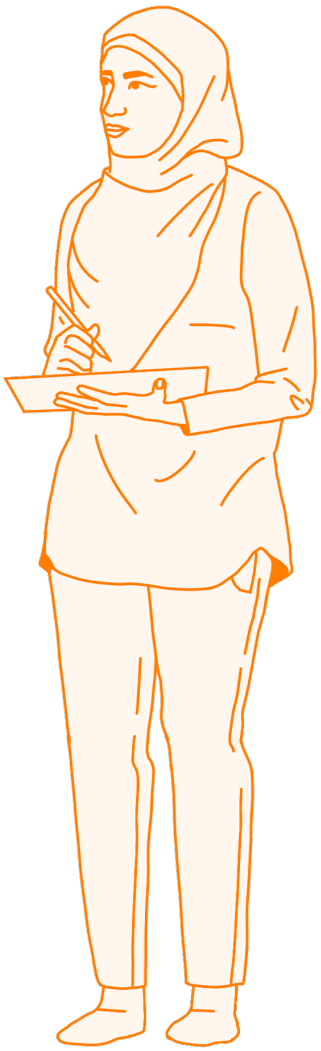
Structural and enabling approaches

A note on group-based delivery of interventions

MHPSS interventions may be delivered individually or in group settings. When groups may include GBV survivors, specific safety measures are required to protect participants' safety and confidentiality and to minimise the risk of harm. These include:

- GBV survivors should never be identified, labelled or singled out within a group setting
- Conduct a safety assessment prior to implementation to identify potential risk for participants (such as stigma, discrimination, or backlash).
- Set clear group expectations and agreements around safety, respect and confidentiality at the outset of the intervention.
- Where possible, have at least two facilitators present so that one can provide individual support to participants who experience distress or strong emotional reactions during sessions.

For further guidance, see The Global Women's Institute and Trócaire (2023) Supporting Uptake of Survivor-Centred Practice: Building consensus between GBV and MHPSS workers around shared guiding principles and recommendations for progressing practice (page 18)



GBV case management

GBV case management is a structured process for providing coordinated, holistic support to GBV survivors. It involves a designated organisation taking responsibility for ensuring that survivors understand their options, that their needs are identified and addressed in a coordinated way, and that they receive consistent emotional support throughout the process.[171] A core component of case management is safe and ethical handling of case data, including the collection, documentation, storage, and where appropriate, sharing of information.[172]

GBV case management includes focused psychosocial support, which typically aligns with layer three of the MHPSS pyramid (see figure 3). The case management process involves case workers – who are not mental health specialists – assessing survivors' emotional and psychosocial state by exploring how they are feeling, observing signs of distress or behavioural changes, and supporting survivors to identify strengths, protective factors, and opportunities such as education or livelihoods that may contribute to both emotional and practical support.[173]

A central element of the survivor-centred approach is building trust and connection between the survivor and case worker. The ongoing relationship between a GBV case manager and a survivor can provide an important foundation for healing and recovery. In addition to coordinating practical support, case workers may use simple psychosocial tools and techniques, such as relaxation exercises, sharing information about the impact of GBV to help normalise response, and connecting survivors to services they wish to access.[174]

While many survivors will benefit from this non-specialised support, some will require specialised mental health care. GBV case management plays a critical role in helping survivors who wish to access specialised services to identify appropriate options and facilitating referrals.

Despite its importance for survivors' recovery and wellbeing, GBV case management services are increasingly under threat due to funding constraints. A recent global UN Women survey found that 89% of 428 women's rights organisations and civil society organisations reported high or severe reductions in women's and girls' access to essential support services for survivors, including psychological care.[175] In Ukraine, an assessment by UN Women found that more than 60% of organisations addressing VAWG have been forced to reduce or suspend programmes following the US funding suspension in early 2025, leaving many survivors without access to psychosocial and mental health support.[176]

Psychotherapy approaches

Psychotherapy, or 'talk therapy' encompasses a range of behavioral, cognitive, and integrative models delivered individually or in groups. While psychotherapy is widely studied for treating common mental health problems such as depression, anxiety and trauma, relatively few approaches have been specifically tested with GBV survivors, although some show promising evidence of effectiveness.

A systematic review assessed the effectiveness of psychological therapies for women who self-reported any experience of IPV, focusing on outcomes of depression, self-efficacy and harm

NAVIGATE:

Response interventions

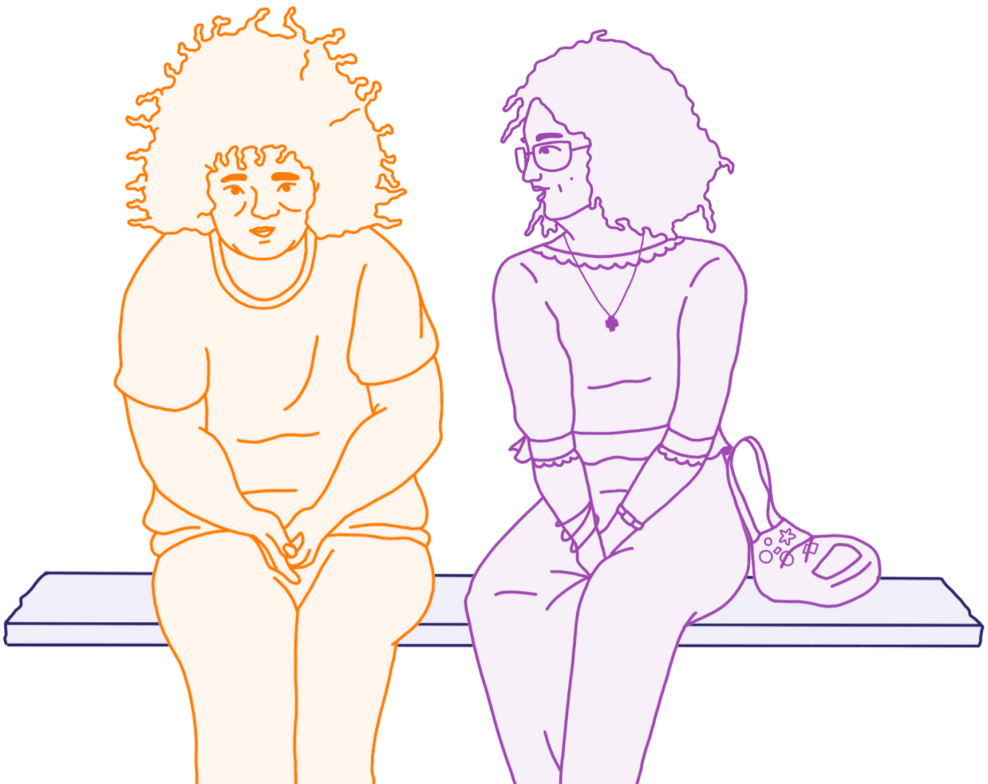
Prevention and risk reduction interventions

Structural and enabling approaches

indicators.[177] The review included 33 trials involving 5,517 women from predominantly HICs as well as several countries in the Global South (Iran, India, Kenya, Nigeria, Pakistan). Results showed that psychological therapies 'probably' reduce depression and anxiety symptoms among women who have experienced IPV. The review found no differences in outcomes based on intervention type, recruitment setting, or provider. However, longer interventions (five or more sessions) demonstrated stronger effects on reducing depression compared to shorter interventions.

Cognitive behavioural therapy (CBT) has been the most widely researched and implemented form of psychotherapy. CBT includes different approaches, including those specifically designed to address trauma.[178] These therapies aim to help individuals develop coping skills by modifying unhelpful thinking patterns, emotional responses, and behaviours in relation to stressful or challenging experiences.[179] Sessions typically take place with a therapist or trained lay provider, alongside homework or practice in between sessions. CBT has strong evidence for treating a range of common mental health problems, including depression and anxiety, as well as for substance use problems.[180]

Current evidence indicates that several CBT-based approaches can effectively treat mental health problems experienced by GBV survivors, including those designed specifically for survivors of sexual violence and abuse. One key informant stressed the need to deliver CBT skills in a way that does not imply survivors are at fault or 'lacking' skills that put them at risk of GBV. Instead, the focus should be on how these skills can support survivors' mental health, wellbeing, and personal goals.



NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

The table presents three CBT-based approaches that are among the most widely implemented and researched with GBV survivors in low-resource and humanitarian settings: **Cognitive Processing Therapy (CPT), Trauma-Focused Cognitive Behavioural Therapy (TF-CBT),** and **Problem Management+ (PM+).**

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

CBT-based approaches implemented with GBV survivors

Cognitive Processing Therapy (CPT)

Overview: Originally developed for survivors of sexual violence with PTSD symptoms, CPT helps trauma survivors challenge negative thoughts such as self-blame and uses cognitive restructuring to develop new perspectives. CPT directly addresses areas particularly relevant for survivors of sexual violence, including power, control, esteem, intimacy, and safety.

Evidence: CPT is supported by strong evidence from both high- and low-income settings. It is effective for treating PTSD[181] and can also reduce depression and anxiety symptoms.[182] CPT has been successfully applied with sexual violence survivors and conflict-affected populations in humanitarian contexts, including the DRC, Iraqi Kurdistan, and southern Iraq.[183]

Implementation: CPT can be delivered by specialists or trained lay providers, though it requires intensive training and supervision. Manuals are available for both individual and group delivery.

Example of approach: An RCT in the DRC evaluated group-based CPT for 157 women compared to 248 women receiving individual support.[184] Psychosocial assistants completed two weeks of training and received weekly supervision. Group-based CPT led to greater reductions in PTSD and depression/anxiety symptoms and improved functioning for women than individual support alone, with benefits maintained at six months. A seven-year follow-up demonstrated partial retention of skills but highlighted the need for long-term support and sustainability.[185] Despite its effectiveness, one consultation participant emphasised that CPT remains resource-intensive due to technical oversight and complexity of training required for effective delivery.

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)

Overview: Originally designed for child survivors of sexual abuse, TF-CBT is now widely used with children and adolescents who have experienced diverse forms of abuse and trauma.[186] The approach often involves non-offending caregivers and combines psychoeducation, relaxation skills, affect regulation, cognitive coping, and trauma processing. TF-CBT aims to reduce self-blame, shame, and cognitive distortions while strengthening coping strategies and resilience.[187]

Evidence: TF-CBT is strongly evidence-based. A 2022 systematic review of 28 RCTs found consistent effects in reducing PTSD symptoms, with additional benefits for depression and anxiety[188], as well as positive parenting skills when caregivers participate.[189] TF-CBT has been successfully implemented in multiple LMICs, including Kenya, Tanzania, Uganda, the DRC and Cambodia.[190] Studies include work with orphans, former child soldiers and other children affected by war, and survivors of sexual violence and exploitation.

Implementation: TF-CBT typically spans 8–25 sessions and can be delivered individually or in group formats. Group-based approaches have been used in some LMIC contexts and may be more feasible in low-resource settings, depending on cultural norms and the type of trauma addressed. A dedicated manual on Implementing TF-CBT for LGBTQ Youth and their Caregivers exists, recognising their elevated risk and cumulative trauma.

Example of approach:

In the DRC, two RCTs of group-based TF-CBT for conflict-affected boys and girls found significant improvements in mental health compared to control groups.[191] Boys showed reductions in PTSD symptoms, psychosocial distress, depression and anxiety, and increased pro-social behaviour.[192] Girls demonstrated reductions in trauma symptoms, depression, anxiety, and conduct problems, with gains in pro-social behaviour,[193] with improvements were sustained at three months follow-up for both groups.

In Cambodia, a pilot study with 12 girls residing in shelters after sexual abuse or trafficking reported reductions in depression (20%), PTSD severity (26%), and shame (44%), alongside improved daily functioning, such as the ability to go to school and form healthy relationships.[194] TF-CBT was feasible for implementation by trained and supervised shelter counsellors.

Problem Management+ (PM+)

Overview: PM+ is part of the WHO's scalable interventions initiative for low-resource and humanitarian settings.[195] WHO's manual on PM+ explains that the intervention draws on elements of CBT but is adapted for implementation in settings where mental health specialists are scarce. It targets adults experiencing adversity and common mental health problems. Sessions focus on problem-solving and behavioural strategies to address both psychological challenges (e.g., stress, fear, hopelessness) and practical challenges (e.g., livelihood concerns or family conflict).[196]

Evidence: PM+ has been evaluated in several LMICs, with evidence indicating reductions in psychological distress, depression and anxiety among adults, including for women with histories of violence.[197] [198]

Implementation: The intervention consists of five individual 90-minute sessions delivered by lay providers after completing eight days of training. Although WHO guidance briefly addresses sexual violence, the model was not developed specifically for GBV survivors. Consultations and research highlight the need for additional adaptations – particularly integrating safety assessments and safety planning – to ensure safe and effective delivery to GBV-affected women.

Example of approach:

An RCT in Nairobi, Kenya with women who had a history of GBV found that those receiving PM+ experienced moderate reductions in psychological distress and post-traumatic stress symptoms at three-month follow-up, compared with women who received enhanced usual care.[199]

In rural Pakistan, an RCT with women affected by adversity (not specifically focused on GBV survivors) demonstrated significant reductions in depression and anxiety symptoms among participating women.[200]

Other psychotherapy approaches with limited evidence of adaptation for GBV survivors

Several other evidence-based psychotherapy approaches are commonly used to address common mental health problems include problem solving therapy, interpersonal psychotherapy (IPT), narrative exposure therapy (NET) and acceptance and commitment therapy (ACT).[201] For example, the Friendship Bench uses problem-solving therapy to help participants address issues affecting mental health. It includes 4-6 individual sessions, six group sessions, and weekly supportive text messages.[202] An RCT found significant

improvements in mental health, including reductions in depression and anxiety.[203] Although GBV is not a focus of the intervention, 70% of participants reported domestic violence at baseline. Published studies do not provide disaggregated results for this group, but the originators note the approach appears particularly helpful for those with IPV histories, as IPV often emerged as a driver of mental health problems in peer-led discussion groups.[204] Digital adaptations of the model, such as the Inuka Coaching Programme in Kenya and Zimbabwe, offer four weekly one-on-one chat sessions, delivered by trained lay health workers, and have shown similar positive mental health outcomes.[205]

While these approaches have been applied with women who have experienced trauma, including in humanitarian contexts, there is limited evidence on their adaptation specifically for GBV survivors or their deliver in survivor-centred, trauma-informed ways. For example, existing NET manuals do not provide guidance for working with GBV survivors[206] and ACT's emphasis on acceptance may inadvertently risk suggesting that survivors should accept situations of abuse, without careful guidance for practitioners.[207]

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

IN FOCUS

Emerging adaptions of Interpersonal Psychotherapy (IPT) for GBV survivors

IPT is a manualised psychotherapy for depression that links interpersonal relationships and mental well-being.[208] While some trials have included women who have experienced GBV, standard manuals seldom address experiences of violence directly or consider how gender inequality shapes intimate relationships.[209] New adaptations are beginning to fill this gap and show promise for integration into GBV prevention programmes.[210]

For example, IPT for Couples (IPT-C) is currently being evaluated in Mozambique to reduce IPV and improve mental health by helping partners resolve disagreements before they escalate into violence.[211] In Uganda, a mental health rights organisation has adapted group-based IPT to include GBV and suicide risk assessments, referral pathways, and structured group discussions. A key informant shared how these groups are helping women share experiences, reduce stigma, and develop strategies to address violence, while normalising conversations about mental health.

IN FOCUS

Use of digital innovations

Evidence on the use of digital tools for mental health care in LMICs is growing but remains limited.[212] A 2020 review found that while digital interventions showed promise, the evidence base was still nascent. Since then, additional studies have emerged, though further research is needed to assess effectiveness, equity, and feasibility of digital tools across different contexts.[213]

Digital treatment programmes have potential to expand access to evidence-based psychological interventions. Modalities such as web-based programmes, smartphone apps, virtual reality tools, and chatbots may reduce barriers to face-to-face care by improving accessibility, flexibility, cost-efficiency, and user autonomy. Meta-analyses indicate that digital interventions, used either as stand-alone or alongside traditional care, can reduce symptoms of depression and anxiety.[214] [215]

Evidence on the use of artificial intelligence (AI) in mental health care, including for GBV survivors, remains at an early stage. Emerging findings suggests that therapy chatbots are generally less effective than human-delivered care and may pose risks for vulnerable users, including triggering emotional distress.[216] This underscores the need for strong clinical, safeguarding, and ethical oversight as such tools continue to develop.

Eye Movement Desensitisation Reprocessing (EMDR) is a structured therapy in which individuals recall a traumatic memory while performing guided eye movements or other forms of bilateral stimulation. This process can reduce the vividness and emotional intensity of distressing memories.[217] EMDR is extensively researched and has demonstrated effectiveness for PTSD, and can also help with anxiety, depression and other distressing experiences.[218] The WHO's violence against women guidelines recommend EMDR as a potential intervention to address mental health problems linked to sexual violence and IPV when delivered by trained health-care professionals with an in-depth understanding of violence against women.[219] However, no rigorous studies have examined the effectiveness of EMDR for GBV-affected groups specifically.[220]

During consultations, an expert highlighted a key limitation in EMDR implementation: providers often lack sufficient training on how to work with GBV survivors: *"There was a lot of enthusiasm for EMDR as a very easy approach to help manage trauma including trauma*

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

for GBV survivors. Yet, all of a sudden, the field was producing all these experts in countries all over the world in EMDR who had no contextual grounding in GBV even though they were working with survivors of GBV."

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

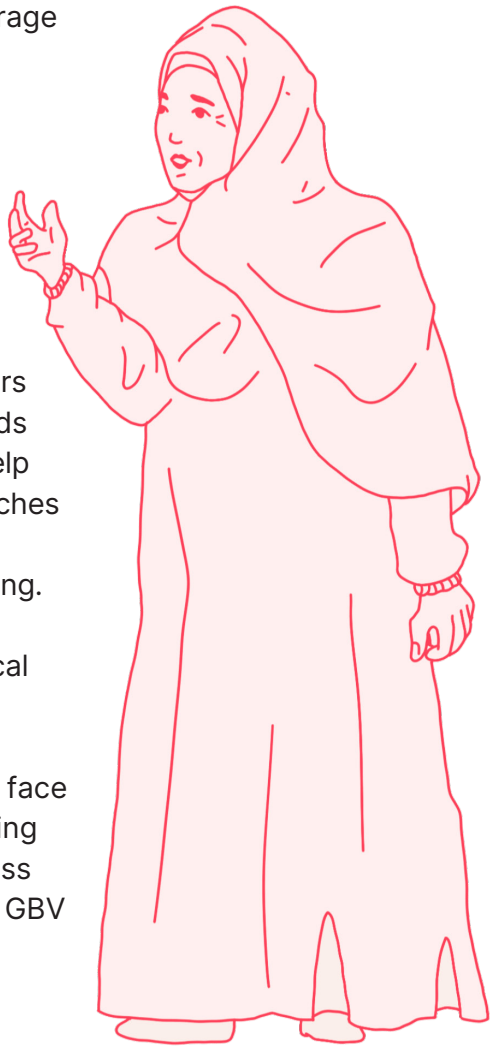
Structural and enabling approaches

EXAMPLE OF APPROACH

EMDR with survivors of sexual violence in Iraq

In Iraq, Free Yezidi Foundation (FYF) provided group and individual psychotherapy, including EMDR, to Yezidi women in the Khanki Internally Displaced Persons (IDP) camp who had experienced sexual violence and displacement.[221] An endline evaluation found that the therapy improved survivors' mental health by reducing trauma-related symptoms and increasing psychological well-being.[222] Clinical measures indicated that participants receiving EMDR experienced greater reductions in trauma symptoms compared with those receiving talk therapy alone. Survivors also reported valuing EMDR for teaching calming and relaxation techniques to manage stress, anxiety, and the physical manifestations of trauma.

Peer-led counselling and social support: Approaches that leverage social networks and strengthen social support are a common strategy for improving mental health, including among GBV survivors.[223] This may involve support from family, friends, or people with shared experiences. Many women and LGBTQI+ survivors are more likely to seek help from peers than from formal services, making peer-led approaches a vital avenue to support survivors within their communities.



The importance of social and community support for GBV survivors is widely recognised. Support from trusted family members, friends and peers can provide safety, comfort, and validation, and can help overcome barriers to accessing formal services. Peer-led approaches were highlighted by multiple consultation participants as a key strategy for supporting GBV survivors' mental health and well-being.

Consultations with LGBTQI+ organisations emphasised the critical role of peer-led approaches in contexts where discrimination or criminalisation of SOGIESC diversity restricts access to mental health services. Even in contexts where LGBTQI+ people do not face criminalisation, negative social attitudes and limited understanding of SOGIESC diversity among service providers can impede access to inclusive care. Key informants emphasised that high levels of GBV and mental health challenges in LGBTQI+ communities make peer-led support especially urgent.

EXAMPLE OF APPROACH

Peer-led and multi-level mental health support for LBT persons

Mitini works to advance the rights and dignity of lesbian, bisexual and trans (LBT) persons in Nepal, many of whom have experienced repeated GBV. During the COVID-19 pandemic, the need for psychosocial support became especially urgent, as some LBT individuals were forced to isolate with unsupportive or abusive family members, while others faced prolonged social isolation. Family reactions to SOGIESC disclosure strongly affect mental health: acceptance can provide protective support, while rejection can contribute to cycles of GBV, livelihood challenges, and mental health problems. Mitini has observed high rates of substance use as a coping mechanism, further exacerbating these challenges. *"They often face GBV by their family members. When they share their identity, some are forced to marry with the opposite sex, some might be forced to leave their home, some might face physical violence within the family. This situation really affects their mental health."*

To address these needs, Mitini developed a mental health project for LBT persons. Early attempts to recruit counsellors revealed a lack of SOGIESC knowledge and awareness of issues facing the LBT community. As a result, Mtini changed their approach and trained LBT community members as peer-counsellors through a six-month programme, equipping them to provide free, psychosocial counselling and to refer clients requiring specialised services to a trusted psychologist. Peer-counsellors offer empathetic, safe support, as LBT individuals often feel more comfortable speaking with someone who shares or understands their experiences.

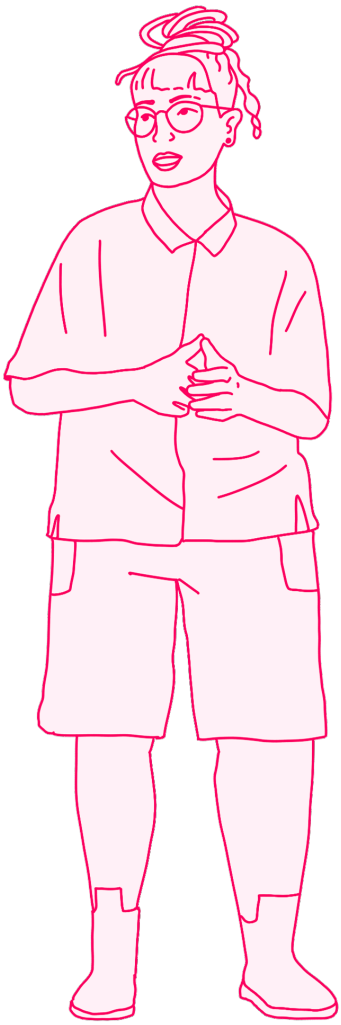
In parallel, Mitini is advocating for policy-level changes to promote more inclusive mental health systems in Nepal for LBT persons, while also working to reduce community-level stigma surrounding common mental health problems. This includes recommending mandatory LGBTQI+ awareness training for all counsellors to ensure safe and appropriate support: *"My concern is always, are the services accessible and friendly to LGBTQI+ people? We need inclusive policies."*

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches



Mindfulness and body-focused approaches

There is growing evidence that mindfulness, yoga and other body-centred approaches can improve the mental health of GBV survivors and reduce trauma-related physical symptoms experienced by some survivors.[224] These approaches adopt a holistic perspective, supporting both mind and body in the recovery process.

Mindfulness-based interventions (MBI): Mindfulness approaches use meditation techniques to cultivate awareness of the present moment, including the breath, bodily sensations, sensory perceptions, cognitions, and emotions, with an attitude of acceptance and non-judgement.[225] Evidence indicates that MBIs can produce small to moderate improvements in symptoms of depression, anxiety, stress and PTSD.[226] [227] Pathways of effect include reductions in self-blame and stigma, improved emotional regulation, and the adoption of new cognitive and behavioral practices, including greater compassion and acceptance towards oneself and others.[228] [229] Although the most rigorous evidence to date on mindfulness and trauma-informed yoga have been conducted with veteran populations[230], evidence specific to GBV survivors is growing.[231] A 2019 systematic review found that MBIs reduced depression and improved post-traumatic stress symptoms among women[232] who had experienced GBV. [233]

Mindfulness approaches have also been paired with art-making and other body-based therapies for survivors of GBV. For example, a pilot study in Iran with 16 women survivors of sexual assault found that eight weeks of combined mindfulness and art-making led to statistically significant reductions in depression, anxiety and shame symptoms compared with a control group.[234] Art activities enhanced engagement, created safe interactive spaces, and improved retention and therapeutic outcomes. A 2023 review of five studies (four in the US and one in Iran) examining MBIs combined with art or body-focused therapies reported improvements in trauma-related cognition[235], emotional regulation, and reductions in depression, anxiety, and shame.[236] All interventions were group-based, in-person and lasted six to ten weeks with weekly or bi-weekly sessions.

EXAMPLE OF APPROACH

Sewing and trauma-informed therapy for survivors

The 'Common Threads' project supports survivors of sexual and gender-based violence through group-based sessions offered over six months with 12-15 women.[237] Participants

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

create personal stories using cloth, alongside trauma therapy, and peer-based social support within a sewing circle.[238] The intervention is delivered by trained, local mental health providers, supporting cultural adaptation and sustainability.

The approach integrates trauma-informed therapy, bodywork, and psycho-education as part of a holistic healing process for GBV survivors. Common Threads has been implemented in multiple contexts, including the US, the DRC, Bosnia-Herzegovina, Nepal and Ecuador. Quantitative data from Nepal and Bosnia-Herzegovina demonstrate positive mental health outcomes, including statistically significant reductions in symptoms of anxiety, depression, and PTSD.[239]

Trauma-informed yoga approaches: Yoga integrates elements of mindfulness, meditation, stress management, and movement, and shows promise for improving mental health by reducing symptoms of anxiety, depression, and PTSD.[240] While much of the existing evidence is of medium- to low-quality, findings are broadly consistent in reporting positive outcomes and highlight yoga as a low-risk, accessible, and low-cost approach.

Studies examining yoga as a complementary approach to treat PTSD suggest that it may reduce symptoms through both physiological and psychological pathways.[241] Controlled breathing, relaxation, meditation, and movement can help reduce hyperactivation of the amygdala in the brain and lower elevated cortisol levels that often accompany PTSD, while mindfulness and emotional regulation practices support psychological recovery.[242] [243]

EXAMPLE OF APPROACH

Yoga for women and girl survivors of human trafficking in Uganda

The *Move with Healing and Resilience after Trauma (HaRT)* yoga programme supports women and girls who have survived human trafficking – and, more recently, other forms of GBV – to recover from physical and emotional trauma and build resilience.[244] Developed in Uganda and later adapted in the Philippines, the programme is delivered through weekly, group-based sessions over 12 weeks, with each session lasting 60–90 minutes.[245] Sessions integrate physical yoga, mindfulness, breathwork, guided visualisations, and group

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

reflection, and are facilitated by a certified yoga instructor trained in trauma, human trafficking, and GBV.[246]

A preliminary assessment with 11 adolescent girls and young women aged 15-20 found reductions in symptoms of PTSD, anxiety and depression, as well as improvements in self-rated emotional and physical health.[247] The assessment indicated that the programme was feasible and acceptable for implementation in a shelter-based setting and that participants valued the group-based format. A randomised controlled trial is underway in Uganda to rigorously assess the programme's impact on survivors' mental health and wellbeing.[248]

A key informant added noted the programme has expanded beyond survivors of trafficking to include young women and girls who have experienced multiple forms of GBV. She highlighted that its strength lies in supporting emotional and physical safety, collective care and peer-to-peer support, and in overcoming barriers such as stigma, cost, and limited access in low-resource settings. Facilitator skills and wellbeing are closely monitored, and reflective sessions help identify emerging issues and reduce the risk of secondary trauma, supporting the programme's overall effectiveness. The approach centres the experiences and resources of survivors, grounded in the premise *"that within our own bodies, we have the resources that we need to heal and recover"*.

Dance and movement therapy: Collective dance, movement, and song have long been part of women's and GBV survivors' healing practices. African feminists and de-colonial approaches to mental health emphasise how these culturally grounded forms of expression can reduce social isolation and stigma, ease emotional distress, and foster social and spiritual connections in culturally familiar ways.[249] Communities have intentionally used collective movement and voice to support trauma recovery and promote resilience. While these approaches remain under-researched, a growing body of evidence suggests that collective dance, singing and other forms of body movement can have positive effects on mental health.[250]

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

IN FOCUS

Addressing stigma and misconceptions about mental health

Consultations highlighted that stigma and misconceptions surrounding common mental health problems are major barriers to help-seeking and undermine the effectiveness of interventions, particularly for survivors of sexual violence in conflict where fear of disclosure is high. One strategy to mitigate stigma is to frame interventions broadly, without explicitly targeting GBV survivors or people with mental health problems. Participants in the consultations emphasised the importance of community-based strategies to challenge stigma, improve mental health literacy, and shift harmful social norms. This can include awareness raising activities, education initiatives, and social norms change initiatives. Approaches should clarify that mental health problems can affect anyone and use locally grounded explanations of mental health and wellbeing.

Stigma has gendered and intersectional dimensions. Men and boys may face barriers to discussing or seeking support for mental health due to norms around masculinity, while women, girls, and LGBTQI+ survivors often experience compounded stigma linked to both experiences of GBV and poor mental health. One key informant in Nepal noted that LGBTQI+ people with disabilities may face multiple, intersecting forms of stigma – such as related to disability, caste, sexual orientation, or involvement in sex work – which further shape experiences of mental health and GBV.

Key informants identified schools, religious groups, and the health sector as critical entry points for addressing stigma and promoting more supportive attitudes, particularly in contexts where service providers themselves may hold harmful misconceptions.

Livelihoods and mental health support for survivors

GBV has wide-ranging social and economic consequences alongside its mental health impacts, including social isolation, stigma and ostracization, which can further contribute to a loss of livelihoods.[251] Survivors may also bear increased financial strain due to medical and legal costs.[252] In response, some organisations, including the African Institute for Integrated Responses to Violence Against Women and HIV/AIDS (AIR), integrate psychosocial and livelihoods approaches, sometimes termed 'livelihoods therapy'[253] to support survivors' economic independence and wellbeing, and counter stigma.

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

The Panzi Hospital in South Kivu, the DRC, embeds this model within its holistic care for survivors of sexual violence.[254] Its socioeconomic pillar provides literacy, numeracy, leadership and other life skills, support for community reintegration, and rebuilding social networks – key contributors to recovery and mental wellbeing.[255]

Consultations with LGBTQI+ organisations highlighted similar challenges: LGBTQI+ individuals who experience violence, family rejection, or threats such as forced marriage often face homelessness, insecure housing, and loss of financial and social support. Informants emphasised that livelihood opportunities are critical for improving mental health and reducing GBV risk among LGBTIQ+ individuals. A key informant from an organisation working with LGBTQI+ people with disabilities described an arts and crafts programme where members produce and sell items made from recycled materials. This model provides both emotional support – *"healing themselves without being labelled as having mental health problems"* – and income generation.

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

EXAMPLE OF APPROACH

Combined mental health and livelihood support for LBTQI+ women

The Women's Health and Equal Rights (WHER) Initiative works to advance the rights and wellbeing of LBQ women in Nigeria through advocacy, education, empowerment, and research. WHER addresses the linkages between GBV and mental health through a multi-pronged approach that combines peer-led psychosocial support, livelihood empowerment, and health systems engagement. A key informant described how documenting GBV – including family violence and so-called 'corrective' rape – revealed that "every case that we have documented always comes with a mental health impact." In response, WHER developed an integrated model that addresses both immediate psychosocial needs and longer-term structural challenges.

Peer-led support is provided by trained LBQ community members who offer psychological first aid and referrals to trusted, SOGIESC-sensitised therapists. This model enables survivors to access support safely, particularly where formal services are experienced as stigmatising or unsafe. In parallel, WHER works with health providers to strengthen the accessibility and inclusivity of general health services.

Mental health support is also embedded within WHER's livelihoods and empowerment programme, which combines mentorship, psychological empowerment, and practical skills development through internships, employment pathways, small business support, and access to seed grants. Participants engage in a mental health component prior to joining livelihood activities, helping them understand common mental health challenges and available support. As the key informant explained: *"Even when we provide mental health support through peer support and therapists, it is not enough – we need to connect it to empowerment and the realities people face after being disowned and violated by their families."*

3.2 Prevention and risk reduction interventions

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

This section reviews evidence on how GBV prevention interventions can improve mental health by interrupting the pathways linking poor mental health with GBV perpetration and victimisation. Most of the available evidence comes from interventions addressing IPV, though some interventions also engage other family members, including parenting interventions to prevent VAC. Few studies have examined whether mental health interventions themselves can reduce GBV perpetration or victimisation. The examples presented here illustrate interventions that have achieved positive outcomes across both mental health and GBV.

Several studies show that GBV prevention interventions can lead to better mental health outcomes, even when they are not explicitly designed to treat common mental health problems. Evaluations from the first What Works to Prevent Violence against Women and Girls programme found that interventions reducing IPV also reduced women's depression.[256] Programmes implemented in Tajikistan (Zindagii Shoista), Ghana (Rural Response Systems), Rwanda (Indashyikirwa), and Zambia (CETA) reported significant declines in IPV alongside improvements in women's mental health.

Couples' interventions

Working with couples to build healthy relationships is a common strategy for reducing IPV, and well-designed interventions have achieved substantial reductions in violence.[257] Effective interventions typically focus on transforming gender relations within couples, delivery by well-trained and supervised facilitators, and use participatory group methods that encourage reflection on gender roles, attitudes, while strengthening communication and conflict resolution skills. This section highlights evidence from two couples' interventions evaluated under the first What Works to Prevent Violence against Women and Girls Programme that are notable for assessing impacts on both IPV and mental health outcomes.[258] Together, these interventions demonstrate how addressing relationship dynamics, gender norms, and economic stressors at the household level can simultaneously reduce IPV and improve mental health.

Couples' interventions evaluated for IPV and mental health impacts

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

EXAMPLE OF APPROACH

Reducing women's experiences of IPV and improving mental health – Indashyikirwa, Rwanda

Indashyikirwa ('agents of change') aimed to reduce IPV, promote more equitable relationships, and strengthen survivor support through four integrated components: a couples' curriculum, community activism, engagement of opinion leaders, and women's safe spaces.[259] The couples' program reached 840 heterosexual couples with a 21-session curriculum delivered over five months, drawing on CBT principles to support couples to recognise how negative thoughts and emotions can trigger harmful behaviors. Community and opinion leader activities targeted harmful social norms, while women's safe spaces provided support for survivors.

An RCT of the couples' curriculum found significant reductions in women's reports of physical and sexual IPV at both 12 and 24 months (55%), alongside reductions in economic abuse and emotional aggression at both time points.[260] Both women and men also reported improvements in mental health, including reduced depression, trauma, and anxiety symptoms. Women's depression declined from 22% at baseline to 14%, with sustained reductions in post-traumatic stress and anxiety symptoms compared to the control group at 24 months.[261]

Developed by CARE Rwanda, Rwanda Men's Resource Centre, and Rwanda Women's Network, Indashyikirwa has since been adapted in the DRC, Kenya, Lebanon, Iraq, South Africa, and Syria.

EXAMPLE OF APPROACH

Combined gender transformative and livelihoods approaches – Zindagii Shoista, Tajikistan

Zindagii Shoista combined income-generating activities with gender-transformative sessions over a 15-month period.[262] The intervention reduced women's experiences of IPV and men's self-reported perpetration, while also improving mental

health outcomes for both partners.[263] Depression scores for both women and men approximately halved between baseline and endline.[264] Families also experienced substantial socio-economic gains: women's income-earning increased four-fold, and food and financial insecurity declined. Qualitative findings suggest that improvements in women's mental health was linked to increased household support, greater autonomy to work, and increased hope for the future.[265]

Group-based curricula for couples that use participatory and gender-transformative approaches are among the most common, evidence-supported strategies for preventing IPV. However, a review by the Prevention Collaborative of more than 50 IPV prevention curricula from the Global South found that few explicitly incorporate strategies to strengthen participants' mental health, highlighting clear opportunities for better integration.[266] To explore these opportunities, interviews with experts developing or evaluating mental health and alcohol reduction interventions identified several promising elements that could be integrated into, or complement, IPV prevention curricula. These include psychoeducation on common mental health challenges and symptoms, building emotional awareness, creating structured opportunities for sharing and connection, and strengthening coping, self-regulation, and stress management skills.

Parenting approaches

Parenting programmes can improve both parent and child mental health, reduce VAC, and help disrupt intergenerational cycles in which childhood exposure to violence increases the risk of IPV in adulthood.[267] These programmes typically use group-based approaches to strengthen parent-child relationships, promote responsive caregiving, and support age-appropriate, positive discipline.[268] In doing so, they can positively impact parental and caregiver mental health, including by reducing parental stress, depression and social isolation.[269] For example, the Sinovuyo Teen intervention in South Africa focused on strengthening caregiver-adolescent relationships through shared activities, praise, emotion management, and conflict resolution. Evaluation findings showed reductions in abuse, substance use, parenting stress, and depression, alongside improvements in parenting practices and social support.[270] Based on an evidence review, the Prevention Collaborative developed a conceptual framework illustrating how parenting programmes can strengthen parental and caregiver mental health (see Figure 4).

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

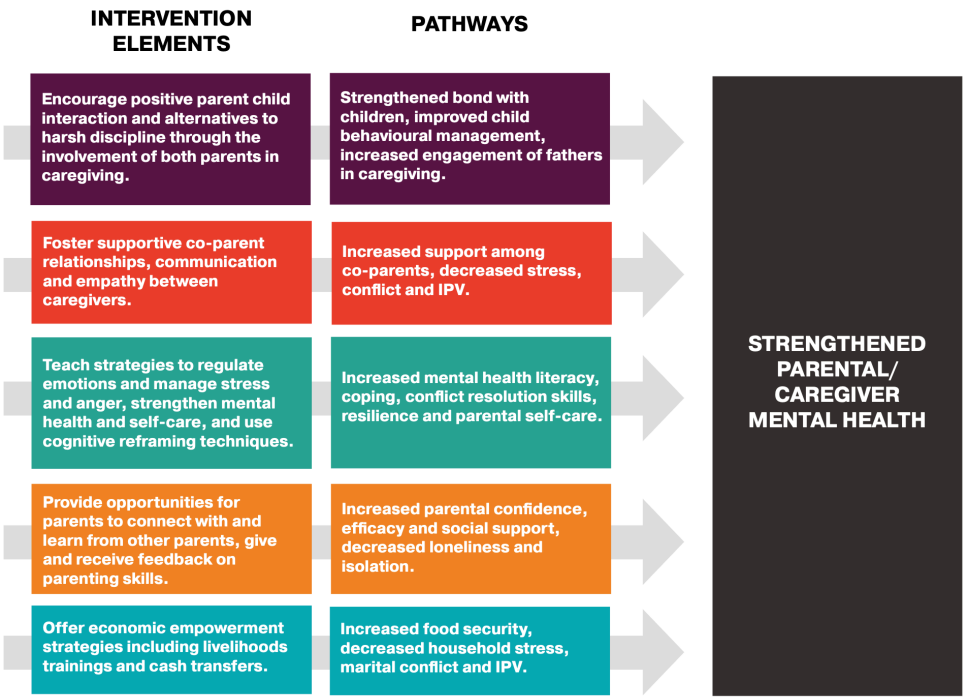


Figure 4: Intervention elements and pathways of how parenting programmes can improve parental and caregiver mental health. Source: The Prevention Collaborative (2025) Improving the mental health of parents and caregivers as a strategy to prevent family violence: what does the evidence suggest?

Parenting programmes evaluated for mental health impacts

EXAMPLE OF APPROACH

Psychosocial and parenting support for war-affected caregivers in Ukraine

Hope Groups was a 10-session psychosocial and parenting support group in Ukraine designed to improve mental health, strengthen positive parenting, and prevent VAC for war-affected Ukrainian caregivers.[271] An evaluation found a 60% reduction in depressive symptoms, over 50% increase in hopefulness, and nearly 80% improvement in self-care among participants.[272] Emotional and physical violence against children fell by 58% and 64%, respectively, alongside better parenting practices, including reinforcing positive behavior and use of non-violent discipline, as well as better child health outcomes. Findings indicate that hybrid and virtual delivery can be effective in conflict settings.

NAVIGATE:

Response interventions

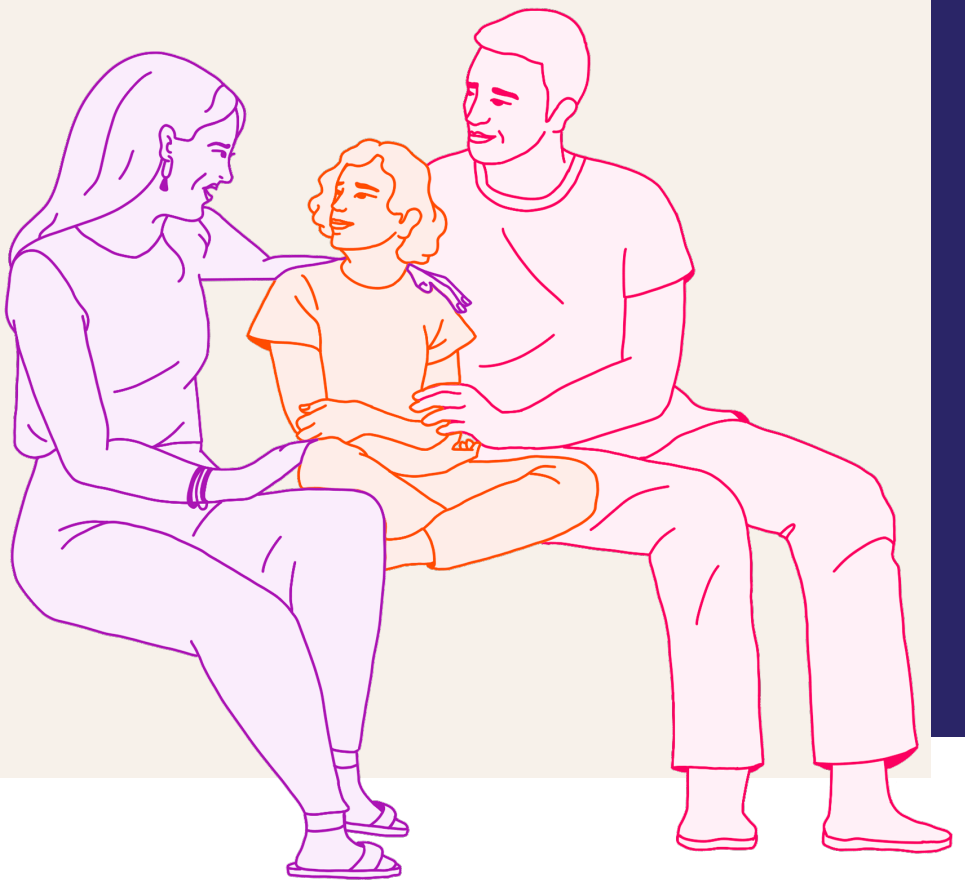
Prevention and risk reduction interventions

Structural and enabling approaches

EXAMPLE OF APPROACH

Couples' and family discussion groups for men and women in the DRC

'Safe at Home' is a family violence prevention program in the DRC delivered over 6-8 months through weekly single-sex discussion groups for men and women in couples, and monthly family sessions including children. The intervention aimed to reduce family violence and improve mental health. In a pilot cluster RCT, women participating in the programme reported significantly lower odds of using physical and/or emotional harsh discipline against their children, compared with women in the control group.[273] The RCT showed significant reductions in in men's perpetration of IPV, with a *non-significant trend* toward reduced harsh discipline of children by men. Mothers' mental distress symptoms decreased significantly, whereas no change was observed among fathers.[274] Researchers suggest that improvements in women's mental health were driven by better relationship quality, psychosocial support, positive parenting, and reduced violence, while these factors appeared to have less impact on men. Further research is needed to address gender-specific challenges, especially related to men's roles as providers and protectors in conflict-affected settings.[275]



NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

Integrated approaches

The following examples illustrate integrated interventions that address GBV and mental health together by targeting shared risk pathways such as trauma exposure, harmful gender norms, alcohol use, and family dynamics. Across diverse contexts, these approaches combine psychosocial support with violence prevention strategies and show promising impacts on both mental health and GBV outcomes.

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

EXAMPLE OF APPROACH

A family-based intervention to support young women in Nepal

MILAP is a family-based intervention designed to reduce IPV and depression among young Nepali women by strengthening communication, enhancing coping skills, and fostering more supportive family relationships.[276] IPV can contribute to depression through social isolation, restricted mobility, reduced self-efficacy and harmful family dynamics and MILAP explicitly targets these pathways.

The intervention is delivered by trained psychosocial counselors and consists of four joint sessions for mothers-in-law and daughter in law focused on gender norms and allyship; four sessions of couples therapy for the woman and her husband; and a final session with all three family members. Two single-arm pilot studies found the intervention to be acceptable, feasible, and effective in reducing IPV as well as symptoms of depression and PTSD among young married women. A community-based RCT is currently under way to further evaluate MILAP's effectiveness.

EXAMPLE OF APPROACH

A group therapy intervention for men who have experienced conflict-related trauma in the DRC

The Living Peace intervention combines psychosocial support, group education, and community outreach to help men cope with conflict-related trauma and promote non-violent, gender-equitable behaviours. First piloted in Eastern DRC in 2012[277], the programme recruited men whose wives had experienced non-partner sexual violence, including couples with and without IPV histories, to reduce stigma and minimise risk of harm.[278] Many men had experienced multiple forms of trauma, such as witnessing sexual violence against family members or being forced to perpetrate it.[279]

The intervention involved 15 weekly group sessions led by trained community facilitators (rather than psychologists), with one session including wives. Sessions focused on sharing experiences, developing coping skills, and practicing take-home exercises. Community outreach activities aimed to reduce stigma toward survivors and rebuild social support systems.

A qualitative evaluation conducted three years later found most women reported IPV had stopped or greatly reduced, and they felt healthier, happier, and more respected within their intimate relationships.[280] Men reported improved emotional regulation and non-violent coping strategies, although some participants with severe trauma continued to require specialised care. Reduced alcohol use was associated with lower levels of IPV and improved family finances, and women reported that children were safer at home.

Subsequent phases of implementation and evaluation (2016–2022) found similar outcomes including reductions in depression, anxiety, and PTSD among men and women, decreased alcohol and drug use, and more gender-equitable attitudes and behaviours. Preliminary RCT findings suggest these impacts – including reduced IPV and VAC – were sustained 1.5 years post-intervention.[281] A key informant who works with Living Peace attributed the programme's success to its focus on the mental health needs of trauma-affected men, and offering men a rare opportunity to share experiences in a safe space and build social capital. Living Peace has been adapted in Lebanon, Cameroon, Sierra Leone, Brazil, and the US.

EXAMPLE OF APPROACH

Addressing mental health, alcohol abuse, and violence among families in Zambia

The Common Elements Treatment Approach (CETA) combines strategies for addressing a range of mental health problems into a single model.[282] Drawing on CBT techniques, CETA supports individuals to manage anxiety, depression, stress, and harmful substance use. In Zambia, CETA targeted families in which women had recently experienced IPV and their partners reported hazardous alcohol use. Participants received 6-12 individual sessions delivered by trained community workers, who selected CBT treatment elements based on each person's needs. The programme also included

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

safety planning for women and support for men to reduce alcohol use, a well-established driver of IPV. An RCT conducted under the first What Works to Prevent VAWG Programme found that women receiving CETA reported a 53% drop in physical IPV and a 56% drop in sexual IPV.[283] Both women and men experienced decreases in depression (reduced by 34% for women and 18% for men) and trauma, while men's hazardous drinking declined by 62%. Follow-up data collected two years later showed that reductions in violence and alcohol use were largely sustained.[284]

Qualitative research identified several pathways underpinning these changes, which included the use of de-escalating strategies (such as stepping away from arguments), improved emotional regulation, and reduced alcohol-related triggers of conflict, including verbal aggression and financial strain.[285] Couples also described greater trust, understanding, and communication, supported by better awareness of their own emotions and reactions as well as their partner's. Although men and women described acting in ways that challenged gender norms, they also described some of the changes from CETA in ways that unintentionally reinforced inequitable gender norms. For instance, women identified 'staying quiet' as a safety strategy that also related expectations of respect or deference to husbands.

CETA Global recently launched EBT-Sim, an AI-powered simulation platform that trains mental health and psychosocial support providers through interactive, avatar-based role plays. The platform enables learners to practice evidence-based skills in realistic scenarios and receive real-time, structured feedback aligned with validated fidelity criteria. Designed to overcome limitations of traditional in-person training and supervision, EBT-Sim supports scalable, consistent, and cost-effective capacity building for frontline and lay providers delivering CETA. While these digital innovations significantly increase the reach and accessibility of training, CETA remains a proprietary model. Implementation typically requires formal partnership with CETA Global to access the full suite of tools and certified supervision, a factor for organisations to consider regarding long-term institutional sustainability and local ownership.

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

3.3 Structural and enabling approaches

NAVIGATE:

Response interventions

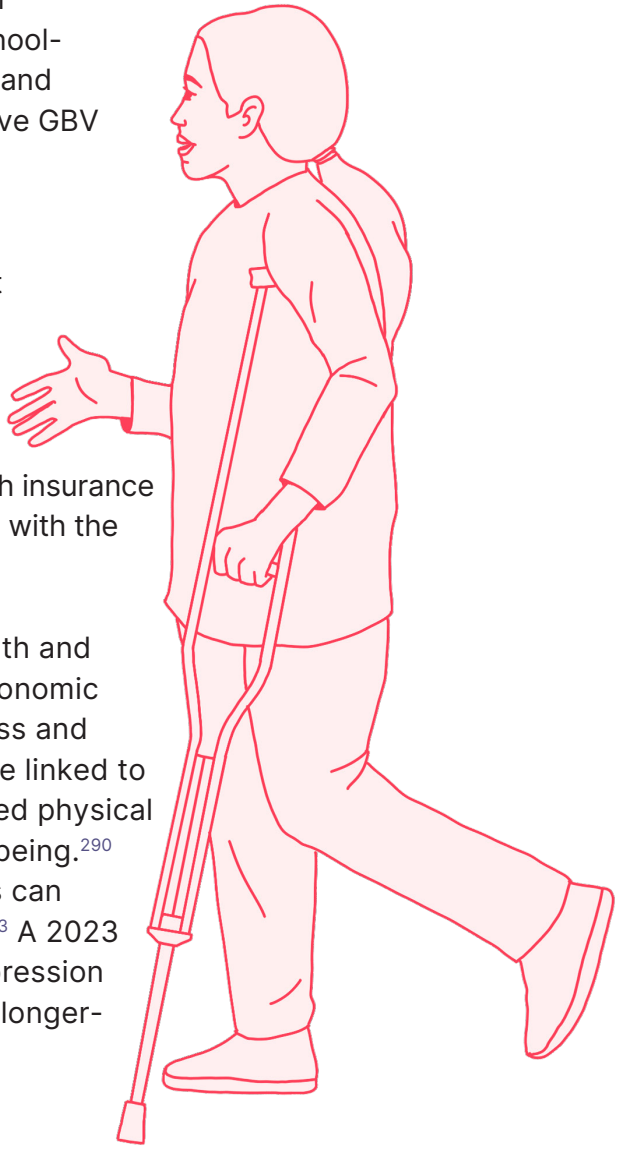
Prevention and risk reduction interventions

Structural and enabling approaches

Feminist researchers and GBV practitioners emphasise the importance of understanding the broader social and political context in which GBV occurs. Survivors often experience multiple traumas, many rooted in systemic gender inequality and socioeconomic disadvantage,[286] which are also key drivers of poor mental health.[287]

Programmes that address these root causes, such as poverty reduction initiatives, can play an important role in improving mental health and preventing GBV. Mainstreaming GBV prevention and mental health considerations into sectoral programmes, such as health, education, and economic empowerment, offers a more holistic and sustainable approach. At the policy level, diplomatic and leadership efforts can play an important enabling role in addressing links between GBV and mental health, as illustrated by the UK's leadership on the Preventing Sexual Violence in Conflict Initiative (PSVI), which has helped advance survivor-centred, trauma-informed principles in international frameworks on sexual violence in conflict settings.

This section synthesises evidence on how economic and social protection interventions can reduce both common mental health problems and GBV. It also examines the role of school-based approaches in addressing GBV and mental health, and the importance of strengthening health systems to improve GBV response and mental health services.



Economic and social security programmes

Economic and social security programmes have significant potential to improve mental health and prevent GBV. A systematic review and meta-analysis found that a range of economic interventions – including conditional and unconditional cash transfers, poverty graduation programmes, asset transfers, housing vouchers, and health insurance – can improve psychological well-being and mental health, with the strongest evidence for unconditional cash transfers.[288]

Cash transfers: Cash transfers can improve mental health and reduce IPV through multiple pathways. By enhancing economic security and emotional well-being, they can reduce stress and harmful coping strategies, such as alcohol use, which are linked to both poor mental health and IPV perpetration.[289] Improved physical health and social inclusion may further strengthen well-being.[290] Evidence from multiple LMICs shows that cash transfers can reduce IPV[291], VAC[292], or both forms of family violence.[293] A 2023 systematic review[294] found short-term reductions in depression and anxiety among recipients[295], with unconditional and longer-

term transfers producing the largest benefits.[296] There is growing evidence that unconditional cash transfers have greater impact for women, including by increasing women's autonomy over how transfers are spent.[297]

Some cash transfer programmes include extra components, known as 'cash+', such as training or in-kind support, which have been found to have even greater effectiveness.[298] They are considered highly promising because the added elements can strengthen the impact of cash transfers and help prevent negative effects on women.[299] In Bangladesh, an RCT found that combining cash transfers with behaviour change communication reduced women's reports of physical IPV after six months, with lasting reductions four years later.[300] In Rwanda, the Sugira Muryango ('Strengthen the Family') programme combined cash transfers with home visits promoting early childhood development and non-violent parenting.[301] An RCT showed a 70% drop in parents' use of harsh discipline and a 51% reduction in IPV among female caregivers.[302] Caregivers also reported fewer symptoms of anxiety and depression.[303] Researchers suggest that integrating parenting support into social protection systems may have boosted participation and commitment.[304]

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

EXAMPLE OF APPROACH

Impacts of a social cash transfer programme mental health and sexual violence, Malawi

The Social Cash Transfer Programme (SCTP) provides unconditional cash support to ultra-poor households that cannot meet basic needs and have no members who are fit to work due to age and/or disability. Families receive about 9,000 Malawian Kwacha (approximately USD 10) monthly, primarily for food, livestock, farming inputs, and school-related costs.[305]

An impact evaluation, a decade after the programme began in 2006, showed benefits beyond food security and household consumption.[306] Adolescents in SCTP households reported better mental health and fewer experiences of sexual violence compared to baseline, with notable reductions in depression among girls.[307] Improved caregiver wellbeing and stronger family support were key factors behind these gains. Caregivers reported 11% less stress and a 22% improvement in perceived quality of life.

Economic strengthening programmes: Economic strengthening interventions include savings groups, microfinance, business development, livestock transfers, and livelihoods trainings. On their own, these interventions show limited evidence for IPV reduction in the short to medium term and can sometimes increase risk. However, growing evidence suggests that combining these with gender-transformative components ('economic plus') is more effective than either approach alone.[308] Economic-plus interventions have been shown to reduce IPV and address related risk factors, such as gender-inequitable attitudes, acceptance of IPV, poor mental health, weak couple communication, and limited financial autonomy. They can also improve women's income, savings, and knowledge of sexual and reproductive health.

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

EXAMPLE OF APPROACH

Combined economic empowerment and gender discussion series – EA$E, Cote d'Ivoire

The IRCs EA$E programme adds a gender discussion series to village savings and loans associations (VSLAs). Couples join sessions on household finances, budgeting, communication, and negotiation, with themes of gender equity and violence woven throughout. From 2010 to 2013, a two-arm RCT in Côte d'Ivoire found that adding EA$E to economic empowerment activities improved gender equity and mental health outcomes.[309] Women who attended over 75% of sessions with their partner reported significantly less physical IPV in the past year. EA$E has since expanded to 18 crisis-affected countries in Africa and the Middle East and is being adapted for displaced populations in the US.[310]

Social security and protection: Compared to cash transfers, there is less evidence on how other social protection programmes – including food or school supply transfers, public work programmes, parental leave to support childcare, unemployment benefits, and insurance for illness or old age – affect mental health and GBV. A 2024 scoping review explored how broader social protection could reduce financial stress, address other GBV drivers and support survivors, including those leaving abusive partners.[311] One example of this is Argentina's Acompañar programme, which combines cash transfers with counselling and help accessing justice and services for women and LGBTQI+ people leaving abusive relationships.[312] Since its launch in 2020, it has reached nearly 200,000 individuals.[313]

Social protection can also include 'domestic violence leave' to enable survivors to arrange housing, childcare, healthcare, and legal support.[314] A systems perspective for research, policy, and programming is essential to link social protection, mental health, and GBV effectively.

School-based approaches

Schools are a critical entry point for promoting mental health and preventing violence among children and adolescents. Whole-school approaches engage multiple stakeholders to address GBV in and around schools in a holistic way.[315] Some interventions have shown positive impacts on both mental health and violence outcomes, including peer violence and children's exposure to violence at home.

For example, two schools-based interventions rigorously evaluated as part of the first What Works to Prevent Violence against Women and Girls programme – in Afghanistan and Pakistan – demonstrated significant reductions in children's depression and peer violence (both victimisation and perpetration), and exposure to domestic violence at home.[316] [317] The intervention in Afghanistan, focused on peace education, also reduced corporal punishment at school and home.[318] Both interventions addressed multiple drivers of violence, including harmful social norms, and engaged schools, families, and communities.

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

EXAMPLE OF APPROACH

A whole-school health promotion intervention in Bihar state, India

SEHER ('dawn' in Hindi) is a multi-component health promotion programme implemented in government secondary schools. It covers hygiene, bullying, mental health, substance use, reproductive and sexual health, gender and violence, rights and responsibilities, and study skills. Activities include a School Health Promotion Committee, role plays and discussions, a letterbox for student concerns, a wall magazine on monthly themes, peer groups, workshops, and individual counselling.[319]

A cluster-randomised RCT compared two delivery models – one by lay counsellors and one by teachers – against a control group receiving the standard government life-skills programme. The lay counsellor model significantly reduced bullying, violence perpetration and victimisation, and depression among students, while improving attitudes towards gender equity and knowledge of reproductive and sexual health.[320] No significant impacts were observed when teachers delivered the programme. At 17 months, effects of the lay counsellor model were even stronger, highlighting the benefits of interventions lasting more than one academic year.[321]

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

Health systems strengthening

Expanding access to mental health care requires strengthened health systems, including policies, budgets, specialised services, and integration into primary care.[323] Yet mental health remains severely underfunded and LMICs face particularly large treatment gaps.[324]

Most interventions in this review are NGO-led trials or projects-based; evidence on system-level approaches integrating GBV and mental health is limited. Literature and consultations highlight the critical role health systems and providers can play, but opportunities are often missed – and some survivors find services harmful or re-traumatising.[325] Providers need a strong understanding of gendered dynamics of violence, its mental health impacts, and intersections with oppression (e.g., racism, homophobia, poverty) to deliver trauma-informed care. While policies often reference these principles, practical guidance and organisational support are lacking. The Lancet Psychiatry Commission on IPV and Mental Health calls for undergraduate and in-service training, supervision, and reflective practice to enable system-level changes in mental health care providers' capacity to respond to GBV.[326]

EXAMPLE OF APPROACH

The Healthy Activity Programme (HAP) for addressing depression in Goa, India

HAP is a brief psychological intervention for adults with moderate to severe depression in under-resourced settings, delivered by trained lay health workers through 6-8 weekly sessions.[327] An RCT with 495 participants found strong reductions in depression severity, suicidal thoughts, and improved functioning, with the largest effects among those with severe depression.[328] Women receiving HAP were 50% less likely to report physical IPV compared to those in enhanced usual care. The reasons for this reduction are unclear, and future research is needed to understand whether changes may have been due to factors such as improved emotional regulation and conflict avoidance (i.e. risk mitigation by women) or due to addressing underlying drivers such as power imbalances and economic stress, particularly when women's partners were involved. HAP is now being scaled up in Madhya Pradesh using a digital platform to train frontline health workers.[329]

Mental health services should include explicit safeguards to prevent and respond to GBV within their own systems, including violence, coercion, neglect, and sexual exploitation or abuse by staff or other

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches

WHO estimates that countries spend only 2% of health budgets on mental health, with most going to psychiatric hospitals rather than psychosocial care.[322]

patients. Mitigating these risks requires system-level action, such as clear safeguarding policies, zero-tolerance protocols, staff training, and safe, confidential complaints mechanisms. Patriarchal norms within health systems also need to be addressed.[330] While emerging evidence suggests training can improve providers' knowledge and attitudes toward IPV,[331] more research is needed to determine whether this translates into better care and survivor experiences.

Access to mental health services is often hindered by stigma, discrimination, cost, and logistical barriers, particularly for marginalised groups in LMICs.[332] Promising strategies highlighted by literature and in the consultations include integrating mental health into primary and community care, training lay workers, and supporting grassroots, user-led alternatives. Delivering mental health interventions through lay providers requires robust training, mentoring, and system integration for sustainability, though evidence on system-level implementation in LMICs remains limited.

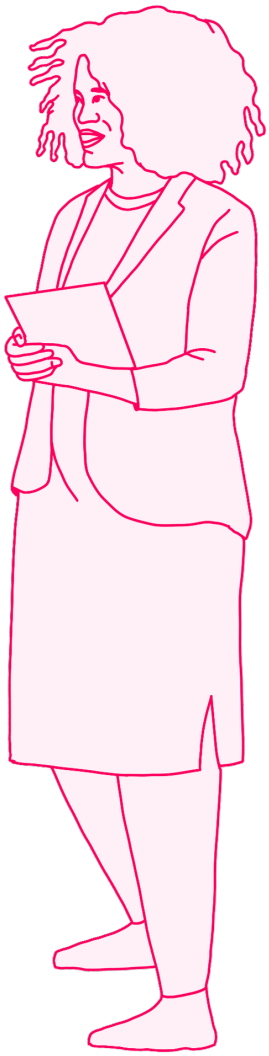
One key informant emphasised the importance of mental health providers screening for IPV, as failing to do so risks undermining care by overlooking a major contributor to common mental health problems among GBV survivors. The Lancet Psychiatry Commission recommends routinely asking all mental health service users – especially women and LGBTQI+ people – about experiences of violence during assessments.[333] To respond effectively, mental health professionals require training in trauma-informed, survivor-centred care, ongoing professional development, and strong referral networks.[334]

NAVIGATE:

Response interventions

Prevention and risk reduction interventions

Structural and enabling approaches



EXAMPLE OF APPROACH

Strengthening mental health integration in perinatal care, South Africa

A qualitative study in Cape Town evaluated a programme delivered by antenatal nurses and lay health workers to promote awareness, detect, refer, and treat perinatal women with common mental health problems and experiences of IPV.[335] The programme significantly increased screening for common mental health problems and IPV, as well as referrals for counselling. Women who received counselling reported feeling better able to cope with their situation, and health education talks were well received by both providers and pregnant women, helping shift attitudes towards seeking mental health support. The study also highlighted common implementation challenges. Nurses struggled to complete screening and referral paperwork within busy schedules, and

NEXT PAGE

CONTINUATION

some women were reluctant to disclose sensitive information to staff who appeared rushed or disengaged. Home-based counselling by community health workers was not always feasible or acceptable.

NAVIGATE:

Response interventions

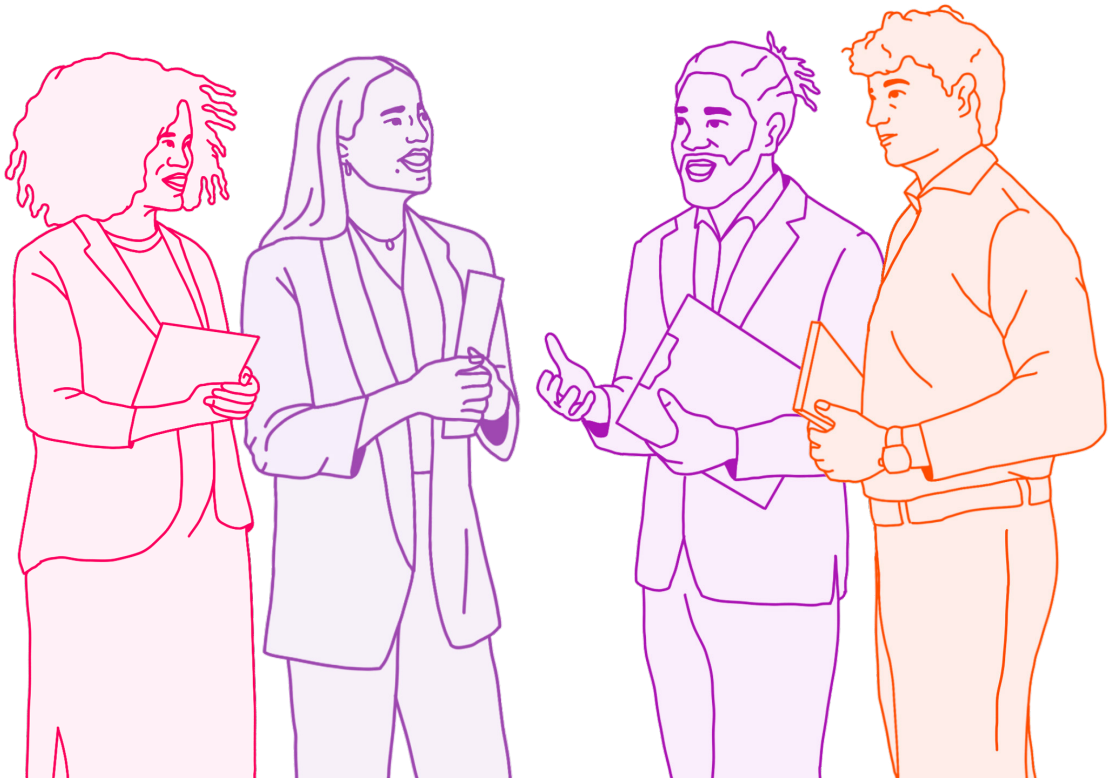
Prevention and risk reduction interventions

Structural and enabling approaches

One-stop centres offer a potential platform for integrating GBV and mental health services within health systems. Many countries in the Global South have adopted these centres to provide accessible, multisectoral care for GBV survivors, but implementation challenges are common. A systematic review of one-stop centres in LMICs identified barriers such as insufficient multisectoral staff, inadequate private spaces, and fragmented services with unclear partner responsibilities.[336]

In Nepal, a cross-sectional study found that health facilities without one-stop crisis management centres (OCMCs) were far less prepared to identify and manage GBV survivors or make referrals compared to facilities with OCMCs.[337] Even where OCMCs were available, gaps in mental health knowledge and capacity persisted, underscoring the need to strengthen public health facilities and train providers in trauma-informed care and psychosocial support.

Both literature and participants in the consultation emphasise the critical importance of engaging survivors and service users in the development of services and systems-strengthening approaches.[338] Meaningful engagement should follow trauma-informed principles, promote diverse perspectives, and value the expertise of people with lived experience, in line with guidance from representative organisations and networks.[339]



4. Recommendations

The following recommendations draw on insights from the evidence review, as well as practice-based knowledge and reflections shared during consultations. The recommendations are grouped into four areas: 1) cross-cutting that apply to **all actors** seeking to address GBV and mental health linkages; 2) **donors and governments**, 3) **GBV and mental health practitioners**, and 4) **researchers** studying GBV, mental health, or their intersections.

ALL ACTORS

All actors

1. **Support locally grounded approaches to mental health.** Begin with culturally specific understandings of mental health, including psychosocial dimensions. Collaborate with local actors and activists leading these efforts and avoid imposing external frameworks that may not align with local contexts.

2. **Strengthen cross-sector collaboration and link research with practice.** Address common silos between GBV and mental health actors; mental health professionals and wider health sector and social services; and researchers and practitioners. Create opportunities for cross-learning and joint action, ensuring meaningful participation of mental health service user associations and GBV survivor networks.

3. **Use approaches that demystify and destigmatise GBV and mental health.** Address stigma at multiple levels:

    - **Within interventions,** use inclusive framing and recruitment strategies that reduce barriers to participation, avoid stigmatising participants and make support more accessible and inclusive.

    - **At community and structural levels,** challenge misconceptions about mental health, address GBV victim-blaming attitudes through gender-transformative approaches, and support accountability for perpetrators. Potential entry points include school-based programming, edutainment programmes, community health and wellbeing interventions.

4. **Engage women, girls, and gender-diverse people with lived experience as experts.** Allocate budget for their time and expertise, involve them from the earliest planning stages, ensure ongoing engagement (not one-off consultations), and provide clear mechanisms for feedback and accountability.

5. **Prioritise mental health and collective care for all staff and activists.** Allocate resources for self-care and collective care to reduce risks of vicarious trauma and

ALL ACTORS

burnout, supporting long-term effectiveness and resilience in these critical roles. Donors should include dedicated budget lines, and organisations should embed these practices in workplace culture.

6. Equip all service providers, programme implementers, and researchers to make safe referrals. Train GBV and mental health actors to make survivor-centred referrals across sectors. Maintain updated service mappings and referral pathways that are accessible and inclusive, developed with input from constituency-led organisations.

DONORS AND GOVERNMENTS

Donors and Governments

7. **Invest in multi-sectoral, comprehensive approaches.** Address both the root causes and impacts of GBV and common mental health problems through coordinated action, using a twin-track approach:

   - Targeted investment in interventions focused specifically on GBV and mental health.
   - Mainstreaming mental health and GBV considerations into broader programmes, including economic empowerment, livelihoods, education, and justice/legal initiatives. Multiple entry points can help disrupt various pathways between mental health problems and GBV, such as preventing VAC and interrupting intergenerational cycles of violence.

8. **Fund research alongside programming on GBV and mental health.** Allocate dedicated resources for evidence generation evidence on what works, for whom, and under what conditions. This should include:

   - Capturing practice-based knowledge from frontline actors.
   - Research on culturally relevant adaptation and quality implementation.
   - Guidance for ethical and effective scaling of interventions proven feasible and relevant in specific contexts.

9. **Strengthen national mental health infrastructure.** Mental health services remain under-resourced, especially in LMICs. While community-based approaches and lay providers are valuable when adequately trained and supported, governments should also:

   - Integrate mental health services into primary care.
   - Build specialised mental health workforces.
   - Equip health workers to provide survivor-centred, trauma-informed responses

and coordinate with GBV services (e.g., through one-stop centres where available).

10. **Provide long-term support to local WROs, CSOs, and survivor-led groups.** These organisations play a critical role in GBV prevention and response, including delivering mental health and psychosocial support. Long-term, flexible funding is essential to develop contextually grounded and evidence-informed interventions. This includes supporting formative research, adaptation, meaningful survivor engagement, and establishment of monitoring and evaluation systems.

11. **Support a twin-track approach for reaching structurally marginalised groups.**

    - Inclusive mainstream services that equip providers to work with survivors in all their diversity.

    - Targeted interventions to address the immediate needs of groups at heightened risk of GBV and mental health problems, ensuring physical and psychological safety.

    - Constituency-led organisations (e.g., LGBTQI+ CSOs and organisations of persons with disabilities) should be actively engaged across both tracks, compensating their expertise and supporting their core activities to strengthen other actors' capacities.

12. **Leverage policy and diplomatic influence to advance trauma-informed, survivor-centred systems.**

    - Use convening power to elevate the mental health impacts of GBV and promote trauma-informed, survivor-centred approaches.

    - Reduce stigma and shift norms by publicly recognising the mental health consequences of GBV, supporting survivor-led advocacy, and promoting language that avoids victim-blaming and discrimination, particularly for marginalised groups.

    - Embed GBV–mental health linkages in policy dialogue and diplomacy, including UN and multilateral fora, peace and security processes, humanitarian coordination, and global health and education agendas.

Mental Health and GBV Practitioners

13. **Increase attention to GBV-mental health linkages in programmes.** Recognise the strong interconnection between GBV and mental health across the prevention–response continuum, and the role both sectors can play in addressing these linkages. Practical steps include:

    - Embedding mental health considerations in GBV programmes and GBV considerations in mental health programmes.
    - Cross-training professionals from both sectors to strengthen capacity for integrated work.
    - Identifying entry points for coordination, such as referral pathways and joint intervention design.
    - Engaging constituency-led CSOs, survivor-led and service-user groups to ensure interventions centre lived experience and expertise.

14. **Adopt survivor-centred, trauma-informed approaches.** Equip service providers to deliver safe, confidential, and non-discriminatory support that minimises harm and risk of re-traumatisation. Leverage existing resources, such as guidance developed by the Global Women's Institute, George Washington University, and Trócaire[340], to inform practice.

15. **Tailor responses to individual needs and healing journeys.** Recognise that healing is non-linear and highly individual. Strengthen assessment methods to understand each person's stage in their healing journey, and tailor intervention type, intensity, and duration accordingly – whether through in-house services or coordinated referrals.

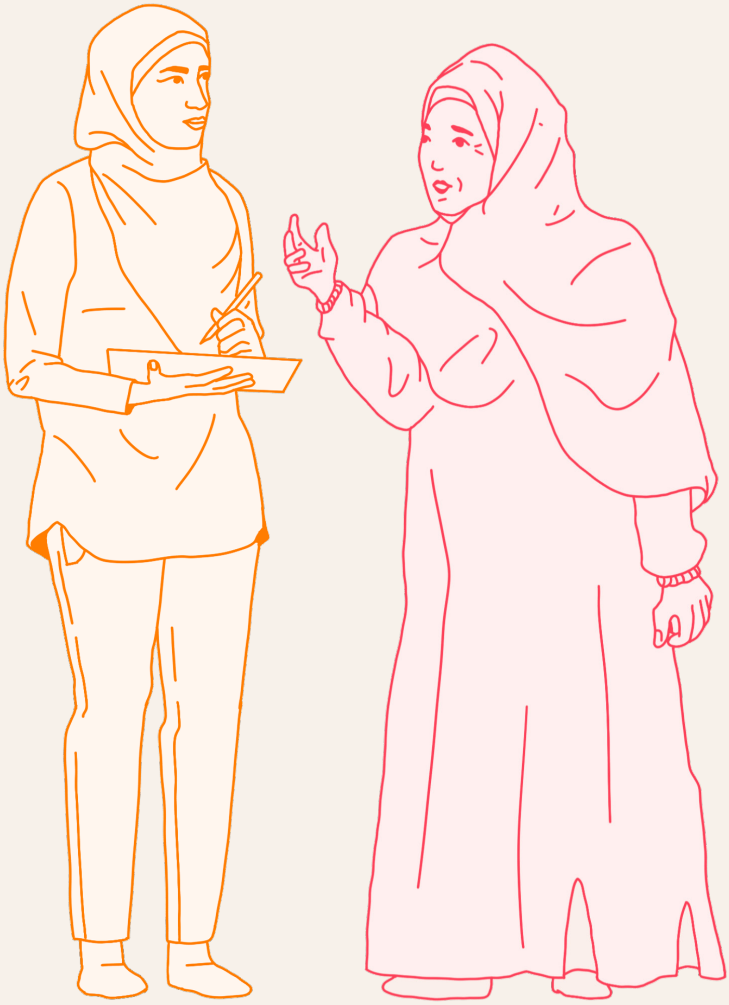
16. **Prioritise implementation science and adaptive practice.** Systematically document and refine the processes of adapting and scaling GBV and mental health interventions, particularly when transferring approaches across contexts. Engage local experts and leverage practice-based knowledge to identify what drives success or creates barriers.

17. **Strengthen long-term M&E and risk monitoring.** Implement robust monitoring systems to track progress, accessibility, unintended outcomes, and potential harms. Sustain M&E over time to identify participation barriers, detect any adverse impacts, and enhance accountability.

Mental health practitioners

18. **Strengthen trauma-informed capacity across non-specialist providers.** Assume that GBV survivors may be present in any mental health intervention or service, whether or not they disclose. Equip staff with basic trauma-informed, survivor-centred skills, including training on the GBV Pocket Guide for psychological first aid (PFA)[341] and referral processes.[342]

19. **Integrate safe and appropriate GBV screening in mental health services.** Establish clear procedures for identifying GBV as a potential driver of mental health symptoms. Recognise that treatment is unlikely to be effective without understanding and addressing this underlying issue.



20. **Adapt mental health interventions to the psychosocial and safety needs of GBV survivors.** Ensure interventions reflect survivors' lived experiences – such as shame, guilt, and stigma – which may strongly influence mental health and wellbeing but are not always captured by standard classifications. Apply a gendered lens and involve GBV specialists in adaptation processes to align with GBV guiding principles, incorporating safety and risk-mitigation protocols (e.g. addressing suicide/self-harm risk,[343] risks in group-based formats, and potential stigma or backlash). GBV specialists can also provide guidance on gender transformative programming.

21. **Expand the safe use of lay workers.** Where appropriate, employ trained and well-supported lay providers to increase access to mental health support in low-resource setting. Ensure thorough training, strong supervision, and sustained support throughout implementation.

GBV practitioners

22. **Increase mental health awareness and literacy across all GBV staff.** Ensure teams understand the common mental health and psychosocial impacts of GBV and recognise how stigma, myths, and personal beliefs about mental health can influence survivor-centred, non-discriminatory practice.

MENTAL HEALTH AND GBV PRACTITIONERS

23. **Strengthen MHPSS capacity within GBV services, WROs, and constituency-led CSOs.** Assess existing capacity to deliver core MHPSS components within GBV case management and reinforce skills through targeted training, mentoring, and accompaniment approaches.

24. **Promote shared principles across GBV and MHPSS actors.** Ensure the consistent application of trauma-informed, survivor-centred care across all services and partnerships.

25. **Continue using and strengthening peer-support, community support, and safe spaces.** Prioritise approaches that foster social connectedness and provide safe environments for individual and collective healing – longstanding pillars in many GBV services, WROs and constituency-led CSOs.

26. **Build evidence on body–mind approaches.** While interventions such as trauma-informed yoga and other body–mind practices show growing promise, the evidence base is still limited compared with interventions like psychotherapy. GBV practitioners and service providers, with their direct insights into survivors' needs and preferences, are well positioned to pilot, document, and evaluate these approaches.

RESEARCHERS

Researchers

27. **Address evidence gaps on the mental health and psychosocial impacts of diverse forms of GBV.** Expand research beyond IPV and NPSV to examine how different types, severities, and co-occurring forms of GBV affect mental health and psychosocial wellbeing. Move beyond diagnostic outcomes (e.g. depression, anxiety, PTSD) to include survivor-prioritised psychosocial dimensions – such as shame, self-blame, stigma, functioning, quality of life, and agency – to better reflect survivors' healing needs and inform relevant interventions.

28. **Strengthen research on how common mental health problems can be a risk factor for GBV perpetration or victimisation.** Evidence is limited on how poor mental health contributes to GBV perpetration or victimisation, particularly among men and boys. More longitudinal research is needed to understand pathways linking common mental health problems with GBV perpetration and victimisation and identify potential entry points to disrupt these pathways through multi-sectoral interventions.

29. **Examine how programmes address social determinants of mental health and their intersections with GBV.** Collect and analyse data on GBV, mental health, and psychosocial outcomes within broader sectoral programmes (e.g., economic empowerment, social protection, education). Ensure ethical protocols, robust safety measures, and referral pathways are in place, particularly when working with marginalised populations.

RESEARCHERS

30. **Advance intervention science to improve adaptation, dosing, and tailoring of interventions.** Research is needed on how best to adapt and implement interventions addressing GBV and mental health intersections. This includes understanding digital approaches, optimal intervention dosing, intensity, and frequency, and how best to tailor interventions to diverse mental health needs and GBV risk factors. Strengthening this evidence base is critical for informing cost-effective, scalable, integrated, and contextually appropriate programmes.

Across these research priorities, ensure the following approaches:

31. **Engage survivors, service-user groups, and practitioners to ensure culturally relevant and actionable research.** Co-develop research measures and approaches with survivor-led and constituency-led organisations as well as mental health practitioners, to ensure concepts and tools are locally meaningful. Adapt standardised measures for cultural appropriateness, pilot changes, and document adaptations. Solutions could include using mixed-methods designs to pair standardised tools with context-specific qualitative insights to capture broader psychosocial impacts. Engage practitioners throughout the research process to support translation of evidence into feasible, contextually grounded interventions.

32. **Disaggregate data and apply intersectional analysis.** Disaggregate data by gender, age, and disability – and other identity factors where relevant and safe to do so– to understand how different groups experience the intersection of GBV and poor mental health, and how these factors influence recruitment, engagement and retention in mental health and GBV interventions. Prioritise intersectional approaches that illuminate how structural inequalities shape risk, impacts, and access to care for women in all their diversity and LGBTQI+ people. Ensure meaningful involvement of representative organisations to uphold do-no-harm principles and align research priorities with community needs.

Annexes

Methodology

This report is based on two specially commissioned desk-based evidence reviews, produced by the Ending Violence Against Women and Children Helpdesk. The first evidence review focused on the relationship between GBV and mental health with focus on mental health impacts of experiencing GBV, and evidence on common mental health problems as a risk factor for both experiencing and perpetrating GBV. The second evidence review identified what approaches have been used to address the linkages between mental health and GBV along the prevention to response continuum. The evidence reviews focused on identifying global evidence through primarily reviewing systematic and meta-reviews. However, recognising the 'global' evidence base is often skewed towards studies from high-income countries (HICs), the reviews made deliberate efforts to identify evidence and programme examples from LMICs.

The methodology for the reviews involved a literature review using searches on Google and relevant electronic databases. This review looked exclusively at reports and research produced in English. There may be evidence that is produced in other languages, which this review has not identified.

Search terms for the first evidence review included: violence against women, violence against women and girls, VAWG, gender-based violence, GBV, violence against LGBTQI+ persons, violence against LBTQ women, SOGIESC based violence, homophobic violence, transphobic violence, intimate partner violence, IPV, IPV exposure, child marriage, forced marriage, human trafficking, sexual harassment, sexual assault, non-partner sexual violence, rape, sexual violence in conflict, conflict-related sexual violence, corrective rape, conversion practices, FGM/C, school-related gender-based violence, online GBV/ VAWG, technology-facilitated GBV, TFGBV, violence against children, VAC, intergenerational cycles of violence, AND mental health outcomes, mental health impacts, mental health consequences, adverse mental health, poor mental health, depression, anxiety, anxiety disorders, post-traumatic stress disorder, PTSD, complex trauma, psychological impacts, psychosocial impacts, distress, self-harm, suicidality, suicidal ideation, substance abuse, eating disorders, sleep disorders, panic attacks, dissociation, minority stress, internalised homophobia AND evidence, systematic review, meta review, meta analysis, review, research, study, data AND global, low and middle-income countries (LMICs), development settings, humanitarian settings, conflict settings, Global South.

Search terms for the second evidence review included: violence against women, violence against women and girls, VAWG, gender-based violence, GBV, violence against LGBTQI+ persons, violence against LBTQ women, SOGIESC based violence, homophobic violence, transphobic violence, intimate partner violence, IPV, IPV exposure, child marriage, forced marriage, human trafficking, sexual harassment, sexual assault, non-partner sexual violence, rape, sexual violence in conflict, conflict-related sexual violence, corrective rape, conversion practices, FGM/C, school-related gender-based violence, online GBV/ VAWG, technology-facilitated GBV, TFGBV, violence against children, VAC, intergenerational cycles of violence

AND mental health outcomes, mental health impacts, mental health consequences, adverse mental health, poor mental health, depression, anxiety, anxiety disorders, post-traumatic stress disorder, PTSD, complex trauma, psychological impacts, psychosocial impacts, distress, self-harm, suicidality, suicidal ideation, substance abuse, eating disorders, sleep disorders, panic attacks, dissociation, minority stress, internalised homophobia AND evidence, systematic review, meta review, review, research, study, data AND interventions; programming; approaches; evaluations; assessments; RCTs; impact; effectiveness; AND global, low and middle-income countries (LMICs), development settings, humanitarian settings, conflict settings, Global South.

The insights in this report are also based on consultations with GBV and mental health researchers and practitioners, and representatives from mental health service-user associations and organisations working for structurally marginalised groups who are disproportionately impacted by GBV and common mental health problems. The consultations aimed to nuance the global evidence-base through exploring key debates, innovative practice, and evidence gaps with a diverse group of stakeholders who brought their unique perspectives and knowledge to the discussions. This included those with contextualised and practice-based knowledge from working at the intersection of GBV and mental health in a range of settings. The participants were spread across the Democratic Republic of Congo (DRC), Ethiopia, Nepal, Pakistan, Uganda, Ireland, Australia, Egypt, South Africa, Nigeria and the US. The consultations have particularly helped shape the recommendations of this report and identified innovative examples of approaches that are less documented in the global evidence base.

The consultations included remote interviews with 22 people working in women's rights organisations (WROs), mental health non-governmental organisations (NGOs), mental health service-user associations, LGBTQI+ civil society organisations (CSOs), international NGOs (INGOs), UN agencies, and universities. In addition, two in-person roundtables were held to gain further insight into the relationship between GBV and mental health, and what actors do to address this relationship, in Nepal and Uganda. In addition to the types of stakeholders listed above, the roundtable in Nepal (20 participants) also engaged government officials working in the health sector. The roundtable in Uganda (14 participants) did not engage government officials due to the hostile situation for LGBTQI+ people in the country. While this report includes focus on how LGBTQI+ people are impacted by GBV and common mental health problems, this was not explored in the consultations in Uganda.

Endnotes

1 WHO (2025) Violence against Children, Factsheet, 29 November 2022

2 USAID (2022) 2022 U.S. Strategy to Prevent and Respond to Gender-based Violence Globally [accessed 22.11.25]

3 Rhys, O., Barnaby, B., Roe, S., & Wlasny, M. (2019). The economic and social costs of domestic abuse. Home Office.

4 USAID (2024) USAID Mental Health Position Paper [accessed 22.11.25]

5 UNHCR (2021-2024) Mental Health and Psychosocial Support (MHPSS)

6 USAID (2022) How to Integrate Mental Health and Psychosocial Interventions in Gender-Based Violence Programs in Low-Resource Settings (USAID Collective Action to Reduce GBV - CARE GBV)

7 See e.g. UN Women (2020) Bridging the Gap: Sexual Exploitation, Abuse and Harassment (SEAH) for discussion on definitions of concepts.

8 The World Health Organisation (2022) Sexual Violence. Violence Info [accessed 23.11.24]

9 See Ahlenback, V. et al., (2023) Technology-facilitated Gender-based Violence: Preliminary Landscape Analysis

10 Hubbard, L. (2020) Online Hate Crime Report 2020

11 USAID (2022) How to Integrate Mental Health and Psychosocial Interventions in Gender-Based Violence Programs in Low-Resource Settings (USAID Collective Action to Reduce GBV - CARE GBV)

12 Luisa, F., et al. (2026). Disease burden attributable to intimate partner violence against females and sexual violence against children in 204 countries and territories, 1990-2023: a systematic analysis for the Global Burden of Diseases Study 2023. The Lancet. 407: 10523: 31-52.

13 World Health Organisation (2025) Violence against women prevalence estimates, 2023

14 World Health Organisation (2025) Violence against women prevalence estimates, 2023

15 World Health Organisation (2025) Violence against women prevalence estimates, 2023

16 WHO (2022) Mental disorders

17 World Health Organisation (2022) World mental health report: transforming mental health for all

18 WHO (2022) Mental disorders

19 "Half of World's Population Will Experience a Mental Health Disorder: Large-scale Study Based on Surveys in 29 Nations Sheds New Light on Major Health Problem," Harvard Medical School and Queensland Brain Institute, July 31 2023

20 USAID (2024) USAID Mental Health Position Paper [accessed 22.11.25]

21 Moitra M, Owens S, Hailemariam M, Wilson KS, Mensa-Kwao A, Gonese G, Kamamia CK, White B, Young DM, Collins PY. (2023) Global Mental Health: Where We Are and Where We Are Going. Curr Psychiatry Rep. 25(7):301-311.

22 WHO (2022) Mental Health in Emergencies, Factsheet [accessed 21.22.24]

23 WHO (2022) Mental Health in Emergencies, Factsheet [accessed 21.22.24]

24 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

25 Vigod, S. and Rochon, P. A. (2020) The impact of gender discrimination on a Woman's Mental Health, EClinicalMedicine 20(2020) and Hosang, G. M. and Bhui, K. (2018) Gender discrimination, victimisation and women's mental health, BJPsych (2018), 213

26 GBD 2019 Mental Disorders Collaborators (2022) Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019, The Lancet Volume 9, Issue 2

27 Ouriaghli, I. S. et al. (2019) Improving Mental Health Service Utilization Among Men: A Systematic Review and Synthesis of Behavior Change Techniques Within Interventions Targeting Help-Seeking, Am J Men's Health, 2019, Jun 11;13(3)

28 Chaplin, T. M. (2008) Gender Differences in Response to Emotional Stress: An Assessment Across Subjective, Behavioral, and Physiological Domains and Relations to Alcohol Craving, Alcohol Clin Exp Res, Author manuscript; available in PMC: 2008 Oct 29

29 Levtov, R. (2024) Addressing harmful alcohol use to reduce intimate partner violence and violence against children in the home. Prevention Collaborative

30 Devakumar D, Palfreyman A, Uthayakumar-Cumarasamy A, et al. (2021). Mental health of women and children experiencing family violence in conflict settings: a mixed methods systematic review. Confl Health. 2021 Oct 15;15(1):74 Conflict and Health 2021; 15(1): 74

31 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

32 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524

33 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

34 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524

35 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524

36 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

37 See for example Ramsoomar, L. et al. (2019) Associations between Alcohol, Poor Mental Health and Intimate Partner Violence, What Works to prevent Violence Programme

38 Bourey, C., Murray, S., Tol, W., Bass, J., Ba, A., and Mahenge, B. Integrating mental health care to reduce intimate partner violence in complex humanitarian emergencies. The Lancet 2025 13(8): E1484-1488.

39 See e.g. Horn, J (2020) Decolonising emotional well-being and mental health in development: African feminist innovations, Gender & development, 28:1

40 Horn, J (2020) Decolonising emotional well-being and mental health in development: African feminist innovations, Gender & development, 28:1

41 African Institute for Integrated Responses to Violence Against Women and Girls & HIV and AIDS and Stephen Lewis Foundation (2022) Towards a Transformative, Feminist Approach to Trauma in Africa: Perspectives from Practice

42 African Institute for Integrated Responses to Violence Against Women and Girls & HIV and AIDS and Stephen Lewis Foundation (2022) Towards a Transformative, Feminist Approach to Trauma in Africa: Perspectives from Practice

43 See Gibbs, A., Dunkle, K. and Jewkes, R. (2018) Emotional and economic intimate partner violence as key drivers of depression and suicidal ideation: A cross-sectional study among young women in informal settlements in South Africa, PLoS One, 2018, Apr 16;13(4):e0194885.

44 Equimundo. (2024) The Manosphere, Rewired: Understanding Masculinities Online and Pathways for Healthy Connection.

45 African Institute for Integrated Responses to Violence Against Women and Girls & HIV and AIDS and Stephen Lewis Foundation (2022) Towards a Transformative, Feminist Approach to Trauma in Africa: Perspectives from Practice, p. 41

46 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524

47 See for example MacGregor, K. et al (2019) A systematic review of short and medium-term mental health outcomes in young people following sexual assault, Journal of Child & Adolescent Mental Health, 31:3

48 Stockman, D. et al. (2023) An ecological approach to understanding the impact of sexual violence: a systematic meta-review, Front. Psychol., 24 May 2023 Sec. Forensic and Legal Psychology, Volume 14 – 2023

49 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

50 The analysis looked at 46 low-, middle- and high-income countries across 201 studies. Most studies were concentrated in the United States.

51 White, S. J et al. (2024) Global Prevalence and Mental Health Outcomes of Intimate Partner Violence Among Women: A Systematic Review and Meta-Analysis. Trauma, Violence, & Abuse, 25(1), 494-511

52 Ramsoomar, L. et al. (2023) Pooled analysis of the association between mental health and violence against women: evidence from five settings in the Global South, BMJ Open 2023;13:e063730

53 The study used baseline data from five GBV prevention studies in four countries. These were: South Africa, Ghana, Rwanda and the occupied Palestinian territories (West Bank and Gaza).

54 Gibbs, A., Dunkle, K. and Jewkes, R. (2018) Emotional and economic intimate partner violence as key drivers of depression and suicidal ideation: A cross-sectional study among young women in informal settlements in South Africa, PLoS One, 2018, Apr 16;13(4):e0194885.

55 See Murphy, M. et al (2019) What Works to Prevent Violence Against Women and Girls in Conflict and Humanitarian Crisis: Synthesis brief, What Works to Prevent Violence

56 See for example figure from South Sudan in Ellsberg, M. (2020) No safe place: Prevalence and correlates of violence against conflict-affected women and girls in South Sudan, PLoS One. 2020; 15(10): e0237965

57 Hossain, M. et al. (2021) Gender-based violence and its association with mental health among Somali women in a Kenyan refugee camp: a latent class analysis, J Epidemiol Community Health 2021;75:327-334

58 Casebolt T, Hardiman M. (2024). Experiences of gender based violence and help seeking trends among women with disabilities: an analysis of the demographic and health surveys. Health Sociol Rev.33(2):125-143. doi: 10.1080/14461242.2024.2350502. Epub 2024 Jun 4.

59 Riley A, Daruwalla N, Kanougiya S, Gupta A, Wickenden M, Osrin D. Intimate partner violence against women with disability and associated mental health concerns: a cross-sectional survey in Mumbai, India. BMJ Open. 2022 Apr 27;12(4):e056475

60 Spotlight Initiative (no year) Understanding the linkages between violence against women and violence against children

61 Spotlight Initiative (no year) Understanding the linkages between violence against women and violence against children

62 The systematic review included 18 studies from 7 countries: 9 from the U.S, two from South Korea, and one study each from the UK, Canada, Ireland, Australia, France, and Pakistan.

63 Doroudchi, A. et al. (2023) Psychological complications of the children exposed to domestic violence: a systematic review, Egypt J Forensic Sci. 2023 May 26;13(1)

64 Kieselbacha, B. et al. (2021) Prevalence of childhood exposure to intimate partner violence and associations with mental distress in Cambodia, Malawi and Nigeria: A cross-sectional study, Child Abuse Negl. 2021 January; 111: 104807

65 The Kessler K6 mental health scale was applied, which includes measures to assess depression and anxiety.

66 Machisa, M., Jewkes, R., Shamu, S., Mahlangu, P., and Chirwa, E. (2025). Exposure To Family Violence and Low Parental Connectedness Associated with Depressive Symptoms, Substance Use and Violence Outcomes Among Adolescents In South Africa. Journal of Family Violence.

67 Stockman, D. et al. (2023) An ecological approach to understanding the impact of sexual violence: a systematic meta-review, Front. Psychol., 24 May 2023 Sec. Forensic and Legal Psychology, Volume 14 – 2023

68 Dworkin, E. R. (2020) Risk for mental disorders associated with sexual assault: A meta-analysis, Trauma Violence Abuse, 2020 December; 21(5)

69 The systematic meta review, from 2023, included 92 systematic reviews or meta-analysis, which in turn represented 1,154 primary studies.

70 Stockman, D. et al. (2023) An ecological approach to understanding the impact of sexual violence: a systematic meta-review, Front. Psychol., 24 May 2023 Sec. Forensic and Legal Psychology, Volume 14 – 2023

71 Cleveland Clinic (2025) Hypomania definition: Hypomania is a condition where one displays revved up energy or activity level, mood or behavior. Hypomania is a less severe form of mania, and both are commonly part of bipolar disorder.

72 Among the 10 studies that were included in the review, four studies were conducted in North America, three in Europe, and three in Sub-Saharan Africa.

73 MacGregor, K. et al (2019) A systematic review of short and medium-term mental health outcomes in young people following sexual assault, Journal of Child & Adolescent Mental Health, 31:3

74 Girls made up 100% of the sample in half of the studies, while in the other half, girls made up 73% to 95% of the samples.

75 See Rubini, E. et al. (2023) Negative consequences of conflict-related sexual violence on survivors: a systematic review of qualitative evidence, International Journal for Equity in Health (2023) 22:227

76 Rubini, E. et al. (2023) Negative consequences of conflict-related sexual violence on survivors: a systematic review of qualitative evidence, International Journal for Equity in Health (2023) 22:227

77 Rubini, E. et al. (2023) Negative consequences of conflict-related sexual violence on survivors: a systematic review of qualitative evidence, International Journal for Equity in Health (2023) 22:227

78 Population Council (2024) Violence Against Children and Youth in Humanitarian Settings: Findings from a 2022 Survey of all Refugee Settlements in Uganda

79 UNFPA (2022) sets out the following definitions of child, early and forced marriage: "Child marriage and early marriage largely refer to the same thing: marriages in which one or both spouses are under 18 years old. However, early marriage is also sometimes used to describe marriages in which one or both spouses are 18 or older, but with a compromised ability to grant consent. For example, the marriage of a 19-year-old who is not physically or emotionally mature, or who does not have sufficient information about her choices, would be considered an early marriage. Forced marriage is a marriage in which one or both spouses do not give full and free consent, regardless of age. Forced marriage can also refer to a union in which one or both spouses are unable to end or leave the marriage." UNFPA (2022) Child marriage – frequently asked question

80 Plan International (no year) Child, early and forced marriage

81 Burgess, R. A. (2022) Overlooked and unaddressed: A narrative review of mental health consequences of child marriages, PLOS Glob Public Health 2(1): e0000131

82 See Baba, H., Yendork, J. and Atindanbila, S. (2020) Exploring married girls' subjective experiences of well-being and challenges. J Adolesc. 2020;79:193–207. pmid:31981841; and Al-Kloub M. I. et al. (2019) Young women's experience of adolescent marriage and motherhood in Jordan. Cult Heal Sex. 2019;21(4):462–77. pmid:30355056

83 See for example Aggarwal. S. et al. (2023) Child marriage and the mental health of adolescent girls: a longitudinal cohort study from Uttar Pradesh and Bihar, India, The Lancet Regional Health - Southeast Asia 2023;8: 100102, and Gage A.J. (2013) Association of child marriage with suicidal thoughts and attempts among adolescent girls in Ethiopia, J Adolesc Heal. 2013; 52(5), in Burgess, R. A. (2022) Overlooked and unaddressed: A narrative review of mental health consequences of child marriages, PLOS Glob Public Health 2(1): e0000131

84 Gage A.J. (2013) Association of child marriage with suicidal thoughts and attempts among adolescent girls in Ethiopia, J Adolesc Heal. 2013; 52(5), in Burgess, R. A. (2022) Overlooked and unaddressed: A narrative review of mental health consequences of child marriages, PLOS Glob Public Health 2(1): e0000131

85 See Ahlenback, V. et al (2023) Technology-facilitated Gender-based Violence: Preliminary Landscape Analysis

86 Plan International (2020) Free to be online? Girls' and young women's experiences of online harassment Surrey, UK: Plan International.

87 United Kingdom, United States, Denmark, Germany, and New Zealand.

88 Schmidt, F. et al (2023) The Mental Health and Social Implications of Nonconsensual Sharing of Intimate Images on Youth: A Systematic Review, TRAUMA, VIOLENCE, & ABUSE 1–15

89 Denmark, Italy, New Zealand, Poland, Spain, Sweden, the UK and USA.

90 Amnesty International (2017). 'Amnesty reveals alarming impact of online abuse against women,' Press Release, 20 November 2017

91 Stevens, F..Nurse, J. R. C., and Budi, A. (2020) Cyber Stalking, Cyber Harassment and Adult Mental Health: A Systematic Review. Cyberpsychology, Behavior, and Social Networking, 2021 Jun; 24(6)

92 Koch, L., Riva, M., and Steinbert, J. (2025). Technology-Facilitated Gender-Based Violence Against Politically Active Women: A Systematic Review of Psychological and Political Consequences and Women's Coping Behaviors. Trauma Violence and Abuse, 2025.

93 See UNESCO (2024) Safe learning environments: Preventing and addressing violence in and around schools

94 Polanin, J. R., Espelage, D. and Grotpeter, J. K. (2020) The Consequences of School Violence: A Systematic Review and Meta-Analysis, the U.S. Department of Justice.

95 Ye, Z. et al. (2023) Meta-analysis of the relationship between bullying and depressive symptoms in children and adolescents, BMC Psychiatry 2023; 23: 215

96 Moore, E. S. et al (2017) Consequences of bullying victimization in childhood and adolescence: a systematic review and meta-analysis, World J Psychiatry, 2017 Mar 22; 7(1)

97 Ranganathan, M. et al. (2021) Measurement and prevalence of sexual harassment in low- and middle-income countries: a systematic review and meta-analysis, BMJ Open, 11(6), e047473

98 Hardt, S. et al. (2023) Sexual Harassment in Low- and Middle-Income Countries: A Qualitative Systematic Review, Trauma Violence Abuse, 2023 Dec; 24(5)

99 Talboys, S. L. et al. (2017) What Is Eve Teasing? A Mixed Methods Study of Sexual Harassment of Young Women in the Rural Indian Context, SAGE Open, Volume 7, Issue 1

100 DIVA (2019) Unjust, Unequal, Unstoppable: Fiji Lesbians, Bisexual Women, Transmen and Gender Non-Conforming People Tipping the Scales Toward Justice

101 FRA (2020) A long way to go for LGBTI equality, European Union Agency for Fundamental Rights

102 Botswana, eSwatini, Ethiopia, Kenya, Lesotho, Malawi, South Africa, Zambia and Zimbabwe

103 The study measured three signs of PTSD: (1) flashbacks, nightmares or reliving of the traumatic incident, (2) avoidance behavior and (3) feelings of jumpiness/ irritability/ restlessness. These were based on the diagnostic criteria for PTSD in the DSM-V.

104 Müller, A., Daskilewicz, K., Kabwe, M. L., Mmolai-Chalmers, A., Morroni, C., Muparamoto, N., Muula, A. S., Odira, V. Zimba, M. and the Southern and Eastern African Research Collective for Health (SEARCH) (2021) Experience of and factors associated with violence against sexual and gender minorities in nine African countries: a cross-sectional study, BMC Public Health (2021) 21:357

105 Muller, A., and Hughes, T. L. (2016) Making the invisible visible: a systematic review of sexual minority women's health in Southern Africa, BMC Public Health (2016) 16:307

106 The survey was conducted with 3,798 individuals in Botswana, eSwatini, Ethiopia, Kenya, Lesotho, Malawi, South Africa, Zambia and Zimbabwe.

107 Müller, A., Daskilewicz, K., Kabwe, M. L., Mmolai-Chalmers, A., Morroni, C., Muparamoto, N., Muula, A. S., Odira, V. Zimba, M. and the Southern and Eastern African Research Collective for Health (SEARCH) (2021) Experience of and factors associated with violence against sexual and gender minorities in nine African countries: a cross-sectional study, BMC Public Health (2021) 21:357

108 RoCK (2019) "I married a man to satisfy my parents" Family Violence towards Lesbian, Bisexual and Transgender (LBT) People in Cambodia

109 For an overview of the evidence base on TFGBV against LGBTQI+ persons, see Ahlenback, V. (2022) Ending Violence Against LGBTQI+ People: Global evidence and emerging insights into what works

110 Hubbard, L. (2020) Online Hate Crime Report 2020

111 United Nations Free & Equal (2023) LGBTQI+ youth: Bullying and violence at school

112 For a summary of this evidence base, see Özdere, M. (2023) School Violence Against LGBT-Q: A Review Study, ISPEC International Journal of Social Sciences & Humanities, 2023, Volume 7, Issue 2

113 The review was global but a majority of studies came from the U.S (77), followed by studies from the UK (7) and China (4).

114 While the review did not focus only on school-based victimisation, the authors noted that a large proportion of the studies included in the review had taken place in school settings.

115 Williams,. Et al. (2021) A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide, PLOS ONE 16(1): e0245268

116 TUC (2019) Sexual harassment of LGBT people in the workplace

117 Flores, A. and Conron, K. J. (2021) LGBT People's Experiences of Workplace Discrimination and Harassment, UCLA Williams Institute

118 See Ahlenback, V. (2022) Ending Violence Against LGBTQI+ People: Global evidence and emerging insights into what works

119 The survey included 489 participants across 80 countries.

120 Bishop, A. (2019) Harmful treatment: The Global Reach of So-Called Conversion Therapy, Outright International

121 Jones. T., Power, J. and Jones, T. M. (2022) Religious trauma and moral injury from LGBTQA+ conversion practices, Social Science and Medicine, Volume 305, July 2022

122 Doan-Minh, S. (2019) Corrective Rape: An Extreme Manifestation of Discrimination and the State 's Complicity in Sexual Violence, Hasting Women's Law Journal, Volume 30, Number 1, Winter 2019

123 Human Rights Watch (2011) "We'll Show You You're a Woman" Violence and discrimination against Black Lesbians and Transgender Men in South Africa

124 United Nations Independent Expert on protection against violence and discrimination based on Sexual orientation and Gender Identity – IESOGI (2020) Report on Conversion Therapy

125 CAL & GALCK (2016) Research on The Lived

Experiences of Lesbian, Bisexual and Queer Women in Kenya

126 FARUG (2019) The lived realities of lesbian, bisexual and queer (LBQ) women in Uganda

127 Hughes, T. et al. (2023) Trauma, mental health, and health care experiences of lesbian and bisexual women in Rwanda, Psychology of Sexual Orientation and Gender Diversity, 10(1)

128 Ramsoomar, L. et al. (2023) Pooled analysis of the association between mental health and violence against women: evidence from five settings in the Global South, BMJ Open 2023;13:e063730

129 Gibbs, A. et al. (2020) New learnings on drivers of men's physical and/or sexual violence against their female partners, and women's experiences of this, and the implications for prevention interventions, Global Health Action, 13:1, 1739845

130 Gibbs, A. et al. (2020) New learnings on drivers of men's physical and/or sexual violence against their female partners, and women's experiences of this, and the implications for prevention interventions, Global Health Action, 13:1, 1739845

131 Kirkbride, J. B. et al. (2024) The social determinants of mental health and disorder: evidence, prevention and recommendations, Word Psychiatry, 2024 Jan 12;23(1)

132 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

133 See for example Ramsoomar, L. et al. (2019) Associations between Alcohol, Poor Mental Health and Intimate Partner Violence, What Works to prevent Violence Programme

134 These were in South Africa, Ghana, Rwanda, and the Occupied Palestinian territories (the West bank and Gaza).

135 The study consisted of standardised population-based household surveys with a multistage representative sample of men aged 18–49 years in nine sites in Bangladesh, China, Cambodia, Indonesia, Sri Lanka, and Papua New Guinea.

136 Fulu, E. et al. (2013) Prevalence of and factors associated with male perpetration of intimate partner violence: findings from the un multi-country cross-sectional study on men and violence in Asia and the Pacific, Lancet Global Health, Volume 1; Issue 4, October 2013

137 Ramsoomar, L. et al. (2023) Pooled analysis of the association between mental health and violence against women: evidence from five settings in the Global South, BMJ Open 2023;13:e063730

138 Schmidt, F. et al (2023) The Mental Health and Social Implications of Nonconsensual Sharing of Intimate Images on Youth: A Systematic Review, TRAUMA, VIOLENCE, & ABUSE 1–15

139 Bitar Z, Elias MB, Malaeb D, Hallit S, Obeid S. (2023) Is cyberbullying perpetration associated with anxiety, depression and suicidal ideation among lebanese adolescents? Results from a cross-sectional study. BMC Psychol. 11(1):53. Is cyberbullying perpetration associated with anxiety, depression and suicidal ideation among lebanese adolescents? Results from a cross-sectional study - PMC

140 See Polanin, J. R., Espelage, D. and Grotpeter, J. K. (2020) The Consequences of School Violence: A Systematic Review and Meta-Analysis, the U.S. Department of Justice and Ye, Z. et al. (2023) Meta-analysis of the relationship between bullying and depressive symptoms in children and adolescents, BMC Psychiatry 2023; 23: 215

141 See Ramsoomar, L. et al. (2023) Pooled analysis of the association between mental health and violence against women: evidence from five settings in the Global South, BMJ Open 2023;13:e063730

142 Ramsoomar, L. et al. (2019) Associations between Alcohol, Poor Mental Health and Intimate Partner Violence, What Works to prevent Violence Programme

143 Promundo and Sonke Gender Justice (2018) Breaking the Cycle of Intergenerational Violence: The Promise of Psychosocial Interventions to Address Children's Exposure to Violence. Washington, DC: Promundo-US and Cape Town: Sonke Gender Justice

144 Widom, C. S. et al. (2007) A Prospective Investigation of Major Depressive Disorder and Comorbidity in Abused and Neglected Children Grown Up, Arch Gen Psychiatry. 2007;64(1)

145 The study consisted of standardised population-based household surveys with a multistage representative sample of men aged 18–49 years in nine sites in Bangladesh, China, Cambodia, Indonesia, Sri Lanka, and Papua New Guinea.

146 Fulu, E. et al. (2013) Prevalence of and factors associated with male perpetration of intimate partner violence: findings from the un multi-country cross-sectional study on men and violence in Asia and the Pacific, Lancet Global Health, Volume 1; Issue 4, October 2013

147 Machisa, M. T, Christofides, N. and Jewkes, R. (2016) Structural Pathways between Child Abuse, Poor Mental Health Outcomes and Male-Perpetrated Intimate Partner Violence (IPV), PLoS One, 2016, Mar 17;11(3): e0150986

148 Promundo and Sonke Gender Justice (2018) Breaking the Cycle of Intergenerational Violence: The Promise of Psychosocial Interventions to Address Children's Exposure to Violence. Washington, DC: Promundo-US and Cape Town: Sonke Gender Justice

149 Stern, E. (2025). Improving mental health of parents and caregivers as a strategy to prevent family violence: What does the evidence suggest? The Prevention Collaborative

150 David, V. B. (2021) Associations between Parental Mental Health and Child Maltreatment: The Importance of Family Characteristics, Social Sciences; Basel Vol 10, iss. 6

151 Murphy, D. A. et al. (2011) Anxiety/Stress among Mothers Living with HIV: Effects on Parenting Skills & Child Outcomes, AIDS Care. Author manuscript; available in PMC: 2011 Dec 1, and Marcal, K. E. (2021) Pathways to adolescent emotional and behavioral problems: An examination of maternal depression and harsh parenting. Child Abuse & Neglect 113: 104917.

152 England, M. J. and Sim, L. J. (2009) Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention, Chapter 4: Associations Between Depression in Parents and Parenting, Child Health, and Child Psychological Functioning. England MJ. National Academies Press, USA, and Barrett, S. et al. (2024) Interventions to Reduce Parental Substance Use, Domestic Violence and Mental Health Problems, and Their Impacts Upon Children's Well-Being: A Systematic Review of Reviews and Evidence Mapping. Trauma Violence Abuse, 25(1)

153 Cohen L. R. et al. (2008) The impact of cumulative maternal trauma and diagnosis on parenting behaviour. Child Maltreat 13(1)

154 Gibbs, A. et al. (2020) New learnings on drivers of men's physical and/or sexual violence against their female partners, and women's experiences of this, and the implications for prevention interventions, Global Health Action, 13:1, 1739845

155 Ibid.

156 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

157 Khalifeh, H. et al. (2016) Recent physical and sexual violence against adults with severe mental illness: a systematic review and meta-analysis, Int Rev Psychiatry. 2016 Oct;28(5):433-451

158 Khalifeh, H. et al. (2015) Domestic and sexual violence against patients with severe mental illness, Psychological Medicine, 45(4), 875-886

159 'Severe mental illness' was defined as either having a psychotic disorder, measured using a validated diagnostic instrument or from clinical records; or being under the care of secondary mental health services.

160 Khalifeh, H. et al. (2016) Recent physical and sexual violence against adults with severe mental illness: a systematic review and meta-analysis, Int Rev Psychiatry. 2016 Oct;28(5):433-451

161 Watson, J., Maylea, C., Roberts, R., Hill, N., and McCullum, S. (2020) Preventing gender-based violence in mental health inpatient units, ANROWS Research Report.

162 Sexual Risk Behaviours and Sexual Abuse in Persons with Severe Mental Illness in Uganda: A Qualitative Study Patric Lundberg, Eva Johansson, Elialilia Okello , Peter Allebeck , Anna Thorson, PLoS ONE, Lundberg P, Johansson E, Okello E, Allebeck P, Thorson A (2012) Sexual Risk Behaviours and Sexual Abuse in Persons with Severe Mental Illness in Uganda: A Qualitative Study. PLoS ONE 7(1): e29748. doi:10.1371/journal.pone.0029748

163 Bourey, C., Murray, S., Tol, W., Bass, J., Ba, A., and Mahenge, B. Integrating mental health care to reduce intimate partner violence in complex humanitarian emergencies. The Lancet 2025 13(8): E1484-1488.

164 Lakin, D. P., García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

165 Purgato, M. et al (2018) Psychological Therapies for the Treatment of Mental Disorders in Low- and Middle- Income Countries Affected by Humanitarian Crises, Cochrane Database of Systematic Reviews 2018 (7)

166 Koutra, K. (2022) Trauma Recovery Rubric: A Mixed-Method Analysis of Trauma Recovery Pathways in Four Countries, International Journal of Environmental research and Public Health, Volume 19, Issue 16

167 Koutra, K. (2022) Trauma Recovery Rubric: A Mixed-Method Analysis of Trauma Recovery Pathways in Four Countries, International Journal of Environmental research and Public Health, Volume 19, Issue 16

168 UNHCR (2025) Mental Health and Psychosocial Support (MHPSS)

169 UNFPA (2019) The Inter-agency Minimum Standards for Gender-Based Violence in Emergencies Programming

[170] The Global Women's Institute and Trócaire (2023) Supporting Uptake of Survivor-Centred Practice: Building consensus between GBV and MHPSS workers around shared guiding principles and recommendations for progressing practice

[171] GBV IMS Steering Committee (2017) Interagency Gender-based Violence Case Management Guidelines (1st Ed.)

[172] O'Connor, M. (2019) Key Guidelines, Standards and Tools on GBV Case Management, GBV AoR Helpdesk

[173] GBV IMS Steering Committee (2017) Interagency Gender-based Violence Case Management Guidelines (1st Ed.)

[174] UNFPA (2019) The Inter-agency Minimum Standards for Gender-Based Violence in Emergencies Programming

[175] UN Women and Ladysmith. (2025). At risk and underfunded: How funding cuts are threatening efforts to end violence against women and girls.

[176] UN Women (2025) Impact of United States funding suspension on Ukrainian women's organizations (Rapid assessment). UN Women.

[177] Hameed M. et al. (2020) Psychological therapies for women who experience intimate partner violence. Cochrane Database of Systematic Reviews 2020, Issue 7.

[178] Lakin, D. P., García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

[179] American Psychological Association (2024) What is Cognitive Behavioral Therapy?

[180] American Psychological Association (2024) What is Cognitive Behavioral Therapy?

[181] See for example Asmundson, G. J. G (2019) A meta-analytic review of cognitive processing therapy for adults with posttraumatic stress disorder, Cogn Behav Ther, 2019 Jan;48(1):1-14

[182] Cunradi, C. and García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

[183] Lakin, D. P., García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

[184] Bass, J. et al (2013) Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence, New England Journal of Medicine 368 (23): 2182–91

[185] Lakin, D. P. et al. (2022) The end of a trial: Perspectives on cognitive processing therapy from community-based providers in the Democratic Republic of Congo, J Trauma Stress. 2022 Feb;35(1):269-277

[186] Psychology Today (2024) Trauma-Focused Cognitive behaviour Therapy

[187] Promundo and Sonke Gender Justice (2018) Breaking the Cycle of Intergenerational Violence: The Promise of Psychosocial Interventions to Address Children's Exposure to Violence. Washington, DC: Promundo-US and Cape Town: Sonke Gender Justice

[188] Thielemann, J. F. B. et al. (2022) A systematic review and meta-analysis of trauma-focused cognitive behavioral therapy for children and adolescents, Child Abuse & Neglect, Volume 134, December 2022, 105899

[189] Promundo and Sonke Gender Justice (2018) Breaking the Cycle of Intergenerational Violence: The Promise of Psychosocial Interventions to Address Children's Exposure to Violence. Washington, DC: Promundo-US and Cape Town: Sonke Gender Justice

[190] See Thielemann, J. F. B. et al. (2022) A systematic review and meta-analysis of trauma-focused cognitive behavioral therapy for children and adolescents, Child Abuse & Neglect, Volume 134, December 2022, 105899; Dorsey, S. et al. (2020) Effectiveness of Task-Shifted Trauma-Focused Cognitive Behavioral Therapy for Children Who Experienced Parental Death and Posttraumatic Stress in Kenya and Tanzania, JAMA Psychiatry, 2020 Jan 22;77(5); and Promundo and Sonke Gender Justice (2018) Breaking the Cycle of Intergenerational Violence: The Promise of Psychosocial Interventions to Address Children's Exposure to Violence. Washington, DC: Promundo-US and Cape Town: Sonke Gender Justice

[191] Promundo and Sonke Gender Justice (2018) Breaking the Cycle of Intergenerational Violence: The Promise of Psychosocial Interventions to Address Children's Exposure to Violence. Washington, DC: Promundo-US and Cape Town: Sonke Gender Justice

[192] McMullen, J. et al. (2013) Group trauma-focused cognitive-behavioural therapy with former child soldiers and other war-affected boys in the DR

Congo: A randomised controlled trial. Journal of Child Psychology and Psychiatry, 54(11), 1231-1241

193 O'Callaghan, P. et al. (2013) A randomized controlled trial of trauma-focused cognitive behavioural therapy for sexually exploited, war-affected Congolese girls. Journal of the American Academy of Child & Adolescent Psychiatry, 52(4), 359-369

194 Bass, J., Bearup, L., Bolton, P., Murray, L., and Skavenski, S. (2011). Implementing trauma focused cognitive behavioural therapy (TF-CBT) among formerly trafficked-sexually exploited and sexually abused girl in Cambodia: a feasibility study. Johns Hopkins Bloomberg School of Public Health and World Vision.

195 Lakin, D. P., García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

196 WHO (2016) Problem management Plus (PM+)

197 Bryant el al. (2017) Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: A randomised clinical trial, PLOS MEDICINE, August 2017

198 Rahman, A. et al. (2016) Effect of a Multicomponent Behavioral Intervention in Adults Impaired by Psychological Distress in a Conflict-Affected Area of Pakistan: A Randomized Clinical Trial, JAMA, 2016;316(24):2609-2617

199 Bryant el al. (2017) Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: A randomised clinical trial, PLOS MEDICINE, August 2017

200 Rahman, A. et al. (2016) Effect of a Multicomponent Behavioral Intervention in Adults Impaired by Psychological Distress in a Conflict-Affected Area of Pakistan: A Randomized Clinical Trial, JAMA, 2016;316(24):2609-2617

201 Lakin, D. P. and García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

202 Opper, N. (2024) Friendship Bench: Programme Summary. Prevention Collaborative

203 Chibanda et al., (2016) Effect of a Primary Care–Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe: A Randomized Clinical Trial, JAMA Network, 2016;316(24):2618-2626

204 Erin Stern interview with the founder of Friendship Bench.

205 Doukani, A. et al. (2021) A community health volunteer delivered problem-solving therapy mobile application based on the Friendship Bench 'Inuka Coaching' in Kenya: A pilot cohort study, Glob Ment Health (Camb). 2021 March 10;8e9

206 Lakin, D. P., García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916; and Volpe, M. E. et al. (2017) Narrative Exposure Therapy: A Proposed Model to Address IPV-related PTSD in Parenting and Pregnant Adolescents, Fam Community Health, 2017, Jul-Sep; 40(3)

207 See Lakin, D. P., García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

208 Cunradi, C. and García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

209 See WHO (2016) Group Interpersonal Therapy (ITP) for Depression and Weissman, M. M. and Mootz, J. J. (2024) Interpersonal Psychotherapy: A global reach, Oxford University Press 2024

210 Stern, E., and Levtov, R. (2025) Opportunities for Innovation: Strengthening Mental Health and Addressing Alcohol Use through IPV Prevention Curricula. The Prevention Collaborative.

211 Mootz, J. J. et al. (2024) Community-informed perspectives of implementing interpersonal psychotherapy for couples to reduce situational intimate partner violence and improve common mental disorders in Mozambique, Glob Ment Health (Camb). 2024 Oct 21;11

212 USAID (2024) USAID Mental Health Position Paper

213 Carter, H. et al. (2021) The emergence of digital mental health in low-income and middle-income countries: A review of recent advances and implications for the treatment and prevention of mental disorders, J Psychiatr Res. 2021 Jan; 33

214 Linardon, J. et al. (2024). Current evidence on the efficacy of mental health smartphone apps for symptoms of depression and anxiety. A metaanalysis of 176 randomized controlled trials. World Psychiatry 23, 139–149 (2024).

215 Linardon J, Anderson C, Messer M, Liu C, Torous J. (2025). Transdiagnostic-focused apps for depression and anxiety: a meta-analysis. NPJ Digital Medicine. 2025 15;8(1):443.

216 Abdulai, A. (2025). Is Generative AI Increasing the Risk for Technology-Mediated Trauma Among Vulnerable Populations? Nurs Inq. 32(1):e12686. Is Generative AI Increasing the Risk for Technology-Mediated Trauma Among Vulnerable Populations? - PMC

217 Maxfield, L. (2019) A Clinician's Guide to the Efficacy of EMDR Therapy, Journal of EMDR Practice and Research, Volume 13, Issue 4

218 Maxfield, L. (2019) A Clinician's Guide to the Efficacy of EMDR Therapy, Journal of EMDR Practice and Research, Volume 13, Issue 4

219 WHO (2013) Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines

220 Lakin, D. P., García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

221 Womersley, G. and Arikut-Treece, Y. (2019) Collective trauma among displaced populations in Northern Iraq: A case study evaluating the therapeutic interventions of the Free Yezidi Foundation, Journal of Mental Health and Psychosocial Support in Conflict Affected Area, Intervention, 17(1), 3-12.

222 Stern, E. (2024) Addressing Violence against Refugee and/or Forcibly Displaced Women and Girls: Results from the UN Trust Fund's Special Window 2016-2022

223 Stern, E. (2023) Pathways between poor mental health and intimate partner violence, Prevention Collaborative

224 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative and Lakin, D. P., García-Moreno, C. and Roesch, E. (2022) Psychological Interventions for Survivors of Intimate Partner Violence in Humanitarian Settings: An Overview of the Evidence and Implementation Considerations, Int J Environ Res Public Health. 2022 Mar; 19(5): 2916

225 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

226 Khoury, B. et al. (2013) Mindfulness-based therapy: a comprehensive meta-analysis, Clin Psychol Rev, 2013 Aug;33(6):763-71

227 This included 19 randomized control trials with data on 1173 participants.

228 Boyd, J. E. et al. (2018) Mindfulness-based treatments for posttraumatic stress disorder: a review of the treatment literature and neurobiological evidence, J Psychiatry Neurosci. 2018 Jan; 43(1): 7–25

229 Kerrigan, D., Mantsios, A., Moreno, L., Gomez, H., Perez, M., Donastorg, Y., Karver, T. S., Savage, V., Sibinga, E., & Barrington, C. (2025). Developing a Community-Led Mindfulness Instruction Intervention to Improve Mental Health and HIV Outcomes Among Female Sex Workers in the Dominican Republic. *Mindfulness*, 2025 *16*(7), 2029-2044.

230 See Gallegos, A. M. (2020) Effects of Mindfulness Training on Posttraumatic Stress Symptoms From a Community-Based Pilot Clinical Trial Among Survivors of Intimate Partner Violence, Psychological Trauma: Theory, Research, Practice, and Policy, 12(8)

231 See for example the reviewed studies and population samples in Boyd, J. E. et al. (2018) Mindfulness-based treatments for posttraumatic stress disorder: a review of the treatment literature and neurobiological evidence, J Psychiatry Neurosci. 2018 Jan; 43(1): 7–25; and Hopwood, T. L and Schutte, N. S. (2017) A meta-analytic investigation of the impact of mindfulness-based interventions on post traumatic stress, Clinical Psychology review, Volume 57, November 2017 – both illustrating the disproportionate focus on veterans in research.

232 The samples included women who had experienced childhood sexual abuse, domestic violence, and non-defined interpersonal violence.

233 Esper, L. H. and da Silva Gherardi-Donato, E. C. (2019) Mindfulness-based interventions for women victims of interpersonal violence: A systematic review, Arch Psychiatr Nurs. 2019 Feb;33(1):120-130

234 Goodarzi, G., Sadeghi, K. and Foroughi, A. (2020) The effectiveness of combining mindfulness and art-making on depression, anxiety and shame in sexual assault victims: A pilot study, The Arts in Psychotherapy, Volume 71, November 2020

235 Trauma-related cognitions can for example include

negative cognitions about the self (e.g. related to self-blame and shame) and negative cognitions about the world (e.g. that people can not be trusted).

236 Tilley, D. S. et al. (2023) Mindfulness-based interventions for adult survivors of sexual assault: A scoping review Journal of Sexual Aggression, 1–17

237 Cohen, R. A. (2013) Common Threads: a recovery programme for survivors of gender based violence. Intervention 11(2)

238 Common Threads Project (2024) What is Common Threads project?

239 Common Threads Project (2024) Numbers at a Glance

240 See Stern, E. (2023) Pathways between poor mental health and intimate partner violence, Prevention Collaborative; and Park, C. L. and Slattery, J. M. (2021) Yoga as an Integrative Therapy for Mental Health Concerns: An Overview of Current Research Evidence, Psychiatry International, Volume 2, Issue 4

241 Park, C. L. and Slattery, J. M. (2021) Yoga as an Integrative Therapy for Mental Health Concerns: An Overview of Current Research Evidence, Psychiatry International, Volume 2, Issue 4

242 Park, C. L. and Slattery, J. M. (2021) Yoga as an Integrative Therapy for Mental Health Concerns: An Overview of Current Research Evidence, Psychiatry International, Volume 2, Issue 4

243 Eleison Foundation (2023) Launching HaRT Cohort 2

244 HaRT (2024) HaRT uses and builds evidence to enhance our impact

245 Namy et al., (2021) Healing and Resilience after Trauma (HaRT) Yoga: programming with survivors of human trafficking in Uganda, Journal of Social Work Practice, Volume 36, 2022, Issue 1

246 Namy, S. and Carlson, C. (2025). HART Programme Summary. Prevention Collaborative. https://prevention-collaborative.org/wp-content/uploads/2025/07/5_HaRT-Programme-Sum-FINAL.pdf

247 See HaRT (2024) HaRT uses and builds evidence to enhance our impact

248 See HaRT (2024) HaRT uses and builds evidence to enhance our impact

249 Horn, J. (2020) Decolonising emotional well-being and mental health in development: African feminist innovations, Gender & Development, Volume 28, 2020 – Issue 1

250 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

251 Horn, J. (2020) Decolonising emotional well-being and mental health in development: African feminist innovations, Gender & Development, Volume 28, 2020 – Issue 1

252 What Works to Prevent Violence (2020) Economic and Social Costs of VAWG: Evidence Brief, March 2020

253 Horn, J. (2020) Decolonising emotional well-being and mental health in development: African feminist innovations, Gender & Development, Volume 28, 2020 – Issue 1

254 Mukwege D, Berg M (2016) A Holistic, Person-Centred Care Model for Victims of Sexual Violence in Democratic Republic of Congo: The Panzi Hospital One-Stop Centre Model of Care. PLoS Med 13(10): e1002156.

255 Mukwege D, Berg M (2016) A Holistic, Person-Centred Care Model for Victims of Sexual Violence in Democratic Republic of Congo: The Panzi Hospital One-Stop Centre Model of Care. PLoS Med 13(10): e1002156.

256 Ramsoomar, L. et al. (2019) Associations between Alcohol, Poor Mental Health and Intimate Partner Violence, Evidence Review, November 2019, What Works to Prevent Violence Against Women and Girls Global Programme

257 Kerr-Wilson, A. et al. (2020) A rigorous global evidence review of interventions to prevent violence against women and girls, What Works to Prevent Violence Against Women and Girls Global Programme

258 Kerr-Wilson, A. et al. (2020) A rigorous global evidence review of interventions to prevent violence against women and girls, What Works to Prevent Violence Against Women and Girls Global Programme

259 The Prevention Collaborative (2021) Programme Summary: The Indashyikirwa programme, Rwanda

260 Dunkle, K. et al. (2019) Impact of Indashyikirwa: An innovative programme to reduce partner violence in rural Rwanda, What Works

261 Ramsoomar, L. et al. (2019) Associations between Alcohol, Poor Mental Health and Intimate Partner Violence, Evidence Review, November 2019, What Works to Prevent Violence Against Women and Girls Global Programme

262 See the prevention Collaborative (2024) Zindagii Shoista, Evidence hub

263 Ramsoomar, L. et al. (2019) Associations between Alcohol, Poor Mental Health and Intimate Partner Violence, Evidence Review, November 2019, What Works to Prevent Violence Against Women and Girls Global Programme

264 Mastonshoeva, S., et al. (2021) Zindagii Shoista: Living with Dignity. Mixed methods evaluation of intervention to prevent violence against women in Tajikistan

265 Mastonshoeva, S., et al. (2021) Zindagii Shoista: Living with Dignity. Mixed methods evaluation of intervention to prevent violence against women in Tajikistan

266 Stern, E., and Levtov, R. (2025). Opportunities for Innovation: Strengthening Mental Health and Addressing Alcohol Use through IPV Prevention Curricula. The Prevention Collaborative

267 Spotlight Initiative (no year) Understanding the linkages between violence against women and violence against children

268 Africa Early Childhood Network (AfECN) (2024) Compendium of African Initiatives to Support Parents & Caregivers

269 Doyle, K. et al. (2023) Brief 1: Parenting Programmes to Reduce Violence against Women and Children: Why is it Important. UNICEF Innocent and UNICEF (2023) What Works to Reduce Violence against Children and Women in the Home in Low-and Middle-Income Countries? A review of parenting programmes informed by Social and Behaviour Change (SBC) Strategies. UNICEF Innocenti-Global Office of Research and Foresight

270 Cluver L.D. et al. (2018) Parenting for Lifelong Health: a pragmatic cluster randomised controlled trial of a non-commercialised parenting programme for adolescents and their families in South Africa. BMJ Glob Health31;3(1)

271 Hillis, S. (2024) The effectiveness of Hope Groups, a mental health, parenting support, and violence prevention program for families affected by the war in Ukraine: Findings from a pre-post study, Journal of Migration and Health, Volume 10, 2024

272 Hillis, S. (2024) The effectiveness of Hope Groups, a mental health, parenting support, and violence prevention program for families affected by the war in Ukraine: Findings from a pre-post study, Journal of Migration and Health, Volume 10, 2024

273 Falb KL, Asghar K, Blackwell A, Baseme S, Nyanguba M, Roth D, Hategekimana JD. 2023. Improving family functioning and reducing violence in the home in North Kivu, Democratic Republic of Congo: a pilot cluster-randomised controlled trial of Safe at Home. BMJ Open: 13(3):e065759.

274 Balachander M. et al. (2024) Effectiveness of a family violence prevention program on mental health outcomes for adult men and women in North Kivu, Democratic Republic of Congo: Insights from a pilot trial. Cambridge Prisms: Global Mental Health, 11, e99,

275 Affleck, W., Selvadurai, A. and Sikora, L. (2018) Underrepresentation of men in gender based humanitarian and refugee trauma research: A scoping review. Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas, 16(1)

276 Shrestha M, Heylen E, Sigdel K, Dhimal M, Nepal P, Pant P, Jha RK, Rimal R, Khatri R, Joshi S, Sharma S, Shrestha S, Poudel S, Mainali S, Sapkota S, and Acharya B. (2025). A randomized controlled trial of a multi-component family intervention to lower depression and address intimate partner violence (MILAP) among young married women in Nepal: a study protocol. Research Square 2025: 7048952.

277 Equimundo (2025) Living Peace: Healing from trauma in high-violence communities

278 Tankink, M. T. A. and Slegh, H. (2017) Living Peace in Democratic Republic of the Congo: An Impact Evaluation of an Intervention with Male Partners of Women Survivors of Conflict-Related Rape and Intimate Partner Violence

279 Equimundo (2025) Living Peace: Healing from trauma in high-violence communities

280 Tankink, M. T. A. and Slegh, H. (2017) Living Peace in Democratic Republic of the Congo: An Impact Evaluation of an Intervention with Male Partners of Women Survivors of Conflict-Related Rape and Intimate Partner Violence

281 The published results from the RCT are forthcoming. For more information on the RCT design, see Jansen, S. et al. (2022) A clustered randomized controlled trial to assess whether Living Peace Intervention (LPint) reduces domestic violence and its consequences among families of targeted men in Eastern Democratic Republic of the Congo (DRC): Design and methods, Evaluation and Program planning, Volume 95, December 2022

282 Applied Mental Health Research Group (2019) The Common Elements Treatment Approach: A Proven Way to Treat Violence Against Women & Alcohol Abuse – Evidence from a RCT in Lusaka, Zambia

283 Applied Mental Health Research Group (2019) The Common Elements Treatment Approach: A Proven Way to Treat Violence Against Women & Alcohol Abuse – Evidence from a RCT in Lusaka, Zambia

284 Kane et al., (2021) Two year treatment effect of the common elements treatment approach (CETA) for

reducing intimate partner violence and unhealthy alcohol use in Zambia, Global Mental Health 8, e4, 1-4

285 Murray et al. (2021) A qualitative exploration of mechanisms of intimate partner violence reduction for Zambian couples receiving the Common Elements Treatment Approach (CETA) intervention, Soc Sci Med 2021, Jan: 268: 113458

286 See African Institute for Integrated Responses to Violence Against Women and Girls & HIV and AIDS and Stephen Lewis Foundation (2022) Towards a Transformative, Feminist Approach to Trauma in Africa: Perspectives from Practice

287 Stern, E. (2023). Pathways between Poor Mental Health and Intimate Partner Violence. Prevention Collaborative

288 Romero, J. et al. (2021) The Effect of Economic Transfers on Psychological Well-Being and Mental Health

289 The Prevention Collaborative (2019) Evidence Brief: Cash Transfers and Intimate Partner Violence: Findings from a Review of Quantitative and Qualitative Studies in Low- and Middle-Income Countries

290 Wollburg, C. et al. (2023) Do cash transfers alleviate common mental disorders in low- and middle-income countries? A systematic review and meta-analysis, PLoS ONE, 2023; 18(2): e0281283

291 Stern, E. and Heise, L. (2024) Women's economic empowerment and intimate partner violence: untangling the intersections, Evidence Brief

292 Peterman, Amber & Roy, Shalini (2021) "Cash transfers and intimate partner violence (IPV) in low- and middle-income settings: A joint research agenda to inform policy and practice," June 2021, International Food Policy Research Institute (IFPRI), and Bacchus L.J. et al. (2024) Interventions that prevent or respond to intimate partner violence against women and violence against children: a systematic review. Lancet Public Health 9(5)

293 Lachman, J. M. et al. (2021) Effectiveness of a parenting programme to reduce violence in a cash transfer system in the Philippines: RCT with follow-up. Lancet Reg Health West Pac. 2021 Oct 5:17 ; Baranov, V. (2021) Theoretical underpinnings and meta-analysis of the effects of cash transfers on intimate partner violence in low- and middle-income countries. The Journal of Development Studies, 57(1); and Bonilla, J. et al. (2022) Evaluation of Mozambique's child grant: a cash and care intervention to reduce violence against women and children

294 A large share of included trials was conducted in Sub-Saharan Africa (13/17), with four studies located in Malawi, four in Kenya, two in South Africa, and one each in Zambia, Mali, and Uganda. Three trials were run in Latin America (Nicaragua and Ecuador) and one in Bangladesh.

295 The recipients of the cash transfers in the included studies were predominantly female, with half (8/16) studies targeting women only, or mostly women.

296 Wollburg, C. et al. (2023) Do cash transfers alleviate common mental disorders in low- and middle-income countries? A systematic review and meta-analysis, PLoS ONE, 2023; 18(2): e0281283

297 Peterman, A. et al. (2024) Social safety nets, women's economic achievements and agency: A systematic review and meta-analysis. Centre for Global Development.

298 Peterman, A. and Roy, S. (2022) Cash transfers and intimate partner violence: Research view on design and implementation for risk mitigation and prevention

299 Ibid.

300 Roy, S. et al. (2019) Can transfers and behavior change communication reduce intimate partner violence four years post-program? Experimental evidence from Bangladesh, IFPRI Discussion Paper 01869

301 Jensen, S. K. G. et al. (2021) in Cookson, P. T., Fuentes, L. and Bitterly, J. (2024) Addressing gender-based violence through social protection: a scoping review, Development in Practice

302 Jensen, S. K. G. et al. (2021) Effect of a home-visiting parenting program to promote early childhood development and prevent violence: a cluster-randomized trial in Rwanda, BMJ Glob Health. 2021 Jan;6(1)

303 Betancourt, T. S. et al. (2020) Promoting parent-child relationships and preventing violence via home-visiting: a pre-post cluster randomised trial among Rwandan families linked to social protection programmes, BMC Public Health (2020) 20:621

304 Jensen, S. K. G. et al. (2021) Effect of a home-visiting parenting program to promote early childhood development and prevent violence: a cluster-randomized trial in Rwanda, BMJ Glob Health. 2021 Jan;6(1)

305 Government of Malawi (2022) The Social Cash Transfer Programme (SCTP)

306 Abdoulayi, S. et al (2017) Evaluating The Effectiveness Of An Unconditional Social Cash Transfer Programme For The Ultra Poor In Malawi, International Initiative for Impact Evaluations

307 Angeles, G. et al (2019) Government of Malawi's unconditional cash transfer improves youth mental health, Social Science and Medicine, Volume 225, March 2019

308 Stern E., and Heise, L. (2023). Women's economic empowerment and intimate partner violence: Untangling the intersections. The Prevention Collaborative

309 Gupta, J. et al. (2013) Gender norms and economic empowerment intervention to reduce intimate partner violence against women in rural Côte d'Ivoire: a randomized controlled pilot study. BMC Int Health Hum Rights 13, 46

310 Gupta, J. et al (2023) Ea$ing into the USA: study protocol for adapting the Economic and Social Empowerment (EA$E) intervention for US-based, forcibly based populations, BMJ Open, Volume 13, Issue 4

311 Cookson, P. T., Fuentes, L. and Bitterly, J. (2024) Addressing gender-based violence through social protection: a scoping review, Development in Practice

312 Cookson, P. T., Fuentes, L. and Bitterly, J. (2024) Addressing gender-based violence through social protection: a scoping review, Development in Practice

313 Mahmud, F. E. (2023) "Harnessing Social Protection to Address Violence Against Women and Girls", Blog post 28.02.23, Socialprotection.org

314 Cookson, P. T., Fuentes, L. and Bitterly, J. (2024) Addressing gender-based violence through social protection: a scoping review, Development in Practice

315 UNGEI (2020) Ending School-Related Gender-Based Violence: A series of thematic briefs

316 See Corboz, J. (2019) What works to prevent violence against children in Afghanistan? Findings of an interrupted time series evaluation of a school-based peace education and community social norms change intervention in Afghanistan, PLoS One 2019 Aug 6;14(8):e0220614 and Karmaliani et al., (2020) Right To Play's intervention to reduce peer violence among children in public schools in Pakistan: a cluster-randomized controlled trial, GLOBAL HEALTH ACTION 2020, VOL 13, 1836604

317 Karmaliani et al., (2020) Right To Play's intervention to reduce peer violence among children in public schools in Pakistan: a cluster-randomized controlled trial, GLOBAL HEALTH ACTION 2020, VOL 13, 1836604

318 Corboz, J. (2019) What works to prevent violence against children in Afghanistan? Findings of an interrupted time series evaluation of a school-based peace education and community social norms change intervention in Afghanistan, PLoS One 2019 Aug 6;14(8):e0220614

319 Sangath (2022) Strengthening the evidence base on effective school-based interventions for promoting adolescent health programme (SEHER)

320 Shinde, S. et al. (2018) Promoting school climate and health outcomes with the SEHER multi-component secondary school intervention in Bihar, India: a cluster-randomised controlled trial, Lancet, 392 (10163)

321 Shinde, S. et al. (2020) A multicomponent secondary school health promotion intervention and adolescent health: An extension of the SEHER cluster randomised controlled trial in Bihar, India, PLOS Medicine, February 2020

322 WHO (2022) World mental health report: transforming mental health for all

323 USAID (2024) USAID Mental Health Position Paper

324 USAID (2024) USAID Mental Health Position Paper

325 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524

326 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524

327 Mental Health Innovation network (no date) Healthy Activity Programme (HAP)

328 Patel et al (2017) The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: a randomised controlled trial, The Lancet 2017; 389

329 Empower India (no date) Healthy Activity Program (Scale-up) - EMPOWER India

330 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524 and The Global Women's Institute (2024) Barriers to and Challenges Accessing Specialized Care for Survivors of Gender-based Violence: Formative Research Findings from the Democratic Republic of Congo, Iraq, and South Sudan

331 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and

mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524 and The Global Women's Institute (2024) Barriers to and Challenges Accessing Specialized Care for Survivors of Gender-based Violence: Formative Research Findings from the Democratic Republic of Congo, Iraq, and South Sudan

332 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524

333 Ibid.

334 Ibid.

335 Abrahams, Z. et al. (2022) Implementation outcomes of a health systems strengthening intervention for perinatal women with common mental disorders and experiences of domestic violence in South Africa: Pilot feasibility and acceptability study. BMC Health Serv Res 22, 641

336 McKeon Olson, R. et al. (2020) The implementation and effectiveness of the one stop centre model for intimate partner and sexual violence in low- and middle-income countries: a systematic review of barriers and enablers, BMJ Global, Volume 5, Issue 3

337 Deuba K. et al. (2024) Assessing the Nepalese health system's readiness to manage gender-based violence and deliver psychosocial counselling. Health Policy Plan. 2024 Feb 22;39(2)

338 Oram, S. et al. (2022) The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy, Lancet Psychiatry 2022; 9: 487–524

339 See for example The Global Mental Health Peer Network (2022) Competing for Equality in Funding and Remuneration: Lived Experience Collaboration, Engagement and Consultation

340 See The Global Women's Institute and Trócaire (2023) Supporting Uptake of Survivor-Centred Practice: Building consensus between GBV and MHPSS workers around shared guiding principles and recommendations for progressing practice

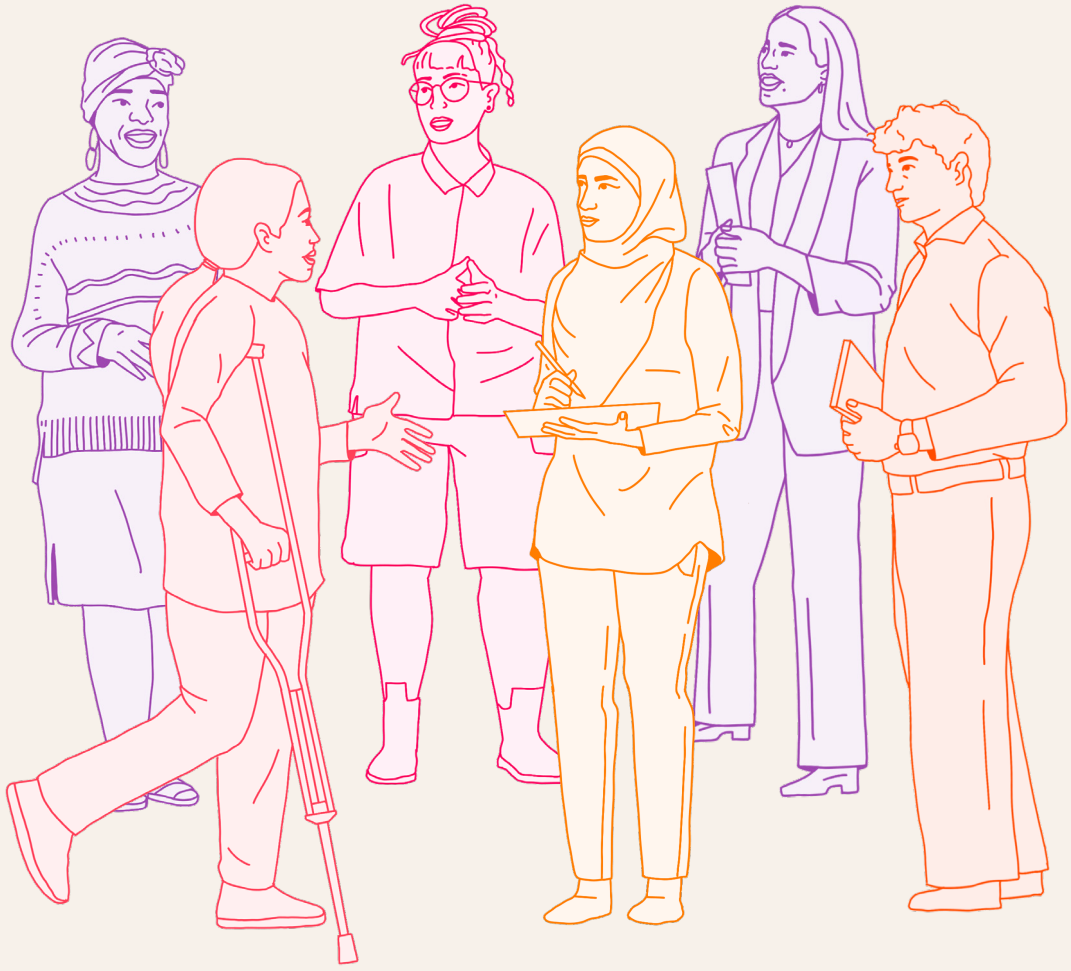
341 See the GBV Pocket Guide – How to support survivors of gender-based violence when a GBV actor is not available in your area

342 See The Global Women's Institute and Trócaire (2023) Supporting Uptake of Survivor-Centred Practice: Building consensus between GBV and MHPSS workers around shared guiding principles and recommendations for progressing practice

343 Ibid.

UK International Development
Partnership | Progress | Prosperity

WhatWorks
TO PREVENT VIOLENCE



Intersections of Gender-based Violence and Common Mental Health Problems:

Understanding the Evidence and Strengthening Integrated Action