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Synopsis

Developing a mental health support package for women survivors of domestic violence and modern slavery in South Asia: a multiple methods design

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Abstract

Background: Women survivors of domestic violence and modern slavery in South Asia face substantial harms to their mental health, but their advocates lack evidence-informed practice guidance on how they might support their well-being and address common mental disorders. In this synopsis, we summarise the development of a support package to help fill the gap. Our aim was to design a package of contextually appropriate interventions with which non-specialist providers could support the mental health of women survivors of domestic violence and human trafficking.
Methods: Our work involved a transdisciplinary group located in Afghanistan, India and Sri Lanka, with collaborators in the United Kingdom. To identify potential components of the support package, we reviewed existing guidelines, examined and undertook literature reviews and interviewed and held focus group discussions with survivors of domestic violence and human trafficking, service providers and academics. We convened multidisciplinary consultations and examined routine service data on support requirements. We considered our findings alongside published theory, developed a programme theory and articulated it in a package of support.

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Findings: We developed a core support package and four locally adapted versions for caseworkers and field workers who support women survivors of domestic violence and human trafficking. Content areas include background information on domestic violence and modern slavery, trauma, socioecological influences, principles of counselling and ethics and confidentiality. The package includes advice on safety assessment and response to basic needs, mental health assessment, first aid, and suicide prevention, psychoeducation, crisis intervention, supporting mental health, problem-solving and goal-setting. It provides information on mental health assessment and distress reduction techniques, collaborative planning and review.
Conclusions and future work: We will continue to review the use of the package, networking with providers and survivors to allow iterative adaptation and improvement. We hope it will be useful, with adaptation for specific settings, for advocates and caseworkers in providing comprehensive and appropriate non-specialist support for the mental health of women survivors of violence in South Asia.
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Background

This article summarises the work involved in the development of a package of support for the mental health of women survivors of domestic violence and modern slavery in settings in three South Asian countries: Afghanistan, India and Sri Lanka. Our transdisciplinary group considered the effects on mental health of different forms of violence and the need to improve service providers' ability to integrate mental health into their practice.

Domestic violence and modern slavery are gendered, culturally sanctioned and carried over generations. They are strongly associated with mental ill health, particularly depression, anxiety and post-traumatic stress disorder.[1–6] We use the phrases 'domestic violence' and 'modern slavery' advisedly. Without wanting to overgeneralise, a characteristic of domestic violence in South Asian settings is that it encompasses both intimate partner violence (IPV) and violence by other family members, particularly in the affinal home.[7] We provide support services for survivors whose concerns extend beyond physical and sexual IPV to emotional or psychological violence,[7] coercive control,[8] economic abuse,[9] neglect and what has been termed 'gender-based household maltreatment'.[10] Modern slavery encompasses human trafficking, forced labour, debt bondage or bonded labour, child slavery, forced and early marriage, forced crime and organ harvesting.[11] Although forced labour and early marriage may underlie gender-based household maltreatment, most of the casework we consider is with survivors of human trafficking for sex work.[12]

Domestic violence is a destructive feature of the lives of women everywhere. Recent global estimates suggest that 35% of women aged 15–49 years have experienced physical or sexual IPV in their lifetime and 19% in the last year.[13,14] In conflict-affected contexts, violence is often normalised and instrumentalised by armed forces, magnifying the harmful effects of existing sociocultural norms. In Afghanistan, 46% of women are estimated to have survived physical or sexual IPV in the last year, and 34% psychological violence.[15] The estimates for India are 24% for physical or sexual violence (SV) and 11% for psychological violence.[15] In Sri Lanka, an estimated 6% of women have survived physical or sexual IPV in the last year, and 6% psychological violence.[16] Conflict in Afghanistan and Sri Lanka has reportedly exacerbated women's exposure to abuse amidst a militarised society and added to deeply held discriminatory gender norms. Modern slavery affects 49.6 million people worldwide, of whom 26.7 million are women or girls. The Asia and Pacific region hosts the greatest numbers of victims (55%). About 3.7 million people are thought to be survivors of human trafficking and forced sexual exploitation of adult women.[17]

As well as the different forms of violence, we were also aware of the sited nature of our work within socioecological tiers of influence,[18] and the combined effects of social and structural influences on mental health. Each of us worked in a milieu, in which we were often reminded that individual experience varies with context; that women's experiences of and responses to violence are nuanced. Violence occurs on a composite background of global, regional, national, local and household norms and individual influences. Capabilities, opportunities and motivations at each of these levels influence the individual survivor's response and choice of sources of support. There is, however, common ground within contextual variation. Our experience of supporting survivors of violence suggested that there were commonalities in the mental health effects of violence across settings and across forms of violence. For example, the erosion of trust and self-belief experienced by survivors of domestic violence

is not wholly dissimilar from that experienced by survivors of human trafficking.

The value of developing a support package was premised on our experience that caseworkers and advocates were frequently occupied with the practical assistance required by survivors (shelter, law enforcement, family negotiation) and had less time and background knowledge to develop effective responses for women's mental health. Addressing the needs of survivors in resource-constrained settings requires a combination of institutional, community and mental health responses. Response must take account of the intersectionality between a client's family concerns, socioeconomic status, ethnocultural traditions, political views and sexuality. Building on this, and taking as read the specific psychosocial interventions required of caseworkers, the approach to casework should be intentional, trauma-informed and contribute to mental health.

Our aim was to design a package of contextually and culturally appropriate support for common mental disorders (depression, anxiety, post-traumatic stress disorder and suicidal ideation) among survivors of violence. Our objectives were to understand women's mental health needs, identify candidate components of the support package, determine their feasibility for delivery by non-specialist providers, synthesise a modular package of support and examine its acceptability for survivors and providers.

Methods

Setting

Our UK National Institute for Health and Care Research (NIHR) Global Health Research Group began work in 2018. Members worked in organisations in Afghanistan, India and Sri Lanka, partnering with researchers at five universities in the UK. The partner group connected a series of collaborations between groups who had worked with each other over a number of years. The idea was not to represent South Asia but to bring together a range of settings and actors: organisations with a record of work on primary, secondary and tertiary prevention of violence against women (VAW) and girls [an organisation in Afghanistan and Society for Nutrition, Education and Health Action (SNEHA) India], organisations with a record of work in mental health, but with less experience in response to VAW (Sangath, India and University of Colombo, Sri Lanka), and academics whose individual interests included prevention of VAW and girls and modern slavery. Team members included early career and established researchers in qualitative and quantitative social science, psychiatry and medicine, clinical psychology, epidemiology, philosophy, public health, global health, social work, ethics and communications.

Design

The approach to developing a complex intervention involves a process of development, piloting and feasibility testing, implementation and evaluation.[19] Our programme research pathway is shown in *Figure 1*. We worked iteratively in three overlapping streams to (1) understand survivors' needs and candidate support components through literature review, interviews and focus groups with stakeholders, workshops, and examination of routine service data; (2) work with stakeholders to identify promising models and programme theory and (3) bring the findings together in locally adapted versions of the support package and assess their feasibility and potential uptake. The first components of work package (WP) 1 are summarised below. This synopsis then describes the qualitative interviews and the package development (WPs 2 and 3). For more information on the qualitative interviews conducted in each country, see *Appendix 1*.

Data collection

We collected data through (a) reviews of peer-reviewed and grey literature, (b) individual qualitative interviews and focus group discussions, (c) consultations and (d) quantitative analysis of service records.

Literature reviews

We examined the peer-reviewed literature for existing reviews of interventions applicable to women survivors of domestic violence or modern slavery. Within the grey literature, we collected and considered existing guidelines and manuals for either healthcare providers or survivors themselves, augmenting searches with advice from expert networks. We conducted four new literature reviews: a realist review of psychosocial interventions for women survivors of IPV,[20] a mixed-methods systematic review of the mental health of women and children experiencing family violence in conflict settings,[21] a realist review of psychosocial and mental health interventions for survivors of human trafficking[22] and a realist review of mechanisms of interventions in low- and middle-income countries for the prevention of adolescent IPV.[23] Here we describe the three realist reviews:

1. IPV: a broad range of psychosocial interventions have been developed to support the recovery of women survivors of IPV, but their mechanisms of action remain unclear. Our review adds to the literature on IPV interventions by aiming to provide

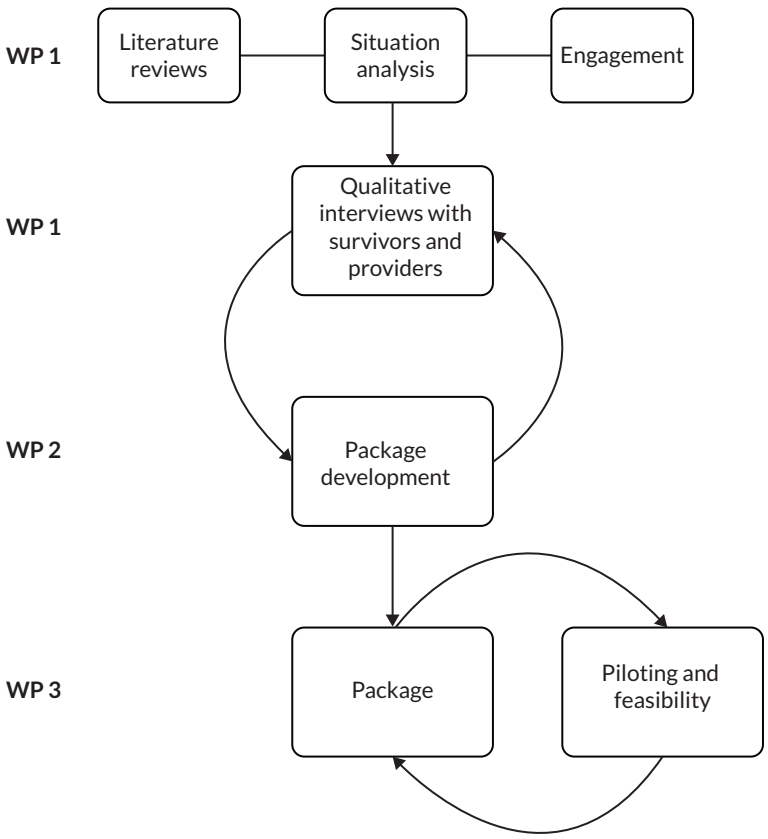

FIGURE 1 Research pathway.

a comprehensive examination of the mechanisms of action of multiple components across the full range of secondary and tertiary psychosocial IPV interventions. Realist review following a prospectively published protocol in International Prospective Register of Systematic Reviews and reported using the Realist and Meta-narrative Evidence Synthesis: Evolving Standards guidelines. Evidence was extracted from 60 reviews and triangulated in expert consultations. Mechanisms of action were categorised as either associated with intervention design and delivery or with specific intervention components (access to resources and services; safety, control and support; increased knowledge; alterations to affective states and cognitions; improved self-management; improved family and social relations). The findings suggest that psychosocial interventions to improve the mental health of women survivors of IPV have the greatest impact when they take a holistic view of the problem and provide individualised and trauma-informed support.

2. Trafficking: more than 50 million people globally are subjected to modern slavery and human trafficking. Adverse mental health consequences of extreme exploitation are prevalent and often severe. The review aimed to identify the influence of these interventions on the mental health and well-being of trafficked people and examine how they worked for which survivors in which contexts. We conducted a systematic and realist review on evaluations of psychosocial interventions for survivors of human trafficking. We searched eight databases [MEDical Literature Analysis and Retrieval System (MEDLINE), MEDLINE In-Process, Excerpta Medica dataBASE, PsycInfo® (American Psychological Association, Washington, DC, USA), Global Health, Cumulative Index to Nursing and Allied Health Literature Plus, Web of Science, and Cochrane] for published evaluations of psychosocial interventions for survivors of human trafficking. We followed a realist approach to analyse the data and report on the limitations of the studies identified. We identified four mechanisms of change as being triggered by the various intervention activities: (1) awareness and understanding; (2) trust, safety and security; (3) agency, autonomy, empowerment and social connections and (4) self-reflection, self-expression and self-care. Improving mental health after traumatic events is an ongoing, non-linear process. Intervention effectiveness and transferability would benefit from more transparent

programme theories and well-articulated assumptions that identify the pathways to change.

3. Adolescents: adolescent girls are among those at the greatest risk of experiencing IPV. Despite adolescence being widely regarded as a window of opportunity to influence attitudes and behaviours related to gender equality, evidence on what works to prevent IPV at this critical stage is limited outside of high-income, school-based settings. We aimed to build on previous systematic reviews of adolescent IPV prevention interventions to generate evidence on the mechanisms of change within them. We conducted a realist review of primary prevention interventions for adolescent IPV in low- and middle-income countries to synthesise evidence on how they work, for whom, and under which circumstances. The review took place in four iterative stages: (1) exploratory scoping, (2) developing initial programme theory, (3) systematic database search, screening and extraction, and (4) purposive searching and refinement of programme theory. We identified 11 adolescent IPV prevention interventions in low- and middle-income countries, most of which demonstrated a positive impact on IPV experience and/or perpetration (n = 10). Most interventions (n = 9) implemented school- or community-based interactive peer group education to transform attitudes and norms around gender and relationships for behaviour change. The central mechanism of change related to gender transformative content prompting adolescents to critically reflect on their attitudes and relationships, leading to a reconceptualisation of their values and beliefs. This central mechanism was supported by two secondary implementation mechanisms: (1) the design and delivery of interventions: interactive, age-appropriate education delivered in peer groups provided adolescents a safe space to engage with content and build communication skills, and (2) the target group: social norms interventions targeting the wider community created enabling environments supportive of individual change. This review highlighted the immense potential of gender transformative interventions during the critical period of adolescence for IPV prevention.

Situation analysis

In addition to the literature reviews, we conducted a situation analysis to further understand the contexts that we were working in. In this study, we aimed to compare women's exposure to violence and mental health conditions in Afghanistan, India and Sri Lanka, while considering the policy and service contexts. A situation analysis tool was developed for the study. We extracted information from grey and peer-reviewed literature and other publicly available data investigating the burden of VAW and mental health conditions, policies addressing VAW and mental health conditions in each country, and the services available to women exposed to violence and women with mental health conditions. Forty-six per cent of women in Afghanistan, 21% of women in India and 5% of women in Sri Lanka, reported experiencing physical violence within the last 12 months of the most recent survey. Meanwhile, 7% of ever-partnered women in Afghanistan, 6% of women in India and 7% of women in Sri Lanka reported experiencing SV during their lifetime. In India, 6.9% of disability-adjusted life-years were attributed to childhood sexual abuse and 4.6% to IPV. In Sri Lanka, 14.6% of women exposed to physical or SV by a partner had engaged in self-harm. We found no data on conflict-related SV and trafficking. All three countries have made commitments to gender equality or preventing VAW. Implementation of some of these policies, however, is unclear. The countries also have had mental health policies and services, but there is currently little intersection between mental health and VAW.

Household and institutional surveys

We had intended to do a household survey in Sri Lanka on violence exposure to augment the information already known in the Indian sites. We designed the study, developed the tools, sought the necessary approvals from the authorities, obtained ethics approval from the University of Colombo and University College London and trained the data collection staff. Unfortunately, we were unable to conduct the data collection due to rise in the number of COVID-19 cases and increased travel restrictions in the country. The study was consequently abandoned.

Figure 2 provides an overview of qualitative research activities. Teams in all three countries conducted semistructured interviews and focus group discussions, with the aim of understanding the experience and needs of both survivors and providers.

Individual interviews and focus group discussions

In order to understand the impact of violence on women's mental health and potential support mechanisms, we conducted qualitative semistructured interviews with survivors of domestic violence, survivors of human trafficking and individuals who provided services to support them. In Afghanistan, we interviewed 60 women survivors of domestic violence living in safe houses or community settings in which they received legal and other (although not psychological) support from civil society organisations in Kabul, Bamyan and Nangarhar

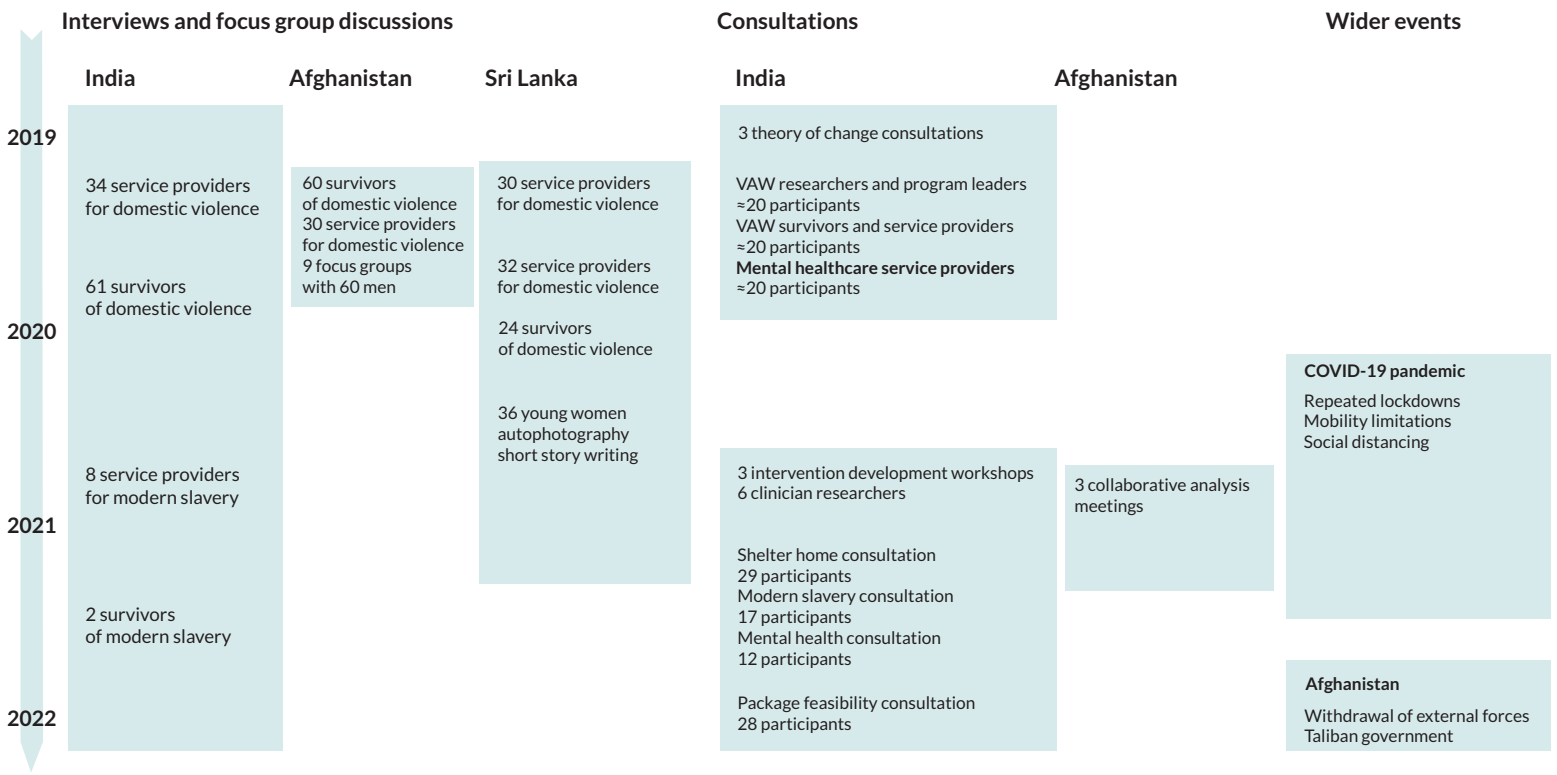

FIGURE 2 Summary of interviews, focus group discussions, and consultations.

provinces. This work highlighted the importance of stigma that led to the silencing of survivors of domestic violence. In this patriarchal society, the notion of honour was important. Reporting the violence or leaving was considered dishonourable. Further details are available.[24] These provinces represent a range of ethnic and linguistic sociocultural histories as well as different exposures and vulnerabilities to the forms of conflict that have occurred over the last four decades. For example, Bamyan was the site of a massacre of Hazara men by the Taliban in the 1990s, leaving behind a generation of single-headed female households. Both Kabul and Nangarhar are areas receiving internally displaced people from across Afghanistan. We asked similar questions in interviews with 30 service providers and in 9 focus groups with men. In India, we interviewed 26 women survivors of domestic violence in Mumbai and 35 in Goa, and 2 survivors of human trafficking for sex work in Mumbai. From Mumbai, we interviewed 20 service providers for women survivors of domestic violence, and 8 who worked with survivors of modern slavery, including organisation directors, programme managers, caseworkers and clinical psychologists. In Sri Lanka, we interviewed 24 survivors of domestic violence in Jaffna and Kurunegala districts, including women with disabilities and a history of migration and conflict-related violence. We interviewed 32 service providers in the same districts, including community- and facility-based state, third-sector and private-sector organisations.

Consultations

We held three consultations in India to develop programme theory, involving 60 participants overall. Our team of researchers included lived experience experts. The first consultation included researchers and programme leaders in VAW. The second included women with lived experience of domestic violence and social workers, peer counsellors and programme managers. The third consultation focused on organisations providing mental health care in community and clinical settings. In the next phase, we consulted 14 service providers (police, psychiatrists and caseworkers, lawyers, and helpline operators) to understand their perspectives on the needs and expectations of women survivors of domestic violence, and potential facilitators and barriers to service delivery. A further 36 young women engaged in autophotography and storytelling in Sri Lanka. We then facilitated three consultations with six researchers and clinicians with experience in mental health and VAW. The aim was to use the findings from literature reviews, interviews and consultations to focus in on potential mental health interventions that a support package might include. The participants discussed component interventions, along with considerations for each of acceptability and feasibility.

As the support package took shape, we held consultations with potential users. A consultation in Mumbai involved 29 people working with shelters for survivors of violence (government superintendents, representatives of the Women and Child Development Department and representatives from third-sector shelters). We aimed to understand the mental health needs of survivors of violence admitted to shelters and to get a feel for the available resources and challenges. A second consultation involved 17 mental health professionals and caseworkers for survivors of human trafficking for sex work, to understand their mental health needs and the processes of support. The focus was on possible divergence and convergence between support for survivors of domestic violence and survivors of modern slavery, the need to provide first-line mental health care for survivors when professional mental health support was unavailable, and an interest in participating in subsequent feasibility testing for packages of support. A third consultation focused on refining the support package through inputs from 17 mental healthcare experts: psychiatrists, clinical psychologists and therapists. We aimed to understand what was feasible when caseworkers assessed the mental health of their clients, how care could be made as trauma-informed as possible, the range of psychological techniques that a caseworker might use and the challenge of goal-setting with clients.

Working versions of the package of support were examined for feasibility at consultations in India, with 28 representatives of organisations working on domestic violence or modern slavery. We also held 2 UK-based workshops to discuss the realist reviews, with 10 service providers in October and 8 in November 2020. In a workshop in March 2022, five service providers reviewed the package of support, with inputs from seven survivors of human trafficking.

Quantitative analysis of service records

Drawing on services for women survivors of domestic violence, we analysed anonymised quantitative record-based information on client support by SNEHA over the year 2019. Of particular interest was the range of interventions that caseworkers were engaging in to support their clients. Findings have been published. The analysis of consultations with 2278 clients showed a range of interventions, including crisis intervention (32%; for example, psychological first aid, a formal suicide risk assessment and making a safety plan); home visits (31%); legal support (17%); an appointment with a clinical psychologist (13%); assistance with police consultation (7%) and medical care (5%).[25]

Community engagement and involvement

We involved three kinds of community: survivors of domestic violence and human trafficking, counsellors, caseworkers, psychologists, psychiatrists and lawyers who provide support for survivors through non-government and government organisations, and academics. Our priority was to engage both survivors themselves and advocacy organisations in framing and testing the package of support.

Equality, diversity and inclusion

We considered throughout the project the power differential between forms of knowledge and the status of participants. For example, in spaces such as consultation meetings, representatives of non-government organisations, psychiatrists and psychologists tend to exercise more power than (lay) survivors of violence. The main way that we tried to deal with this was to interview survivors one to one and to include people with lived experience in workshops with groups with which they already had links. We found it more difficult to arrange interviews with individual survivors of human trafficking than with survivors of domestic violence. Part of this was reticence to engage with other professionals in a context in which legal processes were underway.

Findings

Literature reviews

In keeping with the aim of developing an integrated package of support, we were interested in potential support components that could be delivered by non-specialist providers in South Asian contexts, in which mental health interventions would sit alongside interventions for domestic violence and human trafficking. Beyond the peer-reviewed literature, *Appendix 2*, *Table 4* presents the guidelines and manuals that we examined. The situation analysis is reported separately.[26]

New reviews

The review of interventions for survivors of IPV drew on 60 review articles to develop a conceptual model of potential mechanisms of effect. Women's mental health was most effectively supported by interventions that were holistic, trauma-informed and individualised. They should be grounded in culture and context, honour the intersectionality and complexity of each woman's situation and aim to provide resources to address all her concerns. In addition to improvements in coping and the use of therapeutic techniques, survivors needed to feel safety, support and connection, a reduction in environmental stressors, and reductions in violence.[20]

The review of family violence in conflict settings identified 29 studies, all of which suggested that violence was more common in conflict and post-conflict situations. Family violence was associated with poorer mental health outcomes, although there was heterogeneity in the evidence base. Men's experience of conflict, including financial stresses, appeared to contribute to their perpetration of violence.[21] The review of interventions to prevent adolescent IPV in low- and middle-income countries identified 11 interventions and found limited evidence on what works. A key mechanism of change was the effect of gender-transformative content in helping adolescents to reflect on their attitudes and relationships. The intervention should be interactive, age-appropriate and delivered in peer groups as safe spaces.

The review of interventions for human trafficking survivors suggested that workers such as healthcare providers, law enforcement officers and migration officers needed training and context-appropriate screening tools and protocols to be able to identify people in modern slavery. Immediate care and crisis intervention were needed to build survivors' sense of security and support continuity of care. Integrated, accessible and culturally appropriate psychosocial responses could help promote survivors' self-organisation, functioning and autonomy. Providers needed to inform survivors about the interventions' content and objectives and manage expectations accordingly. Survivors' preferences for how to receive services should be incorporated where possible, including giving them control over the decision[27] on how they would like to navigate their healing process. There was evidence that improvements in mental health may be mediated by other factors, such as improved language proficiency and employment opportunities. Survivors of human trafficking, particularly those who have crossed an international border, may not have the legal right to work, or may not be sufficiently proficient in the language of the destination country, or English, to benefit from services and understand how to access them. Service and service provision should recognise these challenges to ensure survivors' needs can be met and not place additional pressure on case managers, particularly as survivors' observation of such challenges could increase their dependency.[22]

Existing reviews

A number of published reviews overlapped with our area of interest and guided the development of the support package.[4,28–39] All found limited numbers of studies which were small, difficult to compare, and most of which were

from outside South Asia. Reviews have also addressed interventions for IPV in conflict and post-conflict states and humanitarian crises.[34,37] In a systematic review of interventions to support the mental health of survivors of modern slavery, Wright and colleagues say that 'Whilst there is growing recognition that mental health is an increasingly critical area for support provision, there is a lack of evidence-based interventions to underpin this'.[35]

Survivors of domestic violence and modern slavery require their advocates, caseworkers and healthcare providers to be aware of and respond to trauma.[4,33] Terms in this area include trauma-informed, trauma-responsive and trauma-focused care. Trauma-focused interventions appeared to be promising for survivors of domestic violence,[28] but the evidence of benefit was provisional. There was consensus that brief interventions should be individualised and offer information on violence and its effects (psychoeducation), address the dynamics of violence and safety concerns, and enhance cognitive and emotional skills, cultural competence and social connection.[36]

A central issue was the place for interventions such as specialist cognitive–behavioural therapy (CBT) in a situation in which women were experiencing continuing violence. A Cochrane review of psychological therapies for women survivors of IPV suggested that psychological therapies probably reduce depression and may reduce anxiety, but their effectiveness is unclear if they do not address women's needs for safety, support and holistic healing from complex trauma.[30] A systematic review and meta-analysis of psychological interventions for common mental disorders among women in low-income and middle-income countries found that anxiety was more amenable to intervention among survivors of IPV than among women who had not experienced violence. This raises the possibility of including interventions to manage anxiety in non-specialist care, although a similar pattern was not seen for depression, post-traumatic stress disorder or psychological distress.[32]

A systematic review of IPV interventions found that both empowerment-based advocacy and cognitively focused clinical interventions had positive outcomes.[29] Interventions tended to be more successful when they focused on problem-solving and making informed choices, along with helping women to change their thinking about themselves and their situation. Community referral, safety planning and support were particularly helpful after an acute crisis. The review emphasised the importance of a hierarchy of needs, suggesting that basic needs, such as safety, food and shelter, need to be met before women can focus on emotional well-being or mental health. In a systematic review of interventions focused on social support for survivors of IPV, most of the interventions that seemed to improve women's mental health combined advocacy with strong community linkages.[31]

The recent Lancet Psychiatry Commission on IPV and mental health underlined the importance of addressing women's physical situation, suggesting that reducing violence was 'very likely to improve mental health outcomes'.[6] The commission emphasised services that are 'gender sensitive, trauma informed, and coproduced with survivors'. A useful pathway of interaction between service providers and survivors of violence is the World Health Organization LIVES sequence: Listen, Inquire, Validate, Enhance safety and Support (LIVES).[40] Any provider of support should listen empathetically and in private, assess the woman's safety and make a safety plan a priority, respond to her needs and concerns about her children, make the limits of confidentiality clear and document the enquiry, disclosure and safety assessments, and share resources and information. For survivors of modern slavery, there are often additional challenges related to their legal and migration status and their long-term social integration.

We were also interested in using information and communication technology (ICT) as a means of sharing the support package. There is growing interest in virtually delivered material in response to VAW and girls.[41] The development of a range of approaches was accelerated by the COVID-19 pandemic, and there have been several recent reviews. A review of ICT-based IPV interventions found 25 articles, 6 of which addressed mental health and 3 of which helped users to develop action plans.[42] All but one publication in a recent evidence assessment of trauma-focused virtual interventions for survivors of domestic or SV came from high-income countries. The two general types provided either digital safety planning tools or virtual psychological therapies.[43] In a review of 136 app-based interventions for domestic violence prevention, apps addressed emergency assistance (the commonest), safety and avoidance, legal information, and risk assessment.[44] To our knowledge, all the interventions have been designed for use by survivors themselves, rather than as decision guides and recommendations for caseworkers.

Needs of survivors and providers

Table 1 summarises the key findings from interviews with individual survivors and service providers and consultations, classified in terms of their contribution to development of the support package as contextual background, general and specific issues around the mental health of survivors of violence, aspects of current service

TABLE 1 Key findings from qualitative research and their implications for a package of support

Contextual background
Survivors' needs are complex and interrelated
Armed conflict has effects on men's mental health and the resources available to women to leave violent situations
Seeking justice is itself associated with mental health challenges
Survivors often think more about instrumental help than mental health
Mental health
Survivors often find it difficult to identify emotions
Understandings of mental health are contextual and do not reflect professional terminology
Mental ill health is stigmatised, and labels can be used to justify violence
Survivors feel alone in their experience
Survivors of domestic violence commonly experience anger, fear and worry, and guilt and shame
Survivors of modern slavery commonly experience anger, fear and worry, guilt and shame, helplessness, and suicidal ideation
Mental health needs cannot be addressed independently of social needs
Service characteristics
Survivors prefer to seek help from informal sources
There is a preference for community services
There is a perceived lack of support from communities and justice systems
Available services are not always survivor-centred
Providers are not equipped to respond to survivors' mental health needs
There is a lack of mental health professionals
Providers are not adequately prepared to support survivors with suicidal thinking
There is a lack of support, resources and specialised care for mental health
Social workers and barefoot counsellors are potentially available
There is low or no confidence in legal sector actors and agencies
Interagency working is limited
There is a lack of monitoring and evaluation
Package requirements
Survivor involvement in design and delivery
Limited number of potential sessions
Addressing social interventions and mental health simultaneously
Principles of counselling
Safety assessment
Mental health assessment
Tools to gauge trauma and rule out severe mental health concerns
Psychological first aid
Focus on common mental health concerns
Focus on trauma and its consequences

TABLE 1 Key findings from qualitative research and their implications for a package of support (*continued*)

Take a survivor perspective of feelings and function rather than diagnostic categories
Emphasise appropriate referral, working with families and community for reintegration
Grounding and stabilisation techniques
Goal-setting
Aligning the goals of survivor and caseworker
Legal assistance
Health assistance

provision and uptake, and topics and skills that were thought to be necessary components of the package. The results of the qualitative studies are described in more detail in the separate publications[25,45,46] (see *Appendix 1*).

Our findings in all settings were aligned, but differed in degree, the differences lying predominantly in the landscape of service availability. In all settings, programme directors and managers, caseworkers and clinical psychologists stressed the importance of working simultaneously on social interventions and mental health. The needs of survivors of domestic violence and modern slavery were complex. They included basic needs, such as safety, shelter and food; the need for intervention in violent situations and more subtle needs around their mental health. Survivors of violence did not often express their emotions, seeking support for their urgent situational needs and not usually seeking to leave the violent situation. The threshold for seeking formal help was generally high, and confidence that professionals would be able to provide the help they needed was low. There was limited trust in services when they did exist, but they were largely absent from rural Afghanistan and Sri Lanka. Services were not always survivor-centred and were limited in responding with commensurate complexity, and providers were not adequately equipped to respond to survivors' mental health needs. Interviewees in Sri Lanka emphasised a preference for community-based services and low confidence in and limited use of legal support.[45]

Mental ill health was stigmatised in all settings. Stigma was particularly discussed in Afghanistan, and the experiences of violence described by women were often extreme, and sometimes combined with forced sex work, labour, threat of honour killing and restrictions on education and physical liberty. Harms were also perpetuated by healthcare providers and community marginalisation. Persistent armed conflict was a significant factor in both the resources available to women to leave violent situations and in men's mental health. Men often condoned the use of VAW as a means of controlling their behaviour, particularly their vulnerability to indirect and direct SV during armed conflict.[24]

Outputs of workshops with mental health professionals included a list of words survivors might use to describe their emotional state, and a decision that delivering trauma-informed care requires recognition, response and sensitive referral. It was important to explain what the counselling process entailed and how it would proceed. Discussion centred on the availability of caseworkers amidst a lack of availability of mental health professionals, the need for psychological assessment, the need to make psychological and counselling services available in the right places (police stations could be harmful) and the need to work on common mental health concerns with a focus on trauma and its consequences.

Our analysis of anonymised routine data for 2278 clients of counselling services for domestic violence in Mumbai found that supporting survivors required a combination of skills and resources and involvement of multiple institutions: 32% required crisis intervention, 31% home visits from caseworkers and 17% legal support; 13% saw a clinical psychologist, 7% were assisted in consulting the police and 5% received medical care. The main concerns for caseworkers were coping with a heavy workload, responding to women's experience of multiple forms of violence and their desire to stay in relationships, skills in emotional support, ability to undertake and act on risk and mental health assessment, and effective engagement with health, police and legal services.[25]

Consideration of existing theory

Although survivors' stories involve rationalisation, dead-ends and backward steps[47] — a series of cycles punctuated by critical events[48–50] — the idea of a journey was a potential basis for a support package. The journey is both emotional and physical. Emotionally, it has been described as a movement 'from guilt, shame, and depression to

fear and despair, to anger, exhilaration, and confusion'.[51] This journey of reason may or may not be accompanied by physical relocation and is challenged by the harm to self-esteem, self-efficacy and the deconstruction of social identity within violent relationships.[48,52,53]

A hallmark of violence is that, unlike in most other situations in which behaviour change is desired, the consequences of a decision do not depend on the individual. Despite the tendency to blame oneself for domestic violence, someone else is responsible for the harmful behaviour, and women are trying to change their own behaviour in order to change someone else's, which may be beyond their control.[54–56] In cases of modern slavery, psychological and physical coercion vary in scale and nature, but the relationship between victim and perpetrator may be fraught with ambiguity.[57] There are commonalities in the relationships involved in sexual exploitation and domestic violence.[35]

Developed in the 1980s, the transtheoretical model of health behaviour change was framed around public health challenges and has been much used in considerations of the response to domestic violence.[58,59] The model proposes six stages in individual behaviour change: precontemplation, contemplation, preparation, action, maintenance and termination. A particular attraction is that it was designed in order to structure counselling practice (Petrocelli[60] provides a concise review). At its simplest, the initial aim of working with survivors of violence is to help them recognise that they are facing a problem for which they can access acceptable and reliable help.[34,61] Caseworkers then support survivors to make one of three choices: minimising harm and promoting well-being in a violent relationship, stopping abuse and staying or achieving safety by leaving.[54] In developing the support package, we found it useful to think about interventions in terms of 10 processes that Prochaska, DiClemente and Velicer identify as influences on behaviour change (*Table 2*).[58]

Survivors of violence need to survive, grieve and search for meaning in their lives.[48] Dienemann and colleagues proposed three clusters of emphasis: preserving the relationship, preserving the self and preserving the resolution.[64] When the emphasis is on preserving the relationship, the caseworker's focus might be on understanding the cycle of violence, overcoming shame, identifying disruptive relationship patterns, naming the problem as violence, showing concern for the survivor's safety and welcoming her return. When the emphasis is on

TABLE 2 Processes that may be harnessed in counselling women survivors of domestic violence and modern slavery

Process	Example	Possible intervention
Consciousness raising	Receiving information about the self and about violence and becoming aware	Psychoeducation
Dramatic relief	Experiencing and expressing emotions about the violence	Psychodrama
		Role-playing
		Grieving
		Personal testimony
		Media campaigns
Self-re-evaluation	Examining how one feels and thinks about the abusive relationship	
Environmental re-evaluation	Understanding how abuse has affected others in one's life	
Self-liberation	Believing that one can change and committing to act on it	
Social liberation	Non-violence becomes increasingly valued as social norms change	Opportunities through advocacy, policy, nudges
Counterconditioning	Changing the way one responds to the perpetrator and situation	Incident diaries[62]
		Relaxation
		Assertions to counter social pressure
Stimulus control	Redefining the social circle or expanding the reference group[63]	Support groups[62]
Contingency management Helping relationships	Positive and negative reinforcement	Reward group recognition

preserving the self, the focus might be on risks, providing information, and referrals for police and legal support. In the case of human trafficking, the emphasis must be on preserving the self. The caseworker should validate the survivor's mixed feelings about change, assess her mental health and consider referral and the potential benefits of stress management techniques and support groups. When the emphasis is on preserving the resolution, the focus might be on working through the survivor's feelings and helping her to rebuild competencies.

Bringing evidence together into programme theory

Over a series of group meetings and discussions, we synthesised our findings from the literature and data collection into a programme theory that described the potential survivor journey and proposed the content and effects of support (*Figure 3*).

The first column describes the violent environment or conditions outside the individual. Interventions in this category fall under the heading of *resources*, a shorthand for the psychosocial activities necessary to support a survivor. The second column describes the individual's feelings and thinking. Interventions in this category fall under the heading of *reasoning* and imply a combination of psychosocial and psychological activities. The third column, which only begins at a point at which a survivor decides to seek help from a service provider, is effectively a menu of interactions that a support package must provide. The fourth column includes activities that would usually require the involvement of a psychologist or psychiatrist.

Moving from evidence and theory to a package of support

It took about 3 years to collate the evidence for debate and understand the feasibility of each of the components of the support package in discussion with survivors and service providers. *Table 3* summarises the topics or modules that were agreed on as important to include. Some of them (*necessary preparation*) provide background on domestic violence and modern slavery, trauma and the contextual experiences of women experiencing violence. Some of them are prerequisites for an appropriate approach to counselling. The remaining two sections (*consultation with a service provider* and *non-specialist mental health support*) represent the need to simultaneously address resources and reasoning. The distinction between them is porous, since a systematic approach to addressing a survivor's needs will often have implications for her mental health.

From this core evidence-based menu, the content of each module was developed iteratively after reviewing existing similar modules (see *Appendix 2*, *Table 4*), incorporating local information, storylines and scripts and multiple collaborative writing meetings. We adapted the core package for use in four local versions: a manual and training programme and online resource in India, a training manual on assessing psychosocial needs for service providers in Afghanistan and a manual for first responders in Sri Lanka.

Piloting

In India, Sangath piloted the *Pahal* (a new start) intervention manual with three non-specialist health workers recruited in community settings in Goa, and 10 mental health workers from the ongoing community-based *Atmiyata* mental healthcare programme in Mehsana district in Gujarat (in collaboration with the Centre for Mental Health, Law and Policy, Indian Law Society, Pune). The *Pahal* intervention was delivered to 37 women (26 in Goa and 11 in Gujarat) over 4–6 sessions by the non-specialist health workers who were trained for 40 hours, selected after a competency assessment, and supervised on a weekly basis by experts. The intervention was evaluated for acceptability and feasibility using mixed methods, and the programme was modified iteratively based on feedback received during the delivery phase. The suite of intervention materials are being revised based on detailed input on acceptability and feasibility. The trained non-specialist workers completed knowledge tests before and after training and participated in a focus group discussion about the training programme. They participated in additional discussions – once during and once at the end of the intervention delivery phase – to share feedback on the intervention manual, training and supervision, and intervention delivery processes. In general, the intervention was considered acceptable and feasible, and detailed feedback was shared on how the user-friendliness of the manual and the supervision processes could be improved. Most of them reported improvements in their interpersonal communication skills and professional abilities to provide psychosocial support to survivors of domestic violence. Survivors of domestic violence who received the *Pahal* intervention participated in semistructured interviews after they completed the intervention. They were asked about their experience of receiving psychosocial support and perceived positive and negative changes in their life as a result. Most found the intervention beneficial, particularly in improving their interpersonal communication and emotional regulation skills, while others faced barriers in completing the intervention. We received detailed feedback on acceptable characteristics of the non-specialist caseworker, such as being non-judgemental, as well as needs that the intervention could not meet.

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Global Health Research 2025 Vol. 1 No. 2

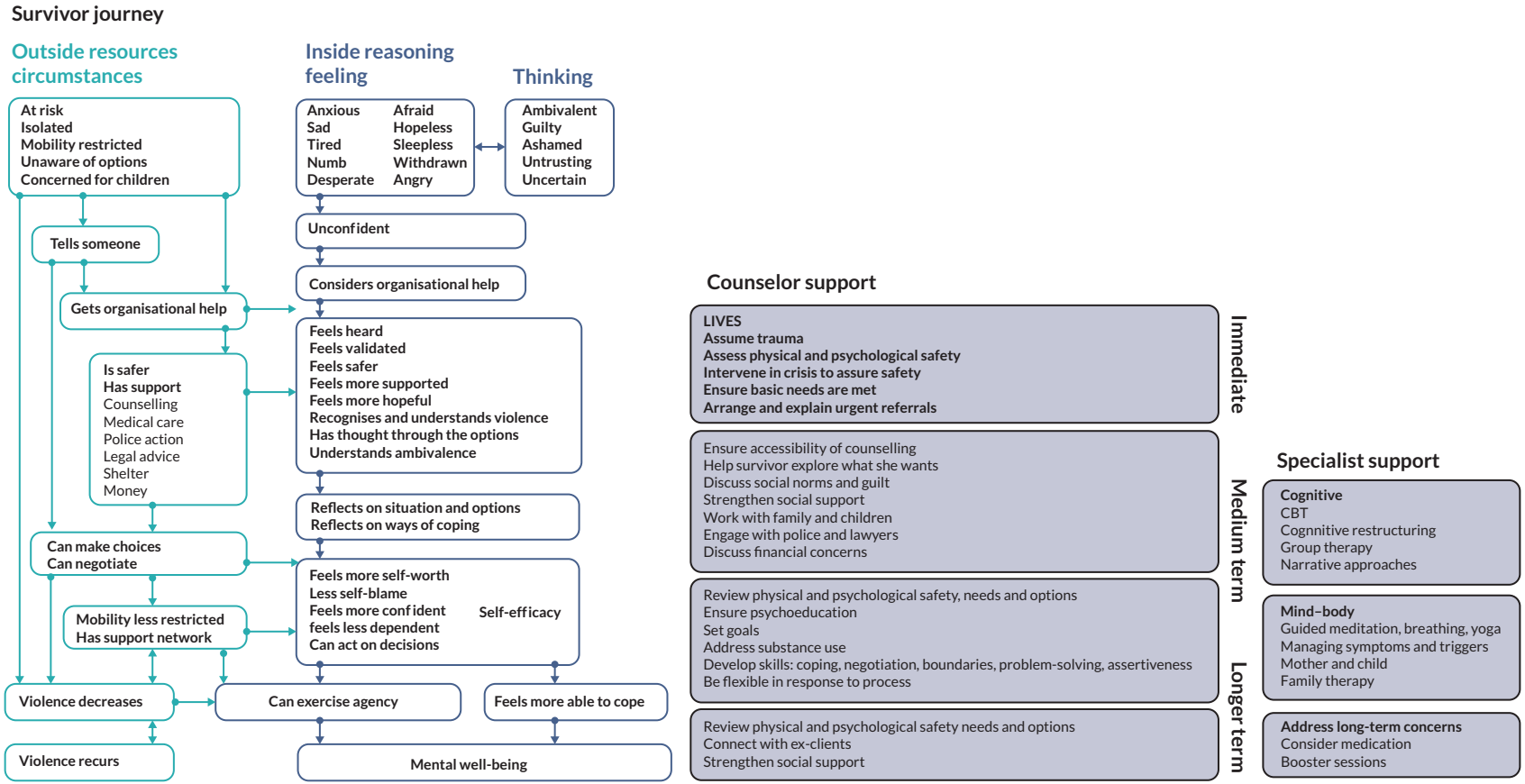

FIGURE 3 Programme theory in the form of a survivor journey.

TABLE 3 Components of the support package

Necessary preparation	Consultation with a service provider	Non-specialist mental health support
Background information	LIVES	Cognitive–behavioural and emotional skill development approaches
Forms of VAW and modern slavery	Listen with empathy	Brief therapy for anxiety
Trauma and how it affects survivors	Ensure privacy	Social connection, community referral and linkages
Trauma-responsive care	Make the limits of confidentiality clear	Boundary setting
Socioecological and situational influences	Mental health first aid and distress reduction	Repeated review and discussion of plans and goals
Response before consultation with a service provider	Suicide prevention	Support for caseworker self-care, burn-out and vicarious trauma
Advice for people to whom survivors may disclose	Psychoeducation on domestic violence and modern slavery, rights, law, medical care, police intervention and shelter	Documentation, monitoring and evaluation
Prerequisites for support	Respond to basic needs	When to refer to a psychologist or psychiatrist
Principles of counselling	Safety assessment and safety planning	
Ethics and confidentiality	Social connection	
Connections with other organisations for referral: shelter, food, education and livelihood, police, medical care, legal support, child care	Share resources and information	
	Intervening in crisis	
	Problem-solving and choice-making	
	Collaborative planning and goal-setting	
	Focus on personal and cultural strengths	
	Mental health assessment	
	Communication skills	

Sources: project research.[4,6,20,21,28–37,65]

We piloted the GARiMA online support package with caseworkers in four SNEHA sites and eight caseworkers from other organisations working on domestic violence and human trafficking. Researchers observed counselling sessions with consent from clients and asked both caseworkers and clients open-ended questions about what worked well and what did not. Most caseworkers had received training in principles of and approaches to counselling, but not in addressing mental health. They knew little about mental health interventions and used observation-based diagnosis and principles of natural justice to help survivors, albeit in an unstructured way. Caseworkers for survivors of human trafficking tended not to set clear goals and timelines but to focus on explaining the counselling process and survivors' options. Caseworkers found the support package relevant and useful as a way to standardise the counselling process. It helped them to work through a combination of psychoeducation and mental health support in a systematic sequence. They found grounding exercises useful for survivors in situations of distress and anxiety, and selected exercises that they found culturally appropriate (visualisation, awareness and orientation in time). Seven survivors of human trafficking reviewed the package of support positively, although they felt that it was important to emphasise the non-linearity of the survivor experience. They underlined the importance of autonomy and involvement in decisions about intervention, including medication. In Sri Lanka, we shared copies of workbooks with beneficiary organisations to test their usefulness for students, staff and volunteers

at Sumithrayo befriending services and the community psychiatry team at Jaffna Teaching Hospital. There were requests to extend the scheme to public health care and for use by psychiatrists.

On the basis of feedback and observation, SNEHA designed and delivered a pilot course on the mental health of survivors of domestic violence, using the multilingual GARiMA package of care as a framework. The 2-month online course of weekly 2-hour sessions delivered through Google Classroom (Google Inc., Mountain View, CA, USA) was attended by 42 participants from 27 organisations and independent consultants across India. Regular feedback was taken through polls and discussions. Overall, participants felt that the support package had led to two major changes in their work: first, they had understood the importance of taking a structured approach to psychosocial and mental health intervention, including psychoeducation, distress reduction and suicide prevention, and modules on boundary setting and goal-setting and caseworker self-care; second, they had been able to deliver mental health interventions for emotions such as anger, fear and worry, and cognitions such as guilt.

Discussion

Over 4 years, we worked collectively to review and define the content needed for a support package for women survivors of domestic violence and human trafficking in three countries in South Asia. Three questions sparked debates that were repeated throughout the process. Who will the package support, who would use and deliver it and what do we mean by intervention to improve mental health?

Who will the package be used to support?

The package was designed to support the mental health of survivors of domestic violence and human trafficking. Contextual differences will necessitate adaptation – for example, whether or not survivors are in an ongoing or post-conflict environment – and there are differences in detail in the contexts of domestic violence and modern slavery.

Who will the support package be used by?

The package is designed to be used by non-specialists. In some cases, these may be individuals with a background in social work. In others, they may be community caseworkers or barefoot counsellors with a modicum of training. They may work in the public or – more commonly – the non-government or voluntary sector. They may be primarily advocates for survivors of domestic violence, survivors of modern slavery or clients with mental health concerns. The package emphasises counselling and communication skills and has sufficient breadth and depth to help users in all three contexts. We do not intend the package to be used as self-learning for survivors of violence themselves. One debate was, at which point in the survivor journey the package would begin? Would it, for example, begin before she had contacted a formal source of support; perhaps be used by general community workers and volunteers? We do not intend the package to be used in this way but have included supplementary guidelines for community members with no background in counselling. Finally, the emphasis is on non-specialist delivery of mental health care, for which there is an evidence base.[66] We hope that clinical psychologists and psychiatrists might find the sections on resources for domestic violence and modern slavery useful, but they are not the primary users. In the same way, the package avoids technical language and (largely as a result of our extensive discussions with mental health professionals), we recommend that non-specialist caseworkers do not venture into therapeutic territory that would be unmanageable and potentially unsafe for themselves and their clients.

What is a mental health intervention for survivors of violence?

The question of what constitutes a mental health intervention recurred throughout the process. At one end of the spectrum are instrumental interventions, such as filing a legal case, and at the other are psychological interventions, such as CBT delivered by a specialist. The middle ground is softer. To pursue the example of filing a legal case, it is clear that the procedures involved would not be thought of as psychotherapeutic, but a moment's consideration suggests that talking to a lawyer, understanding one's rights and getting a clearer picture of the sequence and potential outcomes could go a substantial way to reduce anxiety and reframe cognitions. Semantically, we tended to acknowledge this by describing support for survivors of violence as psychosocial or psychological. A package of support must include interventions for both. Although there is evidence that psychotherapeutic intervention can make a difference to survivors' mental health (particularly mood-related symptoms), there is little point in confining care to it. One option might be to develop a package of approaches that could be added to existing procedures as a kind of adjunctive psychotherapy. We discussed this at most of the workshops but chose another approach: the idea of imbuing the non-specialist caseworker's whole approach with an understanding of mental health and

response to trauma. This was based on five foundational propositions. (1) The emotional support work involved in responding to distress during counselling *is* mental health work. (2) For this and other reasons, the approach to counselling should be intentional, trauma-informed and contribute to mental health. (3) Ensuring safety, provision of information, referral and liaison with medical, police, legal and shelter services is central to mental health care. (4) Response must take account of the intersectionality between a client's family concerns, socioeconomic status, ethnocultural traditions, political views and sexuality. (5) Mental health interventions may not be explicitly clinical but include identification and management of a range of emotions through a therapeutic alliance.

Limitations

Our methods involved reviewing the literature, conducting a situational analysis, and qualitative and quantitative data collection. The specific limitations of the literature and realist reviews and situational analyses are detailed in the individual papers, and, as described, we were unable to conduct the planned large quantitative survey in Sri Lanka due to delays in approvals and travel restrictions during the COVID-19 pandemic. As with other qualitative work, more data collection may have provided greater understanding of the issues. We do, however, feel that saturation was gained. Further work would help to address the situations of particular target groups; for example, those with histories of abuse as children or sexual minority groups.

Our work was compromised by the COVID-19 pandemic. After two annual meetings of the full group, intervention development workshops and collaborative analysis meetings were held online. Generally, partners were able to hold individual interviews and small consultations face to face. The shift to virtual communication helped us to understand some of the dynamics of domestic violence.[67] Some limitations arose from the sequencing of activities in the different sites. The situation in Afghanistan was always challenging because of the entwinement of women's health with wider geopolitical dynamics relating to women's rights, but our colleagues were able to complete all of the planned interviews. Unfortunately, an additional project on mediation was put on hold with the change of government in August 2021. The current government has retracted previous legislation around VAW, limited civil society activities, replaced the Ministry of Women's Affairs with a Ministry of Vice and Virtue and curtailed referral and operation of shelters. Our collaborating organisation is not identified in this synopsis. However, there is support for a health agenda that focuses on mental health and psychosocial support, and this shows potential for future relevance and applicability of the work achieved so far in this context, such as the dissemination of the training manual. The Aragalaya protests in Sri Lanka from March to November 2022 prevented field activities to refine and pilot the package. We make no claim of generalisability for local versions of the package. We do think, however, that the core package is based on a consensus that extends beyond the regional to the global.

Dissemination

Upon creation of the package, dissemination activities were planned in all sites, taking account of their specific situations. Dissemination involved discussions with policy-makers, including running symposia and a roundtable. We planned stakeholder events at which the package and its local adaptations could be discussed. These have been followed by courses for potential users of the package, which have led to the development of a network of non-governmental organisations working on domestic violence and mental health in India. This group are in the process of codeveloping monitoring and evaluation frameworks to be used in the region.

Development challenges

In all its forms and in all countries, addressing VAW and girls is a development challenge. It occurs on a global background of gender inequity, causes acute, chronic and transgenerational harm to health and is associated with losses to human, social and economic capital. The importance for societies is evidenced by its explicit inclusion in United Nations Sustainable Development Goals 5.2 (eliminate VAW, girls and children), 8.7 (end human trafficking and child labour) and 16.2 (end abuse, exploitation, trafficking). Our interest in helping caseworkers to support survivors speaks to the World Health Assembly 2014 resolution on strengthening the role of health systems in addressing violence, the goals of the Global Partnership to End Violence Against Children and the South Asia Institute to End Violence Against Children, and the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children. It also addresses the 1980 Convention on the Elimination of All Forms of Discrimination Against Women and the 2006 UN declaration on response to VAW and girls. The regional development challenge echoes the global challenge. A particular concern is the shortfall in mental health professionals and the need for task-shifting to caseworkers. The lack of prominence of mental health concerns is a gap that we are trying to fill, within the broader context of the 2011 Grand Challenges in Global Mental Health, the 2013 WHO Mental Health Action Plan and UN Sustainable Development Goal 3.4 (reduce premature mortality from non-communicable disease, and promote mental health).

Conclusions and future plans

Summary

In three countries in South Asia with varying political, cultural and conflict environments, we have developed a contextually adaptable support package for the mental health of women survivors of domestic violence and human trafficking. The package is based on recommendations in the existing literature, interviews with survivors, advocates and clinicians, interdisciplinary academic group discussions and theoretical considerations.

Key learning points

The contribution of our work is novel in two ways.

Amidst calls for transdisciplinary research, we have found that it is possible to bring together different forms of knowledge – academic, practice-based and lived experience, written and oral – from global South and North.

It is challenging, but important, to keep the programmatic implications of research in mind throughout. We were in search of practical advice that allows caseworkers to integrate trauma-responsive support for survivors' mental health with social and legal support.

Implications and recommendations

Policy implications

Domestic violence and mental ill health are major causes of distress, morbidity and mortality affecting individuals, families and societies. To reduce the adverse impact, policy-makers must both act to prevent domestic violence and support survivors. The package we produced is a useful tool for the latter, and we urge policy-makers and decision-makers to consider incorporating it into in-service and refresher training. Since in many countries the third sector provides the majority of care for survivors of violence, the package has been designed for use in community settings by health and social workers in non-governmental organisations. Additional training will be required, and funding to ensure it can be used in a sustainable and impactful way. We would also urge further funding to answer the research questions described below.

Our recommendations can be divided into three main groups:

For practitioners: we encourage non-specialist and specialist providers and government and non-government organisations to consider using the package of support in their own communities. Both government and non-government caseworkers will benefit from simple, stepwise guidelines for communication that will help them plan discussions with survivors and include trauma-informed responses that embed mental health in all interactions.

For researchers: we urge researchers to evaluate the effectiveness of the package for survivors' mental health. This includes (1) understanding its applicability and feasibility in multiple contexts, (2) evaluating the effectiveness of the package and (3) identifying the barriers and drivers to uptake and examples of success. In addition, the specific needs of marginalised groups should be explored, with modules added to the package as required.

For policy-makers: a policy environment that values, supports and co-ordinates community services to support survivors of violence is required. This should include pathways that link community care provided by non-governmental organisations with government public services. We appreciate the difficulties in doing this in some settings, but steps in this direction will help survivors.

We welcome feedback that will improve the locally adapted packages.

Priority areas for future research:

In addition to the recommendations for government and non-government health and care professionals, we have three priorities for research that would (1) integrate mental health care with social care; (2) identify approaches to translating trauma-responsive care into service provision and (3) consider family violence, including VAW and children together.

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Data-sharing statement

Because of the sensitive nature of the research, participants did not give written consent for their data to be shared publicly. Some data are available from the corresponding author upon reasonable request.

Ethics statement

Ethical permission for the research activities was granted by the UCL Research Ethics Committee (2744/007, 29 November 2018), The Islamic Republic of Afghanistan Ministry of Public Health Institutional Review Board (24 February 2019), Sangath Institutional Review Board (AN_2018_46, 17 August 2019), the India Health Ministry Screening Committee, the University of Colombo Faculty of Medicine Ethics Review Committee (EC-19-122, 17 October 2019), the Institute for Health Policy Institutional Review Board (2020-026, 28 April 2020), and the London School of Hygiene and Tropical Medicine Research Ethics Committee (22818, 17 November 2020). All primary data collection followed ethical guidelines.[68,69] Interactions with women survivors of domestic violence and modern slavery took place under the aegis of civil society organisations, all of which had protocols for confidentiality, safeguarding, response to distress, and referral. Interviewers were trained in ethical approaches and no transcripts included the names of interviewees. Information on approaches to specific activities is available for qualitative data collection in Afghanistan,[24] India,[70] and Sri Lanka,[45] and for record analysis in India.[25]

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Publications

Core publications

Devakumar D, Palfreyman A, Uthayakumar-Cumarasamy A, Ullah N, Ranasinghe C, Minckas N, *et al.* Mental health of women and children experiencing family violence in conflict settings: a mixed methods systematic review. *Confl Health* 2021;**15**:74. https://doi.org/10.1186/s13031-021-00410-4

Lowe H, Dobbin J, Kiss L, Mak J, Mannell J, Watson D, Devakumar D. Mechanisms for the prevention of adolescent intimate partner violence: a realist review of interventions in low- and middle-income countries. *PLOS Glob Public Health* 2022;**2**:e0001230. https://doi.org/10.1371/journal.pgph.0001230

Paphitis SA, Bentley A, Asher L, Osrin D, Oram S. Improving the mental health of women intimate partner violence survivors: findings from a realist review of psychosocial interventions. *PLOS ONE* 2022;**17**:e0264845. https://doi.org/10.1371/journal.pone.0264845

Mak J, Bentley A, Paphtis S, Huq M, Zimmerman C, Osrin D, *et al.* Psychosocial interventions to improve the mental health of survivors of human trafficking: a realist review. *Lancet Psychiatry* 2023;**10**:557–74. https://doi.org/10.1016/S2215-0366(23)00105-0. Erratum published in: *Lancet Psychiatry* 2023;**10**:e24. https://doi.org/10.1016/S2215-0366(23)00233-X.

Mukerji R, Saboor L, Paphitis S, Devakumar D, Mannell J. How does domestic violence stigma manifest in women's lives in Afghanistan? A study of survivors' lived experiences of help-seeking across three provinces. *Glob Public Health* 2023;**18**:2212035. https://doi.org/10.1080/17441692.2023.2212035

Daruwalla N, Das T, Punekar S, Patil S, Manjrekar S, Pantvaidya S, *et al.* Support needs of survivors of violence against women in urban India: a prospective analysis of client records. *Glob Health Res* 2024. https://doi.org/10.3310/LKNH2423

Deivanayagam TA, Ní Chobhthaigh S, Devakumar D, Patel K, Rannan-Eliya RP; SLHAS Collaborators. Mental health prevalence, healthcare use and access between 2018 and 2022 in Sri Lanka: an analysis of survey data [published online ahead of print May 22 2024]. *Glob Health Res* 2024. https://doi.org/10.3310/HJWA5078

Palfreyman A, Vijayaraj K, Riyaz S, Rizwan Z, Sivayokan S, Thenakoon THS, *et al.* What women want: mental health in the context of violence against women in Sri Lanka – a qualitative study of priorities and capacities for care. *Violence Against Women* 2024;10778012241230326. https://doi.org/10.1177/10778012241230326. Epub ahead of print.

Kaul A, Saboor L, Ahmad A, Mannell J, Paphitis SA, Devakumar D. What are the experiences and psychosocial needs of female survivors of domestic violence in Afghanistan? A qualitative interview study in three Afghan provinces. *BMJ Open* 2024;**14**:e079615. https://doi.org/: 10.1136/bmjopen-2023-079615.

Quinlan-Davidson M, Ahmad A, Asher L, Bhatia U, Daruwalla N, Devakumar D, *et al.* Mental health and violence against women in Afghanistan, India and Sri Lanka: a situation analysis [published online ahead of print April 30 2025]. *Glob Health Res* 2025. https://doi.org/10.3310/GDOM7555

Related publications

Huq M, Das T, Devakumar D, Daruwalla N, Osrin D. Intersectional tension: a qualitative study of the effects of the COVID-19 response on survivors of violence against women in urban India. *BMJ Open* 2021;**11**:e050381.

Palfreyman A, Riyaz S, Rizwan Z, Vijayaraj K, Chathuranga IPR, Daluwatte R, *et al.* Cultivating capacities in community-based researchers in low-resource settings: lessons from a participatory study on violence and mental health in Sri Lanka. *PLOS Glob Public Health* 2022;**2**:e0000899.

Lowe H, Brown L, Ahmad A, Daruwalla N, Gram L, Osrin D, *et al.* Mechanisms for community prevention of violence against women in low- and middle-income countries: a realist approach to a comparative analysis of qualitative data. *Soc Sci Med* 2022;**305**:115064. https://doi.org/10.1016/j.socscimed.2022.115064. Epub 2022 May 25.

Shah A, Catalano A, Bhatia U, Gupta D, Daruwalla N, Osrin D, Nadkarni A. Coping strategies and help-seeking behaviors among survivors of intimate partner violence: a qualitative study of spouses of men with heavy drinking in India. *Health Soc Care Community* 2024;**2024**:1–15.

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About this synopsis

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List of abbreviations

CBT	cognitive–behavioural therapy
ICT	information and communication technology
IPV	intimate partner violence
LIVES	Listen, Inquire, Validate, Enhance safety and Support
NIHR	National Institute for Health and Care Research
SNEHA	Society for Nutrition, Education and Health Action
SV	sexual violence
VAW	violence against women
WP	work package

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Appendix 1

Survivor experiences

The aim of the study was to collect qualitative data in all the sites to understand survivor and provider views.

Afghanistan

This study aimed to qualitatively explore (1) the experiences of female survivors of domestic abuse and mental health problems in Afghanistan; (2) how female survivors of violence and abuse, male members of the community and service providers perceive and respond to mental health and domestic violence in Afghanistan and (3) the provision of mental health services for female survivors of violence and abuse in Afghanistan, including the barriers and challenges faced around accessing mental health services. We used qualitative interviews conducted in Kabul, Bamyan and Nangarhar, and framework thematic analysis. Sixty female survivors of domestic abuse, 60 male community members and 30 service providers who work with female survivors of domestic abuse were interviewed. Experiences of multiple and compounding traumatic experiences of violence, armed conflict and complex and competing psychosocial concerns were common among the female survivor participants. All female survivor participants reported experiencing negative mental health outcomes in relation to their experiences of violence and abuse, which were further precipitated by widespread social stigma and gender norms. Support and service provision for female survivors was deemed by participants to be insufficient in comparison to the amount of people who need to access them. There are many risks and barriers women face to disclosing their experiences of violence and mental health problems which restrict women's access to psychological support. Culturally relevant services and trauma-informed interventions are necessary to respond to these issues. Service providers should be trained to effectively recognise and respond to survivors' mental health needs. The main limitation was that data collection occurred in 2019–20 years before the Taliban seized control of Afghanistan. Our findings should, therefore, be interpreted within the context of Afghanistan's rapidly changing political landscape.

India

We aimed to document the range of responses that a counselling service should be able to provide, based on direct experience of working with survivors predominantly from urban informal settlements. At non-government counselling centres in Mumbai, we analysed unlinked electronic records collected by counsellors supporting survivors of violence. We examined how women knew of the services, how they described their concerns, what they said they expected and what was provided. We quantified the proportions of clients who required crisis intervention, police action, legal input and medical, psychological and psychiatric support. Results: counsellors met with 2278 women clients in 2019, almost half of whom had been encouraged to attend through community outreach. Clients described IPV (37%), domestic violence by a family member other than their partner (22%), or both (27%). Common forms of violence reported were emotional (88%), economic (73%) and physical (71%); 68% of clients reported episodes of neglect, 59% of coercive control and 36% of SV, while 77% had survived three or more forms of violence. Over a median of seven consultations, 32% required crisis intervention, 31% home visits from counsellors and 17% legal support; 13% saw a clinical psychologist, 7% were assisted in consulting the police and 5% required medical care. The record system may have been subject to errors in data entry or systematic differences between counsellor choices, with the possibility of over- or underidentification of need and different counsellors' propensities for and choices of referral. The spectrum of concerns relates to women residents of urban informal settlements, and we should be cautious about their application to other populations. Demand for services was substantial at 200 new clients each month. Key concerns for counsellors were coping with this heavy workload, skills in responding to women's experience of multiple forms of violence and their desire to stay in relationships, skills in emotional support, ability to undertake and act on risk and mental health assessment, and effective engagement with health, police and legal services.

Sri Lanka

Insufficient evidence guides mental health service development for survivors of VAW in Sri Lanka. We aimed to better understand the mental health needs and preferences of SVs of VAW in two diverse locations in Sri Lanka and obtain suggestions for beneficial interventions from diverse perspectives. Provider and survivor perspectives on (1) what constitutes mental health, (2) quality of care and (3) priority areas and stakeholders for intervention were identified through framework analysis of 53 in-depth interviews. Desired care is chiefly psychosocial — not psychological — prioritising socioeconomic, parenting and safe environment needs in non-clinical community settings. Limitations include mixing data collection modes, which was necessitated by COVID-19. While no participants declined to take part citing lack of technology access, mixed modes and particularly remote data collection may have introduced reporting and sampling bias. Women with disabilities and transwomen were few in our sample, as were faith and traditional healers, limiting our interpretations of their respective experiences and potential contributions to reimagining mental health care in the context of VAW. Our evidence points strongly to the need to strengthen non-mental health community-based providers as 'first contacts' and reassessment of health system-centric interventions which neglect preferred community responses and more holistic approaches accounting for women's full circumstances.

Appendix 2

TABLE 4 Existing guidelines used in package development

World Psychiatric Association (WPA) international competency-based curriculum for mental healthcare providers on IPV and sexual VAW	[71]
WHO Ensuring Quality in Psychosocial and Mental Health Care/Enhancing Assessment of Common Therapeutic Factors	[72]
Health care for women subjected to IPV or SV: a clinical handbook. WHO, UN Women, UNFPA	[73]
Caring for women subjected to violence: a WHO curriculum for training healthcare providers	[40]
Responding to IPV and sexual VAW: WHO clinical and policy guidelines	[74]
Medicolegal care for survivors/victims of SV. Government of India Ministry of Health and Family Welfare	[75]
Responding to domestic abuse: a resource for health professionals. UK Government Department of Health	[76]
Coping with trauma: workbook. South London and Maudsley NHS Foundation Trust	[77]
Strengthening health systems to respond to women subjected to IPV or SV: a manual for health managers. WHO	[78]
How to support survivors of gender-based violence (GBV) when a GBV actor is not available in your area: a step-by-step pocket guide for humanitarian practitioners. Inter-Agency Standing Committee Global Protection Cluster: GBV Prevention and Response	[79]
Problem Management Plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity. WHO	[80]
Assessment and management of conditions specifically related to stress: mental health Gap (mhGAP) intervention guide module. WHO, UNHCR	[81]
mhGAP community toolkit: field test version. WHO	[82]