



Research Article

# Conceptualizing a Low Resource-Low Intensity Psychosocial-SRH Integrated Intervention to Improve Sexual and Reproductive Health Care Seeking among Young Women in Humanitarian Settings

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## Abstract

Despite the availability of sexual and reproductive health (SRH) services in some humanitarian contexts, most young women have limited access to these services. Furthermore, many young women in

humanitarian settings suffer from distress and cannot access care. In response to this double burden, WHO is conceptualizing a potentially scalable psychosocial (PSS) and SRH integrated intervention package to improve the use of selected SRH services and

wellbeing among young women (aged 15-24 years) in humanitarian settings. Informed by two systematic reviews exploring the efficacy of PSS and SRH educational interventions on selected SRH outcomes (coupled with expert consultations, reviewing existing WHO PSS interventions for common mental disorders, and active community engagement), a three-tiered PSS and SRH integrated intervention package is being designed to, 1) engage young women and their social circles through community education and advocacy activities, and 2) enhance women's socio-emotional capabilities and SRH-related knowledge and behaviours. This intervention will consist of a women groups 'component (a package of eight-modules), a community component, and up to three sessions of focused support through home visits for vulnerable young women. This article describes the process of conceptualising the intervention package and provides an overview of the content of this PSS-SRH integrated intervention.

**Keywords:** Low Resource-Low Intensity Psychosocial-SRH ; Sexual and Reproductive Health; Potentially scalable psychosocial (PSS)

## 1. Background

Globally, an estimated 34 million adolescent girls and women of reproductive age are forcibly displaced due to humanitarian crises [1, 2]. Research from the field shows that despite having minimum standards and available services, access to family planning and sexual and reproductive health (SRH) interventions and services remains low [3- 9]. Factors that have been identified as being related to this limited uptake of SRH services among young women in humanitarian crises include: accessibility issues (e.g.,

inadequate human resources and other services infrastructure), language barriers, legal residency status, stigma and shyness, gender norms and inaccurate cultural preconceptions (e.g., right to services if unmarried or raped), lack of information on how and where to access existing services, misconceptions about contraceptives, opposition from partners, cost, and exposure to violence and abuse [4, 8, 10-15].

In addition to unmet SRH needs among youth, mental disorders account for a substantial proportion of the global disease burden in this age group [16]. Despite their higher prevalence, mental disorders are often overlooked in humanitarian settings [17] and are associated with a range of health risk behaviours, including inconsistent contraceptive use and other sexual and reproductive risk behaviours [18]. Furthermore, there are significant inequalities in receipt or uptake of medical care for people with mental health conditions due to a range of health system and individual factors [19]. People at risk of mental health conditions may be naturally disadvantaged in their ability to maintain healthy behaviours and having access to health education messages due to social isolation and lack of family support, self-neglect, lack of motivation and other cognitive and socio-economic factors [19]. Emerging evidence supports the notion that SRH interventions for people at risk of mental health conditions can reduce potentially detrimental health behaviours, such as sexual risk taking as well as [20]. Psychosocial interventions that strengthen adolescents' problem solving, interpersonal skills and coping strategies, could reduce psychological distress and prevent or reduce the impact of mental health conditions.

Simultaneously, they can provide the foundational skills for promotion of healthy behaviours and prevention/reduction of health risk behaviours, including SRH risk behaviours, especially when accompanied by broader actions addressing environmental and contextual factors in the family and community [20].

An integrated approach to mental health and SRH issues, such as a combined PSS-SRH intervention, could improve access to evidence-based care and increase wellbeing [20-21]. With this in mind, WHO developed a PSS – SRH integrated intervention package that seeks to empower young women and older adolescent girls living in humanitarian settings through the primary aim of strengthening self-efficacy to access essential SRH services according to their needs, with a secondary aim of improving wellbeing. This manuscript describes the conceptualisation of this multi-level (individual, community, and more focused support) integrative intervention and provides an overview of its contents.

## **2. Development of the Intervention Concept**

The concept of this PSS-SRH intervention package was shaped following two systematic reviews. Their respective Prospero protocols have been published at the national institute for health research <sup>1, 2</sup>. The first one was undertaken to examine the efficacy of PSS interventions on selected SRH outcomes (intimate partner violence, condom and other contraceptive use, sexual behaviour and antenatal care uptake) in men and women age 13 and above, living in low resource settings [22]. This systematic review showed that psychosocial (PSS) and educational interventions can have significant positive effects (of small to medium

magnitude) on the reduction in intimate partner violence, and improvements in condom use and other contraception use. There was no significant effect on improvements in antenatal care uptake or prevention of unprotected sex. The second systematic review [23] aimed to explore, describe and evaluate more rigorously tested SRH interventions for young people in LMIC and humanitarian settings in order to synthesize the evidence-base on identifying which interventions demonstrate effectiveness for improving SRH outcomes. This systematic review found the following two SRH outcomes commonly improved over time: 1) effective contraception and condom use skills, and 2) HIV and STI prevention knowledge. The evidence also suggested that in the context of humanitarian and LMIC settings, the content of such interventions must be adapted to context and the realities of humanitarian emergencies (such as high levels of trauma exposure and loss). We also conducted a basic thematic analysis to examine and describe the components of each of the effective interventions identified in trials in the two systematic reviews. This allowed the intervention development team to summarize and review both common elements of effective interventions and to also examine patterns in barriers, facilitators and delivery methods.

Half of the effective interventions had a community level component or were a mixture of many community activities, such as advocacy or drop-in group educational talks, peer support groups, or enhancement of existing SRH services [24-28]. The most frequently found themes of effective interventions drew from Cognitive Behavioural Therapy (CBT) or interpersonal therapy (IPT) models.

For instance, many interventions included problem solving, self-regulation skills, and goal setting, which are all commonly used in CBT.

Communication and interpersonal skills, which are common to interpersonal therapy were also used. In addition, SRH content most frequently focused on HIV and STI prevention education, family planning education coupled with effective contraception and condom use skills, GBV risk education and skills and SRH-specific assertiveness and communication skills (such as condom use and negotiation). Lay people were most frequently used to deliver the interventions, in a range of settings including at participant's homes, at local clinics or in publicly accessible areas in the community. Echoing these findings is a systematic review of systematic reviews on interventions to improve sexual and reproductive health in youth [18], which recommended multi-component interventions for improvement of sexual and reproductive health of young women, along with comprehensive quality sexual education interventions to shift social norms and generate community support and quality youth responsive health care [18].

Additionally, we looked into WHO's existing portfolio of evidence-based scalable psychological interventions for common mental disorders to identify possible content to include in the intervention. The existing components and content identified in these materials were considered for inclusion, including CBT strategies, problem solving, interpersonal therapy and other elements of psychological first aid/stress management. Furthermore, we developed

the SRH content of this package in line with existent WHO SRH guidance on family planning, safe abortion care, antenatal care, prevention and management of STIs and HIV as well as WHO recommendations on adolescent sexual and reproductive health and rights.

Finally, expert opinion was sought from WHO's network of academic, humanitarian and implementation specialists both from the field of mental health and SRH. At the earliest stage, calls were held with experts, followed by an expert technical consultation meeting held in Geneva in May 2018 to discuss a preliminary concept note with proposed content for the intervention. All experts agreed with the utilization of the suggested PSS elements to increase self-efficacy and with the importance of community activities to increase community buy-in, reduce stigma and to possibly impact gender norms that are often a major barrier to SRH care seeking. An output of the consultation meeting was the development of a theory of change model, based on an ecological framework approach and on the health belief model [29, 30].

The ecological framework provides a structure for considering influencers (e.g., norms and empowerment) from the individual level to the societal level [30], and the health belief model pertains to the importance of knowledge gain and reducing barriers in both SRH and improving wellbeing. Based on which, the proposed theoretical framework for the intervention package is described in the figure below.

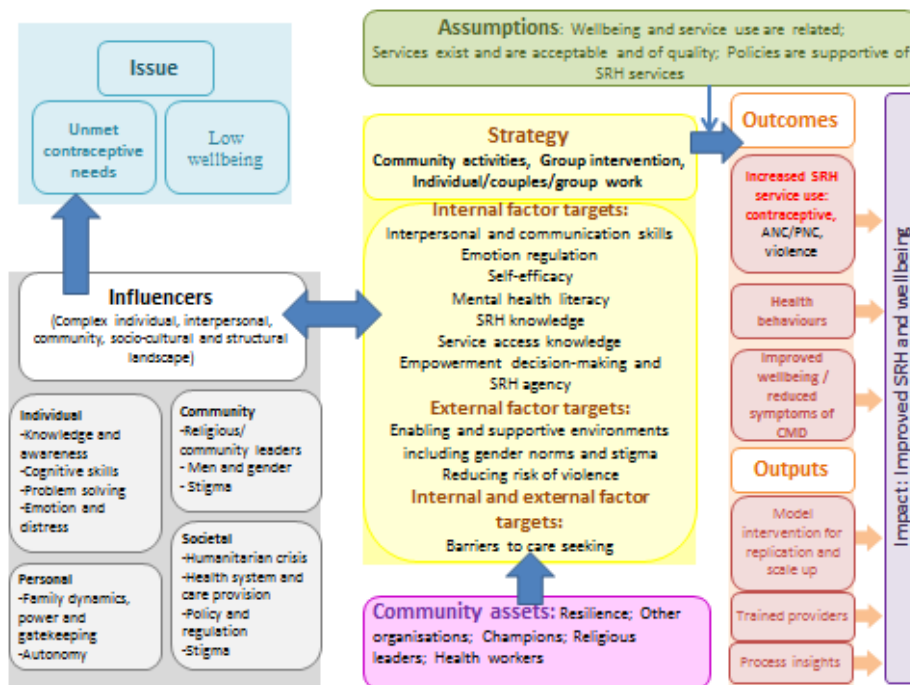


Figure 1: Proposed theory of change of the intervention package.

### 3. Target Beneficiaries

The primary target of the intervention package will be older adolescent and young adult women (ages 15-24) living in humanitarian settings, as very limited research is on this target population in humanitarian settings. The PSS-SRH integrated intervention package aims to improve SRH and mental health/wellbeing outcomes in this population, with specific emphasis on young women with selected unmet SRH service needs (focused on contraception).

It was developed to be suitable for women who are single or in a relationship, may or may not be pregnant or have children already, and they may or may not have a pre-existing mental health problem or disorder<sup>3</sup>. To improve SRH service use and ultimately SRH behaviours in the primary target population, a broader group of people in the family

and communities will need to be reached by the intervention, including specifically partners, parents as appropriate, and peers. Thus, the group intervention package will have an accompanying community component targeting men and older women.

Based on the evidence resulting from the two systematic reviews [22, 23] and the thematic analysis, involving men and the wider community is especially important in communities with high stigma associated with some sexual behaviours (e.g., early sexual initiation, and mental illness and/or gender power inequalities).

Such community engagement has been shown to improve autonomy among young women and reduce the risks for interpersonal violence.

#### **4. Delivery Model**

Based on the available evidence [22, 23] and expert advice, we propose a multicomponent and multilevel package composed of: (i) community-level education and engagement activities; (ii) a group-based psychological intervention combined with SRH education and skills training for young women drawn from evidence-based CBT and IPT components; and (iii) home visits to assess, refer and provide brief specific mental health and SRH support to vulnerable youth and their partners or parents. To increase acceptability, the intervention will be promoted as a health and wellbeing (rather than SRH) package for women living in humanitarian contexts. Given that a major barrier to health services provision is limited availability of human resources [31-33] and considering the promising findings from the aforementioned meta-analysis [22-25], the intervention will be designed to be delivered by non-specialist providers in health, education and social care systems, from trained lay community members and peers to nurses, midwives, para-professional health care providers, social workers or teachers. For the community level activities, the target providers will be male and female peers, and for the group and home sessions, this will be provided by trained female lay community members.

To overcome geographical constraints and encourage integrative service modelling, the intervention package will be designed to be integrated easily into existing health, education and social care services including primary health care, schools and basic needs support services, as well as in the community in general for groups who may be more restricted to their homes or immediate locality. To ensure high-

quality and ethical delivery of the intervention to vulnerable populations, supervision structures and mechanisms for ensuring quality will be included.

#### **5. Description of Intervention Tiers**

##### **5.1 Community level activities (Tier 1)**

Community level activities will serve as a mean to involve men, parents and the wider social networks of the female youth who would receive group intervention sessions (tier two of the package). This is especially important in communities where shame or stigma associated with sexual behaviours and mental illness and/or gender power inequalities can reduce autonomy among young women and increase the risk for interpersonal violence [34]. Community-level activities will also serve to orientate the community to the programme and advocate for and recruit participants for group sessions. Important community stakeholders and gate keepers (including faith leaders and other influential members of the community) will be involved where possible.

The intervention package will include examples of and guidance for running simple community activities such as health and wellbeing talks (psychoeducation and SRH education) and engagement sessions, which are designed with local sensitivities and taboos in mind. Gender acculturation discussions and activities are crucial to help improve access to the group level intervention sessions, and to possibly reduce levels of interpersonal violence within the community. Community level activities will be specific to the context, guided by community needs identified during bottom-up formative qualitative research. Entertainment (such as theatre, TV, radio) may be used as a pathway to engagement and recruitment,

though should not be the sole focus of community level activities. Activities should be run by trained male and female lay persons from the community, working linked to health providers such as nurses or SRH counsellors serving as trainers and supervisors. As part of the community level programme, the quality of the existing SRH services should be strengthened and made more youth friendly, in order to cope with the potential increase in service users as a result of the intervention.

### **5.2 Group sessions for female youth (Tier 2)**

This tier of the intervention will be centred on empowering SRH and PSS knowledge coupled with skills building around SRH self-efficacy for female adolescents and young women (15-24 years of age). Additionally, emotional regulation could provide initial stability in the context of turbulent humanitarian settings and facilitate retention to and ability to engage in the programme. Some elements of the group intervention will be adapted from existing WHO scalable psychological interventions, primarily Problem Management Plus (PM+) and Interpersonal Therapy for depression (IPT) [35, 36]. The SRH content will become more concentrated after session three, following ice-breaking and rapport building,

hence, once the group feels more comfortable to discuss and open up among each other. There will be forums within each session to ask questions as well as discuss relevant SRH issues, including sex.

In principle, this tier will be delivered over eight group sessions, each 90 minutes long (of a maximum of ten women per group), as informed by the two systematic reviews discussed above [22, 23]. To maintain relevance and enthusiasm for the intervention, adolescent girls and women will be free to discuss and use the skills gained to work on life areas that are important to them as well as to apply them to SRH services access issues, in a relevant and person-centred manner. To better address the heterogeneous SRH needs of women in different age groups, the composition of the groups will take into account member's characteristics, such as age (15-17 and 18-24 years old) and marital status and sexual activity. Sessions will have slightly tailored materials for these participant group characteristics. Table 1 provides a brief overview of the proposed content of the group sessions, in line with the theoretical framework discussed above. Table 2 provides a detailed description of each session's objectives and content outline.

**Emotion regulation**

(Increases self-efficacy and perceived control, minimises barriers to care seeking, positively impacts individual level and personal relationship influencers, ameliorates personal attitudes and provides fun and ready-to-use resources to maintain motivation

- Understanding emotions and distress
- Stress management/relaxation (from PM+)

**Further psychoeducation**

Provides knowledge and change in beliefs re: susceptibility, severity, benefits and barriers to care and cues to action, increases self-efficacy

- Overview of psycho-biological and cognitive-behavioural models of distress

**SRH education**

Provides knowledge and change in beliefs re: susceptibility, severity, benefits and barriers to care and cues to action, increases self-efficacy

- Contraception: Reproductive physiology and anatomy; Overview of contraceptive methods [their safety, side effects, how to use and failure of]; Emergency contraception; Myths and misconceptions; Information on Access rights, Access points, availability and cost; Decision making; Values and attitudes; and Postpartum contraception
- STI prevention/safe sex
- Sexual violence in the context of contraceptive use (emphasis on: Access to services for emergency contraception and safe abortion in the context of failed contraception)
- Pregnancy care

**Skills acquisition**

Enhances self-efficacy, increases perceived control and personal attitudes, affects individual and relationship level influencers, minimises barriers to care

- Interpersonal and communication skills building including conflict resolutions, assertiveness and sex/condom use negotiation skills and managing interpersonal disputes
- Problem solving (from PM+ and IPT) in life issues pertinent to youth and in SRH behaviours and service use, including goal setting

**Table 1:** Overview of the content of the group sessions with female youth (Tier Two).



Session	Objective	Plan for sessions	Home Practice
1 <b>Session 1:</b> Introduction and Emotion Regulation Skills	-Introduce and orientate group to each other and to the programme -Establish group guidelines -Provide education on emotions and feelings -Teach grounding skill for management of strong emotions & distress -Support adolescent to gain skills and understanding of emotions and acute distress	<ul style="list-style-type: none"> <li>• Introductions, group guidelines</li> <li>• Identifying and labelling feelings</li> <li>• Grounding</li> </ul>	-Try the grounding exercise each day
2 <b>Session 2:</b> Linking Actions and Feelings	-Discuss personal strengths, and how they might relate to SRH -Learn how social support and self-care can improve feelings and how to strengthen social support	<ul style="list-style-type: none"> <li>• Personal strengths</li> <li>• Social support seeking</li> <li>• Self-Care<sup>2</sup></li> </ul>	- About date, time, how will do it, etc.
3 <b>Session 3:</b> Communication and Assertiveness Skills	- Learn about the importance of good communication and learn different communication styles and skills -Provide information on health services access points and learn assertiveness to address barriers for accessing services	<ul style="list-style-type: none"> <li>• Communication skills</li> <li>• Local health service access (including SRH and mental health) access points</li> <li>• Assertiveness skills</li> </ul>	- Practice assertive communication in at least one situation -Continue grounding exercises and wellbeing activities
4 <b>Session 4:</b> Family Planning and Contraception	-Learn about reproductive systems and develop sexual self-efficacy - Learn about effective contraception – Facts and myths - Develop communication skills with family members	<ul style="list-style-type: none"> <li>• Reproductive Physiology education</li> <li>• Family Planning and Contraception education</li> <li>• Assertiveness skills with family members</li> </ul>	- Think about contraception needs or problems - Continue practicing assertive communication -Continue relaxation and well-being exercises
5 <b>Session 5:</b> Contraception for Health and Problem-Solving Skills	-Learn about sexually transmitted infections (STIs) and protection methods from STIs - Develop problem solving skills and how to apply to SRH issues	<ul style="list-style-type: none"> <li>• STI education</li> <li>• Problem solving</li> </ul>	-Practice step 1 of problem solving on any topic -Continue relaxation exercises and wellbeing activities
6 <b>Session 6:</b> Problem	- Practice problem solving for protecting our health -Educate on gender norms, healthy relationships, and sexual	<ul style="list-style-type: none"> <li>• Return to problem solving (35 minutes)</li> <li>• Problem-solving skills building group activity</li> </ul>	-Try to use problem solving steps to gender dynamics issue, or any solvable problem

Solving and Gender Norms	violence -Learn about signs of unhealthy and healthy relationships	<ul style="list-style-type: none"> <li>• Problem solving</li> <li>• Gender norms and norms education</li> <li>• Healthy and unhealthy relationships and Gender Based Violence</li> </ul>	-Continue grounding exercises and wellbeing activities
7 <b>Session 7:</b> Consolidating Skills and Contraception Action Planning	- Apply assertive communication skills to relationship conflict - Consolidate skills acquisition from previous sessions - Learn about pressure lines, how to negotiate contraception use, and steps for contraception action planning - Prepare the group for ending.	<ul style="list-style-type: none"> <li>• Dealing with relationship conflict using communication and problem solving</li> <li>• Negotiating contraception use</li> <li>• Contraception Action Planning</li> </ul>	-Try to accomplish your own contraception action plan -Think about a personal self-care plan -Continue relaxation exercises and wellbeing activities
8 <b>Session 8:</b> Skills Practice and Closing	-To learn about and develop steps for contraception action planning -Consolidate skills acquisition from previous sessions -Locally appropriate closing ceremony to celebrate achievement of finishing.	Contraception action planning Consent, saying no and meaning it Emergency contraception Skills practice Goals for the future Closing ceremony	-

1. Cross cutting: (a) Check in, grounding exercise and discussion on homework; (b) Knowledge gain: education followed by discussion; (c) Skills acquisition: practice activities, (e.g., role play), (d) closing and homework review
2. Participants can take comfort breaks as needed (e.g., bathroom, water, stretch legs), not built into sessions.
3. Group processes and management guidance, as well as general therapeutic skills can be taken from PM+ and IPT manuals, so this would not need to be written from scratch.
4. Suggest that facilitator is available 30 minutes before and/or after session for women to raise questions or problems in confidence.
5. All sessions will include free childcare- add ECD activities to childcare sessions.
6. Consider providing hot meal after each session
7. Facilitators will choose several SRH questions submitted to the confidential box prior to the next session and review with supervisor how to reply and anticipate possible reactions or responses from the group

**Table 2:** Outline of the Content for the Female Youth group session curriculum (tier two).

### **5.3 Focused home sessions for highly vulnerable youth (Tier 3)**

Further, a more intensive element will be made available in the form of two or three individual home visits for female youth who have self-identified during the group sessions as being particularly vulnerable (e.g., those who are at risk of poor SRH outcomes, or are married at a very young age, experiencing or at risk of IPV, sex workers or youth with mental health concerns). Assisted referral would be the main element of this part of the programme, combined with evidence-informed brief interventions (e.g., safety planning for IPV-affected or sex working women, motivational interviewing for alcohol use and/or violence among perpetrators, or focused education for those with mental health and heightened SRH needs). These sessions will engage the parents or partner, when and where necessary and safe to do so and gender acculturation may be incorporated into these sessions where gender norms are perceived to serve as barriers to care seeking or in the events where IPV is present. The facilitator of the home-based sessions will be very closely supervised by a specialist or a social worker, due to the complexity and gravity of the participants' needs. The same holds true for the facilitators of the group sessions as well as the community tier to ensure the delivery of the intervention package with highest attainable quality.

### **5.4 Adaptability and pilot testing**

The intervention package was designed, keeping ease of integration into existing health, education or social care systems within humanitarian settings globally in mind. WHO stresses on the importance of sensitive, community-driven contextual and cultural adaptation

of the generic intervention package. The final product includes guidance on how to work with communities to inform the adaptation of the intervention to other humanitarian settings and implementation strategies (such as guidance on service entry points, selecting and recruiting facilitators, managing supervision structures and identifying barriers and facilitators).

It should be noted following the finalization of this package, the content will be thoroughly adapted (through an iterative qualitative research process) among communities of Syrian refugees in Lebanon, Turkey and Jordan as part of a larger research programme. This work will be followed up with by a multi-site pilot testing for acceptability, feasibility, effectiveness and cost effective of the proposed PSS-SRH integrated intervention package, using a community-based randomized clinical trial in each of the three sites.

## **6. Conclusion**

The available evidence, experience from the ground and theoretical underpinning support the notion that an integrated multicomponent PSS and SRH intervention focusing on enhancing emotional regulation, psychoeducation, SRH education as well as skills acquisition (communication skills, problem management, decision making and self-efficacy), delivered by trained local non-specialist providers may enhance the use of SRH services and the well-being of adolescent girls and young women's in humanitarian settings [20, 24-28].

We have developed an innovative, low intensity- low resource-multi-level intervention, based on feedback from research partners in three countries, results of

two systematic reviews, and extensive expert consultation. Work is now underway to adapt it to the context of Syrian refugees residing in Lebanon, Jordan, and Turkey, and experiences will inform finalisation of adaptation and contextualisation processes and guidelines for use in other settings. This intervention has great potential for broad dissemination and to improve access to appropriate services to positively impact the health and wellbeing of young women living in humanitarian settings on a global scale.

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### **Authors' Contributions**

MH conducted the thematic analysis, coordinated the discussion with various experts and prepared the manuscript. LK designed the research, obtained funding, monitored the development of the concept note, organized and convened the expert consultation and prepared the manuscript. LK, RV, FB, and BF supported the development of the group session curriculum. CS contributed to the development of the concept note and the revision of this manuscript. LS coordinated, monitored and reviewed the development of the concept and revised this manuscript. All authors read and approved the final manuscript.

### **Competing Interests**

The authors declare that they have no competing interests.

### **End Notes**

The authors alone are responsible for the views expressed in this article and they do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated.

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## References

1. UNHCR. Global Trends: Forced Displacement in 2015 (2015).
2. Askew et al. Sexual and reproductive health rights in emergencies. *Bull World Health Organ* 94 (2016): 311.
3. Macklin A. Legal Aspects of conflict-induced migration by women. *Reproductive Health Matters* 16 (2008): 22-32.
4. Yasmine R, Moughalian C. Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions. *Reproductive Health Matters* 24 (2016): 27-35.
5. Moritz, A. Supporting refugee women's strategies for coping with challenges during maternity in resettlement; Shifting the focus from vulnerability to agency. *Revista Iberoamericana de Salud y Ciudadania*, 1(1): Enero-junio (2012).
6. Southall D. Armed conflict women and girls who are pregnant, infants and children: a neglected public health challenge. What can health professionals do? *Early Human Development* 87 (2011): 735-742.
7. Mullany LC, et al. Access to essential maternal health interventions and human rights violations among vulnerable communities in Eastern Burma. *PLOS Medicine* 5 (2008): 1689-1698
8. UNHCR. 3P Regional Refugee and Resilience Plan 2017-2018 in Response to the Syrian Crisis (2017).
9. Masterson A, Usta J, Gupta J, et al. Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. *BMC Women's Health* 14 (2014): 2-8.
10. Finnerty F, Shahmanesh M. Sexual and reproductive health in the European refugee crisis. *BMJ* 92 (2017): 485-486.
11. Tanabe M, Nagujjah Y, Rimal N, et al. Intersecting Sexual and Reproductive Health and Disability in Humanitarian Settings: Risks, Needs, and Capacities of Refugees with Disabilities in Kenya, Nepal, and Uganda. *Sexual Disability* 33 (2015): 411-427.
12. Krause et al. Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the Minimum Initial Services Package. *Conflict and Health* 9 (2015): 1-10.
13. Mall S, Swartz L. Sexuality, disability and human rights: strengthening healthcare for disabled people. *SAMJ* 102 (2012): 792
14. Biddelecom AE et al. Adolescents' views of the preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *Afr J Reprod Health* 11 (2007): 99
15. Blanc AK et al. Patterns and trends in adolescents' contraceptive use and discontinuation in developing countries and comparisons with adult women. *Int Perspect Sex Reprod Health* 35 (2009): 63-71.
16. WHO. World Health Statistics (2017).

17. Ventevogel P, van Ommeren M, Schilperoord M, et al. Improving mental health care in humanitarian emergencies. *Bull World Health Organ* 93 (2015): 666A-666A
18. Patton GC, et al. Out future: a Lancet commission on adolescent health and wellbeing. *The Lancet* 387 (2016): 2423-2478.
19. Lawrence D, Kisely S. Inequalities in healthcare provision for people with severe mental illness. *J Psychopharmacol* 24 (2010): 61-69.
20. Higgins A, Barker P, Begley CM. Sexual health education for people with mental health problems: what can we learn from the literature? *Journal of psychiatric and mental health nursing* 13 (2006): 687-697.
21. UNFPA. Emerging issues: Mental, sexual and reproductive health (2008).
22. Riedel EM, Turner D, Kobeissi L, et al. The impact of psychosocial interventions on condom and contraceptive use in LMICs: Meta-analysis of randomized controlled trials. *Global Public Health* 30: 1-18.
23. Desrosiers A, Betancourt T, Kergoat Y, et al. A systematic review of sexual and reproductive health interventions for young people in humanitarian and lower-and middle-income country settings. *BMC Public Health* 20 (2020): 666.
24. Abramsky T, Devries K, Michau L. The impact of SASA!, a community mobilisation intervention, on women's experiences of intimate partner violence: secondary findings from a cluster randomised trial in Kampala, Uganda. *J Epidemiol Community Health* 70 (2016): 818-825.
25. Bhutta ZA, Soofi S, Cousens S, et al. Improvement of perinatal and newborn care in rural Pakistan through community-based strategies: a cluster-randomised effectiveness trial. *Lancet* 377 (2010): 403-412.
26. Cowan FM, Pascoe SJ, Langhaug LF, et al. The Regai Dzive Shiri Project: results of a randomised trial of an HIV prevention intervention for Zimbabwean youth. *AIDS* 24 (2010): 2541-2552.
27. Kamali A, Quigley M, Nakiyingi J, et al. Syndromic management of sexually-transmitted infections and behaviour change interventions on transmission of HIV-1 in rural Uganda: a community randomised trial. *Lancet* 361 (2003): 645-652.
28. Wagman JA, Gray RH, Campbell JC, et al. Effectiveness of an integrated intimate partner violence and HIV prevention intervention in Rakai, Uganda: analysis of an intervention in an existing cluster randomised cohort, Uganda. *Lancet Glob Health* 3 (2015): e23-e33.
29. Luquis R, Kensinger WS. Applying the Health Belief Model to assess prevention services among young adults. *International Journal of Health and Education* 57 (2018): 37-47.
30. Svanemyr J, Amin A, Robles OJ, et al. Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches. *Journal of Adolescent Health* 56 (2014): S7-S14.

31. Kakuma R, Minas H, van Ginneken N, et al. Human resources for mental health care: current situation and strategies for action. *Lancet* 378 (2011): 1654-1663.
32. McPake B, Witter S, Ensor T, et al. Removing financial barriers to access reproductive, maternal and newborn health services: the challenges and policy implications for human resources for health. *Hum Resour Health* 11 (2013): 46.
33. Fulton BD, Scheffler RM, Sparkes SP, et al. Health workforce skill mix and task shifting in low income countries: a review of recent evidence. *Hum Resour Health* 9 (2011): 1.
34. WHO. Promoting gender equality to prevent violence against women (2009).
35. WHO. Problem management Plus: Individual psychological help for adults impaired by distress in communities exposed to adversity (2016a).
36. WHO. Group Interpersonal Therapy (IPT) for Depression (2016b).



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