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Self-help plus and problem management plus – a qualitative study to assess acceptability and feasibility with rape and GBV survivors in South Africa

Samantha Willan [a,b,*], Zamakhoza Khoza [a], Sinqobile Mngadi [a], Jani Nothling [a], Thobeka Majola [a], Mpumelelo Mabhida [a], Tholsie Gounden [a], Mbalenhle Shabalala [a], Amanda Zembe [a], Gugu Gigaba [b], Rachel Jewkes [a,c,d], Naeemah Abrahams [a,e]

[a] Gender and Health Research Unit, South African Medical Research Council, Pretoria, South Africa
[b] The School of Applied Human Sciences (Psychology), University of KwaZulu-Natal, Durban, South Africa
[c] South African Medical Research Council, Tygerberg, South Africa
[d] School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Parktown, Johannesburg, South Africa
[e] School of Public Health and Family Medicine, Faculty of Health Sciences, University of Cape Town, Cape Town, South Africa

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ABSTRACT

South Africa has extremely high rates of gender-based violence and rape, and survivors are at very high risk of developing PTSD and depression, alongside high levels of rape-related shame and stigma. Globally there are very few interventions to support the emotional wellbeing of GBV and rape survivors. This study adapted two WHO interventions, Self-Help Plus (SH+) and Problem Management Plus (PM+), both aim to strengthen coping, stress management skills and resilience, particularly in resource-limited contexts. No previous research has examined the acceptability and feasibility of combining SH+ and PM+ as stepped interventions for GBV survivors. The study adapted both interventions to the local South African context, tested the interventions cognitively and then undertook a feasibility and acceptability study with 144 women from Women's Shelters and Thuthuzela Care Centres (one-stop rape support centres) in eThekwini, South Africa. We implemented both interventions as a stepped intervention, involving 10, 2–3-hour group sessions, and undertook interviews at baseline, 3- and 6-months post baseline. Similar to what was found in other studies both SH+ and PM+ appear to be feasible and acceptable. The participants reported that they enjoyed learning the new skills and used them, and appreciated the social aspects of the sessions, connecting with new friends and having a 'purpose to get up'. SH+ and PM+ offers a low cost, lay-person facilitated mental-health and wellbeing intervention which could be adapted and rolled out through TCCs and other service providers in South Africa, providing much needed mental health support for survivors.

1. Background

South Africa has an exceptionally high rate of gender-based violence (GBV), including rape, with 42,569 rapes, of females by males, reported to the police in 2023/4 (SAPS, 2025). Female rape survivors are at a higher risk of developing PTSD and depression compared with those females who experience other trauma (Abrahams et al., 2021; Dworkin, 2020). The first longitudinal study of female rape survivors in South Africa, the Rape Impact Cohort Evaluation (RICE) study, reported a 48.5 % prevalence of PTSD 3 months after the rape, with 61.2 % of survivors having depression and 19.2 % reporting high levels of stress (Nothling, 2022). PTSD and depression comorbidity was high, with 42.1 % of participants meeting the criteria for both disorders (Nothling, 2022). The study also found high levels of rape stigma, particularly internalised shame and blame, which compounded and fuelled the emotional distress (Willan et al., 2024). GBV survivors who may not have been raped frequently experience similar mental health burdens and IPV-related stigma, shame and self-blame (Friedberg et al., 2023; Woldie et al., 2025) (see Table 1).

GBV refers to any act of violence against a person of any gender because of their gender, it includes sexual, physical, emotional/psychological and economic violence, and is driven by gender inequalities and patriarchy. In this paper we focus on GBV perpetrated against women by male perpetrators, and while recognising that rape is a

* Corresponding author. Gender and Health Research Unit, South African Medical Research Council, 491 Pater Mokaba Ridge, Durban, South Africa.
E-mail address: Samantha.willan@mrc.ac.za (S. Willan).

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critical aspect of GBV, in some instances we specify GBV *and* rape, not to imply that rape is not GBV, but rather to recognise that most of the participants are rape survivors.

In South Africa, in addition to mental health challenges, GBV and rape survivors have to navigate the terrain of the country's very high HIV prevalence (Dunkle and Decker, 2013; Jewkes et al., 2010). The association between HIV and GBV is well established (Li et al., 2014) however, until the RICE study, little was known about HIV acquisition following rape. The RICE study findings showed that the increased risk for HIV acquisition for women, after rape was driven by risky sexual practices in the months following the rape, fuelled by psychological distress (Abrahams et al., 2021). Among the key HIV prevention interventions is Pre-Exposure Prophylaxis (PrEP) which has been available in the public health services in South Africa for the last few years (DOH, 2021). However, many challenges with uptake have been reported (Shamu et al., 2021). Given the high prevalence of psychological disorders after rape, and GBV, and the risk of HIV acquisition, there is an important need for interventions to improve mental health for survivors and enable uptake and adherence to HIV prevention interventions, including PrEP (Keynejad et al., 2020).

Thus, there is a need for interventions to address female GBV survivor's emotional wellbeing and HIV prevention. Self-Help Plus (SH+) and Problem Management Plus (PM+) are mental health interventions developed by the World Health Organisation (WHO) and aim to strengthen coping and stress management skills, resilience and social support networks, particularly in resource-limited contexts (Epping-Jordan et al., 2016). Both interventions have shown promise in different settings such as East Africa, West Asia, Colombia and Europe, particularly with women facing adversity (Acarturk et al., 2022; Bryant et al., 2017, 2022; Dawson et al., 2016; De Graaff et al., 2023; Karyotaki et al., 2023; Knefel et al., 2022; Mediavilla et al., 2023; Miller-Suchet et al., 2024; Purgato et al., 2021, 2025; Rahman et al., 2019; Riello et al., 2021; Tol et al., 2020; Turrini et al., 2022).

SH+ and PM + use distinct transdiagnostic approaches drawing from cognitive behavioural therapy (CBT) (PM+) and Acceptance and Commitment Therapy (ACT) (SH+) (Keynejad et al., 2020). SH+ was developed for use with adults experiencing psychological distress, PM+ was developed for people experiencing depression, anxiety or stress. Both were specifically developed for use in resource-constrained settings with limited mental healthcare support, WHO also recommends that implementors provide additional referrals and support where needed. Neither are intended for use with people with severe health problems such as suicidality or severe impairment related to mental, neurological or drug use disorders (World Health Organization, 2018, 2021). As PM+ was designed to benefit people with more severe mental health problems it is often offered to people who still experience symptoms after completing SH+.

Each intervention comprises five sessions. SH+ is delivered to large groups (Epping-Jordan et al., 2016) while PM + can be delivered in smaller groups or individually. Both interventions use trained non-professionals (Brown et al., 2018) to facilitate the sessions and were designed to be adaptable to different contexts (Dawson et al., 2015; Epping-Jordan et al., 2016). The SH + package is delivered to groups of up to 30 people by a trained and supervised non-specialist facilitator who uses pre-recorded audio as the main delivery tool for therapeutic content, alongside illustrated posters of the SH + strategies used and an illustrated self-help book, *Doing What Matters in Times of Stress (DWM)*. The book is a shortened version of the SH + content, which can aid learning/practice during SH + or be self-administrated with the audio (Karyotaki et al., 2021; Musotsi et al., 2022; Riello et al., 2021). SH + utilises pre-recorded sessions as it aims to reach large, hard-to-reach, marginalised populations, where small, participatory, actively facilitated sessions would be infeasible, such as refugee populations. The facilitators support the sessions by answering questions, reading instructions, stopping/starting the audio and supporting participants' emotional wellbeing (Augustinavicius et al., 2023; Brown et al., 2018; Tol et al., 2020). PM+ is available individually or for groups of up to 12 people following a more traditional participatory delivery approach, fully facilitated by trained facilitators, with no audio material. The PM + package also includes illustrated posters and a relatable storybook to illustrate how a fictitious character Ezria, uses skills from PM + to deal with adversity.

Randomised control trials (RCTs) assessing SH + have been done in Uganda, Turkey, Italy, Germany, Austria, Finland, England and Scotland. These studies compared SH + to Enhanced Care as Usual (standard care). In most of the studies, participants in the SH + arm showed improvement in mental distress and mental well-being (Acarturk et al., 2022; Karyotaki et al., 2023; Tol et al., 2020). A meta-analysis emphasised that SH+ is useful as a first-line intervention especially in settings where there are high levels of psychological distress and mental health challenges (Karyotaki et al., 2023). While both SH+ and PM + have been used with GBV exposed populations, and some studies assessed psychological distress in GBV survivors (Tol et al., 2020), only one, using PM+ in Kenya, focussed specifically on GBV survivors (Bryant et al., 2017). A review of interventions to improve mental health outcomes for GBV survivors in LMICs found that there were 16 interventions developed in the last five years, of which PM+ was the only intervention found to effectively implement treatment into health care settings (St. John and Walmsley, 2021). PM + has mainly been tested in LMICs and approximately 70 % of the participants have been women (Mwangala et al., 2024). Findings from the RCT testing PM + among women who experienced GBV in Kenya found they showed moderate improvements in mental health outcomes 3-months post-baseline but was not as effective for PTSD symptoms (Bryant et al., 2017).

Both interventions were developed as standalone interventions, however, recommendations from several studies suggested that SH+ and PM+ be considered within a stepped-care approach and where possible be integrated with a more intensive mental health intervention (Karyotaki et al., 2023; Tol et al., 2020). Schäfer and colleagues (2023) recommended combining SH+ and PM+ with additional standard care where possible, as a "basic intervention for stress-exposed populations". Two recent studies have tested a stepped-care approach using SH+ and PM+, both used the SH + book *Doing What Matters* (DWM) plus PM + as the stepped programme (Mediavilla et al., 2023; Purgato et al., 2023). Findings from Mediavilla et al.'s (2023) study with health workers experiencing psychological distress in Spain indicated a significant reduction in anxiety and depression for intervention participants 2 months post-intervention. Purgato et al.'s (2025) study with immigrants in Italy also indicated significant reductions in anxiety and depression. It also reduced PTSD and improved wellbeing. For both studies, a positive effect was most evident among participants with higher anxiety and depression at baseline (Purgato et al., 2025). Both studies indicated additional psychosocial support from assigned helpers, which might have also impacted effectiveness. Despite relatively extensive implementation of both interventions with stressed populations, no previous research has examined the acceptability and feasibility of combining SH+ and PM + as stepped interventions for women experiencing GBV, including rape.

This study aimed to fill this gap by adapting SH+ and PM + for South Africa and testing the feasibility and acceptability of an adapted stepped intervention (SH+ and PM+) and PrEP in strengthening mental health outcomes and PrEP uptake and use among GBV, including rape, survivors in South Africa. We conducted a feasibility and acceptability study with outcomes assessed in two intervention arms against a delayed intervention control arm. The intervention arms comprised rape survivors and GBV survivors, all were offered SH + followed by PM + combined with the provision of pre-exposure prophylaxis (PrEP) for those we were HIV-negative. We also assessed the impact of the intervention on depression, anxiety, PTSD, self-blame, shame, sexual risk taking and PrEP uptake. This paper draws on the qualitative data collected from the pilot study; the quantitative results will be presented in a forthcoming publication.

2. Methods

2.1. Participants and setting

Women rape survivors were recruited from three Thuthuzela Care Centres (TCC), public sector one-stop centres (NPA, 2020), in the eThekwini area, in KwaZulu-Natal. GBV survivors were recruited from Women's Shelters, mostly managed by Non-Governmental Organisations (NGOs) in the same geographic location. The inclusion criteria for rape survivors from the TCC's were that they should be a survivor of rape perpetrated by a male in the past six months and aged between 18 and 45, high risk years for HIV acquisition. At the TCC, women were approached by research assistants, informed about the study and invited to participate. For women recruited from Women's Shelters, the inclusion criteria was that the woman had to be residing in a shelter because she had experinced abuse from a male intimate partner. There was no age criteria for shelter women since they were small groups of women living in close contact with each other and we did not want older women to feel excluded because of age. The shelter staff were asked to identify women who were eligible for the study, to explain the study to them and ask them if they would be interested in participating. Interested women were invited to the study site, where they were fully informed of the study and enrolled.

A total of 144 women participated in the study. Fifty-four women recruited at the TCC were in the intervention group and 52 from the TCC's were in the group who received the intervention on completion of the study. The 38 women from the Women's Shelters were all in the initial intervention group. Most participants were Black African and isiZulu speaking, although there was a small number of English-speaking Indian (4), Coloured (2) and White (3) participants.

2.2. Self-help plus (SH+) and problem management plus (PM+)

Table 1
Self-help plus and problem management plus session outline.

Self-Help Plus		
Session	Key concept addressed in each session	Key focus of each session
Session 1	Grounding	Focus: Bringing attention back to the present moment, instead of being caught up by distressing emotions.
Session 2	Unhooking	Focus: Building on the grounding skills, it is used first to identify difficult thoughts and feelings and then to use grounding (breathing exercises) to unhook from those thoughts.
Session 3	Acting on Values	Focus: Identifying personal values and then behaving in a way that is in line with these values to reduce stress.
Session 4	Being Kind	Focus: Kindness directed towards oneself as well as towards others to help reduce stress.
Session 5	Making room	Focus: Learning how to tolerate stress while still acting in a way that is consistent with one's values.
Problem Management Plus		
Session 1	Managing Stress	Focus: Identifying adversity and practising breathing exercises to manage adversity and stress.
Session 2	Managing Problems	Focus: Identifying solvable problems and providing a 7-step practical process to solve problems.
Session 3	Get Going, Keep Doing	Focus: Recognising when one becomes inactive, often due to stress, and encouraging ways to become active.
Session 4	Strengthening Social Support	Focus: Recognising the value of social support and encouraging engagement with social support networks.
Session 5	Staying Well and Looking Forward	Focus: Recognising and celebrating goals achieved through the intervention and encouraging continued use of the strategies moving forward.

2.3. Intervention adaptation

Our adaptation process was undertaken in discussion with the WHO team who designed both interventions and provided ongoing adaptation and implementation support. We followed a similar adaptation process to the Kenyan study (Bryant et al., 2017). The first phase occurred over 6 months and focused on contextual adaptation of both interventions (including images, metaphors, idioms, names and stories) and translation of materials into the local language, isiZulu (audio recordings, manuals, posters, and the book). Followed by cognitive testing of the adaptation with 20 women from local communities in eThekwini. After cognitive interviewing, further changes were made to the adapted materials as needed. The second phase was the pilot study which ran from August 2022 to December 2023 and involved testing the stepped intervention and offering PrEP to HIV-negative women. The addition of offering PrEP was included to support the aim of reducing the risk of HIV acquisition amoung GBV, including rape, survivors.

The primary focus of the adaptation process was to ensure contextual relevance and understanding for Black African isiZulu speaking women in eThekwini. The translation went beyond technical language translation, ensuring locally used language, experiences, expressions, idioms etc. The intervention materials adapted included facilitators' manuals and posters (for SH+ and PM+), *Doing What Matters* book and the audio materials (for SH+), and the PM + storybook (which was renamed to *The Story of Thandi* to better relate to this context). The content was reviewed and adapted by researchers with a background in public health and psychology, working with GBV survivors and intervention design science. Following the content adaptation, the material was translated into isiZulu by a professional translator and back translated and reviewed by research team members who were first-language isiZulu speakers. Images were adjusted by a local visual artist to represent the eThekwini isiZulu-speaking population and setting. Audio recordings were then recorded by a local, award-winning, isiZulu-speaking female professional voice artist. She was selected for her particular voice and energy which was calm, uplifting and engaging.

2.4. Facilitator training

Once materials were completed six facilitators were trained over two weeks, by a trainer specialising in adult education, with a sound understanding of the methods used in the interventions and GBV. The facilitators were part of the research team and had been involved in the adaptation and were able to deliver the interventions in both English and isiZulu. The facilitators all had a tertiary level qualification, most had previous facilitation experience, and all spoke and wrote isiZulu and English. All were women, as this is known to be more acceptable to female GBV survivors. Training involved critical explorations of the content and methods, practising the skills, building familiarity with the sessions and facilitation skills. Facilitators were then taken through the intervention, conducted teach-back sessions and received feedback and suggestions to develop their skills as needed. The team also received refresher training related to professional and ethical principles involved in working with GBV survivors, this included training on conducting a suicidal risk assessment for participants presenting with suicidal ideation and then linking them to psycho-social care when necessary.

2.5. HIV testing and provision of pre-exposure prophylaxis (PrEP)

We followed standard procedures for HIV testing and providing PrEP as per the South African Department of Health. We offered HIV counselling and testing to all participants using Determine HIV 1/2 rapid test and the One Step Anti-HIV as a confirmatory test. A separate HIV

consent testing procedure was followed. HIV negative participants were offered PrEP, after counselling on initiation and side effects management was provided by a trained study nurse. We provided the oral medication, Truvada (Tenofovir Disoproxil/Emtricitabine) which is approved by the South African Health Products Regulatory Agency (SAHPRA) in 2015 (Mediavilla et al., 2023), it is currently available and distributed by the National Department of Health as part of HIV prevention management. At the end of the study the nurse and participant discussed continuation of PrEP and a referral was made to a clinic best suited to the needs of the participant. HIV positive participants were also counselled and referred to HIV services if ARVs were not yet initiated. Given that South Africa has a large HIV testing and treatment programme, ART is widely accessible and HIV testing widely practiced. Thus, it was not considered particularly sensitive offering women HIV testing as part of the study, nor to refer those living with HIV who have not yet commenced treatment to a clinic to start treatment.

2.6. Intervention delivery

We offered all participants the stepped approach of SH + followed by PM+, if participants chose. Recognising that SH+ is primarily a mindfulness intervention, we appreciated that many GBV and rape survivors may need additional mental health support following SH+, hence the decision to also offer PM + which is designed for more severe mental health problems. This combined/stepped approach has been implemented in a number of settings (Karyotaki et al., 2023; Tol et al., 2020). Given that many GBV and rape survivors often experience severe mental distress, we decided to pilot both interventions to test whether the mindfulness skills from SH + followed by PM + could offer meaningful support for this population. We thought having the combination of the mindfulness skills (SH+), followed if chosen, by extra support may alleviate some survivor-related mental distress, and potentially reduce emotional dysregulation which often leads to risky sexual behaviour post-rape, and thus in HIV prevention.

All participants were offered the five SH + sessions, and upon completion all were offered PM+, to begin the following week. All participants signed up for PM + although not all were able to attend. Each group had between 8 and 10 women for both SH+ and PM+, most groups included a mix of women from the TCCs and shelters. Each session had two facilitators and each group decided on their preferred language. Sessions ran weekly and were 2–3 h long, resulting in a total of 20–30 h of intervention time, over ten weeks. Participants were each given R350 (approx. US$20) per session and/or interview for their time and transport expenses and were provided with a light lunch after each session. Thirteen intervention groups were run, 9 were held in isiZulu and four in English.

SH+ was delivered through pre-recorded audio and facilitators were present throughout and asked to try to ensure women engaged with the content. They used energising exercises as needed to keep women engaged. *Doing What Matters*, and posters were also used to supplement the skills building. Posters were referred to, primarily to support understanding for women who were more visual learners, and the book was given to the women to take home with them to support on-going learning and implementation. PM + included posters and Thandi's story and was facilitated without the aid of any audio material.

2.7. Data collection

All women completed quantitative and qualitative baseline individual interviews. After each intervention session, the groups participated in short FGDs. A subset of intervention group participants were included in follow-up qualitative and quantitative individual interviews at 3-and 6-months. They were selected purposefully to represent a wide range of experiences, such as those who completed most SH+ and PM + sessions, and those who attended fewer sessions, those who started PrEP, and those who did not and those who were active participants and others who were quieter participants. Facilitators completed observation notes of intervention sessions. Attendance records for each session were maintained.

A total of 144 qualitative interviews were undertaken at baseline, 23 participants were interviewed at 3-months (15 from TCCs and 8 from shelters), and eighteen were interviewed at 6-months (11 from TCC and 7 from shelters), they were not all the same women at 3 and 6 months, as some of the women from the 3 month interviews were no longer available. Short FGDs were conducted with 12 groups after each session, with a total of 125 discussions.

Baseline quantitative and qualitative interviews enquired about anticipated barriers and facilitators for attending the intervention sessions, demographic information and wellbeing. Brief FGDs with participants after each session reflected on what they liked or disliked about the session and facilitation, any attendance barriers they experienced and their motivation for attending sessions. At the 3- and 6-month follow-up individual interviews they were asked how they felt after attending the intervention sessions, examples of how they applied the skills in their daily lives, which parts of the intervention they found most useful, if they had experienced changes in their behaviour since completing the intervention, if they would recommend the intervention to a family member or friend, what could be changed to make it easier for women to attend the session in the future, what could be done to improve the sessions, and their experience of PrEP (for those who enrolled for PrEP). Interviews were conducted in isiZulu or English, as preferred by participants, audio recorded and translated and transcribed in English.

2.8. Data analysis

Content analysis of the qualitative data was undertaken by the first five authors to understand women's experiences of the interventions, and any skills development and use. All transcripts, observation notes and attendance records were reviewed to identify common comments and themes. The themes were then organized against the original areas of interest namely: acceptability, feasibility, skills application and outcomes. Themes that emerged were identified and discussed, inconsistencies reconciled, and sub-themes agreed.

2.9. Ethics

Ethical approval was obtained from the South African Medical Research Council, Human Research Ethics Committee, EC041-10/2021. Participants provided written informed consent at the beginning of the interviews, and pseudonyms were used throughout the paper to ensure anonymity. Participants were reminded at each interview that they could withdraw consent at any time. Research staff were trained in Good Clinical Practice (GCP) to ensure the protection of participants and the data in the research process.

Any participant who showed distress at any point was offered containment support by a staff member with psychology training and was given a list of in-person and telephonic services they could consult for further support. In cases of extreme distress or indications of more substantial mental health difficulties the professional clinical psychologist on the team offered support and organised professional referrals.

3. Findings

Of the 144 women who were enrolled at baseline, 108 participated in SH + sessions, and 85 continued with PM + sessions. Seventy-six women (70.4 %) attended all 5 sessions of SH+, twenty-one (19.4 %) attended 4 SH + sessions, and eleven (10.2 %) attended 3 or less sessions. For PM+, sixty-eight (80 %) attended all five sessions, 12 (14.1 %) attended five sessions, and 5 (5.9 %) attended 3 or less sessions.

3.1. Acceptability

To assess the acceptability of the interventions we asked women what they did and did not enjoy about the sessions, and why, what they thought of the delivery approaches and methods, and suggestions for improving the sessions.

Women reported mixed feelings about the delivery methods in SH+, however they reported enjoying the methods in PM+. Many mentioned wanting more interaction during the SH + sessions and that the intervention may have been more effective if it was delivered by the facilitators rather than listening to audio recordings. Long periods of sitting and listening to audios made them lethargic, and inattentive, some mentioned finding it *'hard to listen to'*, *'boring'* and that *'it made them sleepy'*. Of the thirteen SH + groups, eight mentioned feeling sleepy or facilitators observed participants falling asleep during the sessions.

> *"Listening to the audio was new and I couldn't pay attention for long. It was boring, low and serious. I was feeling sleepy so I could not concentrate throughout …"* (SH+, Session 1, FGD).

SH + Session 4, (Being Kind), appeared to make them particularly sleepy, and they mentioned finding it particularly long compared to other sessions.

> *"During the 4th session they [participants] were sleepy, and we [facilitators] had to take more breaks to get them to concentrate on the audio."* (SH+, Facilitator Observation Notes)

Facilitators observation notes mentioned similarly that with SH+, they had to be innovative with additional strategies not mentioned in the Facilitators Guide to ensure participant engagement and address the lethargy that the audio sometimes induced. This included stretch and energising breaks if they noticed that participants were sleepy or losing interest.

> *"Some people started feeling sleepy, but we stretched and took breaks" (*Facilitator Observation Notes)

> *"The facilitators helped by playing games and dancing when they could tell we were losing focus"* (SH+, Session 4, FGD)

Facilitators would also pause the audio to ensure that the participants understood the language being used and the context of what was being said.

> *"Often, I paused the audio and asked them if they understood because from my observation they were completely lost or did not show any interest throughout the five [SH+] sessions."* (Facilitator Observation Notes)

On the other hand, most of the women enjoyed the delivery methods in PM+, specifically mentioning enjoying the group discussions, sharing their own experiences and the facilitation styles.

> *"I enjoyed PM + more than SH+. It was more engaging. We could share our stories and the sessions were beneficial. There was group work, and we presented. It was a more open space. We could get advice."* (6-month, IDI)

> *"We are enjoying the discussions, writing down things and standing in front of the group … You loosen up, unlike when you are just listening to the audio …"* (PM+, Session 1, FGD*)*

Despite our efforts to ensure the isiZulu was accessible, participants mentioned at times struggling with some of the isiZulu words and phrases as they found them hard or "*too deep*" (SH+, Session 2, FGD). Indeed, Group 10 emphasised this difficulty repeatedly in their FGDs.

> *"It was new, and the isiZulu is too hard."* (SH+, Session 1, FGD)

> "[The] *isiZulu audio being used was too strong, it's not the way we usually talk."* (SH+, Session 4, FGD)

Women appreciated the *Doing What Matters* book, and the illustrations (in the book and posters), as it was something tangible they could use to practice the exercises at home. It also helped them to grasp new and complex concepts. Additionally, some used the books to teach the concepts and exercises to others at home.

> "… They [books] were helpful because I saw it as something that I can use in the future, especially if I have sleepless nights … I am happy that we received a guide to use at home to revise. The pictures made everything easy to understand …" (SH+, Session 1, FGD)

With PM+, women reported that the story about Thandi, which wove throughout PM + as part of the delivery, helped keep them engaged, they found her character and experiences relatable and interesting.

> *"Reading the story keeps us interested as we just longing to hear what is going to happen."* (PM+, Session 1, FGD)

> *"All the groups mentioned enjoying and relating to Thandi's story that was told alongside the PM + activities."* (Facilitator Observation Notes)

Additionally, participants who were shy about sharing their own stories found it easier to participate through reading Thandi's story aloud.

> "*Some women were introverted, and did not want to present, and it became difficult as the same people had to keep presenting. We did find a compromise with reading Thandi, everyone was able to participate in the reading*." (Facilitator Observations Notes)

However, women also highlighted that applying the skills in 'real-life' situations was sometimes difficult, despite enjoying them in the group sessions. The facilitators mentioned that the women talked about how when they are home or in the community, or in a difficult situation, they often struggle to apply the new skills.

> "*It is hard for her to use the skills that she learns when she is at home. She wishes not to go back to her community because she is trying hard to help herself through the skills but someone in her community always distracts her."* (Facilitators Observation Notes)

When participants were asked for suggestions for improving the interventions most women suggested changes around delivery methods for SH+ and said that PM + did not need changing. They described PM + as a space in which "*we could share our stories, and the sessions were beneficial. There was groupwork and we presented. It was a more open space. We could get advice." (*6-month, IDI*)*. While with SH+ "*the audio takes too long. There needs to be both facilitation and audio."* (6-month, IDI). Many participants resonated similar sentiments and suggested that the SH + delivery method needed to be similar to PM+.

> *"Don't use the audio. There is no participation. It [SH+] is tiring"*. (6-month, IDI)

> "*Add more activities and allow us to share in SH + sessions*." (3-month, IDI)

When asked which skills and content were most and least useful, a few areas came up repeatedly as very useful. These included 'being kind' (SH + Session 4), followed by 'grounding' (SH + Session 1), 'breathing' (both SH+ and PM+), 'unhooking' (SH + Session 2). They said that 'grounding' helped them to relax while 'being kind' supported them to recognise the importance of being kind to themselves, and others. Women reported enjoying all of the PM + sessions and specifically mentioned 'problem solving' (PM + Session 2), 'get going, keep doing' (PM + Session 3) and 'strengthening social support' (PM + Session 4).

> "*[We] liked learning about grounding and being curious. Using grounding to remove yourself from bad thoughts"* (SH+, Session 1, FGD)

> *"We enjoyed the skill of being kind. Remembering that if you aren't kind to yourself then it means you can't fully be kind to others"* (SH+, Session 4, FGD).

"*[The] new strategy of unhooking from bad thoughts. Breathing exercise, the short and the longer way, and how to deal with difficult thoughts"* (SH+, Session 2. FGD)

"*Learning about solving problems, knowing how to tell between … solvable vs unsolvable [problems]. We also enjoyed learning about solving one problem at a time and finding possible solutions instead of trying to solve problems all at once"* (PM+, Session 2, FGD)

"I enjoyed today's topic, Social Support. I enjoyed learning how to create social support and where or who can get social support from." (PM+, Session 4, FGD)

However, women also reported that some of the skills were very unfamiliar or difficult and therefore they did not practice them as much. In particular, the breathing techniques received mixed reactions, some found the methods physically uncomfortable and did not use them (some struggled to breathe deeply, or to hold their breath, or did not enjoy closing their eyes). However, about half the women really valued the skill and reported practising it a lot.

"*The breathing exercise (balloon exercise) made my tummy sore* (SH+, Session 4, FGD)

"Closing our eyes during the exercise was weird so I decided not to close them." (SH+, Session 1, FGD).

"With PM+, I am finding it easier to deal with difficult situations – can control my breathing more" (6-month, IDI)

Some women mentioned that on occasions they did not enjoy the sessions because the content and the exercises were emotionally challenging, especially for the women who were experiencing many personal challenges. One participant mentioned that there were "*too many thinking exercises*" (SH+, Session 4, FGD); and another said that:

"*The topic was a bit challenging as it touched on a sensitive area, we had to reflect on the things we are going through"* (SH+, Session 4, FGD).

All the groups mentioned that their facilitators were very skilled and that they enjoyed working with them. This was explicitly said in interviews and was also evident in the gratitude shown towards the facilitators during the sessions and at the final sessions where some presented their facilitators with cake and small gifts. The women described the facilitators as welcoming, approachable, supportive, caring, patient, non-judgemental, attentive, open-minded and pleasant. They appreciated that facilitators were interactive and participated in the exercises with them.

"It is easy to work with them because when you tell your story you can tell that the facilitator is listening to you. If it is a sad story, you can see it on their face that they feel for you. When one of us comes up with a solution you can see that they are welcoming that." (PM+; Session 3, FGD)

"… It was easy because they were also participating in everything with us. They are helpful, they also exercise with us. Everything done here is different but in a good way …" (SH+, Session 2, FGD)

Women also welcomed the emphasis placed by facilitators on confidentiality within the group and that they were respected if they did not want to answer a question.

"This group has grown me mentally and emotionally by having group discussions and believing that whatever we share will remain confidential." (SH+, Session 5, FGD)

Participants also appreciated that the facilitators ensured that women with babies and children could actively participate, by providing child-friendly spaces and entertainment for toddlers. One facilitator noted the steps taken to support mothers' participation.

"Participants had to juggle the kids and concentrating … we provided cushions for babies to sleep on and tablets for the toddlers so they could watch Teletubbies." (Facilitator Observation Notes)

3.2. Feasibility

To assess the feasibility of women attending the sessions we explored whether women experienced, or anticipated experiencing, challenges attending sessions and what motivated them to attend. At baseline, we asked women what they thought might make attendance difficult. Most women mentioned their reliance on public transport to reach the study site and many anticipated challenges related to public transport strikes and the cost of transport. Additionally, they talked about, severe weather, childcare, missing work, student exams, attending court cases, medical appointments or collecting social grants. Among women who did not participate in PM + we noted that a number of shelter-based women left the shelters and were not able to get to the research site thereafter, additionally a number of women found employment.

While attendance was high women did mention some challenges with attending, especially concerning transport money and childcare, and partners who did not want them to attend. While we reimbursed women for transport expenses, sometimes they did not have money to get to site to begin with.

"I had transport money issues, but I managed to borrow." (PM+, Session 5, FGD)

"I s*truggled to find someone to look after my child because I didn't want to bring him in this bad weather."* (SH+, Session 2, FGD)

"[My] b*oyfriend did not want to allow me to come*." (SH+, Session 5, FGD)

When we asked for suggestions to improve the two interventions many focused on addressing the transport and childcare issues, recommendations included collecting the women and having a childminder at site,

"*Chatsworth [where the Durban site is located] transport is a big issue, organise transportation so we can be present all the time. Some have kids so you need to meet them halfway by organising a nanny for a day onsite*." (6-month, IDI)

On a practical level, they said that receiving reminders of appointment dates and times, via a phone call or WhatsApp message, was helpful to ensure they remembered to attend.

The women mentioned a number of factors that motivated them to attend, including enjoying learning new skills, the emotional support, the social aspects, and appreciating the money "*The money we receive makes a difference.*" (SH+, Session 4, FGD). Several women said that having a reason to get up in the morning, getting out of the house, meeting other women, forming new friendships and sharing together were all factors that made them happy and encouraged them to attend regularly. Furthermore, being around women who had similar experiences was supportive, and encouraged them to share their stories, they could give each other advice and they formed new friendships.

*"… This program is very helpful. It makes things easier when you realise that you are not alone …" (*3-month, IDI)

"Gain new knowledge and skills. To be out of the house as we are always home. Curious what the next sessions will be like. To meet with group members." (SH+, Session 4, FGD)

Women also mentioned having a sense of accomplishment when reviewing the goals that they set for themselves in the beginning of PM+ and looking back at what they have achieved in previous sessions.

"… We enjoyed reviewing our goals and seeing that there is change in our life. I enjoyed reviewing myself individually to see what I wanted, where I am and where I am going …" (PM+, Session 5, FGD)

By the final session women said they felt really connected with their group members and facilitators and nearly all groups reported feeling sad and emotional because the sessions were ending. They spontaneously formed WhatsApp chat groups in which they continued to support each other.

"… It was nice to see everyone, and it was also emotional as we will be seeing each other for the last time. We enjoyed meeting, sharing, and going through everything we have learnt in these precious sessions …" (SH+, Session 5, FGD)

3.3. Reported use of skills at 3 and 6 months

At 3- and 6-months post baseline we asked women to provide examples of where and how they used the skills learnt in the intervention in their daily lives. We also explored whether their strategies for handling stress had changed since the intervention, and whether, and why, they would recommend the intervention to a friend or family member.

All participants mentioned using some skills acquired during SH+ and PM+. Most participants mentioned 'grounding', 'unhooking', (both from SH+) and breathing (from both interventions), as skills that they relied on to deal with difficult situations. Situations including dealing with conflict with partners, at work and with family and for handling other emotionally difficult situations, including the loss of loved ones.

"When I have fights in my relationship, I use the breathing exercise to calm down" (3-month, IDI)

"… When my mother says negative things to me. I use grounding and I say kind things to myself. I use kind words …" (6-month, IDI)

"Before I couldn't manage my stress but now, I can slow down my breathing and calm down. I am also able to lean into my social support by talking to others, something I couldn't do before. They can give me advice and I can decide what I need and don't need." (6-month, IDI)

Other skills were also mentioned, although not as frequently, such as 'problem management', and 'managing stress' (both from PM+) to calm down.

"I can solve problems now by using the problem management steps." (6-month, IDI)

"Learning about solving problems, knowing how to tell between practical and impractical problems – solvable vs unsolvable [problems]. We also enjoyed learning about solving one problem at a time and finding possible solutions instead of trying to solve problems all at once." (PM+, Session 2, FGD)

Participants also mentioned using valuable practical skills such as managing their finances better, *"PM + helped, especially in managing my finances"* (6-month, IDI) and breathing through pain "*The breathing helped me with period pains."* (6-month, IDI).

Importantly, none of the women mentioned using the skills when they were under extreme stress, such as a very violent physical fight.

The facilitators noted in their observations that the participants' behaviours and levels of group participation shifted as the intervention progressed and their confidence grew in the latter sessions. While we believe some of this was due to the intervention, we recognise this cannot all be attributed to the intervention as some post-rape recovery usually occurs irrespective of interventions.

"By just looking at their appearance you could see that they look different, some started dressing up and applying make-up, they felt different, and they became more confident to speak and voice their opinions." (Facilitator Observation Notes).

All women indicated that they would recommend the interventions to other women, mostly this was because they felt all women would benefit, as they had, from learning these skills.

"… I think everyone should learn these skills they are essential for survival …" (6-month, IDI)

"… Yes, I would recommend it because it has personally helped me. It is such an eye opener. I discovered a lot of things about myself through this programme …" (3-month, IDI)

"… It was life-changing and good for me. So, if the intervention could continue and help other people that would be good and we had good facilitators …" (3-month, IDI)

4. Discussion

This study explored the feasibility and acceptability of a stepped SH+ and PM + intervention, delivered to female GBV survivors in South Africa, by trained non-professionals. The participants reported that they enjoyed learning the new skills, with PM + delivery methods being preferred. They also enjoyed the social aspects of the sessions, connecting with new friends and having a 'purpose to get up'. At 3-and 6-months they described many instances of applying the new skills. In terms of impact on the women's mental health, the quantitative results found a significant decline in depression scores among women from the TCC's and a significant decline in PTSD scores among women from shelters at 3- and 6-months, as well as a significant decline in complex PTSD scores among women from the TCCs and shelters at 3-months (forthcoming paper). These findings are similar to results of other SH+ and PM + implementation studies which showed they were feasible and acceptable in most settings they were tested in however, these were almost exclusively in crisis or refugee settings (Karyotaki et al., 2023; Miller-Suchet et al., 2024; Schäfer et al., 2023), and non in South Africa, nor as a stepped-care approach with GBV survivors. Furthermore, while SH+ and PM+ were not developed to specifically address HIV risk, recognising that HIV is fuelled by poor mental health post GBV and rape (Abrahams et al., 2021; Friedberg et al., 2023; Woldie et al., 2025), we hypothesise that any improvement in mental wellbeing among survivors is likely to reduce HIV risk, although the timeframe of this study did not enable us to measure this. Thus, this study provides insights about implementation of the stepped intervention in a setting with high levels of interpersonal violence and trauma.

These findings are important as SH + has not been evaluated previously for use specifically with GBV survivors. While PM + has been evaluated in a few settings with GBV survivors as the primary target, namely Kenya (as an individual intervention) and Colombia (group-based intervention), (Bryant et al., 2017; Miller-Suchet et al., 2024; St. John and Walmsley, 2021). Our study provides positive findings for the group-based PM+ and SH + approach with GBV survivors. Additionally, the team are not aware of any evaluations in South Africa, although we are aware that it is being considered for use among adolescents. These results support previous research which found both to be effective in constrained public health settings and that they can be delivered by non-professional workers (Akbay-Safi et al., 2021; Bryant et al., 2017). Given the limited affordable, accessible and acceptable emotional and mental wellbeing support and services for GBV survivors in South Africa, these interventions offer a realistic opportunity to support survivors in this resource constrained setting. We recognise that many GBV survivors may need additional support to ensure full emotional recovery, especially around rape and IPV-related stigma, self-blame and shame, nonetheless, SH+ and PM + have shown to offer critical support and skills as one important intervention. The authors of this paper are currently working on further studies to address these additional support

needed for survivors.

Despite high levels of acceptability and feasibility, women reported mixed feelings about the delivery methods. They enjoyed both interventions overall, however, they expressed some frustrations with the SH + delivery methods, preferring PM+. In our setting, we would recommend using more participatory facilitation methods for SH+, which should lead to greater acceptability, this is similar to the recommendation during the adaption phases in the Uganda Pilot (Tol et al., 2020). We note that the audio approach was developed by WHO to support large groups, up to 30 people, and support fidelity to the intervention, and implementers may want to reflect on what may work best in their context. Despite some delivery frustrations, at 3-and 6-month interviews, women mentioned applying several skills from both SH+ and PM+. In particular, they mentioned regular use of skills related to the sessions on 'unhooking' and 'grounding' (both SH + sessions), 'managing stress', 'managing problems' and 'social support' (all PM + sessions), and 'breathing' (both interventions). Suggesting that despite the women finding the SH + sessions less engaging, nonetheless they learnt skills and applied them. Women also mentioned that attendance was sometimes difficult because of a lack of money to travel to sessions, and childcare responsibilities, this was also seen in another PM + evaluation (Miller-Suchet et al., 2024). We note there was no session on stigma and that this is important to address with GBV survivors, as such we recommend adding such a session for future use with GBV survivors.

Women noted that the skills were more effective in some situations than others. They were reportedly effective during verbal disagreements with family and partners, often used to de-escalate conflict situations and when handling sad memories and the death of loved ones. However, they never mentioned using them when the women were under extreme stress such as physically aggressive situations with partners. Perhaps this is because moments of extreme violence do not allow 'space' for the necessary pause, reflection and practice of mindfulness skills such as breathing, unhooking and grounding. At such moments the fight-flight-fawn response is likely activated, making it difficult for the person in the moment, to practice skills that require attention control, especially when the skill is new and not practiced habitually. This may point to the interventions having limited effectiveness depending on the situation and degree of conflict, and also the need to emphasise to participants the importance of regular practicing of the new skills. This is supported by earlier research which highlighted that SH+ and PM + are designed to support common mental health problems such as depression, anxiety, stress or grief, and self-identified practical problems such as unemployment and interpersonal conflict. But is not appropriate for severe mental health problems, such as suicidality or psychosis (Akbay-Safi et al., 2021; Dawson et al., 2015). This study also supports research which found that SH+ is most effective for participants who scored lower in wellbeing and were unemployed at baseline (Karyotaki et al., 2023). Many women in the study scored low for emotional wellbeing at baseline, all were from very poor communities, and nearly all were unemployed (forthcoming paper). Indeed, we note that SH+ and PM + can be useful in contexts such as KwaZulu-Natal where women experience multiple trauma exposure, compounded with high levels of unemployment, which limits access to more traditional mental health care.

This study confirmed the increasing call for meaningful, local adaptation and contextualization of interventions to increase acceptability and feasibility (Nyongesa et al., 2022). Further we showed that these processes, are resource (money, time and staff) intensive and are best undertaken by researchers from local communities to ensure in-depth understanding of context, language nuances, idioms, imagery etc. To this end the study team undertook extensive adaptation over 6-months and had comparable findings around acceptability and feasibility to the Ugandan study, which utilised a similar adaptation process, yet, despite the positive findings we still identified areas that need further adaptation.

Despite the extensive adaptation process undertaken by researchers from eThekwini, many of whom had adapted interventions before, and working with an award winning, dynamic, local female voice-artist and local isiZulu speakers, the translation of a few concepts and words were still un-relatable for some women. Importantly, the language spoken in some settings are often dialects, and only in oral form, making written translation challenging. Our study found that despite the team being aware of the importance of using a form of isiZulu which is spoken in urban eThekwini and avoiding 'old', 'traditional' or 'textbook' isiZulu we still received feedback that the women found some of the isiZulu "*too deep*". It was encouraging however to see that the contextualized images, metaphors/idioms, examples and Thandi's story received no negative feedback and seemed to be very relatable and enjoyed. These challenges were similar to what the Ugandan study found where the local language they translated into, Juba Arabic, is not traditionally written nor read, therefore translating the written work was challenging, resulting in their recommendation that in some contexts adaptions should not follow formal language conventions (Purgato et al., 2021). This study highlights the very real challenge of translating for meaning and relevance when working with abstract concepts, such as mindfulness, and emphasises the need for ongoing adaptations as roll out occurs. It further highlights the challenges of working with highly marginalised and vulnerable communities, who are more likely to be semi-literate or use dialects that are not widely translated or written.

Finally, the payment of stipends and travel expenses appears to be a critical enabler for attendance in many settings of high poverty, and particularly for interventions targeting women who tend to be poorer and shoulder more of the domestic expenses. Many of the women mentioned that without the travel reimbursement they would not have been able to attend. One possibility where there is limited funding, may be to hold the sessions where participants live, which will avoid the travel expenses.

This study had some limitations, including the limited follow up period, however, we feel that it was sufficient to provide important insights into feasibility, acceptability and whether women recalled and used the skills. A major limitation is that we tested the model of SH + followed by PM+ and so we are unable to say whether we would get a similar response from participants if we had only used one intervention. We can note that the women reported using and benefitting from aspects of both interventions, which seems to support either using them both or a future adaptation that combines and shortens them. Additionally, we did not undertake interviews with the facilitators, although they did keep observation notes, as such we do not have their detailed view on feasibility, although they are all authors on the paper, and inputted to the analysis. Finally, given we adapted for our specific target population, we are unsure how these findings would apply in other, South African, isiZulu-speaking settings, however we expect similar results.

5. Conclusion

South Africa has very few public health services or interventions to support the emotional healing and wellbeing of GBV, including rape, survivors, who are at great risk for depression, PTSD and other mental-health challenges. This study has shown strong promise and confirmed the feasibility and acceptability of the interventions, and it should be followed by an impact evaluation to establish effectiveness. We would recommend a further adaptation of SH+ and PM + for our setting and a study with multiple arms to assess the added value of having both SH+ and PM+ and/or a study arm with a blended intervention. Thereafter the adapted version of SH+ and PM + offers a low cost, lay-person facilitated mental-health and wellbeing intervention which could be adapted and rolled out through TCCs and other service providers in South Africa.

CRediT authorship contribution statement

Samantha Willan: Writing – review & editing, Writing – original

draft, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Zamakhoza Khoza:** Writing – review & editing, Writing – original draft, Validation, Formal analysis, Data curation, Conceptualization. **Sinqobile Mngadi:** Writing – review & editing, Writing – original draft, Validation, Formal analysis, Data curation. **Jani Nothling:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Thobeka Majola:** Writing – review & editing, Data curation, Conceptualization. **Mpumelelo Mabhida:** Writing – review & editing, Formal analysis, Data curation, Conceptualization. **Tholsie Gounden:** Writing – review & editing, Formal analysis, Data curation, Conceptualization. **Mbalenhle Shabalala:** Writing – review & editing, Formal analysis, Data curation, Conceptualization. **Amanda Zembe:** Writing – review & editing, Formal analysis. **Gugu Gigaba:** Writing – review & editing, Formal analysis, Conceptualization. **Rachel Jewkes:** Writing – review & editing, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Naeemah Abrahams:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

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Declaration of competing interest

I have nothing to declare.

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