Case Study

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Innovative Community-Based Approaches to Addressing Access to Sexual Violence Services

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Executive Summary

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This Case Study has been presented as a final project of the Master in Global Health ISGlobal – Universitat de Barcelona. Supervised by Olivia Hill (MSF) & Azucena Bardají (ISGlobal).

This paper's objective is to evaluate if community based interventions, with a specific focus on those employing information communication technology, can assist in facilitating access to health services to women affected by sexual violence in low income countries; including areas of conflict and displaced populations.

It is claimed that to tackle sexual violence it is important to address the cultural norms that support it as well as the various barriers that women meet when accessing services. The studies included, highlight how community based interventions which are multi-level, multi-sectorial and culturally situated, can have a positive impact in responding to sexual violence. Positive outcomes include a reduction in Post Traumatic Stress Disorder (PTSD), depression and anxiety among survivors, an increase in service uptake and positive responses from women affected by sexual violence using the services.

The benefits also include a heightened collaboration of services, resulting in a more efficient provision. However community based interventions that are not integrated into the cultural and social context, or lacking appropriately trained staff can have damaging effects in tackling sexual violence and improving service uptake for survivors, such as community rejection or demoralisation, fragmented resources and deferred uptake.

The report also emphasises the challenges for services responding to sexual violence in displaced populations and conflict settings, and how further analysis and efforts into such programs is needed. Research into information communication technology to support community based sexual violence programs encouragingly shows that they can play an important role in responding to sexual violence in low income countries.

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Background

Sexual violence is a global public health problem of epidemic proportions, requiring urgent action. It is estimated that 1 in 3 women will experience physical and or sexual violence by a partner or non-partner in her life time[1], and this can be experienced throughout different phases of life[2,3]. Although prevalent in all settings and across all cultures, the figures for lower income countries are almost twice as high as those in high income countries and are particularly striking in conflict settings where sexual violence is one of the most pervasive forms of violence[4].

Despite the increase of awareness and interventions tackling sexual violence there are many challenges, and with the issue reaching such high proportions many women are not receiving the care that they need. This is often due to the very nature of sexual violence which is a multifaceted problem that is influenced by an interaction of socio-cultural, personal and situational factors[5]. These attitudes and beliefs transcend into a range of laws, practices and customs that create great challenges to the protection and health care response for women; and the punishment of abusers[2]. Therefore as cultural attitudes and beliefs have such a strong role in the construction, experience and response to sexual violence it is important that they are understood and challenged so that interventions tackling sexual violence are socially and culturally relevant; something that is often tackled in community approaches.

The use of technology is also increasingly used in health interventions, particularly at the community level. Globally the use of information communication technology has become more and more widespread. Even in low income countries where consumer goods are limited, it is estimated that around 70% of people have access to a mobile phone6 and other forms of communication technology (radio, television etc). Previous research and practice are also establishing a strong evidence base that communication has a major role to play in improving health[6] which really draws attention to the role of technology in development and health interventions. This paper therefore examines the significance of the community context, and how facilitating these approaches can be used in an innovative way to increase access to the services urgently needed by survivors of sexual violence. It also aims to evaluate the role that Information Communication Technology (ICT) can play in responding to sexual violence in these challenging contexts.

Objectives

This paper evaluates how community based approaches, with a focus on information communication technology, can assist in facilitating access to health services to women affected by sexual violence in low income countries this includes areas of conflict and displaced populations where a majority of the studies have stemmed from. Primarily the report seeks to examine existing community based interventions which are responding to sexual violence. It then identifies the key actors that are involved in delivering response interventions in the community. Many of these focus on the prevention of SGBV, as well as the response, as they are interlinked. It also analyses and discusses the role that community based interventions may play in assisting access to health services to women affected by sexual violence in low income counties, in addition to addressing the added value that information communication technology can bring when used in community based interventions tackling sexual violence in resource poor settings.

Methods

This paper is based on a review of the current literature detailing community-based interventions responding to sexual violence in low-income countries, with a particular focus on the role of technology. It gathers data from low-income countries that include those affected by conflict and natural disasters in LIC's where sexual violence is hugely increased. The countries included are DRC, Ethiopia, Somalia, Nigeria, Uganda, Liberia. Both qualitative and quantitative studies have been incorporated in this report, including primary research studies, systematic reviews and grey literature. The search terms used (see Figure 1) include three areas of search that were cross checked to ensure inclusion. The studies included followed predefined selection criteria, and work was also classified to ensure that the data included was ethical, adequate methods, subjective and open about results (for example did not exclude information that may not fit a hypothesis). Finally included studies were then evaluated thematically to reveal the studies themes, and grouped to produce the outline of the review.

Figure 1
Search Terms

SGBV based terms:
Sexual violence OR gender violence OR rape OR sexual assault OR women

Community based terms:
"Community based intervention" OR "community driven response" OR "community directed intervention" OR "Community health workers" OR "mobile health services" OR "mobile health care"

Technology based terms:
"Technology" OR "technologies" OR "information technology" OR "communication" OR "mobile phones" OR "SMS" OR "internet platforms"

Definitions

Several terms have been used throughout the research. The key definitions for each of these are the following:

Sexual Gender Based Violence (SGBV)

Sexual violence is an umbrella term that covers many harmful practices. The following WHO definition of sexual violence is used throughout this report:
'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.'[1]

Community

The WHO definition of a community is *'a group of people, often living in a defined geographical area, who may share a common culture, values and norms, and are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them.'*[7]

Community Based Interventions (CBI)

The definition used by the WHO[8] is that a community based intervention is a response that is working in or for a community. A CBI should encourage community participation and involvement, which moves towards community engagement[9] where community members are involved in decision making, planning and programme implementation, monitoring and evaluation[8].

Results

A. What is the Community Context of Sexual Violence?

Society, culture and gender norms all have an effect on sexual violence, and this is an issue often contextualised by communities. Several studies have revealed how permissive social norms in the communities that validated inequality between men and women were directly linked to the increase of violence[10,11]. These led to emphasise that women were at a much greater risk and reported far more violence in these regions. For example a comparison of a region where sexual violence was socially permissive in Nigeria, in contrast to where it was less permissive, showed an increased odds ratio of 2.58[10] of a woman suffering from sexual violence. This appears to be even more amplified in displaced communities and/or conflict settings[2,12,13].

Similarly, permissive state-level social norms towards violence were positively associated with a woman's report of sexual violence showing an increased odds ratio of 1.80[10], which has an effect on health seeking behaviour and the care that women receive when they seek help. The attitudes of stakeholders within the community also affected the care that service providers offered to survivors, and even transcended to a tolerance of violence from survivors or their families. It was also emphasised that one of the most important ways to respond to sexual violence is through tackling community concepts of violence[5], and having a clear understanding of what violence is in each community[14].

Therefore a community's attitudes and beliefs surrounding sexual violence transcend into a range of laws, practices and customs that can create great challenges to the protection and health care response for women and the punishment of abusers. In addition to the increased prevalence of sexual violence they also affect the way that reporting and response to sexual violence happens, which in turn leads to the global health endemic of sexual violence today.

B. Challenges and Access Barriers to Services within the Community

There are several access barriers that are met at the community level in responding to sexual violence. Community attitude's and strategies to stop sexual violence at the community level are often challenged by beliefs and gender norms that tolerate and legitimize male violence[5,10,11,15]. These determinants in turn lead to the isolation of survivors, a lack of social support and affected help seeking behaviour which leads to limited reporting and service uptake.

Sexual violence is highly stigmatised in most settings and it can be seen through several studies that it is amplified in certain communities. Studies in Ethiopia and Nigeria highlighted that the fear of being blamed and a perceived lack of support from families, friends, and services has shown to lead to under-reporting and affecting help-seeking behaviour[11,15]. Women also reported a fear of dishonour, after being affected

by sexual violence[5]. Survivors sometimes also stated a fear of traditional practices that may arise from the assault if they tried to pursue justice, for example in some cultures forced marriage of the rape victim to the perpetrator is enforced to restore honour[13].

Studies also showed how these barriers have a large impact on survivors impairing access to health care, and many of them do not report sexual violence or seek health care in low income settings due to the negative impacts that can result[15]. This seemed particularly relevant in rural communities where the health support system is interlinked with the rest of the community; there is a fear of confidentiality, physical safety and the risk of repercussion[5,11,15]. Both service users and providers agreed that social stigma prevented reports, particularly in case of sexual violence:

> *"For example, she might not get the kind of trust from the person that she's come to tell. Maybe that person might tell to other people in order to insult. That's going to be one challenge. Another thing, you know, everybody will hurt her again saying that, "Oh, you've been raped. So you are kind of useless."*–Service Provider FGD, Ethiopian Refugee Camp[13].

Figure 2
Factors Affecting Help-Seeking Behaviour
* see 5,11,13,15

Justice and accountability was also a concern for survivors that led to a barrier in accessing services. Some survivors reported this further adding to social stigma, with their testimonials being renounced or disbelieved by local justice systems or having negative repercussions. Where there are services in a neighbouring community that allow for improved confidentiality, other barriers arose such as a lack of finance or transport to access these other services[13]. Some women also reported barriers they met of finding childcare for young children, or of other responsibilities in the home or at work that would be jeopardized if going to access health care services[11]. One survivor in the Addis Ababa camp in Ethiopia reported a lack of finance to pay for an interpreter needed in accessing services. Another barrier was that if women did seek treatment they are only treated for physical outcomes of the violence[13], which is lacking the mental and emotional support that is essential for recovery. Women in low-income countries also face barriers from a lack of awareness regarding their rights, health complications and available sexual violence services.

These barriers that are found in communities that endorse sexual violence and prevent access to services are not only devastating to the individual yet also to the community as a whole, having a wide range of negative consequences reaching to the structural level.

C. Key Actors in the Community

Within communities there are often several key actors, many of whom play an important role in considering sexual violence responses. These may include community leaders, religious leaders or elders, traditional healers, health care provides, education providers, community health workers, families, justice system etc[5,16]. Understanding their roles and how all of these actors work together has been shown imperative to ensure an effective response[17–19] and programs which involved community stakeholders and worked collaboratively with other actors have been shown to be more likely to produce an accessible service.

However within these there are also issues about who decides which stakeholders matter and it is important to involve stakeholders from all levels of the community to ensure that the less powerful are heard respectively[5,16]. Working with local women's rights groups and including those from marginalized populations is very important in ensuring effective responses[28], as is ensuring governmental and nongovernmental institutions, including the police force, health centres, churches/religious centres, and schools, have been identified as playing a strong role in moulding attitudes about sex and sexual violence within a given community[3,5,19]. The majority of the interventions showed to reach health care needs of survivors more effectively when they worked with other providers especially in the form of the 'one stop shop' model, which in resource poor settings can be a very effective and efficient way of meeting needs.

D. Community Based Interventions Responding to Sexual Violence

There has been a variety of interventions identified that are working within communities to tackle sexual violence ranging from; group counselling, support groups, focus groups, combined psychological and economic mediations and psychotherapeutic care[5,11–14,20]. These are often looking at prevention of sexual violence in addition to its response, by improving the information, education and communication relating to sexual violence topics[14]. The studies analysed highlighted the importance of community mobilizing and participation in these approaches, and showed that interventions that are multi-level and culturally situated are more likely to have a positive impact[3,5,20]. They also noted that CBI's can work as a 'one stop shop' for sexual violence survivors where one service can care for all needs at a primary point of call [14]. If staff are trained appropriately the response to the needs of sexual violence survivors is improved[28].

The impact of community based interventions were analysed in different ways, yet the data showed how the majority of these interventions have a positive response in efforts to curtail sexual violence. A randomised control trial evaluating the impact of community based interventions tackling sexual violence and HIV in Uganda showed a >39% reduction in relative risk of past year physical (including sexual) violence which was related to the effects of the CBI model undertaken[21]. Other quantitative results show a decrease in PTSD, depression and anxiety symptoms amongst survivors involved in CBI's, in addition to an increase in services uptake[12,22]. Positive qualitative responses of women who were engaged in these programs were also reported[12,23].

Aspects of community based interventions that were proven to be effective included an emphasis on mobile health programs which helped to facilitate uptake of services amongst survivors by moving around the local communities, and increased services by implementing computerised data management system[15]. Additionally heightened collaboration with

other stakeholders and institutions in the community was shown to be of importance in ensuring positive impact from CBI's[5,11]. For example, the use of 'one stop shops' are becoming more and more widespread by service providers with largely positive results. For example the Monrovia's Star of the Sea Health Centre in Liberia offered women psychosocial and legal support alongside health services. This multi-partner intervention included family planning, and maternal and child health services as well as health checks, vaccine administration and treatment for sexually-transmitted infections and was found to better respond to women and help decrease access issues [29]. A similar approach is starting to be implemented amongst other NGO's working in the area of sexual violence response (e.g. Physicians for Human Rights), again with optimistic results in terms of heightened service provision.

However other studies warned that CBI's working to tackle sexual violence can be counterproductive if there is not a supportive system in place for the community[24]. In analysing CBI's in Uganda, it was reported that at times the community awareness campaigns did little to change social climate, stating that badly implemented programs 'can build hope and then demoralise'[24]. Limitations such as thrusting rights messages into communities where people do not yet recognise that sexual violence is a problem was reported to create defensiveness, confusion and rejection. Similarly focusing on an end result (i.e. curtailing of physical violence) is meaningless when the context of a relationship is not explored and a sporadic engagement with different sectors (e.g. religious leaders, police, health care providers, local government officials) results in fragmented interventions[24] .

It was also noted in one study that CBI's reaching to the general population of a community may not be effective at outreaching to all groups. One study in DRC[15] for example, found that their community based mobile health program missed the younger population hence recommended specifically targeted services for certain population groups.

E. ICTs and the Role of Communication in Sexual Violence Response

The use of technology and communication is becoming more widespread throughout health interventions, and several examples have been identified in looking at the role that the media and technology can have within community based approaches responding to sexual violence. Several studies stressed how improved communication can also help address social factors that are harmful to health, which as shown are important in responding to sexual violence[5,13,14,19]. Reports from community stakeholders emphasised that by creating opportunities for people to engage in dialogue and debate also enables them to anticipate in decisions about health services within their community and hold leaders and service providers to account.

> *"The best solution is increasing the community's awareness using media and forums. In addition, schools should teach about gender issues from the very beginning so that the generation can be changed"* (A 78 years local community elder in Ethiopia[11]).

Other studies showed how ICT's were used throughout programs working with the community and specific case studies have been identified as examples of the role that ICT's can have in responding to sexual violence in low income settings (see Appendix). Elements that have shown to be effective include the use of mobile phones, social media, edutainment models, SGBV mapping and computer management systems[5,14,19].

Several interventions have used the local radio or television programs to make an "edutainment" model. These provided an interactive way to educate the community and broader society about sexual violence and challenge the norms and values that support it within specific communities [5]. For example South African based Soul City worked using media and communication related to SGBV, focusing on involving men, culture and religion, the link between SGBV and HIV/AIDS, conflict-related SGBV, and communicating awareness to resource poor settings. A particularly successful element of the campaign was through television and media dramas in addition to a mass distribution of an information booklet. This in addition to collaboration with other organisations was shown to improve advocacy and led to increased understanding about what SGBV is and the services available for survivors.

Mobile phones were also used in several different interventions, with positive impact. For example, in responding to SGBV in Haiiti, Digital Democracy implemented a rape crisis help line that was especially designed for mobile phones that survivors in Haiti could call 24 hours a day. This was free from mobile phone service providers, and enabled heightened referral to other services, as well as improved data collection on SGBV. So far the intervention has handled over 3,500 calls and connected hundreds of women affected by SGBV to free medical, legal and psychosocial services (Digital Democracy:2014). A similar SGBV response platform- Clique 180, is currently in use in resource poor settings in Brazil. Clique 180 utilises a geo-location service of the user which then is matched to information regarding local services, opening hours and details of how to reach them.

Methods of data collection and SGBV mapping via a secure system are being utilised by an increasing number interventions and with positive impact. These platforms allow local women to track, analyze, map and share data on incidents of violence. For example the work implemented by Digital democracy in Haiti has resulted in over 1,000 incidents having been reported to police, government, and other influencers over the last two years heightening coordination, and similar programs such as Ushahidi in Cambodia or Harrassmap in Egypt have also resulted in improved SGBV services.

These reporting systems allowed for women and girls to report instances of violence via website, app or text message. Social media is also being increasingly used within this type of intervention. Safe City India for example has used hash-tags and social media (blogs, Twitter etc) so that users can tweet information regarding sexual violence incidence that are used in mapping and reports. These reports are then shown on a map so that women can localize particularly unsafe areas or hotspots where violence occurs which is a valuable tool for taking steps to avoid high-risk areas. An additional forum element of these applications further enables communication within communities about sexual violence, which as shown has a strong role in ensuring survivors best access services.

The use of ICT's in interventions therefore really seems to reduce access barriers (for example stigma) and appear to have a large role to play in health seeking behavior. Interventions using mobile phones for generating data and responding to health needs seem to encourage health seeking, which is a good tool in creating effective SGBV responses at the community level and seem to assist in improving SGBV services. Although much of the data regarding ICT's and sexual violence response is at present pioneering, it seems to bring a strong added value for improving services. So much so that other organizations and service

providers are also at time of writing instigating research into these areas. For example, a Global Mapping project with UN Women and Microsoft is currently underway on women's access to and use of mobiles phones to prevent, document and respond to violence in public spaces – in the cities of Rio de Janeiro, New Delhi and Marrakech. This research aims to cross regionally analyse the impact of the use of ICT's and their factors that can work to prevent and respond to sexual violence in public spaces, or, to the contrary, facilitate the perpetration of violence against women. The results of this research are due to be released later in 2014, yet it seems there will be an increasingly important role for technology to play in health interventions.

Limitations

The principal limitation of this report is that it is a review drawing on the availability of current data, and at times there has been limited analysis and research in some areas. For example the work looking at SGBV interventions focusing on displaced people has little full investigation to date. Another limitation is that has been difficult at times to judge the impact of some of the interventions included as some studies did not include measurable indicators for gauging this.

Recommendations

The paper has shown some of the evidence and gaps there are in research surrounding community based approaches to sexual violence. Particular gaps for example, are concerning interventions targeting refugees/IDP´s and it would be beneficial to have further research using qualitative methods in these areas. Similarly, further qualitative research is also recommended with community stakeholders, service providers and users to highlight the impact and barriers encountered in this type of intervention. The continued analysis on the role of ICT's is also important so to best utilise these tools in sexual violence response.

Yet in ensuring that sexual violence responses are effective there are many areas to consider such as the necessity of women's empowerment, political will and support, role of NGOs, advocacy etc. The implementation of community based interventions seem to be effective approaches in meeting these needs however it is imperative that there are appropriate guidelines in place across all sectors and that a collaboratory multi-sectorial approach is undertaken in order to curtail sexual violence.

It is also recommended that an emphasis is placed on the monitoring of impact and evaluation of community based interventions. This should allow for identifiable measures, so that the strengths and weaknesses of interventions are identified and can be translated into planning and research.

Conclusion

This paper has emphasised some important messages for service providers looking to respond to sexual violence in low resource settings. It has stressed the importance of implementing interventions at the community level, understanding the local context and determinants that create sexual violence. It has also revealed the positive impact that interventions which work in this context, with properly trained staff and collaboratively with communities can have in reducing sexual violence - although care must be taken to include stakeholders from all levels of the community to ensure that the less powerful are heard respectively.

The positive impact of community based approaches is mainly in a reduction of the health compromises survivors face when affected by sexual violence, an uptake of SGBV related services and reduction of access barriers, heightened service provision and collaboration with other providers, in addition to a positive response from survivors. The increasingly used model of a 'one stop shop' in communities to respond to survivors sexual violence needs in one centre at a primary point of call has also been shown to have a positive effect in ensuring response, particularly in resource poor settings. However, interventions must ensure that outreach to specific groups within communities are also catered to as some data has highlighted challenges in meeting certain groups.

The report has also shown how ICT services can really play an instrumental role in these interventions: seeming to bring an enhanced coordination of services, better management of SGBV data, change in health seeking behaviour, improved health status of survivors and justice outcomes. These findings are very encouraging to those working to reduce the burden of sexual violence.

The data has however highlighted large gaps relating to community based sexual violence responses in conflict settings and with displaced populations; further qualitative analyses is urgently needed if we are to achieve in effectively curtailing sexual violence in these settings. Similarly data has demonstrated that more services which are working with communities to respond to sexual violence are critical, especially in resource poor settings. Further analyses should also be paid to the role of ICT's in improving these responses, again utilising a more qualitative methodology so to aid greater understanding to the benefits and limitations of these tools from the community's perspective.

Appendix

Figure 2
A. Case Studies of Specific ICT's Used in Sexual Violence Response

Name	Details	Impact
Ushahidi	The platform allowed for data collection, interactive mapping of SGBV occurrence, facilitating response to SGBV survivors. Highlighted how SGBV services can be effectively improved through this kind of platform and enable coordination between service providers.	Used in 379 communes (out of 1,621) in Phnom Penh, Battambang, Siem Reap and Kampong Thom provinces in Cambodia, which allowed for improvement of SGBV services. Enhance collaboration between service providers.
Harrassmap (Developed by Frontline SMS and Ushahidi)	Similar mapping system to Ushahidi, based in Egypt. Women can submit incidences of harassment by text message. The platform then shows 'hotspots' for harassment and also provides support information to those affected.	Builds knowledge of current areas and trends of sexual violence reporting enhancing service provision. Improved survivor referral and uptake of SGBV services. Enhanced collaboration between service providers.
Safe City, India	Mapping system in place showing hot spots of sexual violence in India. Includes open forum for service users to publish experiences, and links to provider information. Uses hash-tags and social media so that users can tweet information.	Improved understanding of hotspots Increased service referral
Clique 180/ UNWomen (Resource poor settings in Brazil)	Free Smartphone application tested in 10 favelas (shantytowns) in Rio. It includes nation-wide services and information indicating which local, state-level or federal public services, non-governmental or academic resources are located closest to the user, their hours of operation and how to get there.	Improved access of services. Reduction of stigma.
Digital Democracy/ KOFAVIV Haiti 572	Rape crisis hotline providing information for survivors. Designed for mobile phones; calls are answered 24 hours a day and free from main Haiti service providers. Built a secure system to collect SGBV data, allowing local women to track, analyze, map and share data on incidents of violence. Used social media and blogs to report and raise awareness of SGBV.	Improved referral and access -over 3,500 calls of which SGBV victims referred to free medical, legal and psychosocial services. Over 1,000 incidents have been reported to police, government and other influencers over the last two years.
CREAW (Centre for Rights Education and Awareness)	Community based program working in resource poor settings in Kenya (mobilising local media, technology and SGBV.	Improved access to medical treatment and legal advice. Showed improved health status of women in programs.
Soul City (Resource poor settings in South Africa)	'Edutainment' (education/ entertainment) working with the community and broader society on SGBV. Utilised media to transmit issues related to SGBV, focusing on involving men, culture and religion, the link between GBV and HIV/AIDS, conflict-related GBV, and communicating awareness.	Led to increased awareness of SGBV and services. Increased advocacy, led to political change

B. Evidence Table of Included Non Grey Data

Quantative Experimental Studies

Reference	Focus of Study	Methods	Findings	Limitations
Anjalee Kohli et al, 2012	Mobile Health Program Outreaching to women affected by sexual violence in Democratic Republic of Congo.	Case Study, Trial. Clinic rotated between 6 village centres, seeing 772 survivors of sexual violence in the study period.	Improved access by working with community. Better follow up; 70% women returned for repeat visits and were treated.	Showed gaps in services: age/access discrepancy became apparent, the majority of women were over 20 (missing younger women).
Abramsky, Tanya et al, 2012	Analysis of CBI's responding to sexual violence in Uganda.	Cluster randomised controlled trial, using SASA logic model to implement SGBV response in the community.	Widespread positive effects of CBIs; 39% or greater reduction in relative risk of SV in communities where CBI's.	Possible 'Contamination' of cases and controls. Limited duration and follow up.
Bass et al, 2013	Psychotherapeutic care to communities in Democratic Republic of Congo. Analysed effectiveness of providing care to women in communities who had been effected by SGBV.	Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence. Group counselling or individual to those with severe depression/anxiety.	Reduced PTSD, depression and anxiety symptoms. Based on Hopkins Symptoms Check (0-3 highest) women reported (2.0 at baseline, 0.8 at the end of treatment, and 0.7 at 6 months after treatment) of community based therapy.	Sample randomisation was difficult to measure. Symptoms.
De Beus et al, 2007	Psychosocial interventions for female sexual violence survivors in Liberia.	Clinical trials yet also using qualitative methods.	Positive responses of women in the communities using these services.	

Quantative Non Experimental Studies

Reference	Focus of Study	Methods	Findings	Limitations
Asagary et al, 2012	SGBV interventions responding to IDPs & refugees	Systematic review of interventions.	Found little evidence evaluating SGBV interventions in these settings. Call for further analysis	Little evidence base.
Wietse, A et al, 2013	SGBV in areas of armed conflict.	Systematic review of mental health and psychosocial support interventions.	Community based counselling and groups showed decrease of PTSD symptoms and slight increases in the support and waitlist conditions.	No statistical significance of these effects was reported.

Qualitative Studies

Reference	Focus of Study	Methods	Findings	Limitations
Abeya, Sileshi Garoma Afework, Mesganaw Fantahun Yalew, Alemayeh Worku, 2012	Community attitude, strategies and measures to stop SV at community level in Ethiopia. 1 urban, 4 rural districts.	Focus groups, qualitative interviews.	Access barriers Community context of SV.	Possibly not generalisable to other sites - based on interviews.
Wirtz, A et al, 2012	Development of a screening tool to identify female survivors of gender-based violence in Ethiopia.	Qualitative interviews.	Access barriers, types of violence, difficulties in responding to SV with displaced people.	Recruitment of participants limited.

Abbreviations

CBI (Community Based Intervention)
DRC (Democratic Republic of Congo)
FGM (Female Genital Mutilation)
GNI (Gross national income)
HIC (High Income Country)
ICT (Information Communication Technology)
IPV (Intimate Partner Violence)
LIC (Low Income Country)
MIC (Middle Income Country)
MSF (Médecins Sans Frontières)
NICE (National Institute for Health and Care Excellence)
PAHO (Pan American Health Organisation)
PTSD (Post Traumatic Stress Disorder)
RCT (Randomised Controlled Trial)
SGBV (Sexual Gender Based Violence)
UNFPA (United Nations Population Fund)
WHO (World Health Organisation)

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