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What responses, approaches to treatment, and other supports are effective in assisting refugees who have experienced sexual and gender-based violence?

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Abstract

Violence, insecurity, persecution, and human rights violations have led to the forced displacement of an estimated 68.5 million people as of 2018 (UNHCR, 2018a). Of those 68.5 million, 25.4 million are refugees - the highest number ever recorded; 3.1 million are asylum seekers; and 40 million are internally displaced (UNHCR, 2018a). Humanitarian emergencies exacerbate the unequal power relations and structural inequalities that underpin the sexual and gender-based violence (SGBV) experienced by girls and women, as well as boys and men (UNOCHA, 2016). In some humanitarian emergencies, more than 70 percent of women have experienced gender-based violence and an estimated one in five displaced women will experience sexual violence (UN Women, 2017). Conflict-related sexual violence against men and boys has been documented around the world, though data to determine prevalence are limited (Solangon & Patel, 2012). Following displacement, and even after permanent resettlement, different kinds of insecurity such as breakdown of family and community networks, shifting gender roles, and limited access to resources can also increase the risk of SGBV. Responses to SGBV need to adapt to varying contexts and needs across the refugee journey, however there is no comprehensive evidence base for understanding how these needs evolve at different points for people on the move. This working paper is a critical overview of the current state of knowledge on responses to SGBV for refugees, asylum seekers and internally displaced persons across all stages of the refugee journey.

Contents

Scope and methods for review

Definitions

Refugees

For the purposes of this working paper, refugees, asylum seekers and internally displaced people are defined as people who are or have been displaced within or outside their home country due to persecution or conflict.

Sexual and Gender-based violence (SGBV)

SGBV is defined in accordance with the Inter-Agency Standing Committee (IASC) 2015 Guidelines (p. 5) as an "umbrella term for any harmful act perpetrated against a person based on socially ascribed gender differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty". SGBV includes, but is not limited to, different forms of sexual violence (such as sexual harassment, rape and sexual exploitation), intimate partner violence, forced and early marriage, occurring in both private and public domains. Included in this definition is gendered violence against women and girls, men and boys, and lesbian, gay, bisexual, transgender and intersex (LGBTI) persons.

Responses to SGBV

In this working paper, we use the 'responses to SGBV' to refer to actions that provide survivors with specialist care, support or assistance (IASC, 2015). These responses differ depending on the type of SGBV being targeted, the level of intervention - which can include anything from basic services and security to specialised support - and the refugee context.

Stages of 'refugee journey'

Given the importance of context for determining what is possible in terms of SGBV response, and possibly also for determining survivors' priorities and needs, we have described responses as occurring during one of three different phases of the 'refugee journey'. These are categorised as:

1. Conflict or immediately post-conflict settings
2. Displacement in countries of first asylum or following internal displacement e.g. within refugee camps or urban sites. These are typically resource-poor settings and/or settings hosting large numbers of refugees with few prospects of long-term settlement or integration

3. Resettlement, typically in relatively resource-rich countries such as those within Europe, North America or Australasia where refugees have been given either temporary or permanent protection status.

Scope

Inclusion criteria

An iterative approach was taken, whereby the search terms were refined during the process of research (Boell & Cecez-Kecmanovic, 2014). Publication types were limited to peer-reviewed journal articles and service delivery evaluation reports, and technical reports in English.

The inclusion criteria were studies that referenced responses to SGBV in refugee populations in the abstract or overview, and/or studies that provided recommendations for responses to SGBV in refugee populations in the abstract or overview. Inclusion of the relevant literature was based on their relevance to the search frame, thus a small number of included studies focus on SGBV responses in (refugee-producing) conflict settings rather than following displacement. A small number of included studies also describe their sample as 'immigrant' rather than 'refugee' but are focused on immigrant groups likely to have had a refugee experience (e.g. West African migrants in the U.S. or Ethiopian immigrants in Israel).

Exclusion criteria

The review does not include studies that were attempting to assess the prevalence or describe the causes and types of SGBV experienced by refugees without reference to specific responses. Studies focused on responses to generalised trauma (rather than SGBV) and responses to SGBV experienced by people who were primarily victims of trafficking (rather than refugees) or people affected by other humanitarian emergencies (such as natural disasters), were not included within the scope of this review.

For the purpose of this review, responses are also taken to be distinct from prevention (taking action to stop SGBV from first occurring) and mitigation (reducing the risk of exposure to SGBV) (IASC, 2015). Prevention and mitigation generally involve targeting the root causes of SGBV, including gendered social norms and gender inequality. This requires longer-term approaches focused on structural and behavioural change, which are outside the scope of this working paper. Despite this distinction, we recognise that response and prevention are part of a continuum. Responses to SGBV may also work to prevent further violence and many authors focusing on response emphasise the importance of prevention. While we have not conducted an exhaustive search of the prevention literature, where papers addressed both they have been included.

Method for literature search

Guidelines for responding to SGBV were sourced from the websites of prominent United Nations (UN) and international non-governmental organisations (INGOs) such as the United Nations High Commissioner for Refugees (UNHCR), United Nations Population Fund (UNFPA), and the World Health Organisation (WHO). The databases – Medline (Ovid), PsycINFO, PubMed, Scopus, and Google Scholar were searched using the search strategy outlined in Table 1. The abstracts/overviews of the located literature were reviewed using the exclusion criteria, and those which remained were further reviewed using both the inclusion and exclusion criteria. Reference lists of relevant literature were also examined. Finally, the remaining literature was read in-depth using a data extraction tool developed to support the recording of key information, including research design, intervention levels, type of SGBV targeted, location, key findings and methodological quality.

Table 1. Search Strategy	
Search frames	**Term**
Gender-based violence	sexual harassment OR sexual abuse OR sexual exploitation OR sexual violence OR sexual assault OR trafficking OR gender-based violence OR violence against women OR domestic violence OR intimate partner violence OR forced marriage OR child marriage OR early marriage OR survival sex OR rape
Responses	evaluation OR evidence OR best practice OR good practice OR intervention OR trauma-informed care OR therap* OR treatment OR response
Refugee	Refugee* OR forced migra* OR asylum seeker*

Structure of this report

We begin with a brief overview of the content focus of the most widely-referenced humanitarian guidelines which provide standards for responses to SGBV by humanitarian actors in complex emergency and displacement settings. These guidelines can be broadly categorised as providing recommendations for response primarily focused on individual survivors or on systems and settings.

In addition to these guidelines, a total of 54 journal articles and reports met the inclusion criteria. Included papers reflected three basic study designs:

1) Evidence reviews, summaries and commentaries (19 papers);

2) Primary data collection with SGBV survivors and/or service providers leading to recommendations for response (20 papers); and
3) Evaluation of SGBV responses (15 papers).

The remainder of the review is structured in line with these study designs as each gives rise to a different type of evidence. Papers that report on evaluations of interventions will be discussed in greatest detail. Given the importance of context for determining what is possible in terms of SGBV response, and possibly also for determining survivors' priorities and needs, within each study design section we have categorised responses according to their setting: 1/ conflict settings; 2/ countries of first asylum or following internal displacement, within both refugee camps or urban sites; or 3/ resettlement.

The review concludes with a discussion of the key findings and recommendations.

Humanitarian guidelines for responses to SGBV in the field

There have been a number of guidelines on responses to SGBV in humanitarian settings that have been produced by UN agencies and international non-governmental organisations. For the purposes of this review, we have conceptualised the most widely referenced guidelines from the Inter-Agency Standing Committee (IASC), WHO, and UNFPA as either individual or systems level guidelines. The guidelines are a product of a cyclical process, both shaping and shaped by the experiences of SGBV practitioners and experts across the humanitarian sector over time. However, little evidence exists on the scope and effectiveness of the application of these guidelines in practice.

Individual level guidelines

The major guidelines at the individual level are the *Guidelines for Medico-Legal Care for Victims of Sexual Violence* (WHO, 2003), *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* (WHO, 2004), and, published almost 15 years later, the *Inter-Agency GBV Case Management Guidelines*, published by the Gender-based Violence Information Management System (GBVIMS) Steering Committee (2017).

The initial focus of the two early WHO guidelines is sexual violence, specifically through the lens of improving clinical care practices. Female survivors are prioritised, though the WHO (2003) guidelines do point to specific issues that might arise with male and child survivors. Sexual violence is framed as both a human rights and public health issue, with the WHO (2004) guidelines defining survivors' rights through the principles of the right to health, human dignity, non-discrimination, self-determination, information, privacy, and confidentiality. The WHO (2004) guidelines are designed specifically for humanitarian settings, while the WHO (2003) guidelines are generally applicable to both humanitarian

and non-humanitarian settings with a particular regard for settings with severe contraints on the capacity to provide comprehensive health services and as such has become a useful tool for sexual violence responses in refugee settings. The WHO (2004) guidelines are more comprehensive, providing context to sexual violence, examining trends and consequences, as well as confronting rape myths and unconscious bias that practitioners may hold. Nevertheless, the two sets of guidelines complement each other, providing step-by-step recommendations for the preparation, forensic and physical examination and follow-up care of survivors of sexual violence.

The *Inter-Agency GBV Case Management Guidelines*, on the other hand, provide a step-by-step guide for SGBV case management in humanitarian settings (GBVIMS Steering Committee, 2017). This includes the following steps:

1. Engaging with the survivor to build trust and rapport, assessing risk, and gaining informed consent
2. Assessing the survivor's situation and needs, providing psychological first aid and information, and determining whether a survivor requires further case management services
3. Developing a case action plan, making referrals, and documenting plans
4. Assisting and advocating for survivors in implementing the case action plan, and leading case coordination
5. Monitoring case progress, revising and reassessing needs if necessary
6. Closing the case

Case management is a focused non-specialised method of support that links survivors to basic needs, mental health and psychosocial support services and resources. In line with the WHO guidelines, it is recommended that case management be approached through the principles of the right to safety, confidentiality, dignity and self-determination, and non-discrimination –now referred to as the 'survivor-centred' approach. The theoretical and practical foundations justifying this approach are linked to the learnings from social work case management, trauma theory and practice, women's movements, and evidence from survivors. Most significantly, this guideline is uniquely inclusive, detailing the specific case management needs of LGBTI, men, and people with disabilities, as well as women and girls.

System level guidelines

The major guidelines at the system-level are the *IASC Guidelines for GBV* (IASC, 2005), its updated republished version, *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action* (IASC, 2015), and *The Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies* (UNFPA, 2015), also known as *MISP*. Overall, these guidelines advocate for

multi-sectoral collaboration and coordination, and the mainstreaming of gender and SGBV into humanitarian responses.

The *Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies (MISP)* specify operational standards to support multisectoral support services for survivors of SGBV (UNFPA, 2015). These responses include specialised health care with an emphasis on clinical management of rape, mental health and psychosocial support, safety and security, legal aid, socioeconomic empowerment, and mainstreaming across sectors, as well as referral systems to manage disclosures. While the MISP makes mention of men and boys, as well as LGBTI, pregnant women and adolescent girls and children, it does not elaborate on the diverse needs of specific groups within SGBV responses.

The 2005 *IASC Guidelines for GBV* are structured around a series of action sheets for coordination, assessment and monitoring, protection, human resources, water and sanitation, food security, shelter, health, education and communication (IASC, 2005). Notably, it is in these guidelines that the language of GBV is first introduced as an umbrella term for different forms of gendered violence. In line with the individual-level guidelines of the time, the central focus is sexual violence and women and girls. The updated and republished version, the 2015 *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action* provide guidance and tools for humanitarians across all sectors to coordinate, plan, implement, monitor and evaluate actions related to the prevention, mitigation and response to SGBV across all stages of humanitarian response – from preparedness to recovery (IASC, 2015). Expanding on the 2005 IASC guidelines, a broader definition of SGBV is applied and the underlying principles are a human-rights based approach (sustainable solutions addressing human rights through systemic change); survivor-centred (survivors' rights, needs and desires are prioritised); a community-based approach (affected populations lead strategies related to their assistance); and a systems-based approach (macro-level analysis and solutions).

The health and protection sectors are primarily responsible for SGBV response. The main recommendation for the health sector is maximising the quality of care available to survivors at health facilities. This includes the provision of appropriate clinical care to sexual assault survivors, through private consultation rooms, supplies to provide survivors with care, and training, supporting and supervising health providers in identifying forms of SGBV and providing quality care to survivors. The guidelines also recommend standardised data collection and ethical documentation, specific measures to meet the needs of at-risk groups (child survivors, LGBTI survivors, people with disabilities), and referral pathways for multi-sectoral support. The main recommendations for the protection sector are enhancing capacity of security to respond to SGBV incidents such as protocols and procedures for assisting survivors, as well as investigating and collecting evidence for prosecution

(if possible and if the survivor chooses to pursue legal action), supporting legal aid clinical and judicial processes, specialised prosecution units for SGBV crimes, training for all actors who are part of the justice system, and referral pathways for multi-sectoral support.

The sectors that do not provide specialist SGBV response are identified as: camp coordination; education; food security and agriculture; humanitarian mine action; nutrition; housing, land and property; shelter, settlement, and recovery; water, sanitation, and hygiene; and humanitarian operations support. While these sectors do not have specialist supports, staff are recommended to have the capacity to provide information to SGBV survivors in a survivor-centred manner, which is presented as a cross-cutting responsibility across all humanitarian sectors. This requires having up-to-date information on support services, referral pathways, options to report risk, and critically, the capacity to conduct psychological first aid. Psychological first aid (PFA) is a supportive response to a human being who is suffering, in distress or in need of support. It is stated that PFA requires a respect for safety, dignity, and rights, cultural sensitivity, being aware of emergency response measures and self-care. The guidelines adapt guidance from (WHO, 2012; WHO, War Trauma Foundation, & World Vision International, 2011), presenting three steps: Look (checking for safety, basic needs, and serious distress); Listen (approaching, asking and listening to people's needs and concerns); and Link (support access to information, basic needs and services, loved ones, and social supports) (Figure 1).

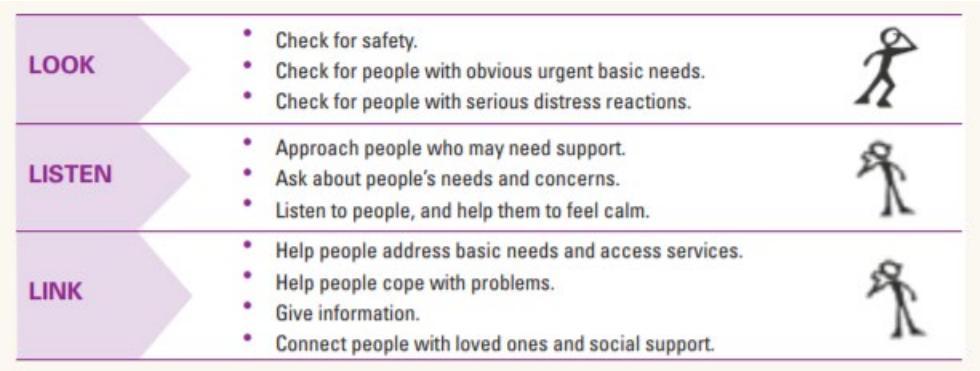

Figure 1 Psychological First Aid, IASC, 2015

Literature review findings

As noted above, the following is arranged according to type of evidence (evidence reviews; studies reporting findings from primary data collection with recommendations for response; and evaluations of SGBV responses). Within each of these major sections, studies are organised by setting (conflict settings; displacement settings; and resettlement settings). The extent to which evidence concerns individual or system level responses is also discussed.

Key findings and recommendations from evidence reviews and commentaries

Articles and reports included in this section range from systematic reviews of published evidence to commentaries based on authorial experience and opinion. As with the guidelines discussed above, publications in this section generally do not differentiate between conflict, post-conflict and displacement settings so these subheadings are merged for this section (13 papers). Articles focused on resettlement settings are discussed separately (6 papers).

Conflict and displacement settings

Several evidence reviews that focused on responses to SGBV in conflict and post-conflict settings serve primarily to highlight a lack of evidence in this area (Asgary, Emery, & Wong, 2013; Murphy et al., 2016; Schopper, 2014; Tol et al., 2013). A systematic review of prevention and management strategies for the health consequences of gender-based violence in refugee settings conducted by Asgary and colleagues (2013) located no articles that met their inclusion criteria. The authors concluded that 'there is a dire need for accessible research that evaluates the efficacy and effectiveness of various GBV prevention and management strategies in displaced populations' (Asgary et al., 2013, p. 89). They note further, that all the guidelines for response emphasise the need for data collection, monitoring and assessment. If such data is being collected however, they note that it has not been published in readily retrievable forms (Asgary et al., 2013). A systematic review published by Tol and colleagues (2013) with a similar focus, located seven relevant studies, which they described as limited, though tentatively suggesting the beneficial effects of mental health and psychosocial interventions, with more rigorous research urgently needed.

An evidence brief for the flagship DFID 'What Works to Prevent Violence Against Women and Girls' programme has the promising title, *What works to prevent and respond to violence against women and girls in conflict and humanitarian settings?*, but concludes there is a lack of reliable prevalence data and robust evidence on what does work to prevent and respond to SGBV during conflict and humanitarian emergencies (Murphy et al., 2016). A review by Robbers and Morgan synthesised published literature on the effectiveness of interventions to prevent and respond to SV against female refugees and similarly found a lack of rigorously evaluated interventions in displacement settings (Robbers & Morgan, 2017). Nonetheless, recommendations based on each of these reviews, which focused on both response and prevention, converge. Murphy and colleagues (2016) contend that the evidence that *is* available suggests that the most successful programs are multifaceted, address underlying risk factors, and actively engage all community members - not only survivors and/or perpetrators; while Robbers and Morgan suggest that programs emphasising engagement/participation and training/education have the potential to target underlying causes of SV. They argue that interventions that engage community members in their design and delivery also

have the potential to address harmful gender norms through education and advocacy and facilitate cooperation between stakeholders (Robbers & Morgan, 2017).

Several publications urge a 'comprehensive' health approach to SGBV violence in conflict settings although recommended responses often lack detail. In some cases a comprehensive response is conceptualised quite narrowly, as responding to the full range of reproductive health needs of survivors (Jewkes, 2007), or focusing on providing a variety of 'safe shelter types' (Freccero, 2015).

Other authors recommend a broader approach. Critiquing intrapersonal interventions to address Syrian refugee women's health needs, Yasmine and Moughalian (2016) argue that systemic violence must be tackled using an ecological and intersectional approach. Designing interventions that target microsystemic, organisational, institutional, environmental, economic, and policy levels, plays a pivotal role in enhancing individual refugee health (Yasmine & Moughalian, 2016). Similarly, a number of authors conclude that humanitarian organisations must attend to the medical, psychological and social impacts of sexual, violence with multi-sectoral and multi-level interventions. These include health and legal responses, physical design for increased safety, increased leadership, data collection and evidence-based programming. Social and service delivery barriers to reporting and documenting cases and accessing care must also be addressed (Marsh, Purdin, & Navani, 2006; Samari, 2017; Shanks & Schull, 2000).

A review specifically focused on the rehabilitation needs of girl child soldiers - whose experiences have commonly included SGBV - makes a similar range of recommendations with a focus on prevention as the priority through legal responses and coordinated advocacy at local, national and international levels. The review also recommends provision of viable alternatives to enlisting through education and income generating activities. This study also highlights the importance of indigenous forms of mental health therapy and the need to work with families and community leaders to improve reintegration and acceptance post-conflict (Stevens, 2014).

A rare paper offering guidance for the care and support needs of male survivors of conflict-related sexual violence raises additional themes describing such violence as intended to produce emasculation, feminisation, 'homosexualisation', and demonization resulting in shame, confusion, guilt, fear and isolation (Russell, Hilton, & Peel, 2010) . The authors recommend public information campaigns, establishment of generic drop-in centres for boys, safe spaces, telephone helplines, psychological interventions, service provider training, and different gender translators.

Resettlement

Three of the six papers included in this section focused primarily on the need to reform legal and policy frameworks in order to improve responses to SGBV faced by refugee women (Freedman & Jamal, 2008; Keygnaert & Guieu, 2015; Liew, 2015).

Based on case studies of the situation of refugee women in France, Italy, Egypt and Morocco, Freedman and Jamal (2008) recommend that policies and legislation to fight violence against women both at national and at EU levels should include specific measures to tackle violence against migrant and refugee women and enable them to receive appropriate support – employing other migrant and refuge women as interpreters and mediators for example. These measures should consider the specificities of migrant and refugee women's situation, particularly their legal situation within the country, and should ensure the primacy of basic human rights (protection from violence) over immigration status (Freedman & Jamal, 2008).

Keygnaert and Guieu (2015) are also critical of European legal and policy frameworks, which, they argue, apply too narrow a scope regarding sexual violence, focusing solely on female victimisation and ignoring vulnerable groups such as LGBTI, undocumented migrants and sex workers. Policy documents that they analysed, also focused predominantly on sexual violence in countries or cultures of origin (eg. sexual violence in war, torture, trafficking and FGM) while ignoring vulnerability to violence following migration to Europe (Keygnaert & Guieu, 2015).

Liew (2015) examines gender-based claims for protection by asylum seekers under Complementary Protection provisions in Canadian law. His analysis suggests that this provision erroneously limits successful protection claims as it fails to fill gaps in grounds for protection under the Refugee Convention and simultaneously encourages harmful discourse on violence against women.

Three evidence reviews focused on intimate partner violence in resettlement settings and provided recommendations for practice. James (2010) lists principles that are fundamental to working with refugees in a therapeutic setting as trust, confidentiality, flexibility, self-determination, and empowerment. Community-led approaches that 'honour cultural differences while challenging abuse' are also recommended (James, 2010, p. 282). Other authors note that refugee's experiences of domestic violence is often accompanied by social and economic marginalisation, underscoring their need for social support, information, and culturally competent assistance (Bhuyan & Senturia, 2005). Bilingual and bicultural services, community outreach and involvement, language classes and male-behaviour-change program are amongst recommendations for provision of culturally appropriate supports in these settings (Bhuyan & Senturia, 2005; Taft, Small, & Hoang, 2008).

Summary

Many of the papers reviewed in this section highlight the lack of evidence for the effectiveness and impact of responses to SGBV experienced by refugee populations either in conflict and displacement settings or in resettlement contexts. Based on the evidence there is however, almost all authors stress the need for provision of multi-sectoral, multi-faceted responses explicitly (or implicitly) based on an ecological and intersectional understanding of the causes and consequences SGBV. Thus, recommended interventions are to provide culturally appropriate individual care and treatment as well as to engage with families, communities, and legal and policy frameworks. Attending to underlying social and economic marginalisation and empowerment of women and girls is also recommended.

Studies with recommendations for response based on primary data collection

Publications included in this section are based on studies comprising primary data collection with SGBV survivors and/or service providers that included recommendations for responses. Two studies were carried out in conflict or immediate post-conflict settings; nine studies were concerned with displacement settings; and nine studies were conducted in resettlement settings.

Conflict settings

Two of the included studies were carried out in (conflict or immediate post-conflict) settings. Mootz and colleagues (2017) conducted focus group discussions and key informant interviews with girls and women (n=34) and boys and men (n= 43) in a conflict-affected region of north-eastern Uganda. They found that SGBV was ubiquitous, with poverty and being widowed constituting intersecting vulnerabilities. Women who were victims of sexual violence frequently then suffered further domestic physical violence. The authors recommended community, organisational, and policy-level interventions, which include attention to intersecting vulnerabilities in addition to psychological interventions for affected women and girls (Mootz et al., 2017).

A quantitative study conducted in Kosovo collected survey data from 1358 women, finding that 6.1% had been raped or witnessed rape. High rates of PTSD were not however, statistically associated with rape alone. The authors recommended community mobilisation, economic opportunities and inclusion of women in distribution of aid as preventive measures, along with psychosocial and medical interventions for victim survivors (Hynes & Cardozo, 2000).

Displacement settings

Three quantitative survey studies focused on the correlates and consequences of intimate partner violence (IPV) in refugee camps and urban refugee settings. Two of these studies were conducted by the same researcher in Jordan with Palestinian refugees (Al-Modallal, 2012, 2016) finding low use of either positive or negative coping strategies and higher rates of physical health problems for victims

of psychological violence than for victims of physical or sexual violence. A study surveying Eritrean women in a refugee camp in Ethiopia found high rates of violence linked to knowing other victims, being a farmer, having a 'drunkard' partner and being Muslim (Feseha, G/mariam, & Gerbaba, 2012). Each of these studies is likely to have been affected by sampling and response biases. They prompted general recommendations (not necessarily arising specifically from the studies' findings) for IPV screening, awareness raising, counselling and support to victims, male counselling, and for psychological, social and economic empowerment of women.

A qualitative study involving focus groups with 157 refugees from various nationalities in Kakuma refugee camp in Kenya explored refugees' narratives about how IPV was dealt with and how community responses interacted with formal response systems. Community responses did not necessarily result in women receiving protection from violence and only cases regarded as the most serious reached the UNHCR and its implementing partners. Development of a more coordinated response was recommended (Horn, 2010).

Izugbara and colleagues (2018) interviewed 20 refugee community workers (RCWs) employed in Dadaab refugee camp in Kenya. Their roles included promoting and facilitating access to assistance for survivors of SGBV, facilitating SGBV education campaigns and promoting positive behaviour change regarding SGBV in the community. RCWs demonstrated elevated knowledge of the forms and drivers of SGBV in their community but some did not deem early marriage, FGM and wife-beating to be acts of SGBV. Challenges to their work included insecurity, opposition and violence by community members. The authors concluded that RCWs fulfilled an important function with respect to responses to SGBV and called for interventions to address challenges identified by these workers (Izugbara et al., 2018)

Two studies focused specifically on reproductive health services. One multi-method project investigated the availability, service delivery, and barriers to access to emergency contraceptive pills (ECPs) along the Thailand–Burma border. The authors recommended provider training, education campaigns and organisational information sharing to address low rates of use of ECPs associated with a lack of evidenced-based protocols and misinformation (Hobstetter, Sietstra, Walsh, Leigh, & Foster, 2015). Chynoweth conducted a study in which stories were collected from refugee Iraqi men, women and young people in Jordan to explore their priority reproductive health needs and service gaps. Participants reported high levels of sexual violence, high reproductive health need, and significant service gaps especially coordination of care and prevention of sexual violence. Recommendations included additional funding for services, a focal point to coordinate services, provision of care to

survivors of sexual violence, emergency obstetric care, provision of condoms and opportunities for economic participation to reduce poverty (Chynoweth, 2008).

Keygnaert and colleagues (2014) undertook a study in Morocco where they trained twelve sub-Saharan 'transit' migrants as community researchers who subsequently interviewed 154 (60 F; 94 M) peers. The study found extremely high rates of SGBV including high rates of gang rape. Perpetrators were mostly Moroccan or Algerian officials and sub-Saharan gang leaders. The undocumented and unprotected status of victims was seen as the key underlying risk factor. Participants recommended awareness raising as a protective measure with the authors also emphasising the need for legal and policy changes to protect human rights and migrants' lives (Keygnaert et al., 2014).

In the only study located for this review, which focused specifically on refugees with a disability, Marshall and Barrett (2018) conducted interviews and focus groups with humanitarian organisational staff and carers of refugees with communication disabilities in Rwanda. This study highlighted the specific vulnerabilities of refugee-survivors of SGBV who have a communication disability. Increased risk of SGBV for refugees with a communication disability was linked to reduced access to sexual and reproductive health education, discreditation, stigma, being considered an easy target, lack of understanding by service providers and reduced ability to report. Recommended responses included identification of people with communication disabilities; an inclusive approach to sexual and reproductive health education, general education and employment; provider training; involving refugees with communication disabilities in SGBV response planning, implementation and evaluation; providing a range of communication methods; multi-agency collaboration; and high-quality funded research on SGBV, communication disability and refugees (Marshall & Barrett, 2018).

Resettlement

The majority of studies conducted in resettlement contexts came to similar conclusions with respect to recommended responses. These focused on the need for outreach to, and partnerships with, communities; English language, life skills and rights education for women; and culturally appropriate services including employment of bicultural and bilingual staff with one study also pointing to the need for specialist housing for women from refugee backgrounds leaving abusive relationships (Gill & Banga, 2008).

Three studies investigated experiences of IPV and help seeking for IPV amongst African immigrants to the United States. In one study, focus groups and interviews with 32 West African, primarily refugee, immigrants (19 female; 13 male) found that support structures within the West African community existed but all maintained a gender hierarchy that left women dissatisfied. The authors recommended that service providers use outreach to provide culturally informed education and partner with

progressive religious leaders and engage women leaders in the community (Akinsulure-Smith, Chu, Keatley, & Rasmussen, 2013). Sullivan and colleagues (2005) conducted focus groups with 18 Amharic speaking refugees women survivors of domestic violence. Based on their participants' responses, recommendations included life skills and English language classes, childcare, rights and legal education, legal support, and use of bilingual and bicultural service providers. Similar recommendations arose from Keller and Brennan's study in which they interviewed eight victim advocates, justice personnel and other service providers who worked with the Sudanese community in Nebraska (Keller & Brennan, 2007).

A quantitative survey with North Korean refugee women living in South Korea (n=180) looked at correlates of different forms of abuse and recommended in response empowerment, provision of job skills and culturally tailored services (Um, Kim, & Palinkas, 2016).

Two studies looked specifically at cultural practices and spiritual beliefs as resources for refugee women who have been the victims of sexual violence. Atlani and Rousseau (2000) conducted ethnographic research with Vietnamese refugees in France and Canada. They argue that flexibility of response is essential for women who had survived rape during the Vietnamese exodus to enable them to 'participate in a collective discourse that protects her links to her family and community, as well as her own sense of a meaningful world' (Atlani & Rousseau, 2000, p. 446). This argument is based on a case study of Vietnamese refugees transforming their idea of victimhood using the Buddhist Law (understood as the inescapable process of cause and effect or *huatqua bao*) to rationalise and remove the burden of the collective experiences of sexual violence in a context where it was 'necessary' to protect the lives of the group that was fleeing. Smigelsky and colleagues (2017) came to a similar conclusion regarding the need for incorporation of religious practices and spirituality into interventions by mental health practitioners and community advocates. This recommendation was based on their study into the spiritual experiences of Congolese survivors of sexual violence living in Tennessee (Smigelsky et al., 2017).

A Swedish study in which midwives were interviewed about their experiences of providing antenatal care to Somali refugee women found that trust was key to enabling midwives to be an important 'bridge' to other healthcare and social work professionals in a context of previous or ongoing violence. Trust was built through focusing on individual women's resources and needs, addressing language barriers and adapting to different conceptions of violence across cultures (Byrskog, Olsson, Essen, & Allvin, 2015).

Keygnaert and colleagues (2012) employed community researchers to investigate violence experiences of 223 refugees, asylum seekers and undocumented migrants living in Belgium and the

Netherlands. Their study highlighted the argument made by the same authors elsewhere (Keygnaert & Guieu, 2015) that SGBV is not *only* a problem that refugees encounter prior to settlement in Europe. Only one quarter of their respondents did *not* report violence, with 87 of 223 reporting personal experience of SGBV and 79 reporting SGBV experienced by a close peer since arriving in Europe. More than half of the reported violence was sexual, and most violence had been perpetrated by (ex) partners or asylum professionals. They argue that their results show refugees in Belgium and Netherlands are extremely vulnerable to SGBV and responses and preventive measures should be rights-based and include participatory interventions on multiple socio-ecological levels concurrently. Specific recommendations include education regarding SGBV and rights; support for development of social networks; awareness raising; improved services that are safe and accessible; improved rights such as the right to work and shortening the asylum procedure (Keygnaert et al., 2012).

Summary

Recommendations for responses arising from the research reported in this section are often quite general and not necessarily based directly on the specific findings of the study, rather drawing on the wider literature and guidelines we have reported in previous sections. Adding to the previously reported recommendations for multi-sectoral, multi-level interventions however, several authors noted that while culturally-attuned understandings of and responses to SGBV are essential, gender hierarchies sometimes meant that community responses failed to protect women from violence. Awareness-raising, outreach and education as well as participatory and rights-based approaches are recommended.

Studies that evaluated responses to SGBV

These 15 papers included reports of intervention and evaluation studies as well as evaluations of existing responses and services in the field. Four studies were conducted in conflict or immediate post-conflict settings; seven were in displacement settings i.e. refugee camps and urban refugee sites; and four studies were carried out in resettlement contexts.

Evaluation of SGBV responses in conflict settings

Four of the papers evaluated interventions in conflict or immediate post-conflict settings. Three focused on sexual violence with two or these evaluating provision of individual medical or psychological care for victims (Hustache et al., 2009; Tanabe et al., 2013) in Congo and Burma respectively, and one paper comparing the effectiveness of a counselling intervention and a support group and skills training intervention for women in Liberia (Lekskes, van Hooren, & de Beus, 2007).

The fourth paper appraised responses to all types of SGBV in a conflict-affected region of Uganda (Henttonen M, Watts C, Roberts B, Kaducu F, & Borchert M, 2008).

Evaluation of the effects of post-rape psychological support in Brazzaville, Congo found the intervention produced significant and lasting mental health benefits, as measured by the Global Assessment of Functioning scale, immediately after psychological care and one to two years later for the 56 participants retained in the study. The attrition of 108 of 178 of the women initially enrolled however, limited the conclusions that could be drawn and highlighted the difficulty of delivering and evaluating such interventions in an unstable setting (Hustache et al., 2009).

Tanabe and colleagues (2013) assessed the safety and feasibility of providing community-based (as opposed to facility-based) care by trained community health workers and traditional birth attendants to survivors of sexual assault in Karen State, Eastern Burma. Focus groups with community health workers and traditional birth attendants suggested promising feasibility of the model, though focus groups with male and female community members showed little awareness of the pilot and reservations about reporting sexual violence, suggesting a need for greater awareness-raising and trust-building activities for this to be an effective response.

Lekskes and colleagues (2007) conducted a mixed methods evaluation comparing outcomes from two interventions run by different NGOs for victims of war-related sexual violence in Liberia. The first offered a series of counselling sessions, while the second comprised a support group and skills training intervention. The analyses also included a control group comprising women on the waiting lists for assistance. Qualitative research indicated that both interventions were appraised positively by the women who took part. Quantitative analyses found that counselling was effective in reducing trauma symptoms compared with both the support and skill training intervention and the control group. When just those with high post-traumatic stress disorder scores were included in the analysis however, both interventions were effective at reducing trauma symptoms compared with the control group (Lekskes et al., 2007).

Henttonen and colleagues (2008) conducted semi-structured interviews with SGBV experts (n=15) and general health service providers (n=11) to assess the health services provided to SGBV survivors in conflict-affected Northern Uganda. They found that legislation, programming and intersectoral collaboration all existed but health facilities generally lacked sufficiently qualified staff and medical supplies to adequately detect and manage survivors. Greater resources and training for staff were needed to increase coverage and effectiveness of services.

Evaluation of SGBV responses in countries of first asylum

Seven papers evaluated responses to SGBV for displaced populations in first countries of asylum, either in refugee camps or urban settings. Four of the papers reported evaluation findings based on multi-method data collection with service providers and refugee women, while three of the papers focused on providing detailed description of interventions delivered in refugee camps along with the authors' own observations and assessments of their impacts.

Lilleston and colleagues (2018) evaluated the outcomes of the International Rescue Committee's (IRC's) intervention to deliver mobile SGBV services comprising psychosocial support and case management to Syrian refugees in Lebanon. They conducted in-depth interviews with IRC staff (n=11), Syrian women (n=40) and adolescent girls (n=26) finding that by providing free, flexible services in women's own communities, access barriers were effectively addressed. Participants described the services as strengthening social networks, reducing feelings of idleness and isolation, and increasing knowledge and self-confidence. Referring survivors to legal and medical services remained challenging however, and staff needed to be skilled and creative to build trust and ensure confidentiality.

A study in Jordan by Krause and colleagues (2015) was conducted to evaluate implementation of the *The Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies* (MISP). The researchers interviewed 11 key informants, undertook 13 health facility assessments and conducted 14 focus groups with 159 female Syrian refugees. Health agencies had secured funding and established reproductive health focal points and coordinating mechanisms. Some reproductive services, including activities to reduce HIV, and prevent excess maternal and newborn morbidity and mortality were available, though refugee participants generally had negative perceptions of the available services. Communities' lack of information about services and perceived cultural repercussions for reporting violence were deemed likely to have contributed to *no* recent service uptake of clinical management for rape survivors.

The IRC delivered and evaluated an intervention comprising training for health care providers of services following sexual assault in refugee camps in Ethiopia and Kenya, a post-conflict setting in the Democratic Republic of Congo, and an urban refugee setting in Jordan (Smith et al., 2013). The multi-media training was designed to promote compassionate, confidential and competent clinical care. Data were collected through pre and post surveys with 106 healthcare providers, in-depth interviews with 40 providers, and medical record audits in 35 healthcare facilities. The research found no change in negative attitudes, with health workers still disbelieving and blaming women reporting sexual assault, but the research did find significant increases in respect for patient rights to non-discrimination and self-determination. Significant increases in knowledge and confidence in treating

sexual assault survivors and improved practice e.g. supply of emergency contraception, HIV post-exposure prophylaxis and STI prophylaxis and treatment, followed the intervention.

Vu and colleagues (2017) examined the feasibility and acceptability of universal screening for SGBV in a primarily Somali refugee population in the Dadaab refugee camp in Kenya. They conducted 101 exit interviews with screening participants, 19 in-depth interviews with women referred for additional services, and focus groups with 24 service providers. Implementation of this screening and referral program was judged to be a feasible and acceptable way to assist survivors of SGBV. Barriers included heavy workloads in health clinics and lack of private spaces, as well as possible reluctance amongst women to disclose SGBV experiences. Resulting low participation rates and low rates of SGBV reported through screening (2.5% compared with estimated previous-year prevalence of 20%) were serious limitations.

Three papers described interventions delivered in refugee camps with appraisal consisting of the authors' observations and reflections. Two of these were arts-based interventions (Cohen, 2013; Sliep, Weingarten, & Gilbert, 2004) and a third comprised delivery of a cognitive behavioural therapy intervention to Sudanese survivors of sexual violence in northern Uganda (Mogga, 2017).

Common Threads is a multi-dimensional intervention for SGBV survivors that was piloted in Ecuador with Columbian refugees (Cohen, 2013). Conceptualised as combining art therapy techniques, psycho-education, peer support, and psychosocial skill-building, participants hand sew 'narrative textiles' in facilitated small group sessions. The intervention builds on a tradition of textile-based responses to violence in South America, explicitly referencing the *arpilleras*, produced by Chilean women to document systemic violence and abuses during the Pinochet dictatorship. While the paper is focused primarily on documenting implementation of the model, it also reports observations of the group facilitators and author of several therapeutic benefits. These included building connections to others, working through traumatic experiences, stress reduction, and an increase in self-esteem among participants. More rigorous evaluation was recommended with a larger sample in order to make conclusive claims regarding effectiveness of this response.

A Narrative Theatre intervention conceptualised as an interactive community approach to mobilising collective action in response to domestic violence in a refugee camp in Northern Uganda is also described (Sliep et al., 2004). The authors outline the process in detail indicating that during workshops, there was a progression from a focus on an individual to a focus on the household, the greater community, and, ultimately, the society. They reflect that the dynamic interactive process of narrative theatre promoted an increase in awareness and was effective in bringing forward local knowledge (Sliep et al., 2004).

Mogga (2017) describes in detail delivery of a Cognitive Behavioural Therapy intervention in refugee camps in Northern Uganda, to Sudanese refugee women who had suffered primarily sexual GBV. Delivery of the intervention was limited by serious logistical challenges in that setting but she presents a case study of a previously suicidal woman who experienced remarkable benefit from the group-based therapy (Mogga, 2017).

Evaluation of SGBV interventions in a resettlement context

Our review located four studies that reported the outcomes from SGBV interventions for refugees in a resettlement setting. Two of these comprised single case studies of psychological treatments.

In Israel, a program for training Ethiopian social workers (12 women and 5 men) to address domestic violence in the Ethiopian immigrant community was implemented and evaluated (Ben-Porat, 2010). Process data and focus group data were collected after one year. Process data showed that program participants had instituted community, family and individual level interventions. These included organising multi-sectoral committees; community days to raise awareness of the problem and of available services; study days for professionals who worked with the Ethiopian community; and individual and group therapy for male and female community members. Focus group data highlighted that program participation had broadened and enhanced participants' knowledge and skills for intervention. Participants also reported changed attitudes about domestic violence – no longer blaming women for its occurrence - and about the Ethiopian community. They reported an increase in empathy toward members of their community. The findings underscore the need for integration of individual, group and community work and the use of culturally sensitive methods for interventions.

In South Korea, Kim and colleagues (2016) delivered and evaluated the *Thank You, Sorry Love* family therapy program with 12 married North Korean refugees. Half of the participants (n=6) received the intervention, designed to improve marital relationships by encouraging the expression of positive emotions between spouses by focusing on 'what one was grateful and sorry for' (Kim et al., 2016, p. 817). The authors note that families in Korean society are not accustomed to expressing positive emotions to one another. The study found the levels of intimate partner violence for program participants were significantly reduced in both the pre-test to post-test data and pre-test to follow-up test data. These participants also experienced better marital relations and mental health than the females in the control group after completing the program.

We also found two publications that reported on single clinical case studies involving therapies for survivors of sexual violence in the United States. Shulz and colleagues report the success of Cognitive Behaviour Therapy for relieving the post-traumatic stress symptoms of a Bosnian rape victim (Schulz, Marovic-Johnson, & Huber, 2006). Akinsulure-Smith (2012) reported on the case of a female asylum

seeker for whom the Brief Recovery Program for Trauma Survivors was used to facilitate healing. The author suggests that the case highlights the need for integrative methods of psychotherapy (such as cognitive-behavioural, psychodynamic, and interpersonal models) in an interdisciplinary setting to provides comprehensive care that systematically considers biological, psychological and social factors (Akinsulure-Smith, 2012).

Summary

This section of the review confirms the paucity of evidence available for the effectiveness of responses to SGBV experienced by refugees. Only 15 of the 54 papers located for the review evaluated or appraised interventions. Of these, five comprised personal observations and reflections of the authors or single case studies rather than rigorous evaluation. Nine of the studies focused on individualised treatment providing some evidence for effectiveness of psychological and psychosocial interventions for reducing trauma symptoms. Three studies considered interventions combining individual and group level approaches, with reports that the latter were positively appraised by participants with further research recommended to investigate their potential to reduce isolation and increase knowledge and self-confidence.

Only three of the studies reported in this section attempted to evaluate multi-level interventions. A study by Henttonen and colleagues (2008) conducted in conflict-affected Northern Uganda found that greater resources and training were needed to enhance implementation and effectiveness of intersectoral responses. Also in Norther Uganda, a Narrative Theatre intervention was implemented designed to progress from a focus on an individual to a focus on the household, the greater community, and, ultimately, the society. While not formally evaluated, the authors reflect that the process was effective in bringing forward local knowledge (Sliep et al., 2004). Perhaps the best evidence for the effectiveness of a response targeting multiple sectors and ecological levels was provided by the Israeli intervention in which Ethiopian social workers were trained to address domestic violence in the Ethiopian immigrant community (Ben-Porat, 2010). The evaluation indicated that the program led to multi-sectoral community, family and individual level interventions and was successful in changing attitudes about domestic violence.

Discussion and Conclusion

This review demonstrates that recommended responses to SGBV tend to converge across the settings of conflict, displacement and resettlement. Available evidence suggests that intersectional and ecological principles need to underpin interventions. Thus, individual health and psychosocial responses should be supported by engagement with families, community leaders and communities, and by addressing underlying risk factors including harmful gender norms and social and economic

marginalisation. Effective responses are understood to require change at organisational, societal, environmental, policy and legal levels. Several of the papers reviewed also highlight the importance of respecting and responding to cultural differences and incorporating indigenous knowledge in responses while maintaining the primacy of basic human rights and challenging gendered abuse and violence.

Despite this convergence of expert opinion however - and while there is some limited evidence for the value of psychological interventions for reducing trauma symptoms - evidence for the effectiveness and impact of multi-faceted responses remains extremely scarce. As noted above, many of the guidelines and almost all the evidence reviews and recommendations arising from primary data collection with SGBV survivors and service providers emphasise the need for multilevel and multi-sectoral responses, yet the majority of published evaluations appraise individual level health and psychosocial interventions. Publications focused on the implementation and evaluation of responses to SGBV affecting men and boys, refugees with disability and LGBTI refugees are also lacking.

Available evidence for effectiveness of responses to SGBV experienced by refugees only partially reflects the global distribution of displaced populations. Of the studies located: 14 focused on refugees in Africa; nine were based in North America; seven concerned Syrian or Palestinian refugees in Lebanon or Jordan (with one evidence review also including Turkey); six focused on refugees in Europe; two on displaced populations on the Thai/Burma border; and one each on refugees in Israel and South Korea. Eleven of the evidence reviews focused on unspecified refugee populations. The UNHCR's most recently published statistics indicate that the top five refugee-producing countries (in order) are Syria, Afghanistan, South Sudan, Myanmar and Somalia which combine to produce 68% of the world's refugees. Countries hosting the greatest number of refugees (in order) are Turkey, Pakistan, Uganda, Lebanon, Iran, Germany, Bangladesh and Sudan (UNHCR, 2018b). Research focused on SGBV experienced by Afghani refugees in countries such as Pakistan and Iran is notably lacking; no publications based on empirical research with Syrian refugees in Turkey were found; and refugees from Myanmar (particularly the large Rohingya) population in Bangladesh are also seriously under-represented in published research. The mismatch between the location of displaced populations and published research on SGBV undoubtedly reflects a range of factors including the location of researchers and research funding. The majority of the research represented in this review was carried out by researchers based in North America (18 studies plus 9 instigated by INGOs also predominantly North American based), followed by Europe (13 Studies). Four studies were conducted by African-based researchers, three by researchers in Australia and one each in Israel and South Korea. While sexual violence against refugees receives a lot of attention in the media, the research covered in this review was spread over a range of types of SGBV. Just under a third of included studies were

concerned primarily with domestic violence or IPV, just over a third were concerned predominantly with sexual violence, and just over a third addressed all types of SGBV.

To conclude, there are considerable gaps in evidence for what responses, approaches to treatment, and other supports are effective in assisting refugees who have experienced sexual and gender-based violence. While multi-level and multi-sectoral interventions are generally regarded as necessary, there is very little research documenting the implementation of such responses and even less evidence for their effectiveness.

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