# How is Sexual and Gender-Based Violence Addressed in Fragile and Conflict-Affected States? A descriptive literature review using the case studies of the Democratic Republic of Congo, Sierra Leone, and Haiti.

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*How is Sexual and Gender-Based Violence Addressed in Fragile and Conflict-Affected States? A descriptive literature review using the case studies of the Democratic Republic of Congo, Sierra Leone, and Haiti.*

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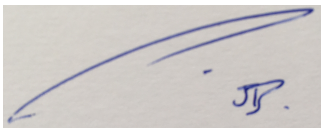
Signature: 

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## LIST OF ABBREVIATIONS

CHW: Community health worker
CRSV: Conflict-related sexual violence
CSO: Civil society organisation
DRC: Democratic Republic of Congo
FAWE: Federation of African Women Educationalists
FCAS: Fragile and conflict-affected states
FORAL: Foundation RamaLevina
FSI: Fragile States Index
FSU: Family Support Unit
IASC: Interagency Standing Committee
IDP: Internally displaced people
IPV: Intimate partner violence
ISSSS: International Security and Stabilisation Support Strategy, Democratic Republic of Congo
LGBTI: Lesbian, gay, bisexual, transgender and intersex
MCFDF: Ministry for the Status of Women and Women's Rights, Haiti
MSF: Médicins San Frontières
NGO: Non-governmental organisation
OHCHR: Office of the United Nations High Commissioner for Human Rights
PEP: HIV post-exposure prophylaxis
PTSD: Post-traumatic stress disorder
RCT: Randomised controlled trial
SGBV: Sexual and gender-based violence
STI: Sexually transmitted infection
SW: Sex worker
UHC: Universal health coverage
UNDP: United Nations Development Programme
UNHCR: United Nations High Commissioner for Refugees
UNICEF: United Nations Children's Fund (formerly known as the United Nations International Children's Emergency Fund)
UNSCR: United Nations Security Council Resolution
USAID: United States Agency for International Development

## ABSTRACT

The high prevalence of sexual and gender-based violence (SGBV) in fragile and conflict-affected states (FCAS) has gained increasing international recognition. This review aims to analyse how SGBV response and prevention programming is implemented in FCAS, using a novel conceptual framework based on current SGBV guidelines. Three case study countries, the Democratic Republic of Congo (DRC), Sierra Leone and Haiti, are used to examine how different contexts affect implementation and coordination of programming.

From the evidence reviewed there are examples of successful programmes to respond to the needs of SGBV survivors and for community-based sensitisation and SGBV prevention, although from a small number of studies. Many programmes however did not have outcome or impact data available. Provision of care was rarely integrated into national systems and was not multi-sectoral. Provision clustered in cities or certain areas of the countries. Coordination between different actors involved in programming was poor in all three countries. Many vulnerable groups affected by SGBV were not provided for.

In conclusion stakeholders involved in providing SGBV programming in FCAS need to engage state structures and communities with a multi-sectoral approach. National coordination mechanisms of SGBV programming are needed to prevent duplication or service gaps. Response programming needs to integrate into national health systems including primary care. Programmes need to publish process and outcome data to build evidence on how to best implement programmes in these environments and also how to address the needs of all vulnerable groups affected by SGBV.



Key words: Sexual and gender-based violence, SGBV, FCAS, the Democratic Republic of Congo, Sierra Leone, Haiti


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# INTRODUCTION

I am a medical doctor from the UK planning to pursue a career in public health. For the past five years I have worked in inner-city London and encountered many cases of sexual assault or domestic violence when survivors accessed acute care services. I was aware of public health policy and the role of non-governmental organisations for service provision within the UK, which are commonly underfunded and overstretched. There is little to no focus on preventing violence or engaging perpetrators. In 2018 I attended a talk delivered by an Iranian woman running a project in Afghanistan to provide safe and culturally sensitive care for survivors of sexual and gender-based violence (SGBV) who had been ostracised by their communities. This was the first time I had heard someone recognise the pervasive and institutionalised nature of SGBV in all settings, and the complex social and political factors that continue to drive this. This talk made me recognise the failings in my own system but also in the global setting. This was the reason I applied to undertake this masters degree at KIT.

SGBV is a global problem but is particularly prevalent in fragile and conflict affected states (FCAS). FCAS present challenging environments for public health programming, where the divide between humanitarian and development agendas is most pronounced. There is more and more research to address the prevalence and drivers of SGBV in these settings, but little evidence for effective programming. Guidelines have been published on how to deliver SGBV programming but these have been focused on response in the humanitarian settings[1–4]. I wanted to examine within this thesis how SGBV programming is actually delivered in these contexts and whether there is evidence to show what programming is effective. Secondly I wanted to examine how these complex environments influence the priorities and implementation of programming. I hope that this thesis will provide evidence to support stakeholders involved in the delivery of SGBV response and prevention programming design and implement effective and coordinated interventions.

# CHAPTER 1: BACKGROUND

Sexual and gender based violence (SGBV) is prevalent in fragile and conflict-affected states (FCAS). The WHO estimates that 35% of women globally have experienced some form of SGBV in their lifetime[5]. This can be much higher in FCAS, for example in conflict areas of South Sudan 65% of women and girls reported some form of SGBV[5,6]. SGBV is defined by the Inter-Agency Standing Committee (IASC) as "any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services. It inflicts harm on women, girls, men and boys"[1].

From the 20th century recognition of both SGBV and the gendered effects of conflict grew in conjunction with the global women's rights movement. Women and children were seen to be especially vulnerable in conflict, in violation of their human rights. The changing nature of warfare led to increased awareness of conflict-related sexual violence (CRSV), highlighted by atrocities such as the mass rapes during the conflict in former Yugoslavia or during the Rwandan genocide in 1994[7]. International policy was developed to define forms of personal or structural violence against women as violations of human rights and forms of discrimination[7-9]. The landmark UN security council resolution (UNSCR) 1325 in 2000, and further resolutions including 1820 in 2008, addressed the rights of women in conflict and displacement and also the necessity of their participation within peace and state building[10]. Much of this legislation however addresses only violence against women and girls. While women and girls are disproportionately affected by SGBV, there is growing recognition of the perpetration of SGBV against men and boys, and against marginalised groups including the Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) community or people living with disabilities[11].

Fragility is defined by the Organisation for Economic Co-operation and Development as "the combination of exposure to risk and insufficient coping capacity of the state, system and/or communities to manage, absorb or mitigate those risks. Fragility can lead to negative outcomes including violence, the breakdown of institutions, displacement, humanitarian crises or other emergencies"[12]. Conflict can be a cause or consequence of fragile situations, but there are also situations of fragility outside of conflict. Assessment of fragility has been developed through projects such as the Fragile States Index (FSI), assessing a range of indicators related to state capacity and resilience[13]. While there has been criticism of the concept of the fragile state as enforcing a Western or Weberian ideal of the role of the state, there remains the undeniable negative consequences on citizens and their human rights[14].

## 1.1 Sexual and gender-based violence in the context of fragile and conflict-affected states

SGBV and FCAS are inherently linked. Ecological models have been used to show that the drivers of SGBV are also drivers of fragility and conflict, from the individual to the societal level. This includes poverty, cultural gender norms that promote a dominant, hegemonic masculinity and exclusive societies that discriminate against women or other groups, for example ethnic or religious minorities[15]. Gender inequality in FCAS has effects beyond SGBV, including poorer health outcomes for women, lack of access to education or financial independence, which in turn are drivers of SGBV in themselves[16]. During conflict or disasters women may take on more responsibilities outside of traditional roles as caregivers, however women have historically been excluded from the peace process or state building, which allows

the re-establishment of patriarchal societies that perpetuate SGBV[17]. FCAS can however undergo significant political reform which provides an opportunity to build policy for gender equality[15,18]. Increasing the participation of women in FCAS has many benefits, including reaching effective peace agreements or strengthening the legitimacy of governments[19].

Pre-existing forms of SGBV within societies are exacerbated in FCAS, while new forms are introduced, including CRSV. During conflict systematic or random acts of rape, forced pregnancies, abortion or sterilisation are used as tools to shame communities or to aid ethnic cleansing, and can be perpetrated by both government and rebel forces[20]. Women or children may be forced to provide sexual services for combatants or those serving as combatants may be subjected to SGBV[20]. Other forms of SGBV such as human trafficking and harmful traditional practices, such as child marriage, can increase and survivors of SGBV are at high risk of exploitation[20]. Displacement increases risk of physical and sexual violence, including sexual exploitation[2]. In a study of Liberian refugees in Sierra Leone in 2003 54% had experienced SGBV after fleeing their homes[20]. SGBV can occur within refugee or internally displaced people (IDP) camps, where perpetrators include humanitarian workers[1]. Daily activities such as washing or gathering firewood can be targeted by perpetrators[1]. Pre-existing forms of SGBV including intimate partner violence (IPV) increase, following the Indian Ocean tsunami in 2004 reported IPV increased up to three times[1].

SGBV has serious impacts on both survivors and societies. SGBV can result in acute physical injuries and even death[1]. It can result in transmission of sexually transmitted and blood-borne infections including HIV, Hepatitis B, C or tetanus[1]. Unintended or forced pregnancies due to SGBV can cause psychological distress or stigma, and survivors may try to terminate these pregnancies through informal means if safe services are not available[1]. Long term effects include chronic health problems such as vaginal fistula or infertility, and increased maternal and infant mortality rates[1]. Psychosocial effects include acute distress, long term psychological disorders including depression or post-traumatic stress disorder (PTSD), substance misuse, suicide, social isolation, and poverty[1]. Access to health care services may be poor, there may be geographical, financial or legal barriers to reaching services[20]. Where acute services are available, lack of knowledge or shame may prevent survivors presenting even for time-limited treatments such as emergency contraception (only effective up to 120 hours following rape) or HIV post-exposure prophylaxis (PEP) (effective up to 72 hours)[21]. There are barriers to survivors accessing legal support or justice. Formal laws may not criminalise SGBV or cases may be dealt with under customary law or informal justice frameworks[22]. In Afghanistan a female survivor may be charged with adultery if she reports rape[23]. Male survivors may face prosecution for sodomy if they report SGBV in situations where this illegal[1].

Assessing the scope of SGBV in FCAS is difficult as there is a lack of accurate, gender-disaggregated data. There are ethical issues in data collection, particularly during conflict or complex emergencies, and there may be a view that this is not a priority in comparison with other interventions[24]. There is likely to be widespread under-reporting[24]. Data that exists may consist of case reports which may not be representative of those 'typically' affected, as there may be a self-selecting group of survivors who come forward to seek help[24]. Data may be extrapolated countrywide from specific programmes or surveys of accessible areas[25]. In some circumstances programmes may falsely inflate numbers by including participants that are not SGBV survivors but have similar unaddressed needs, for example vaginal fistula[26]. There is a lack of data on violence against adolescents and children, particularly those under 15 years where gaining ethical approval for research due to issues around consent is difficult[27]. There is a lack of data of the extent of SGBV perpetrated against men and boys, and also against other groups

including LGBTI or those with disabilities[11]. There is also a lack of data on the extent of women as perpetrators, especially within conflict[16].

## 1.2 Case study country profiles

This review will review three case study countries to allow a more in-depth analysis of how programming for SGBV is delivered in real situations. Three case study countries were chosen; the Democratic Republic of Congo (DRC), Sierra Leone, and Haiti. The countries share various characteristics, all three have indicators consistent with fragility and have been affected by conflict and/or disaster, and all have a well documented prevalence of SGBV. The countries all have their own unique context which allows this review to analyse how context affects implementation of SGBV programming.

### *1.2.1 The Democratic Republic of Congo*


Figure 1: Map of the DRC
Source: https://www.cia.gov/library/publications/the-world-factbook/geos/cg.html

The DRC is one of the largest countries in Africa, with a population of over 74 million people, and has been beset by political unrest and conflict[28]. Following a long authoritarian rule under Mobutu Sese Seko, the country underwent two major wars between 1996-1997 and 1998-2003[28]. Active conflict has persisted in regions of the country and recent political elections have been marred by allegations of corruption[28]. The country is rich in natural resources, which have been inextricably linked to the ongoing conflict. The persisting lack of state legitimacy and governance, economic stagnation, and security concerns has resulted in state fragility. The country is currently ranked 5th in the world on the FSI[29].

The DRC has some of the poorest health indicators in the world. It has an estimated maternal mortality ratio of 846 maternal deaths per 100,000 live births[28]. It faces a double burden of communicable disease, including an ongoing Ebola outbreak since 2018, and increasing non-communicable disease[28,30]. Since 2005 the government has developed strategic health policy, including a commitment towards providing universal health coverage (UHC)[28]. This was alongside the Kinhasa agreement to rationalise the use of foreign aid in line with the Paris Declaration for Aid Effectiveness and the Accra Accord[28,31]. The health system is decentralised with governance at three tiers[28]. Implementation occurs at 516 health zones across the country, most containing a hospital[28]. Service delivery is performed by a number of stakeholders, including the government, faith-based, profit and not-for-profit non-governmental organisations (NGOs)[28]. Many services charge user fees at the point of access, which can

form a significant barrier to citizens being able to access health care. Health system provision of care for SGBV is limited. Services are provided in secondary or tertiary care and mostly run by NGOs[32].From the limited evidence available state-run services lack resources, trained staff, equipment, and medications to provide necessary services for survivors, although this is solely based on assessments from eastern DRC[32–34]. There was no evidence for service provision in the rest of the country.

The prevalence of SGBV in the DRC is high. The use of CRSV including rape, gang rape and sexual slavery, by a number of actors including government forces, has been widely publicised[26]. An estimated 1.8 million women have been raped within their lifetime[28]. Other forms of SGBV including IPV however are also prevalent. In a population study an estimated three million women had experienced IPV, much higher than rape[35]. The nature of SGBV is different in non-conflict areas and is more likely to be perpetrated by someone known to the survivor or directed against children or adolescents than in conflict areas[36]. There is increasing recognition of SGBV perpetrated against men, in a population study in eastern DRC nearly 65% of men surveyed reported some form of SGBV and 20% reported having been raped[37]. There are reports of female perpetration of SGBV towards men, although the extent that this has happened is unclear[33]. There is little evidence as to the prevalence in marginalised groups such as people living with disabilities or the LGBTI community.

### *1.2.2 Sierra Leone*


Figure 2: Map of Sierra Leone
Source: https://www.cia.gov/library/publications/the-world-factbook/geos/sl.html

Sierra Leone is emerging from the effects of conflict and a humanitarian crisis precipitated by the Ebola outbreak in 2014. Political and civil unrest following the end of an authoritarian rule by Siaka Stevens in the latter half of the 20th century was followed in 1991 by a protracted civil war that ended in 2002[38]. The Lomé Peace Accord was signed in 1999, and controversially granted amnesty for acts committed during the conflict[39]. A caveat was added that the UN would not recognise amnesty for war crimes, acts of genocide, crimes against humanity, or serious violations of human rights[39]. Then followed a period of political stability with democratic election processes. Strategic national planning led to economic growth and structural reform, and on many indicators the country had moved into a transition phase of development[40]. However in 2014 the country faced an emerging Ebola epidemic, which affected at least 14,000 people[41]. This escalated to a humanitarian crisis which demonstrated the lack of resilience of the state to respond to such a shock.

The health system in Sierra Leone faces many challenges to rebuild following both the civil war and the Ebola outbreak, which killed an estimated 300 health care workers[41]. The government has developed strategic planning for health, most recently the National Health Sector Strategic Plan(2017-2021)[41]. The health system is organised in three tiers; tertiary referral hospitals, district hospitals, and peripheral health units[42]. There was also an extensive network of over 13,000 community health workers (CHW)[42]. Governance is delivered at two levels, central and district. A range of stakeholders deliver health care in the country but the majority (80%) is delivered through state-run services[42]. Health system expenditure prior to the outbreak was predominately through user out of pocket payments (76%) despite the government increasing the proportion of the total budget towards health[42]. There is very little evidence to allow assessment of the health system service provision for SGBV in Sierra Leone. There is evidence of strategic planning to increase the health system capacity for SGBV however all specialised services appear to be delivered by NGOs[43].

The civil war resulted in mass perpetration of SGBV. SGBV was systematically perpetrated by rebel forces, and to a lesser extent government agencies, and included acts of individual and gang rape, forced pregnancies and abortions, abduction, forced marriage, sexual slavery, and torture[44]. Survivors included men, women, and children[44]. An estimated 250,000 women were raped during the conflict[45]. Children abducted by rebel forces were both survivors and perpetrators of SGBV[44]. There were recorded instances of rape and gang rape perpetrated by UN and other peacekeeping forces, who were also recorded to have sexually exploited women and solicited child prostitutes[44]. In the post-conflict period SGBV continued, as well as harmful traditional practices including child marriage and female genital mutilation[45]. Again there is little evidence as to the prevalence of SGBV perpetrated against populations such as LGBTI people or people living with disabilities. The Ebola outbreak had a disproportionate effect on women and girls, including increased rates of SGBV and teenage pregnancies[46,47]. The situation has not improved and in 2019 the president declared a state of emergency regarding the high rate of SGBV in the country[48].

### *1.2.3 Haiti*


Figure 3: Map of Haiti
Source: https://www.cia.gov/library/publications/the-world-factbook/geos/ha.html

Haiti is currently ranked 12th in the FSI in the aftermath of decades of political upheaval and multiple natural disasters[49]. The latter of the 20th century was dominated by the rule of Francois Duvalier and his son Jean-Claude Duvalier, whose paramilitary group was believed to have committed a campaign of human rights violations[50]. Following the departure of Duvalier a series of coups and a nationwide rebellion in 2004 had serious impacts on governance, state legitimacy, and security[50]. Haiti is geographically and environmentally at risk of natural disasters[51]. In 2010 an earthquake of magnitude 7.3 hit Haiti resulting in over 220,000 deaths and displacement of over 1.5 million people[51]. Haiti has also suffered from tropical storms and hurricanes, including Hurricane Michael in 2016 that which left at least 1.4 million people in need of humanitarian assistance[51]. A cholera outbreak (introduced by the UN peacekeeping force) has affected more than 800,000 people[52]. The country is also facing a migration crisis due to changes in the law of neighbouring Dominican Republic leading to the return or deportation to Haiti of at least 250,000 people of Haitian descent between 2015 and 2017[51].

The health system of Haiti has been severely disrupted as a consequence of these events, especially in the context of human resources[53]. The current health system is divided into 10 health departments, which were further subdivided into 42 health district units in 2012[53]. Health service delivery is divided between public, accounting for 38%, and profit and not-for-profit NGOs[53]. There is a bias towards service delivery in urban areas, with almost half of all health facilities located in the capital Port-au-Prince[53]. The government in Haiti has introduced strategic health planning which includes strategies to progress towards UHC and to build resilience against further shocks[53]. Provision of SGBV services by the health system appears limited to the provision of post-rape services in some health centres[54].

Accurate assessment of the prevalence of SGBV in Haiti is limited by the lack of national data collection systems. Prior to the 2004 rebellion one rural study of reported 54% of women accessing health care had experienced forced sex within their lifetime[55]. Another study reported that 18% of adolescents, both girls and boys, were survivors of SGBV[56]. During the 2004 rebellion an estimated 50% of girls in affected areas were subject to some form of SGBV[57]. There was also an upsurge following the earthquake with NGOs reporting an increase in reports of rape, partially driven by worsening poverty and displacement[57,58]. SGBV also affects men, including vulnerable populations such as male prisoners[59]. SGBV has been reported in IDP camps following the earthquake, including an increase in transactional sex and sexual exploitation in exchange for access to basic supplies[57]. There have been allegations of sexual exploitation towards both UN forces and NGO staff, including Oxfam Great Britain whom the Haitian government has now banned from operating within the country[52].

# CHAPTER 2: PROBLEM STATEMENT, OBJECTIVES AND METHODOLOGY

## 2.1 Problem statement

Addressing SGBV in FCAS is challenging and despite the proliferation of guidelines and policies there remains little evidence as to what are effective approaches in these contexts.

National and international contexts can hinder SGBV service delivery. Health systems may be disrupted, with loss of infrastructure, supplies, and trained health workers[60]. There are issues around security, discrimination, and violence towards both local and international health workers[60]. There is a lack of training in case finding, assessment, and management of medical consequences of SGBV, which is not limited to FCAS[61]. National and customary laws can limit the capacity of programmes to aid survivors seeking justice for SGBV and also prevent provision of necessary services, for example where abortion is illegal[23]. The cultural and gender norms that act as drivers of SGBV in FCAS can limit acceptance of SGBV programming, from the local to national level. Programmes must be context specific to the types of SGBV prevalent in the area, which can be hindered by the lack of available data[61]. In post-conflict environments implementing programmes that address CRSV can be politically sensitive, including situations where parties that have perpetrated SGBV are involved in post-conflict reconstruction[17]. Donor agencies must address the immediate aim of stability which can supersede more complex goals to address drivers of gender inequality and to fully engage women[62]. Implementing policy or programmes must also involve informal or customary institutions which can be difficult for donor agencies to engage[62]. Funding is also an issue, less than 1% of funding between 2000 to 2006 towards UN institutions and NGOs working to protect vulnerable populations was dedicated to SGBV[20].

Guidelines and frameworks for SGBV response and prevention programming have been published by UN agencies, humanitarian and development actors[1,2,63]. They highlight the need for a rights-based, holistic, and multi-sectoral approach to build sustainable programming. They acknowledge the need for quality, gender-disaggregated data and data management systems. There is a lack of evidence however to evaluate the effectiveness of these programmes[64]. The multiplicity of guidelines may lead to contradiction or overlap between programmes. It is acknowledged that many of these guidelines need to include stronger mechanisms for accountability[64]. There are issues of insufficient capacity of these organisations to deliver SGBV programmes and also lack of engagement of international actors with national or local systems[64]. Engagement with national systems is key to build sustainable responses to SGBV[65]. There is a growing movement to prioritise sustainable health system development even during emergencies in FCAS, rather than waiting for stability to be established[66]. This recognises that development needs should not be ignored in the context of a protracted humanitarian response. It also aligns with the Paris Declaration of Aid Effectiveness and the Accra Accord, which stress the importance of state ownership and responsibility for development and alignment of donors to these aims[31].

SGBV is a key issue in FCAS but the challenge remains on how best to address and respond to SGBV in these environments. This review aims to review how SGBV programming is implemented in FCAS. It aims to see how challenges faced in FCAS affect programming implementation and whether there is evidence of effective programmes from these environments. Case study countries will be used to demonstrate how different contexts affect programming but also to assess how programming is coordinated between different actors.

## 2.2 General objective

To describe how SGBV response and prevention programming is implemented in FCAS and what programming has been shown to be effective, using the case studies of the DRC, Sierra Leone, and Haiti as illustrative examples.

### *2.2.1 Specific objectives*

1. To describe SGBV prevention and response programming implementation and effectiveness within FCAS using the case studies of the DRC, Sierra Leone, and Haiti
2. To examine to how SGBV prevention and response programming is coordinated and integrated with state structures within these countries
3. To provide recommendations to national and international stakeholders engaged in delivery of SGBV programming in FCAS on how best to implement SGBV prevention and response programming based on the experiences of the case study countries

## 2.3 Methodology

This study comprised of a literature review of the evidence available to address the study objectives. A literature search was performed in the databases PubMed, Scopus, and search engine Google scholar, using the key words, inclusion and exclusion criteria outlined in Table 1. Searches were also performed for grey literature on Google search, institutional websites, the UK Department for International Development development database, and government websites. Papers were also provided from personal communication with experts via contacts through the author's study institution of KIT, Netherlands. Abstracts were manually reviewed and suitable articles selected. References of selected literature were reviewed for further suitable documents using the snowballing technique. Articles that were selected and met the full inclusion criteria were then analysed for the review, using the strategy outlined in Box 1. Given that only one researcher performed the article selection this may have introduced selection bias, to ameliorate this rejected articles were re-reviewed.

Table 1. Literature search key words and terms, inclusion and exclusion criteria.

| | |
|---|---|
| Literature search key words and terms | fragile' 'fragility' 'conflict' 'post-conflict' 'gender violence' 'sexual violence' 'gender-based violence' 'GBV' 'SGBV' 'intervention' 'programme' 'programming' 'prevention' 'risk mitigation' 'response' 'health system'<br>Separate searches for each case study country including the following terms:<br>- for the Democratic Republic of Congo 'Democratic Republic of Congo' 'DRC' 'Kivu'<br>- for Sierra Leone 'Sierra Leone'<br>- for Haiti 'Haiti' |
| Inclusion criteria | - literature published or accessible in English<br>- literature addressing SGBV and/or response and/or prevention and/or risk mitigation interventions or programming<br>- programmes with a primary or secondary outcome to reduce or respond to one of more forms of SGBV<br>- studies addressing government or health system service provision for SGBV were included as part of Objective 2<br>- clinical screening tools (however tools solely for research data collection were not included)<br>- multi-country programmes that included one or more of the case study countries<br>- all types of evidence were considered, including both qualitative and quantitative data, and both peer reviewed and grey literature, including policy briefs, government and institutional guidelines and recommendations |
| Exclusion criteria | - literature published prior to 2000 prior to the adoption of UNSCR 1325<br>- programmes solely focused on sexual or reproductive health without a specific SGBV component<br>- programmes with no public health component (for example focusing only on reparations to survivors) |

**Box 1: Strategy for analysis**

- Each paper or report was analysed and firstly coded for the type and quality of evidence presented, including whether programme or study outcomes were reported.
- Each item was then coded for the theme of intervention or programme and the type of agency providing the programme. Items were then coded as to what parts of the adapted conceptual framework they met.
- To address health system integration programmes were analysed if they were government run or funded, whether they were run in partnership with any level of the health system, whether referral mechanisms to health system facilities were outlined, or whether the programme was entirely independent.
- These results were then collated in table form for each case study country.
- Given the heterogeneity of the evidence reviewed no statistical analysis was performed.

### 2.3.1 Framework

Selection of a theoretical or conceptual framework applicable to these contexts is challenging. Frameworks for a health system response to SGBV, for example that presented by Garcia-Moreno, are not easily applicable in FCAS as the majority of programming may be provided outside of the health system[61,67]. Conversely frameworks provided by humanitarian agencies designed solely for an emergency response or for specific populations, for example refugees, may not acknowledge any existing health system response[1,3].

The author has created an adapted framework, see Figure 4. This is based on the UN High Commissioner for Refugees (UNHCR) framework (Appendix 1)[68,]. The UNHCR framework addresses four key approaches for SGBV programming in the context of the surrounding legal framework and an overarching multi-sectoral approach[4,68]. The survivor, community and rights-based approaches are also key approaches adopted in the IASC GBV guidelines and other UN agencies[1,63]. The UNHCR additionally outlines an age, gender, and diversity approach to highlight the needs of vulnerable populations that may be commonly excluded from programming. For the purposes of this review two adaptations have been made. The first is that added to the principles of the survivor-centred approach are key areas of service delivery; health care, psychological care, socioeconomic, and justice or legal support. This allows to the review to identify gaps in service provision. The second is that the systems approach outlined in the IASC guidelines will be added to allow an analysis of how organisations, sectors and health systems are approaching SGBV in each context[1]. A summary of the aims of each approach can be found in Box 2.

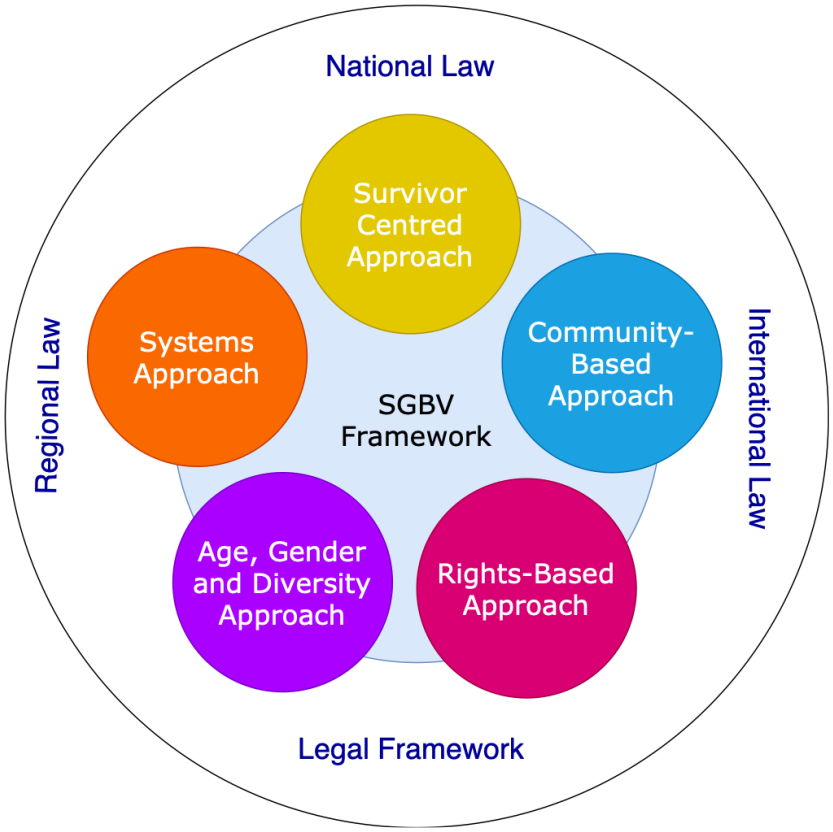


Figure 4: Adapted framework for SGBV response. Adapted from[1,4,68]

### Box 2: Summary of the key approaches of the adapted SGBV framework[1,4,68]

#### *Survivor-centred approach*

SGBV response programming should be holistic and multi-sectoral to address the health, psychological, socioeconomic, and justice aspects of care

*Aims:*

- Safety – the safety of a survivor should be of paramount concern and programmes should recognise that disclosing SGBV may increase the risk of further violence to the survivor
- Respect – programmes should respect the choices, wishes, rights and dignity of survivors
- Confidentiality – the right of a survivor to confidential care should be protected at all times
- Non discrimination – survivors should receive equal and fair care regardless of any personal characteristics

#### *Community-based approach*

*Aims:*

- Programmes should aim to understand the community that they are working within
- Communities should be actively engaged and participate in programming
- Programmes should where possible work with, and support, existing community structures
- The community's aims and protection strategies should be supported

#### *Rights-based approach*

This approach moves away from a needs based approach where participants are seen as passive beneficiaries of programming

*Aims:*

- Programmes should acknowledge survivors as rights holders and support their agency to claim those rights
- Programmes should assess and build capacity for duty bearers to deliver those rights
- Survivors should be empowered and fully participate in programming
- Programmes should acknowledge that it is a right to be protected from SGBV

#### *Age, Gender and Diversity approach*

*Aims:*

- All people of concern should be able to engage equally with programmes, regardless of their age, sex, gender, ethnicity, religion, or any other characteristic
- Programmes should acknowledge individual differences of survivors
- Programmes should ensure that groups are not excluded from or discriminated against, this includes but is not exclusive to groups that may be commonly excluded from programmes: adolescents or older people, LGBTI people, sex workers, people living with disabilities, religious or ethnic minorities or indigenous people

#### *Systems approach*

*Aims:*

- Programmes should acknowledge the need for sector or system wide approaches for SGBV
- Programmes should strengthen capacity and infrastructure and advocate for development of SGBV related policies if they do not exist
- Programmes should improve knowledge, attitudes and skills of providers through sensitisation and training
- Monitoring and evaluation mechanisms should be in place

# CHAPTER 3: STUDY FINDINGS

The following chapter analyses the available evidence for each aspect of the adapted SGBV framework. A flow chart of the literature review can be found in Figure 5.

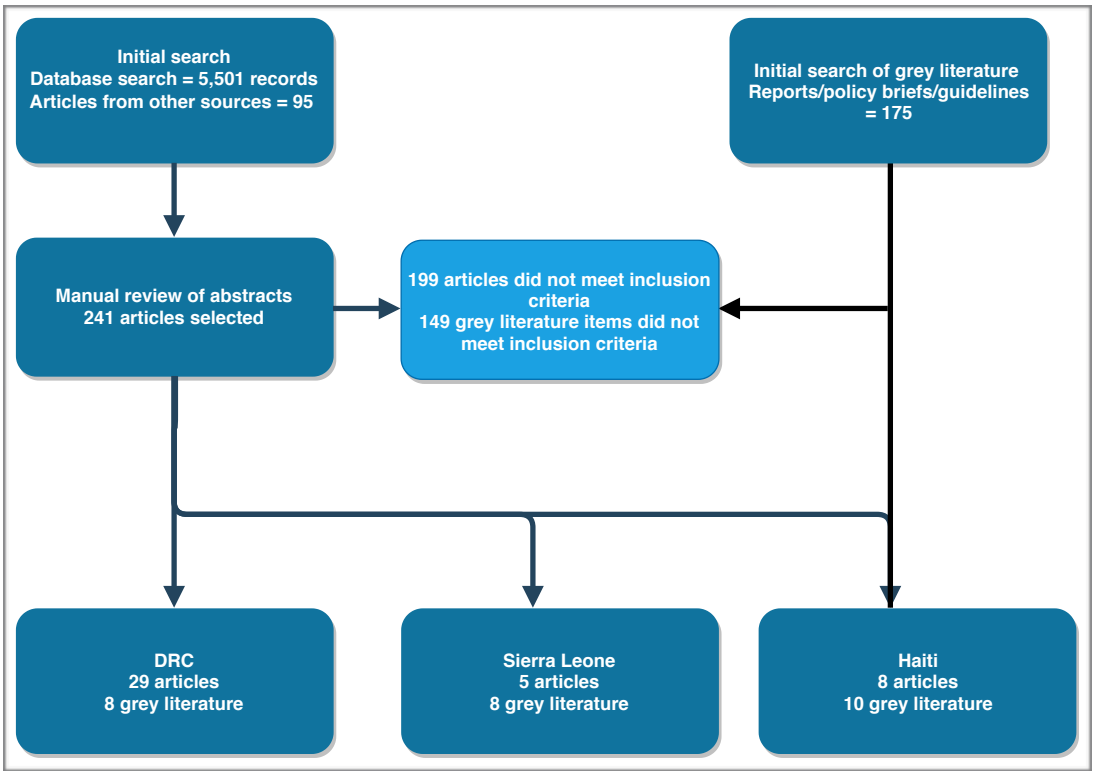


Figure 5: Flow chart of evidence found in the literature review

More evidence was identified from the DRC than the other two countries. Evidence quality was variable, no meta-analyses were found but there were randomised controlled trials (RCTs) even for complex interventions run in conflict-affected areas. The majority of evidence however was from case studies or reports. The literature focused almost entirely on the North and South Kivu regions. In Sierra Leone there was little evidence available. The majority of the literature found was grey literature. From the few peer-reviewed papers evidence was either qualitative or from case reports. All of the peer-reviewed and nearly all of the grey literature was published prior to the Ebola outbreak. In Haiti the literature describing SGBV prevalence or risk factors far outweighed the literature available on programming. The majority of information was available from grey literature. From the peer-reviewed literature available the studies were either mixed methods evaluations or case reports. The literature almost exclusively reported on the post-earthquake response.

## 3.1 Legal framework

An overarching aspect of SGBV programming is the legal framework that surrounds it. This section will review international, regional, and national law (both statutory and customary) applicable in the case study countries. All of these have the potential to support or inhibit effective programming and also influence the priorities of stakeholders and funding. Laws may also affect the capacity of survivors to seek justice or access services.

### *3.1.1 International law*

Multiple aspects of international law are applicable in SGBV programming. SGBV is a violation of international human rights law[1]. This places a responsibility on duty bearers to protect rights holders from SGBV and to provide services to respond to SGBV to fulfil rights such as the right to health[1]. Human rights law is succeeded by humanitarian law in conflict, under the protocols of the Geneva convention which all three case study countries have ratified[1,69]. International criminal law includes the Rome statute in 2002 which defined CRSV as a war crime and a crime against humanity[7]. The UN security council has introduced specific resolutions to address the vulnerability of women in conflict and CRSV, including UNSCR 1325 and 1820[10]. There are limitations on the utility of UNSCR 1325 and 1820 in FCAS, as they are focused only on conflict or post-conflict environments and implementation has been slow[10]. An evaluation of UN activity in Haiti noted that it was difficult to adapt UNSCR 1325 or other resolutions to Haiti as a situation of fragility and disaster[50]. There has been controversy over the most recent UNSCR 2467 as the right of CRSV survivors to sexual and reproductive health services was removed[70]. However it is too early to see the impact this may have on programming and is out of the scope of this review.

SGBV also forms part of the international development agenda outside of conflict. This includes the Convention on the Elimination of All Forms of Discrimination against Women which all three case study countries have ratified[9]. Elimination of violence against women forms part of the UN Sustainable Development Goals, specifically Goal 5[71]. These address SGBV perpetrated against women or children only.

### *3.1.2 Regional law*

Regional country associations have adapted international legislation regarding SGBV to different contexts, including regional action plans for implementation of UNSCR 1325. Both the DRC and Sierra Leone are member states of the African Union which adopted the Maputo Protocol in 2003, addressing both women's rights and SGBV[72]. Both countries have ratified this however Sierra Leone only did in 2015. Both are signatories to the 2006 Maputo Plan of Action which had specific objectives both for SGBV programming and for training of health and legal professionals to respond to SGBV[73]. Regionally Haiti ratified the *Convención de Belem do Pará*, the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women in 1994[74]. Importantly this convention allows for petitions be taken to the Inter-American Commission on Human Rights, which gives a platform for citizens to advocate for their rights if not met by their governments.

### *3.1.3 National law*

National laws applicable to SGBV have been developed to some degree in the case study countries. This is in part to recognise international and regional legislation that these countries are signatories to but also reflects the advocacy of civil society organisations(CSOs)[75]. In all three countries however there remains the issue of persistent impunity for perpetrators, low prosecution rates, and lack of access of survivors to

legal support. Customary law persists in all three countries and may undermine formal legal processes[38,44,76].

In 2006 in the DRC the law was amended to expand the definition of rape and criminalise a wider range of types of sexual violence against a women or a man[75]. The age of a minor was raised to 18 from 14 years of age. It does not recognise rape as a war crime or allow for prosecution of offences by foreign parties[26]. Marital rape is not illegal[76]. The Family Code outlines that a wife is obliged to obey her husband[76].

Following the end of the conflict Sierra Leone established a law reform committee was established which three 'gender' laws to address forms of gender discrimination and domestic violence[45]. In 2012 the Sexual Offences Act was passed for sexual violence crimes and to help address ongoing impunity for perpetrators[38]. In Sierra Leone customary law is protected in the constitution and has jurisdiction in up to 85% of the country[45]. It allows customs such as wife inheritance and chastisement of a wife by a husband with physical force, contradictory to the Domestic Violence Law[38]. Uniquely out of the three case studies Sierra Leone established a Truth and Reconciliation Commission as part of the Lomé Peace Accord[39]. Part of its role was to address crimes committed during the conflict including SGBV alongside a UN security council led Special Court to address significant human rights violations[39].

The Haitian government has implemented national policy and strategic planning against violence against women. However very little has changed in terms of legislation, and rape was only criminalised in 2005[50].

Access to safe abortions should form part of SGBV programming however abortion law remains a contentious issue globally. The Mexico City Policy has been reinstated by the US so that any agency receiving US Agency for International Development (USAID) funds cannot provide or promote abortion services. All three case countries receive contributions from USAID and in Haiti USAID funds a range of SGBV programmes[77]. Abortion is completely prohibited by law in Haiti, even where there is serious risk to the health of the mother[78]. Abortion is criminalised in Sierra Leone based on colonial legislation from 1861, although with a caveat under the medical code of ethics that it can be performed to save the mother's life[79]. The Sierra Leone Ministries of Health and Gender introduced a Safe Abortion Act in 2015 to legalise abortion[41]. This was passed by parliament but the president refused to sign the act (reportedly under pressure from religious groups). It has still not been made in to law. The DRC legalised abortion in 2018 in the DRC in the circumstances of rape, incest, and physical or mental health impact to the mother[80].

## 3.2 Survivor-centred approach

This section will address how the survivor-centred approach has been implemented in the case study countries. This approach is applicable to all SGBV programming, but here will be used in the context of SGBV response programming providing services to survivors. The approach has two main components. Firstly that programming should address the health, psychological, and socioeconomic consequences of SGBV and facilitate access to justice. Secondly where programming is available it should meet the principles of safety, confidentiality, respect, and non-discrimination (outlined in Box 2).

### *3.2.1 Health, psychological, socioeconomic, justice*

*Health*

There are different models to provide care for SGBV survivors, including holistic services offering all four aspects of care. One approach is the use of 'one stop centres', identified by UNHCR as a SGBV 'best practice' initiative[81]. These are increasingly used in low-to-middle income settings, most comprehensively in Malaysia where they have been implemented nationally[65]. These are commonly provided in secondary or tertiary care and provide all necessary services in one centre[65]. Another model is to offer services at different sites with an established referral pathway between them[65]. This however relies on the availability of different partners to provide services and requires robust follow-up processes to ensure survivors receive necessary care.

Two programmes in the DRC adopted a one stop model of care[82,83]. One notable example is the One Stop Centre model run from the Panzi hospital in Bukavu, South Kivu whose medical director Denis Mukwege was awarded the joint Nobel Peace Prize in 2018 for his efforts against CRSV (see Box 3)[83,84]. Heal Africa provides a similar one stop centre through its hospital in Goma[82]. There has been criticism of one stop approaches in the DRC that they do not address other health needs that a survivor may have[25]. Conversely other programmes provided all four areas of service provision through a consortium of partners, where survivors could be referred to one or more services depending on needs[85,86]. One of these reports an aim to strengthen local health facility capacity to manage SGBV but does not outline this further[86].

Only one programme in Sierra Leone provided comprehensive services for survivors. In 2003 the International Rescue Committee established three Sexual Assault Referral 'Rainbo' Centres linked to state hospitals to provide free services for survivors[81]. The programme aimed to hand control of the centres over to the government, however this has still not occurred. In 2014 a local NGO was established to run the centres which remains entirely funded through donor support[43]. The Federation of African Women Educationalists (FAWE) was reported to have provided medical and psychological services to adolescent girls but the nature of this programme was not described[45].

In Haiti the NGO *Komisyon Fanm Viktim pou Viktim* reports to provide holistic care through a centre in Port-au-Prince but no outcome measures of the project were available[54]. *Asosyasyon Fanm Soley Dayiti* provided support to female SGBV survivors but reports of these activities are only available in Creole[87]. The *Médicins San Frontières* (MSF) centre in Port-au-Prince offered both medical and psychological care[21]. The project aimed to refer survivors to organisations providing protection and social services where needed, however cited significant challenges as these organisations were stretched and underfunded[21]. From the limited literature available there seems little provision of comprehensive services outside of Port-au-Prince.

**Box 3: Panzi Hospital One Stop Centre[83,88]**

Panzi hospital, in Bukavu, South Kivu was established in 1999 by a Congolese surgeon Dr Denis Mukwege with international funding. It was initially established to provide gynaecological and obstetric services but has become a world renowned centre for SGBV care.

***Programme design***

The programme has developed a One-Stop-Centre model of care. This programme addresses all four aspects of care for survivors. It provides care for both acute SGBV care and management of long term complications such as vaginal fistula by trained health care professionals. It also provides access to psychologists, lawyers, programmes for social reintegration and mechanisms for economic support from vocational training to survivor group micro-financing initiatives. The initial assessment and treatment is delivered at the hospital. After-care and socioeconomic programmes to support survivors reintegrating into their communities are delivered in a safe house in the local district. The programme is explicit in its commitment to follow a rights-based approach for survivors. All decisions around care are made through a shared decision making process and with informed consent. The programme has specially adapted services for adolescents and children including specially trained paediatricians and dedicated examination rooms. It does provide services for male survivors although this only accounts for 1.5% of their work and no mention is made for any adaptation of services towards men. It also performs community sensitisation work regarding SGBV and services available for survivors.

***Outcomes***

The programme treated over 50,000 SGBV survivors since its inception in 1999. Further outcome measures for the interventions delivered were not available, although the programme website does outline research and programme evaluation as a key initiative.

***Challenges/limitations***

- The programme reported that attempts to expand the programme to other centres were hindered by lack of political will
- Attempts to integrate services into primary care was limited by lack of acceptance for mental health care
- The programme lacked capacity or skills for ongoing evaluation and revision of processes and protocols

Lack of access to services in rural areas was identified as an issue in all three case study countries, with clustering of services in cities or certain areas of the countries. Some mobile or outreach programmes were identified in the DRC including by the Panzi hospital[83]. One project run by the Congolese NGO Foundation Rama Levine (FORAL) established mobile health clinics for SGBV in conjunction with CHWs and local health centres[89]. From a case study of the project while it was able to treat sexually transmitted infections (STIs) it was unable to offer services for other medical complications and did not provide acute services such as emergency contraception[89]. Heal Africa provides mobile clinics for gynaecological surgery, including for fistula, although they do specify if any of these cases were due to SGBV[82]. Outreach services can have negative effects as survivors may wait for long periods so they can attend a mobile clinic rather than accessing local health care facilities[25]. The lack of a cold chain outside of central hospitals and poor patient follow up was a barrier to provision of hepatitis B or tetanus vaccinations[36,90].

The collaborative Prevention Pack programme run from 2013 in South Kivu was a successful example of establishing services in rural areas[91]. It facilitated the provision of a pre-packaged post rape kit including PEP, treatment for STIs, and emergency contraception, to rural health centres with support to improve stock keeping and procurement[91]. The outcomes were positive, with continuous use of the packs and no stock outs recorded over the initial four year period[91]. Notably following the intervention 85% of survivors in rural areas accessed care within 72 hours of rape, much higher than any other study in this review. This may reflective of the multi-method community sensitisation programme that was run alongside the intervention.

### *Psychological*

There is little consensus on how to best deliver psychological interventions for SGBV survivors. One systematic review identified positive outcomes at 1-2 years with two focused sessions alongside medical care but did not specify the methods used for the sessions[92]. In other FCAS settings group counselling or creation of group networks have positive sustainable outcomes[92]. Two RCTs for different types of counselling in the DRC both found statistically significant benefits from group therapy over individual therapy[93,94]. This was also associated with positive effects on engagement of survivors with their community but did not reduce stigma[94–96]. Other interventions provided psychological support as part of a holistic approach. These programmes varied from limited interventions during medical consultation, referral to trained psychotherapists within the same facility or referral to partners[21,81–83,85,86]. These programmes however do not report on outcome measures for this intervention component apart from numbers treated. More than one programme included partners or families for counselling or mediation[83,97]. Loss to follow up to psychological services was a common issue[98]. Programmes linked to health systems faced barriers as psychological services may not exist, especially in rural areas, so there was nowhere to refer patients to[89]. One intervention aimed to increase capacity through task shifting by training lower cadres of staff to deliver psychological interventions, however did not report on the effectiveness or acceptability of the intervention for end users[99].

### *Socioeconomic*

Socioeconomic interventions can help address the social determinants of health, empower survivors, and address stigma. They need to be performed sensitively however as they can have unintended consequences, including increasing IPV[100]. In a systematic review of interventions against IPV in low-to-middle income countries significant reductions in IPV were seen with social/community or combined socioeconomic interventions but not with economic interventions alone[100].

Socioeconomic interventions in the DRC were either run as part of holistic services or as stand-alone interventions. Mechanisms identified included micro-financing, animal asset transfer and vocational training. Issues were identified with loan-based initiatives, including that the loans were too great a risk for those in extreme poverty to accept[101]. Access in rural areas was limited even though these are areas poorly served by other credit mechanisms or banks[101]. One project in the DRC reported successful and sustainable outcomes on health and economic status through an animal-based initiative ‘Pigs for Peace’ in conflict-affected rural areas (see Box 4)[102]. Conversely an RCT of a village-based loans intervention showed no significant impacts on mental health or debt. It did not include physical health or any measure of SGBV incidence as outcome measures[103]. Socioeconomic interventions run as part of holistic programmes did not have outcome data available. Socioeconomic programmes exist for in Sierra Leone but the nature of these is largely unspecified in the literature. A review in 2007 highlighted that many community based organisations were active in providing socioeconomic support for SGBV survivors, especially in rural areas[81]. The government operates micro-credit programme in rural areas and for women, but not specifically for SGBV survivors[38]. In Haiti there is little description of the form that socioeconomic support programmes take[57].

### Box 4: Pigs for Peace[101,102]

The 'Pigs for Peace' programme was developed through a participatory joint research project between two US based institutions, the Great Lakes Restoration NGO and Johns Hopkins School of Nursing, and two Congolese NGOs, FORAL and *Programme d'Appui aux Initiatives Economiques du Kivu*. The research identified two key issues for survivors; health outcomes and social worth. They developed a micro-finance initiative to improve the socioeconomic status of women and so address social determinants of health and SGBV. The initial research identified issues with previous micro-finance programmes based on cash loans and so developed a livestock transfer scheme 'Pigs for Peace'. They identified that women were allowed to look after and control the sale of pigs, rather than other animals that may be the responsibility of men, and that pigs could be raised within the space available to many households.

#### *Programme design*

The programme was started in 2008 and was evaluated by an RCT in 2012. The project established village associations that provided a loan of a piglet to households, not limited to SGBV survivors, alongside training and support on rearing the animals. The project provided continuing support to the associations to manage the scheme. The repayment of the loan was two piglets from the first litter which were then used for loans to other women, the original pig and any other piglets could be kept and used how participants wished.

#### *Outcomes*

The RCT was run over 18 months in 10 villages, with 833 participants (both male and female). The study demonstrated significant outcomes for reduction in household debt ($p=0.028$), improvement in perceived health status ($p=0.026$), reduction in symptoms of anxiety ($p=0.020$), and improvement of symptoms of PTSD ($p < 0.001$) than the control group. No confidence intervals were provided. There was a reported reduction in IPV perpetration in the intervention group although this was not significant. This intervention demonstrates a sustainable programme that improved socioeconomic outcomes but also significant outcomes on physical and mental health.

#### *Challenges/limitations*

- The programme was run by volunteers (at least in pilot phase) and so it is difficult to assess if the programme is financially viable if project staff were reimbursed
- The programme is context specific so whether this is scalable to other populations or non-conflict populations would require further research

### *Justice*

Justice was addressed by programmes either through the provision of free or subsidised legal services or referral mechanisms to the police. There are multiple organisations participating in advocacy and activism to improve access for survivors to justice and improve legislation in all three case study countries, although these are out of the scope of this review. Where provision of legal care or referrals existed there were still very low prosecution rates in all three case study countries. In Sierra Leone collaboration of the Rainbo centres with the police led to a 'large' increase in referrals of women and children, although numbers were not specified[81]. However out of 3,137 cases seen in Rainbo centres in 2018 only 1.2% progressed to a successful prosecution[43]. In the DRC data from the UN Children's Fund (UNICEF) showed out of 7,157 cases seen in a six month period in holistic services only 485 were referred for legal assistance[26]. Collection of forensic evidence was rarely addressed. Commonly a medical certificate is needed to be able to progress towards a prosecution[45]. One study described a mobile phone programme for safe storage and transfer of forensic evidence however this had not yet been implemented in practice[104].

### *3.2.2 Safety, respect, confidentiality and non-discrimination*

Safety is a key concern within SGBV programming in any context but particularly in FCAS, for both survivors and programme staff. Survivors may be in situations at continuing risk of SGBV or accessing services may mean travelling through unsafe areas[92]. Survivors may be at risk of further violence once they have disclosed events or they may face retaliation for engaging with services[92,105]. A systematic review of SGBV interventions in conflict and humanitarian crises identified that lack of protection by programmes led to an increase in stigma and SGBV[92]. Programmes can also address the safety of vulnerable populations as a way to mitigate the risk of SGBV, for example providing fuel alternatives to prevent women needing to leave IDP camps to collect firewood in unsafe areas[92].

Out of the three case studies programming in Haiti demonstrated the clearest agenda for safety of survivors or vulnerable populations. Some projects provided safe houses or shelters for survivors[57]. UN led projects such as START focused on improving safety for women and girls living in temporary shelters or camps to reduce the risk of SGBV, although no outcome measure was reported to demonstrate if this was successful[50]. Programmes addressing safety to reduce SGBV rarely had available outcome measures on SGBV incidence or prevalence. For example a project to distribute handheld solar lights to women in Port-au-Prince for SGBV risk mitigation did not report any SGBV outcome measures[106]. Lack of protection in the form of safe houses identified as a problem in a stakeholder mapping exercise in Sierra Leone. Women who reported violence who were unable to go home then fell on the responsibility of the police family support units (FSU) who did not have the capacity to support them[107]. No specific programmes for shelters were identified in the DRC outside of socioeconomic programmes.

Of the studies reviewed few were explicit regarding confidentiality. Confidentiality is important given the stigma that can result against survivors participating in SGBV programmes, as has been described in other FCAS settings[92]. Many of the programmes identified utilised community referral mechanisms for case finding but did not comment on how confidentiality was maintained. No projects commented on training of auxiliary staff such as receptionists regarding confidentiality. No studies commented on safe data management or storage of notes. Some approaches were specifically adapted to help ensure confidentiality however. Some studies intentionally recruited women who were both survivors and non-survivors to programmes so that participants would not be labelled as survivors[102]. In terms of respect for survivor choice, holistic models of care demonstrate a clear focus on respect with shared decision making and informed consent[82,83]. Respect was not demonstrated in all programmes however, including programmes that placed conditions on accessing care. A complex intervention run by a faith-based organisation for sex workers (SW) in Sierra Leone provided care for survivors and their children but only if they attended compulsory sessions that included religious education[108].

## 3.3 Community-based approach

The community-based approach requires programmes to engage the local community and understand community needs and structures. Effective and sensitive community engagement can lead to improved outcomes for SGBV programming in FCAS settings[92]. Different themes of community engagement have been identified here. The first is community sensitisation, where SGBV response programming engages with the community to raise awareness of both SGBV and the services available. The second is primary prevention, where programmes engage communities or perpetrators of SGBV to prevent SGBV occurring. Some interventions also made available results of community needs assessments or

situational analyses, which not only allowed better contextual understanding but also highlighted the challenges faced in performing such assessments[18,58].

It is important to note that outside of formal SGBV programming existing community structures can also informal support mechanisms for SGBV survivors. A qualitative study of local female social workers in Sierra Leone demonstrated that they provided informal psychosocial and socioeconomic support for SGBV survivors[109]. The study highlighted the fact that as these women lived in the same communities as survivors, and may have been survivors themselves, they could provide contextual and culturally accepted forms of support[109].

### *3.3.1 Community sensitisation*

Community sensitisation was identified in all three case studies with different mechanisms used. In the DRC programmes used existing formal community structures such as CHWs or state public health services for both sensitisation and as referral mechanisms[82,83,85,89,91]. Despite the existing network of CHWs in Sierra Leone they did not form part of any of the SGBV programmes identified. Some projects trained community volunteers to deliver sensitisation and education[36]. Other projects used media such as radio broadcasts or community theatre performances[36,107]. Radio programmes are popular in Sierra Leone and been used for SGBV programming, as they are understood even with low literacy rates and can reach hard to access populations[38,45]. Various programmes in Haiti undertook community sensitisation regarding SGBV to facilitate awareness of referral pathways and available services[21,57]. No projects from the three countries engaged traditional healers which has been done successfully in other settings to increase acceptability of medical and psychosocial care[92].

### *3.3.2 Primary prevention*

Engaging communities to prevent SGBV leads to sustainable long term effects and is a key part of SGBV programming. The majority of prevention programmes identified engaged men to prevent them perpetrating SGBV through a number of mechanisms including dialogue groups and peer-to-peer education. This included the Living Peace programme and Heal Africa outreach in the DRC, and FINE-SL, RADA and MAGE-SL in Sierra Leone[18,82,110,111]. Where outcome measures were available reductions in SGBV were reported. The Living Peace programme reported a reduction in SGBV perpetration but also benefits for the male participants and wider community effects (see Box 5)[110]. The adapted SASA! Programme in Haiti reported changes in attitudes towards SGBV in both men and women, but not if this affected incidence[112].

### Box 5: Living Peace[110,113]

The Living Peace programme was developed in conjunction with the NGO Promundo-US and the *Institut Supérieur du Lac*. An initial research survey in North Kivu demonstrated that communities had been heavily affected by the conflict, there was ongoing perpetration of SGBV and that men who had experienced or witnessed violence during the conflict were more likely to perpetrate IPV. They saw that state services were poor. This lead to the development of a community-based programme to support and empower men as agents of change against SGBV.

#### *Programme design*

The programme targeted men identified by their communities as violent, including perpetrators of SGBV, to address violent behaviours and the effects of traumatic experiences the men had experienced. The project ran through 15 structured weekly sessions to address a series of topics. The sessions were delivered by local facilitators, for example from the police or local CSOs, who were trained by Living Peace master trainers. On a wider level the project aimed to establish an evidence base for psychological interventions for trauma and to encourage gender specific approaches within state structures such as the health system or the police. The programme ran an initial pilot project in 2013 and was fully launched in 2015. `

#### *Outcomes*

A mixed methods evaluation was performed by an independent body. There was reported improvement of physical and mental health of participants and reduction in alcohol use. There was reported reduction perpetration of IPV, decreased economic violence and increased reported sexual consent. Participants reported improved acceptance of SGBV survivors. Participants also went on to promote Living Peace methodologies in their communities. On a wider level they reported improved relationships between the community and the police. They reported that state structures that had engaged with the project continued to use the Living Peace methodology. This research is however based almost entirely on qualitative data, which they recognise as a limitation. No statistical analysis was presented to show that any of these changes were significant. An RCT is planned to further evaluate outcomes.

#### Challenges/limitations

- The project was not able to address some drivers of SGBV, such as poverty, that may result in participants relapsing
- The project does not comment on retention of local facilitators which may impact sustainability
- Follow up of communities that had participated was limited

Other programmes engaged community leaders to work to prevent SGBV in their communities[18,110]. In Sierra Leone the Centre for Democracy and Human Rights engaged religious and traditional leaders to develop action plans for their communities and raise awareness[43]. There are other community-based strategies including community alcohol bans or curfews that have been reported elsewhere, no such projects were identified in the case study countries[18]. One project in Sierra Leone used community listening clubs and radio broadcasts to address SGBV in Sierra Leone as a structural barrier for women to engage with business, with positive short term outcomes (although from a very small cohort)[114]. No projects reported on the retention of peer educators or community leaders which is important for sustainability of such programmes. There are barriers to implementing prevention programming in these settings. MSF noted in the DRC that while they recognised the need for comprehensive SGBV prevention programming, as a humanitarian agency they did not have the training and resources to achieve this[36].

Schools can form effective platforms for both sensitisation and for SGBV prevention as there is existing infrastructure and human resources in the form of teachers or counsellors, although this may be heavily disrupted in FCAS. No study reported advocacy for SGBV to become part of the formal school curriculum. One programme in Sierra Leone provided training for teachers in conjunction with the Ministry of Education[18]. Heal Africa in the DRC and FAWE and Pinkin-to-Pinkin in Sierra Leone ran projects in schools both to raise awareness regarding SGBV but also to prevent school-based SGBV[18,45,82]. No outcome measures are available from these projects.

It is important to recognise that whole communities are affected by SGBV and the trauma of conflict or disasters, not just SGBV survivors. Interventions can have negative effects on the community and can reinforce community perceptions that survivors receive special treatment[26]. The use of safe houses by programmes to provide socioeconomic support before survivors return home rather than delivering these interventions in the community has received criticism that they therefore do not address the community-wide effects of SGBV[26]. Programmes from other contexts demonstrated that some of these negative perceptions could be prevented if the community was engaged in planning of programmes and where programmes offered services for the whole community[92].

### 3.4 Rights-based approach

The rights-based approach should ensure that services are rights not needs-based, recognise that it is a right to be protected from SGBV, and aim for participation and empowerment of survivors.

Holistic programmes such as the Panzi One Stop Centres explicitly outlined their commitment to a rights-based approach[83]. However most of the health and psychological programmes reviewed were needs rather than rights-based. One intervention in Sierra Leone described its participants as 'vulnerable human beings in need of assistance'[108]. Health programmes such as the short-term field intervention in the DRC run by Latet (an Israeli aid organisation) and the Malteser foundation were clearly needs-based[115]. There was no participation of survivors or communities in the project design, and no measures of acceptability or participant satisfaction in the outcome measures of the project[115].

A rights-based approach was much more common in programmes outside of health delivery. Many of the socioeconomic and community-based programmes aimed to empower survivors or vulnerable groups and promote their rights. One programme in Haiti even had specific community-based 'Human Rights Workers'[54]. Some programmes provided leadership training for women or children to become activists[82,83]. Most of the focus on rights however in all three countries is from organisations including CSOs addressing legal or political reform, outside of the scope of this review.

### 3.5 Age, gender, and diversity approach

This approach aims to highlight the need for programmes to include, and where necessary adapt to, groups that are commonly excluded from programming. This section will address to what extent different groups are covered by services. Certain populations were not addressed in any of the case study countries. No programmes in any of countries addressed elderly populations, who are at risk of SGBV especially in the context of displacement. No programme discussed providing services for religious or ethnic minorities.

In the three case study countries the vast majority of programming was for women and girls, however children and adolescent girls have different needs than adult women. Specialist services have been provided for children and adolescents by some programmes[83]. Both Panzi and Heal Africa described having specially trained paediatric staff, adapted examination rooms, and child friendly spaces[82,83]. The Rainbo centres in Sierra Leone saw almost exclusively adolescent girls or children, but did not describe how their services were adapted to them[81]. In Haiti some programmes provided services for adolescent girls, including the MSF centre described above, but these appear to be based mainly in Port-au-

Prince[21]. One programme in the DRC aimed to reduce adolescent girls risk of SGBV through a community-based life skills programme, however in an RTC to evaluate the programme there was no significant reduction in SGBV[116]. Sport can be a useful mechanism, for example Heal Africa used capoeira for children to deal with trauma, but again outcome measures are not available[82].

Adolescents who were former child combatants are a particularly vulnerable group, often having been subjected to SGBV during the conflict. They are often rejected by their communities after the end of conflict and access to care in interim centres is poor[117]. Girl ex-combatants are commonly excluded from disarmament, demobilisation and reintegration processes. In Sierra Leone only an estimated 4% participated[117]. Various programmes in Sierra Leone, including UNICEF and local NGOs such as Caritas-Makeni, have provided health, education and socioeconomic support for this group (not confined to SGBV survivors)[117]. One intervention demonstrated the importance of girls involvement in cleansing rituals and participation in traditional coming of age ceremonies or '*bondo*' as components of successful reintegration into their communities[118]. This raised a significant ethical challenge for the programme as *bondo* in some cases would involve female genital mutilation[118].

No specific services for male SGBV survivors were identified. In the DRC access to healthcare services for male survivors is poor and psychological and socioeconomic interventions are almost non existent[119]. In Haiti the MSF clinic reported providing care for male survivors but this only formed 3% of the patients received and they were not the target of the intervention[21]. None of the community sensitisation programmes mentioned sensitisation around male experiences.

No studies were found for specific interventions for IDP or refugees. In Haiti various UN agencies including UN Development Programme (UNDP) and UN Women have outlined efforts to provide SGBV programming in IDP camps, and more recently to returnees from the Dominican Republic, however the nature and scope of these programmes are not specified[50].

No programmes for SW survivors were identified in any case study country, although one project in Sierra Leone addressed sex work itself as a form of SGBV[108]. In a qualitative study in the DRC both male and female SW were subject to work place physical or sexual violence, which in turn limited their ability to negotiate pay or safe sex[120]. Evidence in Haiti demonstrated female SW experience discrimination when seeking services for SGBV and have also experienced SGBV perpetrated by health care workers and the police[121].

Unique to the three case studies was evidence from Haiti of local NGOs providing services for LGBTI people such as SEROvie (although not specific to SGBV)[122]. However these were heavily disrupted in both infrastructure and loss of human resources following the earthquake[122]. Violence against the LGBTI community increased following the earthquake, with documented cases of gang rape, 'corrective' rape and sexual exploitation[122]. Standard operating procedures for emergency food distribution were seen to be discriminatory towards LGBTI people[122]. A recent partnership between the LINKAGES project and UNDP set up a national working group in Haiti to assess SGBV in key populations, namely female SW, men who have sex with men and transgender women[121].

Only one programme was identified that provided services for disabled people. In the DRC Heal Africa ran community empowerment projects that supported both SGBV survivors and people with disabilities. Only 4.3% of the population reached by the project were disabled however and they did not specify whether any of these were also SGBV survivors[82].

## 3.6 Systems approach

The systems-approach should address SGBV across organisations or sectors to ensure that programming is relevant to the context and is coordinated between actors. It should also ensure that there are no structural barriers to programming being delivered, which includes gender mainstreaming across organisations, provision of training on SGBV and establishment of data collection and management systems. This section will allow an overview of the coordination in each case study country. No national data collection systems were identified in any of the three countries.

### *3.6.1 The Democratic Republic of Congo*

The coordination of the response to SGBV in the DRC is complex with multiple actors involved. Government coordination is nominally the responsibility of the Ministry of Gender, Family, and Children and its provincial divisions[38]. The divisions are responsible for delivery of provincial level programming, however are poorly funded and in areas reliant on external funding to operate[26]. Of the programmes identified in this review none were government run and there was no evidence of a coordinated health system response to SGBV. Out of the SGBV programmes reviewed eight had formal links to the health system, either run through facilities or in partnership with local health zones. The only programmes that outlined referral processes were already running in partnership with the health system. Panzi reported that expansion of their model to other centres and into primary care was limited by lack of political will[83]. On a wider level policy has addressed structural factors influencing gender equality and SGBV, including incorporation gender and SGBV into the constitution and gender specific police reform[123].

Evidence for coordination between the government and other agencies delivering SGBV programming, including UN agencies, is entirely from eastern DRC. Initially mechanisms for SGBV funding impeded successful integration of programmes and hindered long term programmes. Local CSOs and activists reported that it was very difficult for them to gain funding for projects not addressing CRSV[26]. Many funding sources bypassed the government, either due to earmarking of funds, restrictions from donors, or concerns regarding corruption[26]. Two of the major multi-donor pooled trust funds were not directly coordinated by the government and there was no oversight capacity for fund allocation[26]. The government launched a district and zone level coordination body for local and some international NGOs in 2003, however this was eventually stopped[26]. The UN instigated a multi-sectoral coordination committee led by UNICEF however it has been reported that state and local NGOs rarely participated in coordination meetings[26]. The government led Stabilisation Strategy for Eastern Congo and the International Security and Stabilisation Support Strategy (ISSSS) both contain pillars to tackle sexual violence with a strategic multi-sectoral approach[25]. While the ISSSS was initially chaired by UN agencies this is being transitioned to different government agencies who now co-chair each pillar of the strategy. A recent analysis including interviews with stakeholders reported government coordination was improving, for example local health zones assuming responsibility for distribution of any medicines used has reduced poor distribution and misuse of PEP and emergency contraception supplied to SGBV projects[25].

### *3.6.2 Sierra Leone*

Sierra Leone demonstrated the clearest agenda for SGBV out of the three case study countries. Prior to the Ebola outbreak the government developed various national strategies for a state led, multi-sectoral, and coordinated approach for all government ministries and major NGOs.

Coordination is the responsibility of the Ministry of Social Welfare, Gender and Children's Affairs[45]. The National Committee on GBV was established in 2006 to coordinate SGBV programming, including regional GBV Committees comprised of government representatives, UN agencies, and national and international NGOs[45]. A multi-sectoral National Referral Protocol on GBV was introduced[124]. The National Action Plan on Gender Based Violence 2012-2016 outlined eight pillars of action for SGBV, to include response and prevention programming, coordination, and funding[125]. These documents outline guidance on the responsibilities of the health system, including providing free medical care and treatment, and provision of medical reports[125]. It also outlines plans for training of health care professionals of SGBV, delivery of psychosocial interventions, expansion of care into primary care health units and integration of SGBV into the curriculums of medical or nursing schools, with support from UN agencies and NGOs[124,125]. There is very little evidence however to show how or if this has been implemented or the degree of engagement of non-state actors. Each activity had a budgeted cost but it was not outlined where this funding would come from. No evaluation reports are available or any evidence of whether these activities were disrupted or halted during the Ebola outbreak.

One of its core outputs was to integrate clinical care and case management into national structures by 2017. However of the studies reviewed only one had formal links to the health system and is to date entirely operated by an NGO and externally funded. There were no referral mechanisms to the health system in the interventions reviewed, although there appeared to be strong and well established referral mechanisms to the police. Other programmes were successfully coordinated with other sectors including the Ministries of Justice and Education[45]. One clear outcome of this policy is the establishment and expansion of the FSU in the Sierra Leone police force. The UN advocates gender specific police reform as a mechanism both to improve police engagement with communities to reduce SGBV and also to encourage survivors to report SGBV[92]. The FSU were established in 2003 to specifically handle cases of SGBV, alongside wider policy for gender mainstreaming within the police[18]. These units were hindered however by lack of resources, and as awareness of the FSU increased referrals increased without a corresponding increase in capacity[18,38].

A stakeholder mapping report noted that SGBV programming from international NGOs was uncoordinated, with duplication or service gaps[18]. In the immediate post-conflict period organisations noted that SGBV was viewed as a low priority when compared to other recovery processes such as rebuilding infrastructure[107]. A review in 2007 suggested there was a transition from the humanitarian response following the conflict towards longer term development goals, however some actors recognised that the transition was challenging[18]. Local NGOs lacked donor support for long-term objectives such as gender mainstreaming due to limited funding and short-term grants[45]. Some local NGOs formed their own networks, for example the Justice and Governance Network, to help coordinate and pool resources[18]. There have been coordination bodies established by international agencies including the UN and Oxfam for specific activities but there is no evidence as to how effective these are[107].

### *3.6.3 Haiti*

In Haiti national coordination falls under the remit of the Ministry for the Status of Women and Women's Rights (MCFDF). National strategic policy against SGBV has been developed, including a National Action Plan against violence against women[50]. Wider policy included the National Development Plan 2010-2030 and the Gender Equality Plan and Gender Equity in Parliament[50]. The effectiveness of these policies and offices however has been limited by lack of resources and political will. Funding was reduced for the MCFDF to only 0.6% of the government budget in 2016[50]. Of the programmes reviewed here none were integrated with the formal health system or run in partnership with it. No evidence identified a coordinated health system response. Some projects however did aim to strengthen community and police referral mechanisms towards appropriate services[126]. There was conflicting documentation of the role of the MCFDF in coordinating and providing services for SGBV response and prevention.

The humanitarian response was coordinated via a parallel system. The initial earthquake response was coordinated through the UN humanitarian cluster with the aim to 'Build back better' on the basis of the Haitian government Action Plan for National Recovery and Development[50,57]. The response involved a plethora of actors, including UN agencies, humanitarian and development NGOs and private donors[127]. The response faced many challenges and has also subsequently been criticised for failing to meet its agenda for sustainable development[128]. SGBV formed a sub-cluster of the protection cluster led by Office of the UN High Commissioner for Human Rights (OHCHR)[129]. Large scale projects coordinated through international NGOs and the UN included SGBV training and capacity strengthening of the health system response to SGBV[130]. The final evaluation reports however were published in French and so not available for review.

# CHAPTER 4: DISCUSSION

This review has sought to analyse the evidence as to how SGBV response and prevention programming has been implemented and coordinated in FCAS using the case study examples of the DRC, Sierra Leone and Haiti.

### *4.1 Limitations*

There are limitations to this review. The first is the restriction of literature to that published in English, particularly significant in Haiti where even UN data was only available in French. This will likely bias the review towards evidence from international organisations that operate in English or towards programmes funded by them. The quality of evidence was variable, although research in the DRC demonstrates that it is possible to perform RCTs for complex public health interventions even in conflict-affected areas. The main limitation is that the evidence reviewed is in no way representative of the activity of organisations in any of the three case study countries. For example in the DRC in the North Kivu region alone there are an estimated 300-400 organisations responding to SGBV, however literature for less than 40 programmes was identified for the whole country[26]. Many organisations reported to be implementing some form of SGBV programming on their websites or promotional material but no further details of programmes were available by any search means available to the author. Of the programmes identified very few published outcome measures or results from monitoring and evaluation processes. Local NGOs may well not have internationally accessible information but it points to a lack of transparency and accountability that this information is not available from international organisations. This is an issue cited in other systematic reviews of SGBV programming in similar contexts[92]. Where available stakeholder mapping exercises provided a valuable oversight of the different actors delivering programmes but only a few were identified and already many years old.

### *4.2 Legal framework*

All three case studies demonstrated legal reform regarding gender equality and specifically SGBV. Legislation is more comprehensive in the DRC and Sierra Leone than Haiti, although rape is now criminalised in all three countries. This may reflect the fact that following conflict international involvement supports new or interim governments to build constitutions or legislation as part of the peace and state building agenda, which does not happen in the same extent following disaster. The case studies also demonstrate however that legal reform does not correlate with improved justice for survivors and impunity for perpetrators remains. No evidence demonstrated engagement to change customary law processes, despite the fact that these are used in large areas of all three countries and can contradict formal legislation.

### *4.3 Survivor-centred approach*

This review has identified different models of survivor-centred care, however from a small number of programmes without comparable reported outcome measures. The DRC demonstrates that it is possible to establish comprehensive services even within a conflict-affected area. Notably these services were established by local NGOs and are linked to the health system, though not state run. Conversely in Haiti one of the main providers was the MSF centre in Port-au-Prince, parallel to the health system and provided by a humanitarian actor. The one stop centre model seems a logical approach in resource poor settings to rapidly establish all necessary aspects of care within one programme. This however leads to a significant unmet need for those who cannot reach the often limited number of centres, and fails to address systemic shortages in basic care. This can fuel community perceptions of special treatment being given to survivors and perpetuate stigma. Integrating SGBV care into primary health care and

reproductive health services may help to increase access but also strengthen the health system in a wider sense, as it could promote better procurement and stock management to ensure contraception and PEP are always available, establish cold chains for vaccine provision and importantly improve provision of mental health care addressing an unmet need outside of SGBV. This however requires investment, time and coordination between state and non-state actors which has been identified as a challenge in all three case study countries. Outreach and mobile clinics may be appropriate for provision of specialist care, such as Heal Africa's mobile gynaecological surgery clinics for vaginal fistula, but are not appropriate for acute care as survivors would not be able to access emergency contraception or PEP within the necessary time periods.

Dedicated psychological interventions were identified, however these were time-limited projects that may have little effect towards building sustainable provision of psychological services. The results of two RCTs in the DRC agreed with other settings that counselling delivered as group sessions or with a group component had significantly better outcomes. From the socioeconomic interventions described, the best evidence comes from a single animal asset transfer scheme in the DRC. This was in part successful as the scheme was context specific and reflected community participation in the design of the programme. While pigs may not be appropriate for some settings, animal husbandry or other income generating activities may be sustainable mechanisms for support. Microcredit or small loan schemes do not appear appropriate for the very poor, but may be useful in other circumstances however robust evidence is lacking. In all three countries where legal support was available it was under-utilised and did not correlate with increased prosecutions.

Safety is a key concern for survivors in any environment. Programmes that used risk mitigation strategies for women at risk of SGBV however did not report on any indicator for SGBV in their outcomes. The use of safe houses or shelters was a priority in Haiti compared to the other two countries, potentially reflecting the agenda of the security cluster coordinating the SGBV response. The experiences of the FSU in Sierra Leone demonstrated that lack of safe houses became a significant concern as when some survivors had reported SGBV they were unable to return to their communities.

Issues around confidentiality were raised by the literature reviewed. Services based within facilities were not explicit regarding mechanisms to ensure confidentiality such as note storage or patient coding. Many programmes relied on community referral mechanisms, such as community leaders or CHWs. These people may be well known in their communities and requiring survivors to disclose within their communities may break confidentiality but may also be unsafe and risk retaliation against the survivor. This may be significant for IPV where the survivor may still be in the same household as the perpetrator. One option may be that used by Panzi where a combined referral process was used from multiple sources including outreach into communities, giving survivors a choice.

### *4.4 Community-based approach*

Different mechanisms of community engagement were identified from the three case study countries. Mechanisms identified for community sensitisation varied, and within multicomponent interventions the contribution of these mechanisms was rarely reported. The use of existing structures such as CHWs may be a sustainable option but more evidence is needed to support this. Primary prevention programmes that engaged men were associated with positive outcomes in both the DRC and Sierra Leone. In contrast prevention programming in Haiti was more focused on risk mitigation for vulnerable groups rather than long term community engagement. Prevention programming to address the drivers of SGBV should be priority in any setting, including post disaster.

### *4.5 Rights-based approach*

A rights-based approach was much more commonly adopted by multi-component programmes or programmes not addressing health. However many programmes were still needs-based and approached survivors as passive beneficiaries. International organisations involved in coordination, funding and delivery of programming all follow a rights-based agenda within their charters or specifically regarding SGBV but it is difficult to assess how this relates into programming.

### *4.6 Age, gender, and diversity approach*

This research demonstrates a clear bias of programme design towards adult female survivors. Services did exist for adolescent girls and children within adult programmes, with some programmes describing mechanisms for service adaptation. Male SGBV survivors continue to be underserved by SGBV programming, which needs to acknowledge the different physical and psychological effects of SGBV against men compared to women, and the wider effects on families and communities. Community programmes engaging men as part of SGBV prevention may provide platforms for sensitisation or even SGBV response programming for men and boys however this was not identified in any of the case study countries. There were no descriptions of programmes for survivors of any other vulnerable group.

### *4.7 Systems approach*

The case studies provide an analysis of different contexts within FCAS. There was much more available literature for the DRC which may be reflective of the protracted crisis and therefore the time different actors have been engaged within the country. Provision of interventions was almost exclusively in the north and eastern parts of the country, in part reflecting international and donor priorities towards the area and CRSV. This means a large proportion of the country is likely underserved, especially for other forms of SGBV such as IPV. Sierra Leone initially demonstrated a concerted multi-sectoral approach towards integrated SGBV programming, but the degree to which this was reflected in actual programming is unclear. After the international response shifted towards the Ebola crisis SGBV seems to have become a lower priority in both programming and research. The recent declaration of a national emergency regarding SGBV shows that much more needs to be done. The response in Haiti has reflected the humanitarian and security agendas of actors involved in the country after the earthquake and Hurricane Michael. The security cluster in Haiti has coordinated the humanitarian SGBV response and security for at risk women and risk mitigation programming appears to have had a much higher priority here than in the other two countries There is much less evidence for long term sustainable SGBV programming or for SGBV prevention.

Coordination is a key issue identified in this review, where multiple systems of coordination hamper programming and lead to service duplication, inequitable distribution or services or gaps in service provision. One of the outcomes of this research is that while international involvement in FCAS increasingly aims to work with governments and existing structures where possible, the use of cluster coordination, usually by UN agencies, inherently creates a parallel coordination mechanism. This then creates parallel funding mechanisms and programming that are not integrated into state structures and do not strengthen state service provision. The use of short term grants or earmarked funds limits local NGOs to respond to local needs or to establish long term programmes.

One key point from all three case study countries is that the government coordination of the SGBV response was the responsibility of a gender ministry or equivalent, rather than the ministry of health. This has led to policy development and legislation in all three countries and to varying degrees a multi-sectoral approach. This may be why however there has been little emphasis on strengthening health systems to deliver care for SGBV in any of the three countries.

# CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

## 5.1 Conclusion

This review demonstrates there is an increasing recognition by national and international actors of the importance of addressing SGBV in FCAS. However these efforts are poorly coordinated and influenced by wider security or humanitarian agendas. Long-term sustainable programming that builds system capacity and effectively engages local communities should be a priority. More evidence is needed from existing programmes to demonstrate whether they are effective in these contexts. More research is needed on how best to address the different vulnerable groups affected by SGBV.

## 5.2 Recommendations

### *1. Evidence to support programme design and delivery needs to be improved*

- Programming for SGBV must have transparent monitoring and evaluation mechanisms for both processes and outcomes, and publish outcome and impact data. This will provide evidence of whether programmes work and also how they work within a specific context. Training and capacity for this should be supported by more experienced organisations or by research bodies such as universities. Funding mechanisms need to account for the costs involved.
- Databases need to adapt to provide open access platforms to host such outcome data, whether positive or negative, but also for other processes such as situational analyses or cost effectiveness studies to build evidence for best practice for all aspects of programming.

### *2. Provision of care needs to adapt to the needs of all survivors*

- Evidence-based methodologies on how to deliver or adapt services to different survivor needs, irrespective of age, gender or any other characteristic, need to be developed by stakeholders involved in SGBV programming. This should be in collaboration with researchers to ensure data is available as to the prevalence and types of SGBV in different groups. This is not limited to FCAS settings. This should not however limit inclusive and non-discriminatory service provision in the interim.

### *3. A multi-sectoral coordinated response is needed for SGBV programming*

- There needs to be effective oversight and coordination of SGBV programme delivery between state and non-state actors in FCAS to avoid service duplication or gaps. Coordination mechanisms should run with, not in parallel, to the government and multiple mechanisms should be avoided. UN agencies coordinate SGBV responses within security or humanitarian clusters and so would be well placed to support governments to create a single, national coordination system. This should include a register of SGBV programming and actors involved and establishment of national and regional coordination committees, or strengthening of these if they are already in place. These should also facilitate coordination between different sectors including health, education, gender and justice.
- Donors must recognise that effective response and prevention programming for SGBV in these environments needs long term investment and reliable funding mechanisms. Funds also need to be reactive to different context and needs within a country. Earmarked funds and short term grants should be replaced where possible by national multi-donor pooled funds coordinated by relevant government ministries both at the national and regional level. If state legitimacy or corruption are concerns funds should coordinated in partnership with the existing government with explicit time-bound plans on how control will be transferred as legitimacy improves.

- Coordination and programme monitoring must be supported by a comprehensive national, state led, data management system to monitor both ongoing incidence of SGBV and service provision.

### *4. Services for survivors should be integrated with the health system, including primary care*

- Stakeholders need engage with national ministries of health to provide integrated services. Holistic models of care are important but should not be limited in secondary care. The model should be extended to primary care and reproductive health services so that survivors can access care at any point of access to the health system, including medical treatment and psychological care. This needs to include referral mechanisms for other specialist services and capacity for follow up.
- Robust evidence to support interventions is lacking, however evidence supports the use of group sessions for psychological support of survivors in conflict and post-conflict settings.
- Mobile clinics or outreach programmes are only appropriate for specialised services such as vaginal fistula surgery, but should not be used for basic and time sensitive care including medical assessments and provision of treatment such as PEP.

### *5. Effective community engagement should form part of any programme*

- Community sensitisation needs to form part of any SGBV programme to raise awareness. No specific mechanism is proven more effective than another.
- Community prevention programming is successful in reducing SGBV, with the best evidence supporting programmes that target men, and again needs to be coordinated across sectors to ensure SGBV is addressed in all settings.
- Community engagement in the design and implementation of programming is vital to ensure programmes are acceptable and can benefit the whole community.

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## APPENDICES

### Appendix 1: UNHCR Framework for SGBV programming. Source[68]