Best Practices to Prevent and Respond to Sexual Violence: Evidence review and programme considerations

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Best Practices to Prevent and Respond to Sexual Violence

Evidence review and programme considerations

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November 2023
WHAT DO WE MEAN BY SEXUAL VIOLENCE?

Sexual violence is any sexual act committed against the will of another person, either when this person does not give consent or when consent cannot be given.

-- UN WOMEN


A 2015 global review of 142 articles found three promising approaches:

1. School-based dating violence interventions.

2. Community-based interventions to create a gender-equitable environment through projects with boys and girls to support gender equitable attitudes.**

3. Addressing child maltreatment via parenting interventions or interventions with children and adolescents.

Majority of studies from high-income countries

** some evidence from LMICs
Reasons for this review

• To fill a knowledge gap about what strategies have been tested and found effective in LMICs to prevent and respond to sexual violence experienced by AGYW.

• Sexual and gender-based violence was identified by the East and Southern African Champions as a key impediment to their HIV prevention programming efforts.

• Review focused on evidence from all 15 South-to-South Learning Network (SSLN) countries to gather and synthesise contextually-relevant information.
Evidence Review Methodology

Focus of the review: Studies that quantitatively measured effectiveness of interventions to prevent or respond to sexual violence (SV) committed by a partner or non-partner

Timeframe: peer-reviewed articles published in PubMed and Web of Science between 2015 – 2023

Articles included in the review after screening 642 citations for relevance

Data extraction and analysis to explore intervention characteristics and program effects to on SV outcomes among AGYW
Takeaways

Intervention Approaches & Programme Effects
Sexual violence (SV) prevention and response occurs at three levels

1. **Primary Prevention** aims to prevent SV occurrence
   - Examples: community sensitisation on SV, equity and gender norms

2. **Secondary Prevention/Response** aims to respond immediately after SV has happened
   - Examples: evaluation and treatment of injuries, provision of other medical services (pregnancy testing, emergency contraception, HCT and PEP), referral to police or social support etc.

3. **Tertiary Prevention/Response** is focused on rehabilitation and long-term responses to SV
   - Examples: reintegration into family/household, long-term psychosocial counseling and rehabilitation etc.

(Adapted from Centers for Disease Control and Prevention [CDC], 2004)
Most evidence relates to primary prevention of SV

Note: total is >41 because some studies focused on multiple elements of SV prevention
Primary Prevention Programs for SV

84% measured an improvement in their SV outcome
Majority of primary prevention interventions measured improvement in SV outcome through community-based programming
100% measured an improvement in their SV outcome
All secondary prevention/response studies showed improvement in SV outcomes; most from Tanzania.

SV Outcomes Measured

- Post-SV services
- SV Knowledge
- SV Disclosure
- Experience of SV
- Psychosocial Well-being post SV
- AGYW self-efficacy/empowerment

Categorisation of Intervention

- Community-based SV prevention/Gender Norms
- Strengthening SV service delivery
- Empowerment, skills-building, self-efficacy
- SV screening and referral
- Couple communication and skills-building

Only 2 studies measured PEP or other HIV service provision post SV
Tertiary Prevention/Response Programs for SV

100% measured an improvement in their SV outcome
Most tertiary prevention/response evaluations focus on psychosocial well-being and come from Kenya or South Africa, and all saw improvement.
## Elements of tested intervention approaches, Part I

<table>
<thead>
<tr>
<th>Community-based</th>
<th>Engage communities in social change activities (e.g., radio programmes, street theatre, meetings with local leaders) to improve community knowledge and attitudes toward SV and to take action against SV.</th>
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</thead>
<tbody>
<tr>
<td>Empowerment/ Self-efficacy</td>
<td>AGYW’s individual capacity-building within small group settings with multiple exposures and focused on addressing multiple aspects of AGYW’s lives (e.g., violence, HIV risk factors, economic empowerment, education) tend to be effective.</td>
</tr>
<tr>
<td>School-based</td>
<td>Adolescence is a critical opportunity to address attitudes and behaviours related to SV, gender-specific approaches with tailored interventions to adolescent life stages with AGYW and their male peers.</td>
</tr>
<tr>
<td>Psychosocial &amp; Safety Support</td>
<td>Short-term counselling and therapeutic tools (such as art therapy, phone-based apps with educational material and co-designing safety plans) support psychosocial well-being among individuals who are exposed to/at risk of SV and can also prevent repeat SV experience.</td>
</tr>
<tr>
<td>Economic Empowerment</td>
<td>Cohesive groups (with microfinance, financial literacy and/or vocational training programs) provide support to group members.</td>
</tr>
</tbody>
</table>
Elements of tested intervention approaches, Part II

Parenting
- Implemented in concert with AGYW empowerment, community members and school-based; recognized the significant role of trusted adults, parents and caregivers in the lives of AGYW.

SV screening & referral
- Simplified screenings can be included in routine care visits. Additionally, perceived support from healthcare providers can improve physical and mental health outcomes for women who experience SV.

Strengthening SV service delivery
- Clinical mentoring of healthcare providers seems to improve service delivery for SV and improve follow-up for medical, psychosocial and HIV re-testing services.

Couple communication & skills building
- Couple-based approach complemented by community-based and SV service delivery components can increase communication about violence within couples.

Policy Change
- Positive impact of free universal primary education on protection against SV (Malawi and Uganda). Grade attainment may be protective against SV (as in Uganda).
Recommendations
Tailored for key stakeholders
Do engage community leaders to address entrenched gender norms.

Don’t leave out parents and partners/male peers in SV prevention/response programming.

Do design programs that enable sufficient number of exposures / 10+ to the interventions over time.

Don’t neglect training and support of CHWs who are often responsible for delivering SV programs.

Do include programming for both the short-term and long-term response to SV.

Don’t neglect to integrate opportunities to enhance HIV prevention in SV programming (e.g., offering PEP and PrEP).
To prevent SV (primary)
• Don’t delay SV prevention programming with boys and girl; early adolescence is an opportune time.
• Do build AGYW skills and self-efficacy through mentored safe space groups.

To provide immediate care (secondary)
• Do integrate screening questions for SV into ANC and HIV service points.
• Don’t neglect training for healthcare providers to screen for and provide supportive counseling for SV.

To provide long-term support (tertiary)
• Do provide psycho-social support through trauma-focused cognitive behavioral therapy or explore alternatives like art therapy.
• Do dedicate funding and effort specifically for SV programming for AGYW.
• Don’t overlook opportunities for integrating SV prevention within HIV platforms.
• Don’t assume we know how to create supportive, respectful, and accessible police and judicial systems; evidence is needed.
• Do ensure relevant evaluations in underrepresented regions like West Africa.
• Do prioritize policies to support economic empowerment and access to education for AGYW.
• Do recognize there is a large evidence-base for primary prevention strategies for SV.
• Don’t ignore need for testing secondary and tertiary prevention/response approaches among AGYW.
• Do expand geography of where SV programs are tested.
• Do de-link measures of violence so SV can be specifically tracked.
• Do ensure that analyses segment results by age group, specifically for AGYW.
• Do generate evidence for SV prevention interventions among marginalized populations (e.g., people with disabilities, sexual and gender minorities).
Thank you

Suggested Citation: Sycona. (2023). Best Practices to Prevent and Respond to Sexual Violence: Evidence review and programme considerations. Presentation For AGYW & SSLN Champions.

Learn more about the South-to-South HIV Prevention Learning Network (SSLN): https://www.hivinterchange.com/

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Gender-based violence (GBV)* is any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e., gender) roles and power differences between males and females.*

Intimate Partner Violence (IPV)* refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Sexual Violence (SV)* is any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object, attempted rape, unwanted sexual touching and other non-contact forms.

Physical Violence** is the intentional use of physical force with the potential for causing death, injury, or harm.

Emotional / Psychological Violence** is any act or omission that damages the self-esteem, identity, or development of the individual. It includes, but is not limited to, humiliation, threatening loss of custody of children, forced isolation from family or friends, threatening to harm the individual or someone they care about, repeated yelling or degradation, inducing fear through intimidating words or gestures, controlling behaviour, and the destruction of possessions.

*Definitions from the World Health Organization; **Definitions from SVRI
Papers Included in the Evidence Review


