



Mental Health and Psychosocial Wellbeing in Congolese Refugee Survivors of Gender- Based Violence: A Desk Review



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Acronyms

ADF/ NALU	Allied Democratic Forces/ National Army for the Liberation of Uganda
CFS	Child Friendly Spaces
CNDP	National Congress for the Defense of the People
CPT	Cognitive Processing Therapy
DFID	Department for International Development
DRC	Democratic Republic of the Congo
FARDC	Armed forces of the DRC
FDLR	Democratic Forces for the Liberation of Rwanda
FPLC	Patriotic Forces for the Liberation of Congo
FRPI/ FPJC	Front for Patriotic Resistance in Ituri/ Popular Front for Justice in Congo
IPV	Intimate Partner Violence
IRC	International Rescue Committee
JHU	Johns Hopkins University
LRA	Lord's Resistance Army
MILIA	Enyele/ Independent Movement of Liberation and Allies
MONUC	United Nations Organization Mission in the Democratic Republic of the Congo
MUHAS	Muhimbili University for Health and Allied Sciences
NGOs	Non-Governmental Organizations
PILOTS	Published International Literature on Traumatic Stress
PTSD	Post-Traumatic Stress Disorder
R2HC	Research for Health in Humanitarian Crises
SGBV	Sexual and other forms of Gender-Based Violence
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TPO	Transcultural Psychosocial Organization (HealthNet TPO)
TRCS	Tanzania Red Cross Society
UNHCR	United Nations High Commissioner for Refugees
UNSW	University of New South Wales

Background

This desk review of knowledge on mental health and psychosocial wellbeing¹ in the context of sexual and other forms gender-based violence (SGBV), particularly violence perpetrated by an intimate partner (IPV), in Congolese females was conducted in order to inform the Nguvu project. Nguvu, which means strength in Kiswahili, is a project funded by the Research for Health in Humanitarian Crises (R2HC) program. R2HC is jointly funded by the UK Department for International Development (DFID) and the Wellcome Trust. The Nguvu project is aimed at the development and adaptation of an intervention designed to improve mental health and prevent future incidents of intimate partner violence (IPV) among female survivors of intimate partner violence residing in the Nyarugusu refugee camp in Tanzania.

The Nguvu project is a collaboration between the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health (JHU) (Baltimore, USA); UNHCR, the UN Refugee Agency (Geneva, Switzerland); the Muhimbili University of Health and Allied Sciences (MUHAS) (Dar Es Salaam, Tanzania); and the International Rescue Committee.

Methods

Aim

The purpose of this desk review was to summarize existing knowledge on mental health in the context of SGBV among women living in the Democratic Republic of the Congo and refugees from the DRC. Given the location of the study, we were particularly interested in articles/reports on this topic that focused on refugees in Nyarugusu.

Setting

Nyarugusu is a refugee camp located in northwest Tanzania in the Kasulu district. In 2015, Nyarugusu camp hosted approximately 63,555 refugees, most of whom were Congolese (94%). Since the political conflict in Burundi began, over 100,000 refugees entered Tanzania, approximately 77,075 of which currently (April 2016) reside in Nyarugusu (UNHCR, 2016a). Many of the Congolese residents arrived at the camp in 1996 following the war in South Kivu and have thus lived in Nyarugusu for 18 years. In 2015, the United States agreed to resettle 30,000 Congolese refugees in Nyarugusu in the upcoming years (UNHCR, 2015).

Search strategy and analysis

The desk review follows the approach recommended by WHO and UNHCR in their toolkit for assessment of mental health and psychosocial needs and resources in humanitarian settings

¹ The term 'mental health' is used here following the definition of the WHO: "as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (http://www.who.int/features/factfiles/mental_health/en/) Given the large overlap with the term psychosocial wellbeing, the terms 'mental health' and 'psychosocial wellbeing' are used here interchangeably

(World Health Organization & United Nations High Commissioner for Refugees, 2012). A list of search terms related to the population of interest, general context, the humanitarian context, mental health, and gender-based violence were created and organized as detailed in Appendix B. These combinations of search terms were applied to academic literature databases including the Cochrane Database of Systematic Reviews, PubMed, PsycInfo and PILOTS. We also included assessments, evaluations and policy reports from humanitarian actors that were identified through systematic searches of ReliefWeb, MHPSS.net, Alnap, Refworld and other sources. We also requested relevant reports directly from experts. Articles were included if they contained original data, concerned a study population in the DRC, refugees originally from the DRC or refugees in the African Great Lakes Region, and focused on either the general, mental health/psychosocial or humanitarian context for refugees or any Congolese ethnic group.

Results from searches were recorded in Excel format. The Excel files included the date of the search, the database/ source, the search terms that were used, number of total results, number of potentially relevant results, and number of results officially meeting inclusion criteria. Another excel spreadsheet was used for data analysis. In this file we summarized information on the source of information, research objective/questions, study population, study design, measurement tools, socio-cultural considerations, outcomes, and key findings stratified by mental health, gender-based violence, general context and humanitarian context.

The review of the literature on mental health and SGBV among Congolese and refugee women revealed several major themes that were used to structure this review as described in the Table of Contents (Pg. 2). A summary list of the measures used to assess mental health-related factors is included in Appendix A. For further details regarding the search strategy, please refer to Appendix B.

Political historical context

Colonization of what later became the Democratic Republic of the Congo started in the 1870s when the Belgian King Leopold II initiated efforts to control the area. The conference of Berlin in 1885 established the Congo Free State and assigned it via the Congo Society to King Leopold of Belgium. Colonization focused primarily on rapid extraction of resources (e.g. ivory and rubber) through brutal practices which initiated the first global human rights campaign, and

subsequent transfer of the territory to the Belgian state (Hochschild, 1999). Independence from Belgium was gained on June 30, 1960 at which point the country became the Democratic Republic of the Congo with Patrice Lumumba and Joseph Kasavubu as the Prime Minister and President, respectively. Beyond 1960, the situation remained volatile with rebellion of the Army, the governor of the Katanga Province attempting secession, Prime Minister Lumumba's assassination and Colonel Mobutu repeatedly attempting to overthrow President Kasavubu (Michalopoulos, 2014). In 1965, Mobutu assumed power which he retained until the 1990s – the country was renamed Zaire and ruled as a single-party state. In this period, the state was further weakened through political interference in functioning of the justice, security and administrative systems, increasing distrust by Mobutu of members of his



Source:

http://www.jmu.edu/cisr/journal/10.1/profiles/drc/congo_demrep_large.jpg

government, corruption, nationalization of foreign investments, and the exploitation of these by Mobutu to strengthen political control (Stearns, 2011).

Against this background, the 1994 genocide in Rwanda formed the trigger for subsequent conflict. Over a million Hutu refugees moved into Zaire along with Rwandan soldiers and perpetrators of the genocide. The threat that went out from this displacement in Zaire and the support by Mobutu of various rebel groups in the region motivated regional powers' efforts to replace him. By 1996, a regional coalition led by Angola, Uganda, and Rwanda had formed to overthrow Mobutu (Stearns, 2011). Supported by this coalition, Laurent-Desire Kabila

subsequently overthrew Mobutu in 1997 following a march on Kinshasa. At this time, the country again became known as the Democratic Republic of the Congo.

A second period of fighting started in August 1998 between Rwandan and Ugandan backed militias - followed by protracted conflict and a peace deal that reunified the DRC in June 2003. Fighting has since continued with ongoing insurgency by the Mai Mai militia, which were formed in reaction to the Rwandan invasion, and conflicts in North and South Kivu, Ituri, and Katanga. With the involvement of nine African countries and about 20 armed groups, the conflicts in DRC have been named the Great War of Africa. Estimates of mortality due to the conflict for the period 2001-7 are contested, but lie between 0.9 and 2.8 million people (Stearns, 2011).

Nyarugusu Refugee Camp

Nyarugusu is a refugee camp located in northwest Tanzania in the Kasulu district. This camp hosts approximately 130,429 refugees, approximately half of whom are Congolese (UNHCR, 2016b). Many of the Congolese residents arrived at the camp in 1996 following the war in South Kivu and have thus lived in Nyarugusu for 18 years. In 2015, the United States agreed to resettle 30,000 Congolese refugees in Nyarugusu in the upcoming years (UNHCR, 2015).

Nyarugusu camp is divided into zones, villages and clusters. Each cluster contains 60-100 plots that are allocated to a family (Dick, 2002; Tankink, Ventevogel, Ntiranyibagira, Ndayisaba, & Ndayisaba, 2010). In the DRC, the land distribution and authority of these zones would be controlled by traditional leaders, the mixing of ethnicity within Nyarugusu has disrupted these traditional systems and thus limited their authority in the community (Dick, 2002). The most common ethnic group is Bembe, whose origin is primarily in South Kivu (Dick, 2002; Norman & Niehuus, 2015). Other ethnic groups present in Nyarugusu include Fulero, Rega, Shi and Kasa, also mostly from the South Kivu or Katanga regions of the DRC (Dick, 2002). Swahili is the primary language spoken formally in the camp; however, there are numerous other languages spoken and French is common among the educated (Dick, 2002). As per the Refugee Act of 1998, refugees are prohibited from formal employment in Tanzania (Norman & Niehuus, 2015). They are thus primarily dependent on biweekly food rations and other strategies for food and other necessary commodities. Some refugees engage in selling of their food rations for money. Others have small gardens or engage in trade within the camp. Often refugees will work for incentives on NGO projects to obtain small amounts of money (Dick, 2002).

Sexual and other forms of Gender-Based Violence

The conflicts in the DRC have been characterized by large-scale human rights violations, including SGBV, that have been a product of the ongoing conflict and influx of foreign armed groups (Brown, 2012; Kelly et al., 2012; Michalopoulos, 2014). More specifically, two armed groups, the Democratic Forces for Liberation of Rwanda (FDLR) and the National Congress for the Defense of the People (CNDP), are estimated to be responsible for 81% and 24% of SGBV in

conflict and non-conflict areas respectively (Michalopoulos, 2014). Research on the motivations for aggression and abuse among combatants has found motivation to be moderated by voluntary conscription such that abducted as compared to voluntary combatants in eastern provinces of the DRC were motivated by extrinsic versus intrinsic rewards respectively (Haer, Banholzer, Elbert, & Weierstall, 2013). The prevalence of SGBV remains high in the DRC, with a large proportion of SGBV being perpetrated by an intimate partner (i.e. intimate partner violence, IPV). IPV, one form of SGBV, is defined as “any behavior within an intimate relationship that causes physical, psychological or sexual harm” (Krug et al., 2002). Leaders of Congolese communities in South Kivu have argued that apathy from the international community, despite increased awareness, has slowed progress towards reducing the incidence of SGBV. They further claim that the humanitarian response to the conflict and SGBV was inappropriate and did not focus on community needs, which resulted in the misappropriation of humanitarian resources and lack of attention towards underlying, precipitating factors (Trenholm, Olsson, & Ahlberg, 2011).

The United Nations, DRC and United States have proposed the following strategies to address conflict-related SGBV: “(1) reduced impunity for perpetrators, (2) increased prevention and protection against SGBV, (3) improved capacity of the security sector to address SGBV, and (4) increased access to multi-sectoral services for SGBV survivors”(Scott et al., 2013).

Definitions

Sexual and gender-based violence (SGBV) is any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed (gender) differences between males and females.

(Inter-Agency Standing Committee, 2015b)

Intimate partner violence (IPV) is any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behavior includes:

- Acts of physical aggression (e.g. slapping, hitting, kicking, beating)
- Psychological abuse (e.g. constant belittling, intimidation, humiliation)
- Forced intercourse and other forms of sexual coercion
- Various controlling behaviors (e.g. isolating a person from their family/friends, monitoring their movements, restricting access to information/assistance)

(Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002)

Epidemiology of SGBV

A national surveillance study of SGBV in the DRC reported to MONUC from October 2005 to March 2007 identified 218 reports of SGBV involving 500 survivors and 786 perpetrators

(Taback, Painter, & King, 2008). Survivors were mostly female (96%) and 30% were minors. One-quarter of reports involved multiple female survivors. In 16% of reports, the suspect was arrested. Additional details included the proportion of reported SGBV incidents that were witnessed by the survivor's family (8%) and the proportion of reports that occurred during active conflict (8%). The majority of reports occurred in three eastern regions (60%; South Kivu, Orientale, North Kivu) with the largest proportion of reports originating in South Kivu (25%). Over four-fifths of incidents involving armed groups occurred in South Kivu (81%) (Taback et al., 2008).

Heterogeneity between regions in the estimates for lifetime prevalence of SGBV and IPV in females also ranges considerably between regions and populations as highlighted below (Tables 1a-1c). In summary, the prevalence of physical and sexual violence were high among populations in the eastern DRC. The lifetime prevalence of SGBV in population-based samples ranged from 36-40% for sexual violence. The prevalence was even higher among clinic-based samples for which the lifetime estimate of sexual violence was 85%. The lifetime prevalence of IPV in population-based samples ranged from 9-31% for sexual violence and 40-96% for physical violence. The prevalence was also very high in Congolese refugees and refugees from other countries in east Africa.

Table 1a. Prevalence of SGBV among females in the DRC

Region	Sample	Age	SGBV/IPV	Type of Violence	Lifetime Prevalence Estimate	Citation
North Kivu, South Kivu & Ituri District	Population-based	Adult	SGBV	Sexual violence	40%	(Johnson et al., 2010)
North Kivu, South Kivu & Ituri District	Population-based	Adult	IPV	Physical violence	96%	(Johnson et al., 2010)
North Kivu, South Kivu & Ituri District	Population-based	Adult	IPV	Sexual violence	9%	(Johnson et al., 2010)
North & South Kivu	Population-based	Adult	IPV	Sexual violence	25%	(Babalola, Gill-Bailey, & Dodo, 2014)
North & South Kivu	Population-based	Adult	IPV	Physical violence	40%	(Babalola et al., 2014)
South Kivu	Convenience sample of women attending mobile health clinic	Adult	SGBV	Sexual violence	85%	(Kohli et al., 2012)
Goma	Population-based	Adult	SGBV	Sexual violence	36%	(Dossa, Zunzunegui, Hatem, & Fraser, 2014)
Ituri District	Convenience sample of secondary students	Adolescent	SGBV	Sexual violence	38%	(Verelst, De Schryver, De Haene, Broekaert, & Derluyn, 2014)
South Kivu & Ituri District	Population-based	Adult	IPV	Sexual violence	31%	(Johnson et al., 2010)
Democratic Republic of the Congo	Nationally representative	Adult	IPV	Physical, sexual or psychological	53-68%	(Kidman, Palermo, & Bertrand, 2015; Tlapek, 2014)

Table 1b. Prevalence of SGBV among female Congolese refugees

Current Residence	Sample	Age	SGBV/IPV	Type of Violence	Lifetime Prevalence Estimate	Citation
Kampala, Uganda	Random sample of registered refugees	Adult	SGBV	Physical violence	76%	(Morof et al., 2014)
Kampala, Uganda	Random sample of registered refugees	Adult	SGBV	Sexual violence	63%	(Morof et al., 2014)
Kampala, Uganda	Random sample of registered refugees	Adult	IPV	Physical violence	29%	(Morof et al., 2014)
Kampala, Uganda	Random sample of registered refugees	Adult	IPV	Sexual violence	37%	(Morof et al., 2014)
Lugufu Camp, Tanzania	Sample of refugees	Adult	SGBV	Sexual violence	10%	(Dahab, Spiegel, Njogu, & Schilperoord, 2013)

Table 1c. Prevalence of SGBV among refugees

Current Residence	Country of Origin	Sample	Age	SGBV/IPV	Type of Violence	Lifetime Prevalence Estimate	Citation
Tanzania	Burundi	Sample of refugees	Adult	SGBV	Sexual violence	22-27%	(Nduna & Goodyear, 1997)
Tanzania	<i>Mixed</i>	Sample of refugees	Adult	IPV		Highest rate of all refugee camps in Africa (5% of all persons aged 15-49)	(Spiegel, Schilperoord, & Dahab, 2014)

In Nyarugusu camp, a surveillance system has been implemented to monitor the prevalence of SGBV among residents. In about a 6-month period in 2014, over 200 SGBV incidents were reported (Norman & Niehuus, 2015). There has been little change in the estimated number of SGBV cases over time; however, staff in the camps believe that there has actually been a decline in incidence of SGBV as a result of awareness programs, but the willingness of women to report incidents has increased (Tankink et al., 2010). The most common form of SGBV was intimate partner violence. Regarding the type of violence, psychological/emotional violence is most common followed by rape. Incidents are generally reported to case management services and were commonly reported over one month after the incident had occurred; however this reporting period has begun to shorten as a result of recent efforts encouraging women to report SGBV within 0-3 days of the incident.

Risk Factors:

Previous research in refugees from the Great Lakes region (not Congolese) found that women over the age of 12 were most vulnerable to SGBV. Most cases were also perpetrated by refugees in camps as opposed to the country of origin (Nduna & Goodyear, 1997). Factors associated with IPV in Congolese women included women having an attitude of acceptance towards spousal violence, not being the only wife of their husband, not knowing their husband's marital status, having a partner that used alcohol, having a disability/mental illness, being an orphan, being a child of a single mother, being a single mother, disagreements over food and non-food items between a husband and wife, and changing gender relations in the camp with fewer men having the opportunity to provide for their family (Norman & Niehuus, 2015; Tankink et al., 2010; Tlapek, 2014; UN High Commissioner for Refugees, 2005). Sometimes women with mental illnesses are targeted for SGBV because there are superstitions that perpetrating SGBV on a disabled or mentally ill woman will bring the perpetrator wealth or cure them of HIV (Norman & Niehuus, 2015).

Socio-cultural considerations

Studied factors that influence perceptions and responses to SGBV in the DRC include gender, ethnicity, as well as exposure to and involvement in the conflict. A population-based survey of individuals residing in the North and South Kivu areas as well as the Ituri district described people living in these regions as primarily married, Christian, farmers/herders, literate (61%) and landowners (80%) (Johnson et al., 2010). While some generalizations may be made in terms of demographic profiles there are some important factors such as cultural norms and gender roles that may vary by region and have important implications for IPV.

Ethnicity

With approximately 250 ethnic groups, the DRC is very heterogeneous (Michalopoulos, 2014). This cultural heterogeneity needs to be kept in mind when considering generalizations on populations residing in the area. For example, a study comparing IPV in North and South Kivu identified important differences between contexts in terms of risk and correlates of IPV. The authors attribute these differences, in part, to the differences in ethnic composition in these two regions. North Kivu is comprised primarily of the Hunde, Nande and Congolese Hutu (Banyabwisha) ethnicity. On the other hand, South Kivu is comprised primarily of Bashi, Balega,

Bembe, Bafulero and Bavira ethnic groups. Both North and South Kivu also have a large proportion of Congolese Tutsi (Banyamasisi) persons residing in these regions (Babalola et al., 2014).

In Nyarugusu Camp, the majority of Congolese refugees are Bembe, an ethnic group primarily from the Eastern DRC. Unlike many other refugee settings, inter-ethnic conflict was not commonly reported in Nyarugusu until mid-2015 due to the predominance of this ethnic group and the relatively homogeneous ethnic composition of refugees in the camp (Tankink et al., 2010). This has changed since the influx of Burundian refugees in 2015

Gender Roles

Studies conducted in the DRC as well as in Nyarugusu found that gender is an important consideration for SGBV, particularly attitudes towards traditional patriarchal gender roles (Babalola, 2014; Dossa, Hatem, Zunzunegui, & Fraser, 2014; Norman & Niehuus, 2015). In a household survey in the eastern DRC, more egalitarian attitudes towards gender roles was associated with more acceptance of SGBV survivors (not specific to IPV) in Congolese communities (Babalola, 2014); however, patriarchal values are socialized at a young age and involve perceptions of men as being superior to women (Trenholm et al., 2011).

Men, particularly elderly men in Bembe culture which is the predominant Congolese ethnic group in Nyarugusu, are given all decision-making power for their families (Norman & Niehuus, 2015). Traditionally, females are perceived as community assets that are controlled by men in the community. This power asymmetry is highlighted by numerous traditional practices including bridewealth practices, forced and/ or early marriages, widow inheritance/care of widows by males and their family, paternal custody of children, and child compensation (*Fidia* in Kiswahili) to compensate or resolve disputes between families (Norman & Niehuus, 2015). A qualitative study with community leaders (government, hospital, Christian/religious, and judicial-focused NGO leaders) in Bukavu, South Kivu revealed that violence against women might be implicitly reinforced by hegemonic masculinity in eastern DRC. The leaders attributed the high prevalence of IPV to this structural issue (Trenholm et al., 2011). While the goal is often to increase connectedness and reintegration of SGBV survivors into their families and communities, researchers have noted that it is possible that reestablishing connections with a community that maintains traditional gender dynamics characterized by stigmatization and exclusion of SGBV survivors may not result in improved health outcomes for the survivors (Brian J. Hall et al., 2014).

Gender roles appear to be closely related to norms regarding sexuality and autonomy in various socio-cultural groups in the region. For example, *Lokonena* is a concept in Bembe culture that is related to extreme worry about the "destruction" of women and girls. This can occur through inter-ethnic marriages, the breakdown of communities, and sexual violence. Furthermore, due to more limited autonomy in females, the human rights notions may not overlap completely with existing legal norms across all cultural groups. In Bembe culture, rape refers more closely to the concept of *lokonena* or destruction as opposed to non-consensual sexual activity. *Lokonena* is seen as immoral if a woman who is unmarried and whose bridewealth has not

been paid is victimized or if a married woman is victimized. Given that a husband or father controls a female's sexuality, consensual sex with someone who is not her husband or has not paid bridewealth to the family can be perceived by the family as rape (Norman & Niehuus, 2015). Furthermore, understanding of rape has been shown to differ between men and women in the DRC. A survey among adolescents in South Kivu found that men felt entitled to sex with an intimate partner and thus forced sex was not considered rape. Whereas among females all forms of forced sex, including that perpetrated by an intimate partner, was classified as rape (Mulumeoderhwa & Harris, 2015).

In Nyarugusu, structural constraints, such as the inability to participate in livelihood activities, restrictions placed on leaving the camp, and policies surrounding the distribution of food and other goods, led to additional vulnerabilities that may increase risk for SGBV in the refugee camp. The Refugee Act of 1998 was enacted by the Tanzania government and placed restrictions on employment, residence and movement of refugees. In 2011, livelihood activities (e.g. agriculture) were banned. These structural restrictions have made operations within the camp increasingly dependent on humanitarian assistance. When considering IPV within Nyarugusu it is important to recognize the structural factors that have altered cultural gender norms. Men are traditionally expected to be the breadwinner, but the restrictions on employment, self-sufficiency and independence within the camp have made it difficult, in some cases impossible, for men to fulfill these traditional roles. This perceived failure results in shame, anger and violence for some men (Norman & Niehuus, 2015).

Another study conducted in Nyarugusu camp identified additional risk factors and vulnerabilities for sexual violence specifically among adolescent girls that should be considered when designing programs to reduce sexual violence in this setting. Reports of teachers requesting sexual favors from girls in exchange for grades, physical/sexual abuse by authority figures, exchange of sexual acts for basic needs/services (e.g. food, money) were reported. Also, gender-based violence resources and services are generally not made available to adolescent females and typically are targeting adults, making it difficult for adolescents to access these services (Paik, 2012).

Combat History

Norms and values around SGBV may also have been influenced by the persistent violence and other consequences related to the conflict. Approximately one-fifth of North Kivu, South Kivu and Ituri district residents have served as combatants during their lifetimes, many of which were coerced by threats from the armed group directed towards them or their family (Johnson et al., 2010). Researchers have posited that this high degree of exposure and direct involvement in the conflict may have contributed to SGBV becoming normative for many men in eastern DRC, especially among those who grew up during the conflict (Kelly et al., 2012; Leatherman, 2013).

Socio-cultural considerations specific to research and intervention

Norms and values concerning SGBV have implications for research. Previous studies working with Congolese populations affected by SGBV have identified components of recruitment, the

composition of the research team, informed consent, data collection and measurement that may require additional considerations.

Recruitment: With regard to recruitment, researchers conducting a qualitative study that included Congolese female survivors of SGBV in Goma emphasized the importance of increased confidentiality protection to avoid further stigmatization of these women. Thus, the researchers did not include information in their recruitment message or materials that spoke directly about SGBV. This recruitment message was also passed through the community not by the researchers, but rather by community members, in this case literacy session leaders (Dossa, Hatem, et al., 2014; Dossa, Zunzunegui, et al., 2014). Additionally, researchers have emphasized the importance of cultivating partnerships with community leaders and organizations and engaging these stakeholders in a participatory research process (Glass, Ramazani, Tosha, Mpanano, & Cinyabuguma, 2012).

Composition of research team: The participatory research process often involves the inclusion of trained, local research assistants. Training for research assistants includes topics such as data collection methods, sampling, responsible conduct of research, informed consent, considerations when interviewing on sensitive topics, confidentiality, and supporting participants if they become distressed during an interview. Training was also supplemented with field supervision (Glass et al., 2012; Johnson et al., 2010). Given the importance of gender roles, it may be important to consider matching participants with researchers of the same sex to minimize differential vulnerabilities due to gender norms, however studies have done both (matched and not matched on sex) (Johnson et al., 2010; Kelly et al., 2012). Additionally, several studies explicitly described or mentioned the selection of the data collection site. Sites for interviews/data collection were selected based upon convenience, safety and privacy (Dossa, Hatem, et al., 2014; Dossa, Zunzunegui, et al., 2014; Glass et al., 2012). Additionally, one study (two articles) used a local literacy center as the data collection site (Dossa, Hatem, et al., 2014; Dossa, Zunzunegui, et al., 2014). Whether this was done for convenience or to protect the participants and not protect reveal their history of SGBV through their association with a study/clinic/particular site, was not explicitly described.

Informed consent and language: One study described using verbal and written informed consent (Trenholm et al., 2011), while another only included verbal consent (Morof et al., 2014). Most studies translated questionnaires and/or used interpreters to translate interviews into one or more of the following languages: French, Swahili, Lingala, Lari, Kiswahili and/or Mashi/Mushi; (Dossa, Hatem, et al., 2014; Dossa, Zunzunegui, et al., 2014; Johnson et al., 2010; Kelly, Betancourt, Mukwege, Lipton, & Vanrooyen, 2011; Kelly et al., 2012; Mutima, 2014; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013; Trenholm et al., 2011; Verelst, De Schryver, Broekaert, & Derluyn, 2014; Zihindula & Maharaj, 2015). Related to proper translation, one study found that the terminology used to describe SGBV is important. For example, rape and non-consensual sexual experience have very different meanings to participants. For example, SGBV survivors labeling the experience as rape reported elevated levels of daily stressors, stigma, and stressful war-related events (Verelst, De Schryver, Broekaert, et al., 2014).

A randomized controlled trial conducted by O'Callaghan and colleagues evaluated the efficacy of a mental health intervention for female adolescent survivors of SGBV in the DRC. The intervention was a 15-session manualized trauma-focused cognitive behavioral therapy (TF-CBT) intervention that was culturally modified by the authors. Cultural modifications included having the female facilitator discuss strategies to reduce one's risk of future SGBV, integrating familiar games/songs/examples into the intervention, and having a social worker visit the participant's guardian in effort to reduce rejection and stigmatization of the participant (O'Callaghan et al., 2013).

Community participation: It is critical that researchers involve female community members in the planning and implementation of programs and research related to SGBV and share decision-making power (Nduna & Goodyear, 1997).

Consequences of SGBV

Individual-level consequences

Physical, psychological and social consequences of SGBV have been documented at the individual level in multiple studies. Among SGBV survivors, over 83% contracted diseases and over 26% became pregnant as a result of SGBV (Mutima, 2014). Similarly, many SGBV survivors report contracting HIV through SGBV (El-Bushra; Zihindula & Maharaj, 2015). The high prevalence of these biological consequences highlights the general brutality of SGBV acts. Furthermore, SGBV experiences often involved multiple perpetrators (Zihindula & Maharaj, 2015).

Psychologically, SGBV survivors reported feeling as though they had lost their identity during the SGBV attack. Survivors were often blamed for SGBV, which had immediate psychological and social implications. One of the most common consequences was family and community abandonment (discussed in more detail in sections to follow). At the individual-level this resulted in additional pressures and consequences for the survivor because often the husband or family would relinquish all responsibilities, which were then deferred to the survivor. For example, one study reported that survivors were given all responsibilities related to caretaking for children, paying school fees/other expenses, etc. after the attack. Among unmarried women, SGBV survivors generally felt as though their marriage prospects were diminished due to their SGBV history (Zihindula & Maharaj, 2015). In addition, many survivors blamed themselves for SGBV, an attitude that stifled their recovery (Kelly et al., 2012).

Family-level consequences

At the familial level, the most commonly referenced consequence of SGBV involved abandonment and/or rejection of the SGBV survivor due to perceived contamination (Kohli et al., 2013). Among SGBV survivors, approximately 29-31% have reported familial rejection (Kelly et al., 2011; Kohli et al., 2014). Specific aspects of SGBV were more likely to result in familial

rejection. For example, compared to SGBV survivors whose SGBV experience did not directly occur in the context of the conflict, women who experienced conflict-related SGBV had a 17.6-fold increased odds of being abandoned by ones husband (Dossa, Zunzunegui, et al., 2014). Also, women that had a child as a result of SGBV were over four times as likely to be rejected by and more than twice as likely to be forced apart from their family (Hilson, 2013).

The most common reasons for familial abandonment included fear of disease, local norms, having a child resulting from SGBV, a perceived decrease in the survivor's worth, pressure from the community/extended family to abandon the survivor, seeing the survivor as a burden to the family, fear of rebels returning and their association with the survivor, strained communication between the survivor and their family, economic losses, family members witnessing SGBV, and the women surviving more than one perpetrator or SGBV experience (Glass et al., 2012; Kelly et al., 2012; Kohli et al., 2013). Experiencing more types of trauma, violence to others and bodily injury trauma was also associated with increased odds of family rejection (Kohli et al., 2014).

Community-level consequences

SGBV epidemics related to the conflict have had a detrimental effect on communities in the DRC by intentionally destroying social fabrics of communities. The high prevalence of SGBV in the DRC has indeed had a profound effect on the broader community in addition to survivors and their families (Trenholm et al., 2011). One study documented that in situations where community members tried to intervene during an SGBV attack, they too were subject to humiliation and increased risk of harm (Zihindula & Maharaj, 2015). More often, however, community-level consequences relate more strongly to intra-community disruption of social cohesion as opposed to external consequences.

Community rejection has been associated with norms, rules, beliefs, ideas and values that blame the SGBV survivor. In patriarchal societies that consider sexuality a taboo topic, female survivors of SGBV are often suppressed and blamed for violating cultural norms. Furthermore, patriarchal societies may consider wives to be part of the property of their husbands. Failure of a husband to protect his wife from SGBV perpetrators can be humiliating for the husband and blaming the woman often becomes the best strategy to preserve his dignity within the community (Dossa, Hatem, et al., 2014; Kelly et al., 2012). Community stigmatization was reported by SGBV survivors and was generally referred to as gossip or 'finger-pointing' (*kushota kidole* in Kiswahili), which survivors found incredibly humiliating (Kelly et al., 2011; Kelly et al., 2012). Among SGBV survivors, 6-8% reported being rejected or stigmatized by their community (Johnson et al., 2010; Kelly et al., 2011). There was also pressure placed on family members by the community to reject the SGBV survivor. Otherwise, the family was at risk for stigmatization by the community (Kohli et al., 2014).

Some community members recognize that the survivor is not to blame, but such attitudes exist and are often the foundation for negative community responses, stigma and rejection (Kelly et al., 2012). Identifying the community attitudes toward SGBV survivors that may explain rejection has been a common theme in the literature. A factor analysis conducted from a household survey of adults in the eastern DRC identified four factors: victim responsibility,

victim denigration/shame, victim credibility and victim deservingness (Babalola, 2014). Adults that were employed, had more egalitarian attitudes towards gender roles, did not believe that SGBV was prevalent in their community, and were aware about SGBV resources in their community were less likely to endorse the aforementioned negative attitudes about SGBV (Babalola, 2014).

Risk factors for community rejection include being widowed, familial abandonment, experiencing gang rape, and having a child as a result of SGBV (Kelly et al., 2011; Kelly et al., 2012). Similar to familial rejection, common reasons for community rejection were fear of infectious disease, reproductive health problems and a devaluation of the survivor's "worth" post-SGBV (Glass et al., 2012; Kelly et al., 2011; Trenholm et al., 2011).

Mental Health

In prior qualitative research in Nyarugusu and other refugee camps in the Great Lakes region, focus groups discussions have included conversations about mental disorders and identified psychotic disorder, epilepsy and mental retardation as categories that were spontaneously reported when participants were asked to describe mental disorders in the refugee camp. Common mental disorders, such as depression, trauma-related problems and substance use, were mentioned less frequently and not spontaneously. Table 2 describes some of the common symptoms, etiological theories, idioms and treatment strategies by type of disorder described in the interviews conducted with Congolese refugees in Bembe (Tanzania refugee camps), Swahili (Tanzania and Burundi refugee camps) and Kirundi (Tanzania and Burundi refugee camp) (Tankink et al., 2010).

A 2013 survey of mental illness and disability identified 203 registered cases of mental illness in Nyarugusu Camp, most of which were classified as having psychotic conditions (43.3%) followed by depression (38.4%), schizophrenia (17.2%), and other/unknown conditions (1.1%) (Lendaiga, 2013). Many individuals have comorbid mental disorders, but the primary diagnosis is what is included in records and the comorbid conditions are disregarded in this registry. Thus, these proportions describe the prevalence of primary diagnoses in the population. Primary risk factors for these disorders include substance abuse, sexual violence and other forms of trauma/abuse exposures. With regard to sexual violence, the associated psychological trauma is attributed with precipitating mental disorder. For mentally ill patients in Nyarugusu, some of the reported challenges they face include dependence on family members and other support systems to perform activities of daily living, increasing the burden on their families, increasingly poor hygienic conditions due to an inability to look after themselves, disorientation and unsupervised movement that can increase risk for abuse, risk of SGBV and related consequences, discrimination and neglect by the family and community, lack of opportunity to participate in camp activities and programs, poor adherence to medical treatment, substance misuse and cultural stigmatization related to help-seeking (Lendaiga, 2013).

Research in internally displaced Congolese women, not specifically those that had experienced SGBV, reported difficulties with coping among women experiencing mental health problems.

More specifically, the women that reported symptoms of depression, anxiety and post-traumatic stress were more likely to endorse the following maladaptive coping styles: inactive coping, suppression, lack of planning, behavioral disengagement, denial, mental disengagement, lack of emotional and instrumental support, venting, restraint, acceptance and a lack of positive reinterpretation (Nemiro, 2015).

Table 2. A description of mental health problems in Tanzanian refugee camps (Tankink et al., 2010)

Mental Health Problem	Symptoms	Etiological Theories	Idioms	Treatment Strategies
Severe Mental Disorders	Severe behavioral problems, withdrawal, self-neglect, communication problems		Bembe: mshile ('crazy'), mwenye kuchanganyikiwa ('totally confused') Swahili: kicha, payu Kirundi: Umusazi	None identified
Psychosis	Talking to oneself, saying things that aren't true			
Epilepsy	Falling unconsciously, convulsions, excess saliva and urine loss	Contagious or caused by poisoning	Bembe: efuele Swahili: Kifafa Kirundi: intandara	No medication available. Treatment sought from health centers or traditional healers
Learning Disabilities	Leave camp without permission, talk nonsense		Swahili: Kiwelewele, Zuzu Kirundi: Igikehabwenge	Community services include a mental retardation intervention
Depression	Cry all the time, feel their head is heavy		Bembe: miwaci wa malenga ('thinking too much') Swahili: Upweke Kirundi: Akabonge, agahinda	
Psychotrauma	[Not mentioned]		Swahili: Kupagawa Kirundi: Guhahamuka	
Alcohol and Substance Use	Behavioral problems	Not seen as a disorder, but a consequence of other problems	Swahili: Mievi Kirundi: Imborerwa, umunywarumogi	

Mental health and SGBV

In population-based surveys of Congolese adult females in the Eastern DRC, the estimated prevalence of mental health problems (i.e. major depressive disorder, post-traumatic stress disorder, suicidal ideation and lifetime attempts, and current substance misuse) according to self-report questionnaires (not clinical diagnosis) were high (ranging from 17% reporting a lifetime suicide attempt to 54% reporting past-month post-traumatic stress disorder). Adults with a history of sexual violence (male and female), particularly females with a history of conflict-related sexual violence, had a higher prevalence of depressive disorder, PTSD, and

suicidal ideation and attempts relative to adults with no history of sexual violence. With regard to IPV specifically, the estimated prevalence of past-year major depressive disorder, past-month PTSD, past-year suicidal ideation and lifetime suicide attempt was significantly higher among adult females with a history of IPV relative to adult females without a history of IPV (Johnson et al., 2010). These results were consistent with another study that found psychological distress and symptomatology to be higher among SGBV survivors compared to women without a history of SGBV, particularly a history of conflict-related SGBV (Dossa, Zunzunegui, et al., 2014).

The majority of research on SGBV and mental health has focused almost exclusively on PTSD in conflict-related rape survivors. The prevalence of PTSD among female survivors of SGBV ranges from approximately 70-89% (Johnson et al., 2010; Morof et al., 2014; Mutima, 2014; Schalinski, Elbert, & Schauer, 2011). Most met all criteria for PTSD: re-experiencing, avoidance, hyperarousal, and significant distress/functional impairment (Mutima, 2014). Furthermore, severity of PTSD symptomatology was generally high and was found to be associated with shutdown dissociation, considering rape as the only form of SGBV, having more daily stressors, reporting stigmatization and number of traumatic events (Schalinski et al., 2011; Verelst, De Schryver, De Haene, et al., 2014). A factor analysis assessing the PTSD construct in a sample of adult females with a history of SGBV using 16 items from the Harvard Trauma Questionnaire found the data supported a 4-factor model that was comprised of effortful avoidance, arousal, numbing and intrusion factors (Michalopoulos, 2014). PTSD was also found to often present with comorbid conditions such as depression and other anxiety disorders (Schalinski et al., 2011).

One study conducted by health care providers (not mental health specialists) working in a mobile health clinic in the DRC documented the mental health symptoms they observed in their patients. Symptoms related to anxiety, depression and stress/post-traumatic stress were common in patients that had experienced SGBV (Figure 1).

Figure 1. Proportion of SGBV patients at a mobile health clinic reporting anxiety, depression and stress-related symptoms (Kohli et al., 2012)



Several studies also report on risk factors, mediators and moderators of the relationship between SGBV and psychological symptoms. Social support and family dynamics were frequently referenced throughout these studies. Generally, familial social support was associated with reduced PTSD symptoms severity (Mutima, 2014). Conversely, women who were rejected by their family after SGBV were more likely to report symptoms of depression and post-traumatic stress relative to women who were not rejected by their family (Hilson, 2013; Kohli et al., 2014); however, the relationship between SGBV and post-traumatic stress symptoms was greater in magnitude relative to the association between family rejection and post-traumatic stress symptoms (Kohli et al., 2014). Interestingly, talking to other women who have had similar SGBV experiences, a coping strategy anticipated to have a beneficial effect on mental health, actually moderated the relationship between SGBV and mental health status in the unexpected direction. More specifically, women who had been rejected by their family and frequently talked to their peers presented with more severe post-traumatic stress and distress symptoms relative to individuals that had been rejected by their family, but did not frequently talk to their peers about these issues (Hilson, 2013).

Stigma was investigated as a mediating variable by Verelst and colleagues. In this study, the researchers found that stigma largely mediated the relationship between SGBV and mental health outcomes, particularly for depression and PTSD. More specifically, stigma was a full mediator of the relationship between SGBV and depression. Moreover, stigma was a full mediator of the relationship between SGBV and both the avoidance PTSD subscale and the total PTSD score. Stigma was a partial mediator of the relationship between SGBV and hyper-arousal. Stigma did not appear to mediate the relationship between SGBV and anxiety or symptoms of intrusion (Verelst, De Schryver, De Haene, et al., 2014).

Two open-ended qualitative studies also described consequences of SGBV experience(s) for mental health. In these studies, women described their life to be characterized by difficulties, oppression, worries, sadness, feelings of worthlessness, hopelessness, powerlessness and fatalism (Dossa, Hatem, et al., 2014; Zihindula & Maharaj, 2015). Feelings of hopelessness and powerlessness were prevalent among women that had become HIV-positive as a result of SGBV. They described their serostatus as a death sentence and were very worried about the consequences of having this information revealed to members in the community (Zihindula & Maharaj, 2015). Many women described experiences similar to post-traumatic stress symptomatology such as persistent nightmares and re-experiencing SGBV years after it had occurred. Participants also described the stigma and structural pressures apparent throughout the community. One common strategy to avoid humiliation and gossip throughout the community, which often precipitated re-experiencing SGBV, was to isolate oneself. The participants also explained that when SGBV resulted in pregnancy, it often precipitated or exacerbated suicidal ideation (Dossa, Hatem, et al., 2014).

Mental health interventions

Despite the high prevalence of mental health problems in Congolese affected by the conflict, services in the health system are scarce (Integrated Regional Information Networks (IRIN), 2016). Several interventions intended to improve mental health and wellbeing among female

survivors of sexual violence in the eastern DRC have been tested and evaluated, including cognitive processing therapy, psychosocial assistance, and trauma-focused cognitive behavioral therapy. Interventions evaluated using a randomized controlled trial included cognitive processing therapy (CPT) and trauma-focused cognitive behavioral therapy (TF-CBT).

More specifically, the CPT intervention was used to assess the efficacy of group CPT in 405 rape survivors (also included females that witnessed rape) for reducing psychiatric symptoms and functional impairment. In this cluster randomized controlled trial, the control group received individual support. The researchers measured mean changes in depression and anxiety symptoms, PTSD symptoms and functional impairment between study conditions at baseline, 1-month post-treatment and 6-months post-treatment. Results of this study showed significant reductions in depressive symptoms, anxiety symptoms, PTSD symptoms and functional impairment for both the intervention and comparison conditions, however the mean reductions in the intervention condition were significantly larger. The researchers adapted the CPT intervention to only include cognitive portions of the manualized therapy. Thus, they omitted the trauma narrative (exposure) portion of CPT, but the intervention was shown to be effective with comparable effect sizes to exposure-based CPT in other settings. The rationale for doing so was to reduce barriers to administration in group therapy and to improve participant retention. Also, the researchers concluded that while a large proportion of the sample was illiterate and the intervention was delivered during a period of conflict, implementing this program was still feasible and effective (Bass et al., 2013). It is noteworthy that this conclusion reflects the opinions of the researchers, not necessarily the implementing partner that was responsible for integrating the program once the trial had been completed. A subsequent study using data from this trial also found that the CPT group showed significant improvements in group therapy membership, participation, support network size, and emotional support seeking during treatment and at 1-month follow-up. However, support seeking improvements were not maintained at 6-months post-treatment (B. J. Hall et al., 2014).

The TF-CBT among girls aged 12-17 exposed to SGBV in the DRC was evaluated using a randomized controlled trial with a wait-list control and a 3-month follow-up period. In this study, SGBV was defined as rape or sexual abuse/inappropriate sexual touch. The intervention was delivered by nonclinical facilitators and was intended to reduce post-traumatic stress, depression, anxiety and conduct problems. The intervention also sought to improve pro-social behaviors in the sample. Results from this study revealed that TF-CBT was associated with a significantly greater reduction in trauma symptoms, depression, anxiety and conduct problems as well as increases in pro-social behaviors (O'Callaghan et al., 2013). A later study also conducted by O'Callaghan and colleagues (2015) sought to compare the efficacy of TF-CBT to an intervention that was not trauma-focused. In this study, Congolese youth ages 12-17, many of whom had experienced various forms of SGBV, were randomized to receive TF-CBT, a non-trauma-focused psychosocial intervention (child friendly space, CFS) or were assigned to the control condition. Both the TF-CBT and CFS group experienced significant declines in post-traumatic stress symptoms, internalizing symptoms and conduct problems during the follow-up period. After the intervention was complete, the CFS group showed significant declines in pro-social behavior (O'Callaghan, McMullen, Shannon, & Rafferty, 2015).

Staff members of 18 community-based organizations in South Kivu delivered an intervention to SGBV survivors titled the Malteser psychosocial support program. SGBV survivors were referred to the program from other organizations or by word of mouth. The intervention consisted of individual and group counseling, medical care, psychosocial support (including home mediation visits and individual/group counseling), awareness campaigns, and family mediation and home visits. The awareness campaign provided information to women regarding how to find medical and psychological care for SGBV-related problems. The program also contained a prevention component aimed at reducing the incidence of SGBV through education. More specifically, the prevention component aimed to reduce stigma and re-integrate SGBV survivors into communities and their families. The program also aimed to alter norms and perceptions of SGBV by spreading messages related to victim-blaming and infectious disease transmission/treatment. Much of this information was delivered to the community through the radio and newspaper as well as community leaders. A basic evaluation (no control group) of this program found that the prevalence of SGBV survivor rejection/abandonment decreased from 12.5% in 2005 to 6% in 2006 and 2007 (Steiner et al., 2009).

In a cross-sectional study conducted in Goma, SGBV survivors described three interventions that they felt were essential for recovery from SGBV-related consequences: financial assistance, psychosocial assistance, medical assistance, helping to pay for a home, and an awareness campaign to promote the acceptance of children born to SGBV survivors (Dossa, Hatem, et al., 2014).

In an opinion piece, Watts and colleagues warn against excluding survivors of non-conflict SGBV (e.g. IPV) from mental health interventions. The authors discuss the social and cultural aspects of mental health that can influence the acceptability and effectiveness of interventions for different populations and groups within a population. They caution against making targeting of interventions too specific such that it could distress or stigmatize people who may already feel marginalized (Watts, Hossain, & Zimmerman, 2013). This perspective is reinforced in gender-based violence intervention guidelines for humanitarian settings, which also recommend integrating IPV survivors into SGBV programs (Inter-Agency Standing Committee, 2015a).

Barriers to mental health interventions

A common problem presented in the literature was the delay in seeking treatment services after SGBV has occurred. For example, in a sample of SGBV survivors, 45% of women waited over a year to seek SGBV services and only 4% received services within 72 hours of the attack (Kelly et al., 2011). The average time to treatment-seeking was 10.4 months (Bartels et al., 2012). The reason for this delay was only partially due to limited access and logistical barriers (Kelly et al., 2011). Other reasons cited for not obtaining mental health support for SGBV-related problems in a sample of adults in eastern DRC include fear of disclosure, shame, concern that service providers aren't sensitized to SGBV, and participant's not being aware of available services. The participants that were familiar with the mental health services that were available reported that the quality of these services was quite poor (Bartels et al., 2012; Scott et al., 2013).

Furthermore, some interventions focus on making health care practices more sensitive and relevant to SGBV survivors. Such interventions usually focus on the attitudes and competencies of health care staff. For example, Smith and colleagues aimed to reduce negative attitudes (e.g. victim-blaming, questioning victim credibility) through their program, Clinical Care for Sexual Assault Survivors (CCSAS). CCSAS training was offered to healthcare providers in several humanitarian settings, including South Kivu, DRC. Evaluation of this training intervention showed no reduction in such attitudes, but did show an increase in respect for patient's autonomy and non-discrimination. Health care providers also reported increased confidence in the provision of clinical care to SGBV providers. This intervention was rather comprehensive and included training in reproductive and emergency health care in addition to psychosocial support. Results indicated improvements in reproductive and gynecological health care, but psychosocial referrals did not improve post-intervention (Smith et al., 2013).

In a sample of refugee and asylum seekers in Uganda, most of whom had experienced SGBV, 31% of women reported seeking mental health counseling while in Uganda. Among those that did not, many did not know where to access these services (72.9%) or identified language/ethnicity barriers (42%). Approximately 17% cited financial barriers. Only 8% of this sample felt they did not need counseling (Morof et al., 2014). A case report written by a former refugee residing in Nyarugusu reported that she received training in psychosocial work by UNHCR and HealthNet TPO. These trainings taught her to organize support groups, provide individual counseling and mobilize community members (Penge, 2012).

Currently, the International Rescue Committee (IRC) has reported to hold awareness events that target harmful traditional practices and provide community trainings on the types of actions and behaviors that constitute SGBV as part of their protection programming in the Nyarugusu refugee camp. SGBV survivors are encouraged to report any incidents at IRC support centers. Psychosocial counseling, non-food items, legal counseling and other supports are provided through this center or referrals are made (Norman & Niehuus, 2015). Reference Appendix A for a description of the services provided to SGBV survivors through these centers. With regard to persons with mental health concerns, in May of 2016 the IRC brought on a dedicated MHPSS team in Nyarugusu to improve the management of care for persons with mental, neurological, substance use and SGBV-related problems across health, education and protection. The IRC MHPSS team provides focused non-specialized support by facilitating group and individual counselling sessions coupled with case management services for women, men, girls, and boys in existing IRC structures, focusing on healing education, psychoeducation, psychosocial well-being, and increasing functionality. In addition, the IRC MHPSS team facilitates community-based support networks and form peer support groups aimed at addressing local mental health needs, promoting wellness, addressing issues of division/conflict and reducing stigma against mental health issues. This strategy coordinates services provided through the IRC, Tanzania Red Cross Society (TRCS), and UNHCR. IRC Tanzania has identified several areas that need to be prioritized to improve the case of persons with mental health concerns in Nyarugusu. These include building capacity of the formal and informal support and treatment systems, improving the structure of the mental health system through the

strengthening of referral networks and case monitoring practices, the provision of materials (including shelter) to improve safety and reduce caregiver burden, increasing access to legal services for SGBV cases and increasing access to psychosocial and livelihood programs.

Existing resources

In Nyarugusu, the traditional way to deal with IPV specifically, is for the wife to approach the mother-in-law who tries to mediate the situation by counseling with the husband. If this doesn't work, more families are pulled into the situation to attempt to halt the IPV. External SGBV programming (e.g. IRC programs) is perceived as supplementary to these traditional family-based strategies (Norman & Niehuus, 2015). Community leaders (e.g. priests, chiefs) also conduct family mediation in cases of SGBV-related abandonment. Mediation mostly occurred when the family was in need of additional supports such as shelter or help with their children. Mediation included 5 components: (1) having an initial discussion with the abandoned survivor about the problem, (2) repeated meetings with family members that abandoned the survivor, (3) involving additional influential family or community members in meetings, (4) discussing SGBV with the family as a means to attempt stigma reduction, and (5) follow-up meetings that may often include support services to address stressors within the family that may be exacerbating the tensions between the survivor and her family (Kohli et al., 2013). Divorce is culturally unacceptable and thus many women will endure abusive relationships because they believed it was their fate. Some women will leave their home for a short time, but divorce is generally not a culturally acceptable option (Tankink et al., 2010).

In addition to the family and community supports, humanitarian agencies have made available protection services in Nyarugusu Camp to prevent and address SGBV. These services are provided by a variety of stakeholders. In 1996 UNHCR developed a Sexual and Gender Based Programme in collaboration with other agencies that implemented awareness campaigns and trainings on human rights to reduce the incidence of SGBV. This program also involved policy changes such as increasing the proportion of women on food committees and involving women in camp management and leadership. To respond to existing cases of SGBV, the Sexual and Gender Based Programme also established drop-in centers for women where they could seek confidential care (UN High Commissioner for Refugees, 2005).

Since this initial program, SGBV units have been developed to provide services related to peace education, reproductive health, gender, human rights and girls' education. This unit also operates the men's association, which is purposed to increase awareness among men about gender, human rights and the impact of IPV on women; however, this program has been challenging due to resistance and hostility from other male members of the community. Professionals and volunteers, most of whom are refugees, staff these SGBV units. The general protocol for managing an SGBV case is first to accompany the refugee to a health center for medical assessment and treatment, including psychological assistance. The staff member then encourages the refugee to report the incident to the police and helps connect them with community services (Tankink et al., 2010). NGOs have also provided services for women affected by SGBV (e.g. counseling) and implemented SGBV community awareness programs (Norman & Niehuus, 2015). A challenge has been introducing new programs while being sensitive to traditional ways of handling cases of SGBV (Dick, 2002).

Reintegration of SGBV survivors has been a challenge due to the pervasive norms and perceptions of the family and community that devalue the survivor. As part of the reintegration process, an SGBV survivor is expected to contribute productively to her family/ community as a way to regain her “worth”. This notion has led researchers to integrate economic and livelihood components to reintegration interventions such that these interventions may equip survivors with skills and resources that will be valued by the family/community (Glass et al., 2012; Kelly et al., 2012). Successful reintegration of SGBV survivors is generally reported to be a positive experience; however, persistent challenges included having a child as a result of SGBV, the husband remarrying, issues with extended family members, or economic problems for the family related to SGBV (Kohli et al., 2013). Receiving support from the family was protective against some of the community-level consequences of SGBV such as social isolation and feelings of shame (Kelly et al., 2011).

The justice system is another resource for SGBV survivors in terms of reconciliation, reintegration and support services for survivors. In the past, UNHCR and partner NGOs trained legal staff to become SGBV counselors for women (UN High Commissioner for Refugees, 2005). However, there appear to be conflicting attitudes regarding the trustworthiness and perceived effectiveness of the justice system and law enforcement (Kelly et al., 2012; Norman & Niehuus, 2015; Penge, 2012; Scott et al., 2013). NGOs often serve as the liaison between women and the justice system (Norman & Niehuus, 2015). In a mixed methods study of adults in the DRC, most respondents agreed that perpetrators should be punished and that survivors should be compensated. In this study, most respondents favored the legal system over community mediation to obtain justice for SGBV (61% of SGBV survivors reported being forced to accept community mediation) (Scott et al., 2013). Resources and stakeholders that can be accessed by SGBV survivors seeking justice include local authorities/ police, local community officials (e.g. village chiefs) and, to a lesser extent, NGOs. Legal services include prosecution courts, peace tribunals and other processes implemented by community officials or local NGOs (Scott et al., 2013).

While it is important to provide resources to SGBV survivors, it is also necessary to investigate and anticipate unintended consequences of SGBV programming. A qualitative study in a Rwandan refugee camp found that there is a hierarchy in the type of services SGBV survivors seek such that only severe, chronic SGBV survivors seek services from UNHCR and the formal system. Additionally, SGBV services that are in contrast to traditional practices may create tension in the community and, in some cases, men in the community have developed a mistrust for agencies that provide these services (Horn, 2010).

Recommendations

Recommendations in identified studies

In many of the identified articles, particularly those employing qualitative methods, the participants made recommendations regarding SGBV prevention and response. It needs to be kept in mind that these recommendations were generally related to sexual violence (rape) and

may not always be similarly relevant to IPV, the focus of this desk review. Four consistent themes emerged: (1) the importance of policy-level changes and protection efforts, (2) the need for psychosocial and livelihood support services, (3) reintegration, and (4) infectious disease management.

More specifically, participants in one study stated that in order for them to feel safer and more secure about their future, it is important that stakeholders focus on ending the current conflict. Also, participants recommended that the government develop new laws or improve enforcement of existing laws that protect SGBV survivors and prevent further perpetration (e.g. through punishing perpetrators) (Scott et al., 2013).

Participants from several studies emphasized the importance of livelihood assistance and psychosocial support. They recommended economic/employment interventions that would support self-sufficiency and contributions to the community from SGBV survivors and social services. Some of the social services repeatedly requested by participants included subsidizing tuition fees for students, housing, clothing, as well as psychological and medical services (Kelly et al., 2011; Kelly et al., 2012; Kohli et al., 2012; Scott et al., 2013). Women also believed that community educational and awareness campaigns would support re-integration. Some participants believed that marriage/family counseling would be beneficial (Kelly et al., 2011). One repeated reason provided for rejecting SGBV survivors at the family and community level is the assumption that SGBV survivors are contaminated. Several participants requested HIV and STI testing that they could share with family members as evidence of “non-contamination” (Kelly et al., 2011; Kelly et al., 2012).

Other conclusions and recommendations

1. IPV is a pervasive issue that has not received great attention

Significant attention has followed the large scale rape of women which has been a systematic aspect of the war in the DRC. This is reflected in the reports and articles we identified for this desk review: the far majority focused on rape survivors. The attention for SGBV in the context of the war in the DRC does not seem to have been generalized to include attention for IPV. According to data collected in Nyarugusu camp, IPV was the most common type of SGBV (200 cases over 6 months) as has been observed more generally in conflict-affected populations (Stark & Ager, 2011).

2. High levels of mental health and psychosocial problems are identified in SGBV survivors

As expected, high levels of psychological distress and mental disorders have been identified in studies. These include depression, posttraumatic stress disorder, anxiety, and suicidal ideation. PTSD has been the most studied consequence, with high levels identified in most studies. Factor analysis suggests the 4-factor model hypothesized factor structure of PTSD fits experiences in Congolese women. A qualitative study similarly brought up PTSD-like symptoms. Individual emotional experiences are closely tied to social consequences, with women experiencing abandonment, stigma, blame, family tensions and rejection. Given these social consequences and the nature of SGBV it is not surprising that shame and embarrassment were commonly reported. In addition, SGBV survivors experience high levels of physical

consequences (injuries, diseases) that are important in conceptualizing mental health and IPV interventions.

3. Socio-cultural considerations are critical

Issues related to gender, ethnicity, patriarchal values, and the potential normalization of violence against women have been emphasized by studies as being essential to understand SGBV broadly, and IPV specifically in the context of the war in the DRC. Any mental health and IPV programming will have to carefully consider these aspects. In the Nyarugusu refugee camp structural restrictions on movement and employment have impacted gender roles and are additional key considerations. Livelihood opportunities are repeatedly mentioned as being an important component of supporting SGBV survivors.

4. Issues related to self-blame and stigma are highly relevant

These are critical issues not only in limiting access to mental health services, but have also been noted to be critical barriers in recovery from mental health concerns. For instance, a study identified stigma to be a mediator between SGBV experiences and subsequent hyperarousal symptoms. . Efforts to address stigma in SGBV survivors will need to address family and community stigma (including of health workers), as well as stigma directed by women towards themselves after internalizing cultural values regarding experiences of SGBV (e.g. through psychological intervention).

5. Mental health interventions and tested research instruments are available

Two randomized controlled trials have tested cognitive behavioral treatment approaches for rape survivors and found these to be effective in reducing psychological difficulties. A range of mental health measures have been applied that future studies can build on, and these are detailed in Appendix A.

Appendix A: Measures

Construct	Measure	Citation
Attitudes Toward SGBV	The Attitudes Toward Rape Victims Scale (ARVS; adapted)	(Babalola, 2014)
Anxiety	Hopkins Symptom Checklist (HSCL-25; adapted)	(Bass et al., 2013; Hall et al., 2014; Hilson, 2013; Verelst, De Schryver, Broekaert, et al., 2014; Verelsty, De Schryver, De Haene et al., 2014)
	Hopkins Symptom Checklist (HSCL-37)	(Verelst, De Schryver, Broekaert, et al., 2014; Verelst, De Schryver, De Haene, et al., 2014)
Attitudes Toward Gender Roles	Gender-Equitable Men Scale (GEM; adapted)	(Babalola, 2014)
Depression	Hopkins Symptom Checklist (HSCL-25; adapted)	(Bass et al., 2013; Hall et al., 2014; Hilson, 2013; Kohli et al., 2014; Kohli et al., 2013; Morof et al., 2014; Schalinski et al., 2011)
	Hopkins Symptom Checklist for Adolescents (HSCL-37)	(Verelst De Schryver, Broekaert et al., 2014; Verelsty, De Schryver, De Haene et al., 2014)
	Patient Health Questionnaire 9 (PHQ-9)	(Johnson et al., 2010)
Domestic Violence	DHS Domestic Violence Module including items from the Conflict Tactics Scale	(Tlapek, 2014)
Intimate Partner Violence	Conflict Tactics Scale	(Babalola et al., 2014)
Externalizing Problems	Hopkins Symptom Checklist for Adolescents (HSCL-37)	(Verelst, De Schryver, Broekaert et al., 2014; Verelst, De Schryver, De Haene et al., 2014)
Family Rejection	[Questions developed through qualitative work]	(Kohli et al., 2014; Kohlie et al., 2013)
Functional Impairment	[Difficulty performing locally-derived list of tasks]	(Bass et al., 2013; Hall et al., 2014; Hilson, 2013)
Psychological Distress	Self-Reported Questionnaire 20 (SRQ-20)	(Dossa, Zunzunegui et al., 2014)
Psychosocial Functioning	Africa Youth Psychosocial Assessment Instrument (AYPA)	(O'Callaghan et al., 2013)

PTSD	Harvard Trauma Questionnaire (HTQ)	(Kohli et al., 2014; Kohli et al., 2013; Michalopoulos, 2014; Morof et al., 2014)
	Impact of Event Scale-Revised (IES-R)	(Dossa, Zunzunegui et al., 2014; Verelst, De Schryver, Broekaert et al., 2014; Verelst, De Schryver, De Haene et al., 2014)
	Posttraumatic Stress Diagnostic Scale (PDS)	(Mutima, 2014)
	PTSD Symptom Scale Interview (PSS-I)	(Johnson et al., 2010; Schalinski et al., 2011)
	UCLA PTSD Reaction Index Revised	(O'Callaghan et al., 2013)
Social Capital	Integrated Questionnaire for the Measurement of Social Capital	(Hall et al., 2014)
Social Support (Family)	Social Reactions Questionnaire (SRQ)	(Mutima, 2014)
Spiritual Wellbeing	Spiritual Wellbeing Scale (SWBS)	(Mutima, 2014)
Stress (Daily Stressors & Social Stressors/Stigma)	Adolescent Complex Emergency Daily Stressors Scale (ACEDSS)	(Verelst, De Schryver, Broekaert et al., 2014; Verelst, De Schryver, De Haene et al., 2014)
Trauma	[Checklist developed by authors]	(Schalinski et al., 2011)
	[Locally derived checklist]	(O'Callaghan et al., 2013)
	Harvard Trauma Questionnaire (HTQ)	(Kohli et al., 2014; Kohli et al., 2013)
Trauma (War-Related)	Adolescent Complex Emergency Exposure Scale (ACEES)	(Verelst, De Schryver, Broekaert et al., 2014; Verelst, De Schryver, De Haene et al., 2014)

Appendix B: Search Terms

The following searches were used to identify articles in Pubmed, PsycInfo, Cochrane, PILOTS, Alnap, Refworld, MHPSS.net and ReliefWeb:

("Democratic Republic of the Congo" OR DRC OR Congo OR "East Africa" OR Refugee OR Displace* OR Tanzania OR Uganda OR Burundi) AND (Humanitarian OR Emergency OR Disaster OR Conflict OR War OR Violence) AND ("Gender-based violence" OR "Sexual violence" OR "Violence against women" OR Rape OR "Domestic violence" OR "Intimate partner violence" OR "Sexual abuse" OR "Domestic abuse" OR "Emotional violence" OR "Physical violence" OR "Emotional abuse" OR "Physical abuse")

("Democratic Republic of the Congo" OR DRC OR Congo) AND (Demograph* OR Migrat* OR Histor* OR Politic* OR Religio* OR Econom* OR Livelihood OR Poverty OR Gender OR Family OR Tradition OR Ritual OR Health OR Disease) AND ("Gender-based violence" OR "Sexual violence" OR "Violence against women" OR Rape OR "Domestic violence" OR "Intimate partner violence" OR "Sexual abuse" OR "Domestic abuse" OR "Emotional violence" OR "Physical violence" OR "Emotional abuse" OR "Physical abuse")

("Democratic Republic of the Congo" OR DRC OR Congo) AND ("Mental health" OR "Mental disorder" OR Psychosocial OR Psychiatr* OR Wellbeing OR Distress OR Trauma OR Psychol* OR Functioning OR Depression OR Anxiety OR PTSD OR "Post-traumatic stress" OR "Substance use" OR Stress) AND ("Gender-based violence" OR "Sexual violence" OR "Violence against women" OR Rape OR "Domestic violence" OR "Intimate partner violence" OR "Sexual abuse" OR "Domestic abuse" OR "Emotional violence" OR "Physical violence" OR "Emotional abuse" OR "Physical abuse")

("Democratic Republic of the Congo" OR DRC OR Congo OR "East Africa" OR Refugee OR Displace* OR Tanzania OR Uganda OR Burundi) AND (Humanitarian OR Emergency OR Disaster OR Conflict OR War OR Violence) AND ("Mental health" OR "Mental disorder" OR Psychosocial OR Psychiatr* OR Wellbeing OR Distress OR Trauma OR Psychol* OR Functioning OR Depression OR Anxiety OR PTSD OR "Post-traumatic stress" OR "Substance use" OR Stress)

(Refugee AND ("Democratic Republic of the Congo" OR DRC OR Congo OR "East Africa" OR "Great Lakes" OR Tanzania OR Uganda OR Burundi OR Rwanda OR Kenya) AND ("Mental health" OR "Mental disorder" OR Psychosocial OR Psychiatr* OR Wellbeing OR Distress OR Trauma OR Psychol* OR Functioning OR Depression OR Anxiety OR PTSD OR "Post-traumatic stress" OR "Substance use" OR Stress) AND ("Gender-based violence" OR "Sexual violence" OR "Violence against women" OR Rape OR "Domestic violence" OR "Intimate partner violence" OR "Sexual abuse" OR "Domestic abuse" OR "Emotional violence" OR "Physical violence" OR "Emotional abuse" OR "Physical abuse")

(Nyarugusu OR "South Kivu") AND (Demograph* OR Migrat* OR Histor* OR Politic* OR Religio* OR Econom* OR Livelihood OR Poverty OR Gender OR Family OR Tradition OR Ritual OR Health OR Disease) AND ("Mental health" OR "Mental disorder" OR Psychosocial OR Psychiatr* OR

Wellbeing OR Distress OR Trauma OR Psychol* OR Functioning OR Depression OR Anxiety OR PTSD OR "Post-traumatic stress" OR "Substance use" OR Stress) AND ("Gender-based violence" OR "Sexual violence" OR "Violence against women" OR Rape OR "Domestic violence" OR "Intimate partner violence" OR "Sexual abuse" OR "Domestic abuse" OR "Emotional violence" OR "Physical violence" OR "Emotional abuse" OR "Physical abuse")

(Refugee) AND ("Democratic Republic of the Congo" OR DRC OR Congo) AND (HIV OR HIV/AIDS OR AIDS OR STI OR "Sexually-transmitted" OR Sex) AND (forced OR transactional OR violen* OR rape OR abuse)

("Democratic Republic of the Congo" OR DRC OR Congo OR "East Africa" OR Tanzania OR Uganda OR Burundi OR Rwanda OR Kenya OR refugee) AND ((Service OR Treatment OR Care OR Support OR Program OR Intervention) AND ("Gender-based violence" OR "Sexual violence" OR "Violence against women" OR Rape OR "Domestic violence" OR "Intimate partner violence" OR "Sexual abuse" OR "Domestic abuse" OR "Emotional violence" OR "Physical violence" OR "Emotional abuse" OR "Physical abuse"))

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