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A systematic review of training interventions addressing sexual violence against marginalized at-risk groups of women

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Abstract

Women from marginalized groups working in occupations such as domestic work are at increased risk for sexual violence. Scarce evidence exists about training interventions targeting such groups. The article aims to identify community and workplace-based training interventions aiming to increase capacity among marginalized at-risk women to deal with sexual violence. A systematic review was applied. Inclusion criteria were English language published between 2003 and 2013; reporting on delivery and/or evaluation; focusing on any form of sexual violence; delivered to professionals, affected or at-risk women; targeting migrant, at-risk women or domestic workers. Data were extracted on the setting, content, evaluation process and target population. Four studies which focused on prevention or responding to sexual violence were included. One study provided sexual violence training to vulnerable female and one provided a HIV prevention intervention to marginalized women. Learning objectives included increasing knowledge around issues of sexual violence and/or gender and human rights, prevention and response strategies. Two studies aimed to train trainers. All studies conducted an outcome evaluation and two a process evaluation. It seems there is a gap on participatory empowerment training for marginalized women. Community train-the-trainer interventions are imperative to protect themselves and deal with the risk of sexual violence.

Introduction

According to the International Labour Organization (ILO) about one-half of the European migrant worker population are women, mostly employed in temporary and part-time employment, who enjoy far worse working conditions compared with migrant men and women nationals [1–3]. Migrant women are often employed in low-income jobs in the informal domestic and care sector, where an ageing population, increased pressures on the health and social care systems and women's participation in the labour market have created increased demand for domestic helpers and carers [4, 5]. Approximately 10% of migrant women in Europe are employed in domestic work; numbers vary between EU countries, with domestic workers comprising 0.04% of the working population in the Netherlands while reaching 5% in Cyprus [6]. Official numbers do not accurately reflect actual numbers however, as they do not include undocumented women or women who might be employed as care workers but are also involved in domestic work.

Domestic work is characterized by lax control from local governments [1–3] and much of it takes

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place outside the formal economy allowing migrant women to enter employment without a formal contract and often regardless of legal status and language skills. The same characteristics that make domestic work appealing can also result in increased vulnerability to exploitation and abuse from employers. Women are often isolated within the house of employment without formal regulatory procedures to protect them against violation of rights and exploitation [1, 4, 7–13]. One study that looked at the perceived vulnerability of migrant women domestic workers to HIV/AIDS, reported that 9% of participants in the study reported being sexually abused [13].

The World Health Organization (WHO) defines sexual violence as 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work' [14:149]. Forms of sexual violence may vary and may include unwanted sexual advances, demanding sex in return for favours, denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases, forced abortion, forced prostitution and trafficking of people. Sexual violence not only results in short and long-term adverse psychological and social outcomes but also has significant sexual health implications because of the increased risk for sexually transmitted infections and risk of unwanted pregnancies [14–16].

Gender and migration issues have been on the public health agenda of international and local organizations and governments, while the UN Millennium Declaration affirms to both 'combat all forms of violence against women'; and 'to take measures to ensure respect for and protection of the human rights of migrants, migrant workers and their families [...]' [17]. Gender violence has been described as an 'urgent public health priority' [18] but policy-level urgency does not seem to be translated into practice. A recent World Health Organization report concludes that there is still a gap in evidence-based practice when it comes to dealing with sexual violence, including prevention, particularly within a public health perspective [19]. This gap is echoed in low investment for the prevention of gender-based violence and support of survivors [18]. To translate policy to action however, community-based interventions that promote gender empowerment and women's health issues are key.

This article presents findings obtained as part of a DAPHNE III EU funded project that aimed to respond to the increased need for addressing sexual violence against migrant women working as domestic workers in the EU. The project aimed to increase understanding of the phenomenon of sexual violence against migrant domestic workers working across the EU, focusing on those in five EU countries (Austria, Cyprus, Greece, Slovakia, Sweden) [20]. As part of the design of a train-the-trainer manual, a systematic review was undertaken to (i) identify educational/training interventions that have been delivered to increase knowledge, awareness and/or skills to respond to sexual violence and (ii) determine if any had focused on vulnerable or marginalized groups of women. This article will present the findings from this systematic review. The review collected information on the setting; educational content; participants; training delivery and evaluation design of the intervention.

Methods

Literature search

Search and selection strategies aimed to identify all original research studies which reported on the delivery of training interventions or programmes targeting any form of sexual violence including gender-based violence and which aimed to prevent the occurrence of sexual or gender-based violence and/or increase capacity among women to deal with events of violence. This training could be either in the form of train-the-trainers interventions or direct training to the target group itself. Inclusion and exclusion criteria are included in Supplementary Table S2. A broad search strategy to include any studies that have addressed sexual violence was used for two reasons: first, to obtain as much information

as possible on the different methodological approaches that have already been taken to design sexual violence training interventions and second, a preliminary literature review undertaken in an earlier stage of the Commun-AID project came up with a dearth of primary studies which had focused on migrant female domestic workers (MFDWs). The researchers therefore wanted to identify how many, if any, of the existing interventions had targeted a vulnerable marginalized population such as migrant women.

Study selection

The literature search was performed between October 2013 and February 2014. Two reviewers (A.Z. and C.P.) conducted electronic searches through ERIC, ASSIA, Web of Science, CINAHL and Medline and PsychInfo and identified relevant articles. The two reviewers independently prescreened the abstracts of all potentially relevant articles. Combinations of the search terms in Supplementary Table S1 were used. Articles were rejected if the abstract did not meet the inclusion/exclusion criteria. In instances where the study could not be categorically rejected the full text was obtained and screened. All reference lists of potentially relevant studies were also searched for relevant articles. There was no geographical location limitation on the setting of these studies. Only studies published in peer-reviewed journals in the English language between 2003 and 2013 were included.

Data extraction and analysis

The two reviewers then independently assessed the relevant studies for inclusion and then came together to exclude duplicates and agree upon the final list of studies to be included in the review. Discrepancies were resolved by consensus. Identified articles were divided between the two reviewers who independently extracted data using the template designed during the protocol development phase (Supplementary Table S3). The data extraction form was adapted from the one used by Horvat *et al.* [21]. The template extracted information on the following: (i) Setting of the study, (ii) Educational content of the intervention, (iii) Pedagogical approach adopted, (iv) Structure of the evaluation, (v) Assessment and evaluation of the intervention and (vi) Participant characteristics.

Results

Study selection

Through the electronic search of the literature 213 articles were retrieved. After removing duplicate articles ($n = 95$), books or reviews of books ($n = 7$), 47 full text articles were reviewed, out of which four articles fulfilled all inclusion criteria and included in the review (Fig. 1). The majority of studies were based in the United States [22–24], one was based in Nigeria [25] and were all published in peer-reviewed journals in the English language.

Study characteristics

Methods and design

All included studies fulfilled the criterion of providing educational training interventions to women or professionals specific to sexual violence and had described an evaluation of the training provided (Table I). All four interventions used face-to-face training and one study incorporated a distance-learning component enabling networking and technical assistance [24]. The minimum continuous face-to-face contact of delivering the training interventions was 2 h [22] and the maximum was 6 working days broken down into two blocks of 4 and 2 days [24]. Identified studies delivered training interventions that focused on sexual harassment [22, 25], HIV prevention including sexual and reproductive health [23] and violence prevention [24]. Two studies included a train-the-trainer component [23, 24]. Gollub *et al.* trained vulnerable women who would then train other women in their community, while Runyan *et al.* trained health and social care professionals.

Two studies [22, 23] had a prospective two-arm study design with one arm being the control and pre- and post-intervention assessments. One study [25]

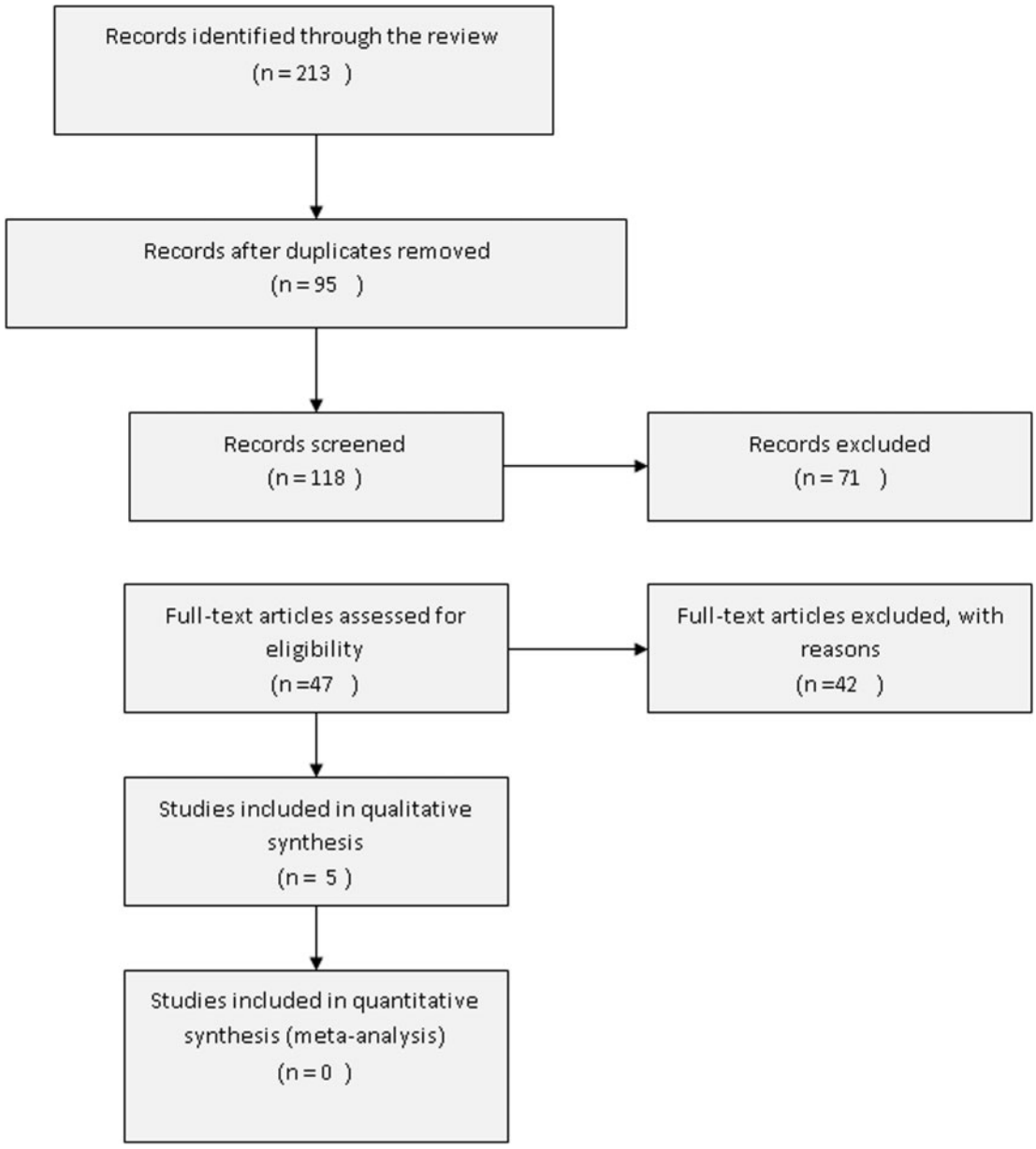

Fig. 1. Flow chart of evidence search and selection.

only incorporated a pre- and post-intervention survey without a control. One study [24] adopted an adult learning action research design that incorporated a prospective intervention evaluation component. Rudyan *et al.* [24] provided two interventions: a 2-day regional workshop addressed to practitioners followed by a 3 month action-learning activity and a 6-day intensive training

Table I. *Overview of studies included in the review*

Author, Yr (country)	Aim of intervention	Participants	Educational content	Methods:	Evaluation	Duration	Findings
Goldberg (2007) (USA)	Assess the effectiveness of work-based sexual assault training on the ability to identify sexual harassment and indented responses TTT: No	Delivering the training: Caucasian female trainers Receiving the intervention: white collar professionals Receiving training: N = 395 Follow-up survey: N = 234	Factual information Relevant legislation and key court decisions regarding sexual harassment; identify fundamental sexual harassment terminology; organisational implications related to sexual harassment; victim responses to sexual harassment and the ramifications associated with the implications related to sexual harassment.	Design: Randomised control study with pre-posttest design at 3 months Teaching/learning methods: Face-to-face lecture-style training to the intervention group	Outcomes evaluation only Outcomes/outcome measures: Intended responses to sexual harassment (Fitzgerald et al, 1995); Conflict avoidance (Howat & London, 1980) Control variables: gender; work experience; previous experience with sexual harassment training; time of assessment.	Two hours training 1 session	Individuals who received training had significantly lower expectations to confront their perpetrators. Conflict avoidance was significantly negatively correlated to intentions to formally report harassment for those receiving the training but positively correlated for the control group.
Gollub et al (2010) (USA)	Provide community training to at-risk women for HIV prevention TTT: Yes	Delivering training: near peers - women who came from the participant community who may have been drug users in the pst but not at the time of the intervention Receiving training: women at high risk for HIV/AIDS N of women enrolled: 189 (91 intervention, 98 control)	Factual knowledge Biology and disease relevant context; protection methods (HIV/STI); reduction strategies (HIV/STI, violence, abuse and violent sex); self-defence. Teaching/training skills Ability to implement role play lessons; to illustrate protection methods and reduction strategies; ability to deliver the training intervention.	Design: randomised-control study with 2-month follow up Teaching/learning methods: Face-to-face training	Process and Outcome evaluations Outcomes/outcome measures: Primary outcomes assessment of feasibility: ability to enrol participants; ability to retain >80% participants; completion rate >65%;; positive intervention acceptability of participants and leaders Secondary outcomes: level of participation in group sessions; changes in	Intervention group: 4 group sessions delivered weekly for 1 month with one reunion session 1 month later Control group: status quo	Successful retention of 95% of participants; positive assessment; pre-post knowledge assessments showed higher levels of improvement for intervention women.

(continued)

Table I. *Continued*

Author, Yr (country)	Aim of intervention	Participants	Educational content	Methods:	Evaluation	Duration	Findings
		N of women completing training: 179			knowledge for anatomy and contraception methods (pre and post assessment); participants' use of contraception methods		
Fawole et al (2005) (Nigeria)	Provision of training to at-risk women apprentices and stakeholders (instructors, police, judicial officers) on sexual violence including work-based sexual violence TTT: No	Delivering the training: the investigators, resource people from NOGs, a reproductive health specialist, representatives of the Chief Judge and Commissioner of the Police, successful small-scale entrepreneurs. Receiving the training: Skills training: women apprentices Received training: N = 323 Follow-up survey: N = 203 Sensitisation training: instructors of apprentices, police and judicial officials.	Factual information Definition, types, risk factors and consequences of gender based violence; economic rights of young apprentices; transmission and prevention of HIV/AIDS; results of a baseline survey; police perspectives on violence prevention against female adolescents; judicial perspectives on violence prevention against female adolescents; suggestions for the prevention of violence.	Design: Community-based training with pre and posttraining assessment for female apprentices at 5 months	Outcomes/Outcome measures: Age, marital status, educational level; knowledge and consequences of violence; perceived vulnerability to violence; knowledge of physical and sexual violence; prevalence of difference forms of violence; proportion who sought redress and where redress was sought.	Two days	Authors report improved levels of knowledge of types of violence and sexual forms of violence; increased appreciation of vulnerability to violence against women; reduced prevalence of beating; increased reports of payment for vocation-related work; slight decline in rape and sexual harassment; increased proportion of victims seeking redress.
Runyan et al (2005) (USA)	Provide training to enhance the capacity of community public health practitioners in preventing violence through the use of	Delivering training: instructors with diverse experiences in injury and violence prevention	Factual information Epidemiology of knowledge; sources of data (evidence based); techniques of	Design: Action Learning approach with quantitative and qualitative evaluation	Process and Outcome evaluations Outcomes/outcome measures:	Regional workshops: 2-day workshops; supervised action learning activity over 3-month period	Preliminary evaluation findings are reported suggesting favourable experiences from trainees. Lessons learned and

(continued)

Table I. *Continued*

Author, Yr (country)	Aim of intervention	Participants	Educational content	Methods:	Evaluation	Duration	Findings
	evidence-based methods. TTT: Yes	Receiving the training: practitioners and leaders of practitioners working in the public health care sector N = not stated	programme planning and evaluation; strategies to achieve sustainability in programmes; approaches to leadership and advocacy Teaching/training skills Training focused on achieving nine core competencies for injury and violence prevention, including developing skills to engage in the primary prevention of violence.	Teaching/learning methods: Face to face; online distance learning approach; networking and technical support	Process: Qualitative assessment of: learners' ratings and comments of training; informal and formal discussions between faculty and staff; observation ratings to assess standard elements of teaching style; telephone interviews and review of action learning projects for assessment of coaching. Outcomes: changes in participants; attitudes and beliefs about the utility and importance of primary prevention of violence, the desirability and barriers to collaborating with other organisations for violence prevention; confidence in applying skills addressed in the training; final project report assessments; follow up interviews; ratings and open-ended questions; observer ratings of standards elements of teaching style.	Centrally-provided training: 6-day intensive training in two blocks separated by 6-month action learning activity.	changes made to the programme are reported.

delivered in two blocks of 4 and 2 days separated by a 6 month action-learning period, addressed to practitioner leaders. Two studies conducted a process evaluation [23, 24], and all four studies conducted an outcome evaluation of the intervention.

Participants

Participants receiving training included social and health care practitioners and practitioner leaders [24], vulnerable women [23, 25], employers and other stakeholders including the police [25] and white-collar professionals who were enrolled on a graduate course [22]. Out of the four studies included in this review only one study targeted a vulnerable population group of women who were at high risk for sexual violence at their workplace [25], and only one trained vulnerable women to be trainers within their community [23]. Fawole *et al.* [25] targeted a population of female apprentices working in the capital of Nigeria, who were at high risk for sexual harassment, exploitation from and dependency on their instructors. Their intervention provided training to two target audiences, namely apprentices themselves; and to instructors, police and judicial officials, aimed to prevent the sexual harassment of apprentices. Gollub *et al. [*23] focused on vulnerable drug-using women from marginalized communities at risk of HIV infection who were trained as trainers. Goldberg [22] focused on a working population targeting white-collar workers for work-based sexual harassment awareness training. Runyan *et al.* [24] provided training to social and health care practitioners to use evidence-based approaches to the primary prevention of violence.

The trainers who delivered the training in these interventions included professionals with experiences in violence prevention [24], near peers [23, 25], the researchers, NGO representatives, and public legal officials [25], and professional white female trainers [22].

Training content and outcomes

The include studies provided training that aimed to address gaps in knowledge [22–25], attitudes [23, 24], trainer-related skills [23, 24], awareness [25] and behaviour-related outcomes [23, 25]. Studies which focused on sexual violence [22, 25] incorporated general factual information aiming to enable participants to be able to identify forms of sexual violence, provided trainees with a definition of sexual harassment, types of sexual harassment [25], knowledge of fundamental sexual harassment terminology [22] and legislative information relevant to sexual harassment or violence such as legislation and court decisions regarding sexual harassment [22] as well as labour-related information such as the economic rights [25]. Epidemiological information on the occurrence of different types of violence, including occurrence statistics was included in one study [24]. Risk factors for forms of violence were included in the intervention by Fawole *et al.* [25]. Consequences of sexual and gender-based violence were included in two studies [22, 25], with one study also including the organizational implications of harassment [22].

Three studies included prevention of sexual violence as part of their objectives [23–25]. The prevention of sexual violence was addressed through the following learning components: methods of prevention, reduction strategies and self-defence. Training included identifying possible ways for prevention of violence through interviews with women (victims and potential victims) and discussions during the intervention with potential victims, potential perpetrators and public officials [25]; strategies for reducing or avoiding violence, abuse and violent sex including using community support [23]. One intervention taught women self-defence [23]. Runyan *et al.* [24] provided training to professionals on evidence-based design, delivery and evaluation of community training violence prevention programmes. Two studies included education on sexual health and the transmission and prevention of HIV/AIDS [23, 25].

All four studies provided information on ways to respond to sexual violence. One study [22] specifically investigated the impact of the training on intended responses to harassment. Responding to sexual violence was addressed through incorporating as part of the training potential victim responses

to sexual violence and the ramifications associated with them, information on local services that can provide support to victims and raising awareness about the benefit of using and building partnerships. Identifying possible victim responses was reported in all four studies that provided a sexual violence training intervention. Victim responses to sexual harassment and the ramifications associated with them, such as retaliation from the perpetrator, were discussed by Goldberg [22] and Fawole *et al.* [25], while Gollub *et al.* [23] discussed escape plans in situations of a violent domestic partner. The issue of stakeholder partnerships and their use in protecting women was discussed in three interventions [23–25].

Train-the-trainer learning objectives

From the two studies that delivered a train-the-trainer intervention [23, 24], one study incorporated a train-the-trainer module as part of the delivery of their intervention [23]. Finally, one study provided training to public health professionals on how to use evidence-based practice to design, deliver and evaluate their own violence prevention intervention [24]. All train-the-trainer components included delivery of factual information plus components on teaching and training skills. Teaching and training skills were included in all two studies, including the ability to deliver the training intervention and skills on using alternative teaching techniques.

Teaching methods and learning tools

All studies utilized face-to-face teaching methods to deliver their training. One study also utilized distance e-learning techniques [24]. Face-to-face techniques included the use of a multitude of ways which can be used to convey information (e.g. presentations, videos, charts, brochures, posters) [22–25], the use of discussions to exchange experiences, opinions and enhance awareness of alternative points of view, brainstorming, [23, 25]; case scenarios, stories, Q & A sessions [25]; problem-solving skills, role playing [23] and action-based learning [24]. To enhance and enable learning, distance-learning methods used on-line e-platforms to upload self-paced learning modules, train-the-trainer materials, evidence-based updates, organized satellite broadcasts, web seminars, conference calls and internet-based communication and informal exchange [24].

Evaluation

All four studies reported an outcome evaluation of their intervention, and two studies reported an assessment of the process of delivery of the intervention [23, 24]. Quantitative evaluation methods were used by four studies, and qualitative methods were used by two studies [23, 24]. All studies assessed participants on pre- and post-intervention levels of knowledge with three studies incorporating a longitudinal follow-up [22, 23, 25].

A variety of outcomes and outcome measures were used to assess both end-of-intervention outcomes and process. Feasibility of the intervention [23] was assessed using the outcomes of: ability to enrol participants, ability to retain participants, completion rate and positive intervention acceptability by participants. Runyan *et al.* [24] assessed the process of providing the intervention through learner's ratings and comments of training; discussions between faculty and staff; observations; telephone interviews and looking at the action-learning projects prepared by trainees.

Knowledge-related outcomes used to assess the educational components included knowledge and consequences of violence, perceived vulnerability to violence, knowledge of physical and sexual violence [23, 25], prevalence of different forms of violence and proportion who sought redress and where redress was sought [25]. Only one study used validated outcome measures to evaluate the training, and these were the Intended Responses to Sexual Harassment scale and the Conflict Avoidance scale [22]. Runyan *et al.* [24] reported outcomes related to the nine competencies addressed by their training, including changes in attitudes and beliefs related to primary prevention of violence; desirability and barriers to collaboration with other organizations; confidence in applying relevant skills; final project report assessments; follow-up interviews; training

ratings and open ended questions and observer ratings of teaching style. A number of control variables were reported to have been used by Goldberg [22] including age, gender, marital status, educational level, work experience, previous experience with sexual harassment training and time of assessment.

Outcomes and outcome measures specific to the train-the-trainer intervention included attitudes and beliefs about the importance and utility of prevention, desirability and barriers to collaboration [24], confidence in applying skills addressed in the training [23, 24] and final project reports and teaching and training style [23, 24].

Gollub *et al.* [23] and Fawole *et al.* [25] reported improvements in knowledge following the intervention, with increased knowledge being observed between the intervention and control groups. Goldberg [22] reported that those who received training reported significantly lower expectations to confront their perpetrators while conflict avoidance was significantly negatively correlated with intentions to formally report harassment. The opposite was found for the control group. Gollub *et al.* [23] reported successful retention of participants and receiving a positive assessment of the intervention. Runyan *et al.* [24] reported preliminary findings from the process evaluation of the intervention, which resulted in changes made to the intervention.

Discussion

This review was undertaken to identify teaching methods, content and evaluation methods specific to training programmes targeting sexual violence against vulnerable, marginalized at-risk women. The aim for this was to design and pilot the train-the-trainer intervention for MFDWs. Reviews have already been published which summarize the literature on prevention efforts that target intimate partner violence and sexual assault [27–29] and sexual harassment [30]. One systematic review has also recently been published looking into the evaluation and effectiveness of primary prevention strategies for sexual violence perpetration [31].

Despite the extensive literature that looks into gender-based violence in general and sexual violence specifically, four studies were identified that fulfilled the inclusion criteria [22–25]. Only one study was identified which targeted a vulnerable group of women at risk of sexual violence at their work place [25]. Fawole *et al.* [25] targeted female apprentices as well as their employers, the police and judicial officials to increase awareness of the issue of gender-based and sexual violence. There appears to be an equivalent scarcity of studies that delivered train-the-trainer interventions and which adopt a bottom-up participatory approach to training. Only one study [23] was identified that provided a train-the-trainer intervention to a marginalized group of women. Out of the four studies identified, two used the experience of women from the target community to design and deliver the training intervention. Two studies included stakeholders who are involved in service delivery to the at-risk population in their training [24, 25]; and finally, three studies incorporated a community participatory or action research approach to their training while attempting to adapt the intervention to the specific needs of the at-risk communities [23–25].

Based on the systematic review by DeGue *et al.* [31], of the 140 studies identified and which targeted primary prevention of sexual violence, 70% were delivered within a college campus setting and only 4 studies reported delivering an intervention within the community. Equally, only three were addressed to specific racial/ethnic groups. DeGue *et al.*' findings reflect the scarcity of studies focusing on marginalized populations within the community identified by this study.

The four identified studies utilized different methodological paradigms and approaches to the design, delivery and evaluation of interventions. Programme evaluations tend to focus on outcome measurements to assess the effectiveness of the intervention and randomized controlled trials are considered to be the gold standard to guide evidence-based policy and practice. This was reflected on the fact that all four identified studies conducted an outcome evaluation but only two an evaluation of the process of delivering the programme [23, 24]

and only one [24] reported making changes because of that. Even though outcome evaluations are very useful in identifying what works, process evaluations are useful in informing the design of new interventions. Follow-up times also tend to be for a short period of time, with the longest follow-up being over 5 months [25] which does not allow for conclusions to be made on the long-term impact of interventions on the outcomes of interest.

Existing training programmes emphasize the provision of factual information related to sexual violence, including a definition of what sexual harassment or violence is, being able to identify sexual harassment or violence, information on prevalence and incidence and responses to sexual harassment or violence including what to do and who to conduct, legal aspects of sexual harassment or violence and available services and networks. Existing interventions appear to adopt a top-down approach with educational content including intended outcomes being defined by researchers or educators. Although this may be effective where educators have an accurate knowledge of the needs of the target population, this will not be as effective in communities where little is known about their educational and training needs. Process evaluations provide information on which components of a programme are effective and which should be modified to improve the delivery [32] and facilitate linking process to outcomes [33].

In the case of training interventions for MFDWs, learning objectives should be defined by the target community's needs so should be conceptualized in the context of migrant at-risk women and their relationship with the receiving society. MFDWs are situated at the intersection of gender, class and race and sociological research has discussed the sexualization of this group of women and their depiction as sexually 'deviant' [34], a perception that shapes the behaviour of male and female employers and potentially the responses of service providers.

Within the literature the marginalization of domestic workers is well presented, with literature discussing the lack of integration and participation of women, unmet health needs including sexual health and problematic relationships between migrant women and the authorities [2, 35–38]. In addition very little is known about migrant women's understandings of gender and gender roles and stereotypes, understandings of sexual identity and appropriate sexual behaviours including understandings of what is appropriate and not appropriate behaviour. Research has shown how women who were sexually harassed or abused in the past tend to adopt more gender role stereotypical behaviours in their interactions with men such as submissiveness [27]. Sochting *et al.* [27] report that contextual and cultural factors such as belief systems around gender role behaviours, perceptions of threatening situations and what situations could be described as such are important for making programmes more effective. These psychological and social factors not only shape the behaviours of victims and perpetrators which may also differ depending on ethnicity and culture but may potentially be relevant to the way professionals and health and social service providers react towards at-risk women or victims of sexual violence.

The issue of sexual violence and gender-based violence is first and foremost a cultural as well as emotional issue with beliefs and perceptions relating to gender and gender-based violence being shaped by cultural norms and experiences [26]. Mackay [26] points out that it may not be the case that all participants attending a training course on gender-based violence will come to the training with the same attitudes towards sexual violence against vulnerable women.

Directions for further research

Community empowerment should be considered a key aspect of any intervention addressing violence against women [18, 39]. To enable that, future research needs to explore in more detail migrant women's experiences of sexual violence in the context of domestic work as well as explore their understandings, beliefs and intended or actual responses to events of sexual violence. The existing individual-centred approaches do not take into consideration the social realities of marginalized, and isolated women from distinct cultural backgrounds

that might differ from those of the mainstream, their levels of health literacy and access to networks and systems of support. Further research needs to better understand these realities to inform the design of more appropriate training interventions that address their particular educational and empowerment needs. Continuity and sustainability is another consideration for such interventions, where a train-the-trainer approach might be particularly appropriate. These should include stakeholders as part of the training to facilitate awareness among those delivering services and coming into contact with vulnerable women as well as increase cultural literacy and sensitivity among professionals. Evidence does point to the presence of stereotypes and discrimination among members of the police, judicial officials and other stakeholders, something that presents barriers to fair treatment of victimized women and to reporting of sexual violence [40–42]

Advocates of community empowerment approaches have stressed the inadequacies of public health approaches that focus on the individual and ignore the social and environmental factors and health and social inequities which shape vulnerability factors [43]. Community participatory approaches enable the collaboration between the community and key stakeholders involved in service delivery through joint training and networking that can facilitate long-term continuity of the programme. Fawole *et al.* [25] through the involvement of both at-risk women and stakeholders reported an increased number of women seeking redress and a slight decrease in cases of violence over a 5 month follow-up period. A community empowerment approach could facilitate a long-term and perhaps more structural changes through continuity from training members of the community to educate other women, the establishment of networks between the community and other stakeholders and placing the needs of the community in the attention of those able to influence decision-making.

Reflecting these concerns, DeGue *et al.* [31] raise the need for more community- and societal-level interventions which address social and environmental determinants. Other authors have also criticized existing education programmes that target sexual violence for focusing on changing attitudes on the individual level and failing in their long-term effectiveness [27, 31]. Within public health, critique against traditional educational approaches of health promotion have brought to the fore empowerment-based approaches, which recognize the value of community empowerment and capacity building through promoting empowerment-related concepts such as health literacy [44, 45].

Conclusions

Extensive literature exists that discusses the social and public health implications of sexual violence and reports on delivery prevention programmes. These mainly focus on intimate partner violence or sexual assaults against college students and rarely include members of ethnic minority populations. Most EU countries experience an influx of female migration with many women being employed as domestic or care workers and this population is well known for experiencing discrimination, human rights violations and fall victim to employer abuse and violence, including sexual violence. However, no interventions have been identified which attempt to increase the capacity of this population to deal with the problem of sexual violence through training. This population presents with specific challenges which distinguish it from others when thinking about designing training interventions. This systematic review identified a gap in the public health literature and especially a lack of educational interventions in the prevention and response to sexual violence against at-risk vulnerable women which needs to be addressed, especially in the current context of increased feminized migration into Europe of women who work in the domestic and care sectors. Based on findings of this review, training interventions.

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Conflict of interest statement

None declared.

Supplementary data

Supplementary data are available at *Health Education Research* online.

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