Desk Review Report: Enhancing the Capacities of IPV and SGBV Service Providers for LBT Women in Rural Western Cape, South Africa

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Acronyms and Definitions

Acronym	Definition
2SLGBTQI+	Two-Spirit, lesbian, gay, bisexual, transgender, queer or questioning, intersex, and other diverse sexual orientations and gender identities
GBV	Gender-based violence
GLBTI	Gay, lesbian, bisexual, transgender, and intersex
HIC	High-income country
IPV	Intimate partner violence
LBT	Lesbian, bisexual, and transgender
LGBT	Lesbian, gay, bisexual, and transgender
LGBTQ	Lesbian, gay, bisexual, transgender, and queer or questioning
LGBTQI+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex, and other diverse sexual orientations and gender identities
LMIC	Low- and middle-income country
MSM	Men who have sex with men
NGO	Non-governmental organisation
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews
SGBV	Sexual and gender-based violence
TVIC	Trauma- and violence-informed care

Introduction

This desk review forms part of the formative research for this study. Alongside key informant interviews and focus group discussions with relevant sexual and gender-based violence (SGBV) service provider clusters in Matzikama municipality, this desk review serves as a complementary synthesis of available literature around improving intimate partner violence (IPV) and SGBV service provision for lesbian, bisexual, and transgender (LBT) women in low- and middle-income countries(LMICs). This review is guided by the research question:

What is known from existing literature about how to improve to SGBV/IPV service provision for LBT women in LMICs through service provider interventions?

The findings of this desk review in conjunction with the findings from key informant interviews and focus group discussions will inform the adaptation and strengthening of Triangle Project's training intervention for IPV/SGBV service providers in Matzikama, Western Cape.

Methodology

This desk review followed a scoping review approach informed by Arksey and O'Malley (2005) in order to thoroughly search for and review relevant literature. Reporting was aligned with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses for Scoping Reviews (PRISMA-ScR), which recommends transparent documentation of the eligibility criteria, information sources, search strategy, screening process, data charting and synthesis (Tricco et al., 2018).

This review's search protocol comprised four databases: Google Scholar, PubMed, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and PsycINFO. The review's search terms including terms for LBT women, GBV, service provider training, and LMIC were compiled using the Boolean search string method. After piloting an initial search string which resulted in very few relevant articles, the team decided to use three search strings This review made use of three search strings to harness a more rounded

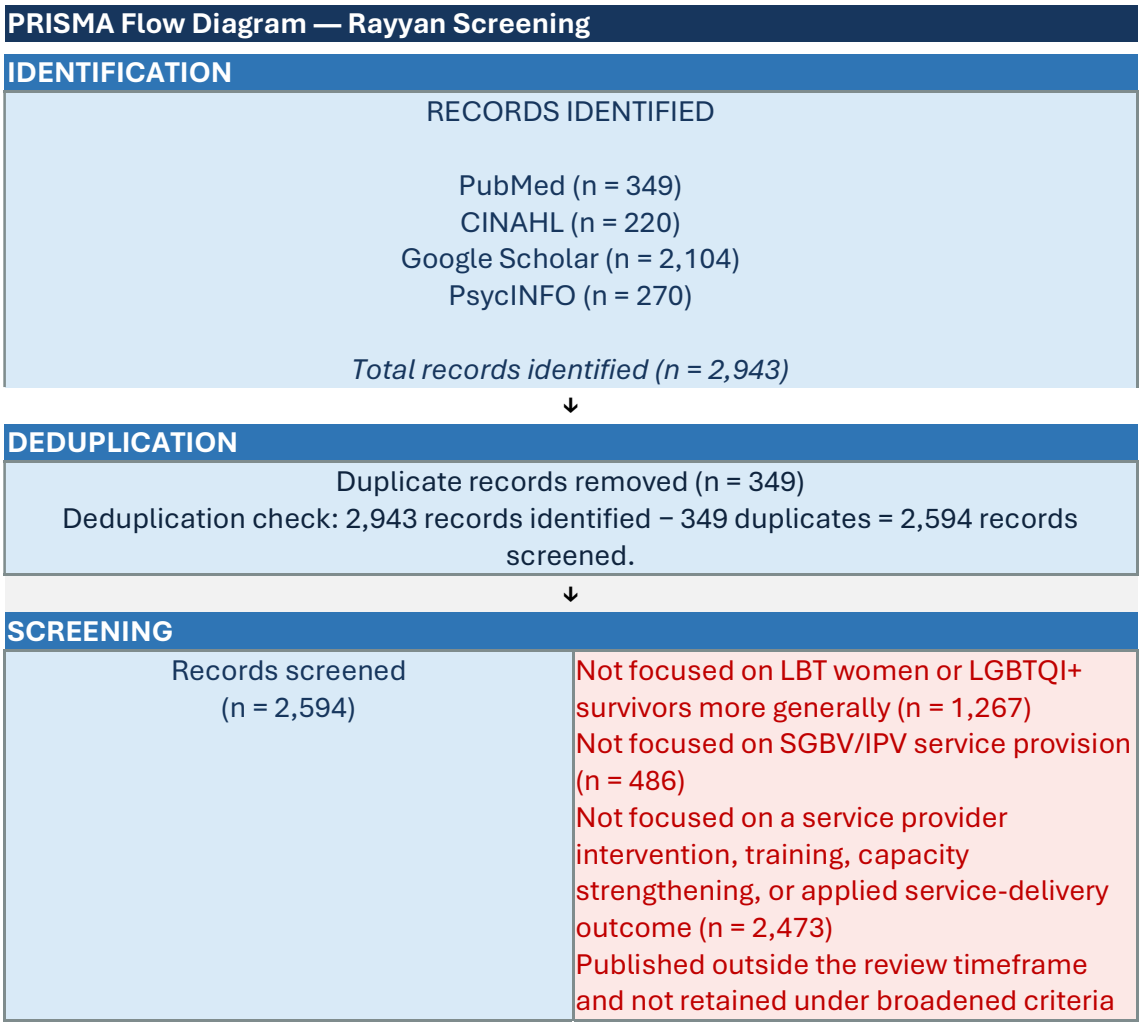
and integrated overview of literature. Search strings were executed in the following sequence:

Search String 1 (includes all constructs)	(("LBT*" “LGBT*” OR "lesbian*" OR "bisexual wom*n" OR "transgender wom*n" OR "gender minorit*" OR "sexual minorit*" OR "queer wom*n") AND ("GBV" OR "gender-based violence" OR "SGBV" OR "intimate partner violence" OR "IPV" OR "domestic violence") AND ("sensitiz*" OR "provider training" OR "capacity building" OR "professional development" OR “capacity strengthening” OR "attitud*" OR “norm change” OR “skill*”) AND ("LMIC*" OR "Global South" OR "developing countr*" OR "low income" OR "middle income"))
Search String 2 (excludes LBT women terms to find articles on service provider training for SGBV/IPV services)	(("GBV" OR "gender-based violence" OR "SGBV" OR "intimate partner violence" OR "IPV" OR "domestic violence") AND ("sensitiz*" OR "provider training" OR "capacity building" OR "professional development" OR “capacity strengthening” OR "attitud*" OR “norm change” OR “skill*”) AND ("LMIC*" OR "Global South" OR "developing countr*" OR "low income" OR "middle income"))
Search String 3 (excludes SGBV/IPV terms to find articles on service provider trainings focused on improving services for LBT women)	(("LBT*" OR "lesbian*" OR "bisexual wom*n" OR "transgender wom*n" OR "gender minorit*" OR "sexual minorit*" OR "queer wom*n") AND ("sensitiz*" OR "provider training" OR "capacity building" OR "professional development" OR “capacity strengthening” OR "attitud*" OR “norm change” OR “skill*”) AND ("LMIC*" OR "Global South" OR "developing countr*" OR "low income" OR "middle income"))

These search strings were individually entered into the four databases. Search results for each database yielded the following numbers of articles and were first screened by title

and subsequently full-text screened according to an established inclusion[1] and exclusion criteria:

PRISMA-ScR Flow Diagram Template



[1] Inclusion Criteria:

- Peer-reviewed journal articles, theses/dissertations and grey literature (policy reports, technical reports)
- published 2015–2026
- studies focusing on LBT women and SGBV/IPV provider training.
- studies located in or about lower-middle income countries.
- English language

Exclusion Criteria:

- Studies focusing solely on transgender men, cisgender heterosexual women or Men who have Sex with Men (MSM) without disaggregated data for LBT women;
- Studies that do not address all of the study's three core concepts (i.e. LBT women, SGBV/IPV service provision, provider training).
- Studies located in high-income countries (HICs)
- Opinion pieces or editorials

	(n = 909) Not conducted in a LMIC (n = 256) Not available in English (n = 10) *Total excluded during screening (n = 2,581)*[2]
↓	
Included from screening (n = 2)	Records requiring further screening (n = 11)
FULL-TEXT SCREENING	
Included following full-text screening (n = 3)	Not focused on SGBV/IPV service provision (n = 4) Not focused on a service provider intervention, training, capacity strengthening, or applied service-delivery outcome (n = 3) Not conducted in an LMIC (n = 1)
↓	
FINAL OUTCOME	
Articles included in the review (n = 5)	Articles excluded (n = 2,589)

Flexibility with Inclusion Criteria

It is important to note that, because few identified articles directly addressed all three critical components of the review's central research question, three inclusion criteria were broadened: the publication timeframe, geographic location, and LBT focus. Accordingly, articles published before 2015 and studies from high-income countries were considered where they offered relevant evidence on strengthening SGBV/IPV service providers' capacity to deliver more inclusive and affirming services. The population criterion was also broadened to include studies addressing LGBTQI+ survivors more generally, rather than only those focused exclusively on LBT women.

Data extraction and analysis

These five articles included were:

- *Beyond: 'We treat everyone the same'* (Barrett and Stephens, 2012).

[2] Some articles simultaneously recorded more than one exclusion reason during the screening process.

- *Beyond Men, Women, or Both: A Comprehensive LGBTQ-Inclusive, Implicit-Bias-Aware, Standardized-Patient-Based Sexual History Taking Curriculum* (Mayfield et al, 2017).
- *The Co-Design of a Trauma- and Violence-Informed Care ELearning Module for the Gender-Based Violence Sector: The Unique Service Needs of 2SLGBTQI+ Survivors* (Van Roessel, 2025).
- *Acceptability and Preliminary Efficacy of a Lesbian,Gay, Bisexual, and Transgender-Affirmative Mental Health Practice Training in a Highly Stigmatizing National Context* (Lelutiu-Weinberger & Pachankis, 2017).
- *Enhancing health workforce capacity through life skills-based interventions: evidence from Pakistan on reducing gender-based violence* (Ali et al, 2025).

A data extraction template was used to chart key information from each included source. Key variables of interest included (1) Article title (including authors and dates), (2) country or region, (3) study population, (4) training intervention, (5) methodology or study/intervention design, (6) Reported Impact, (7)
Enablers to intervention uptake by study population, and (8)
Barriers to intervention uptake by study population. Findings have been synthesised combining descriptive mapping with thematic analysis within each category. The purpose of this desk review was not to assess the effectiveness of interventions through pooled analysis, but to identify key intervention implications relevant to our study.

Limitations

This review is limited by the small and heterogeneous evidence base that directly addresses service-provider interventions for LBT women experiencing SGBV or IPV in LMICs. Because few studies addressed all components of the research question, three eligibility criteria were broadened during the screening process: publication timeframe, geographic location, and LBT focus. The review therefore included some studies published before 2015, studies conducted in high-income countries, and studies focused on LGBTQI+ survivors more broadly rather than exclusively on LBT women. Although these studies offer relevant and potentially transferable lessons, differences in service systems, sociocultural contexts, legal environments, target populations, and intervention settings may limit their direct applicability to LBT women in rural South Africa. The findings should therefore be interpreted as indicative guidance for

intervention design rather than definitive evidence of effectiveness in the Matzikama context.

Findings

The five articles reviewed collectively offer insights into training interventions to improve service provision for lesbian, bisexual, and transgender (LBT) women who experience sexual and gender-based violence (SGBV) and intimate partner violence (IPV). Although only one of the studies was located in a LMIC, each contributes transferable lessons for designing a service provider training intervention to improve responsive SGBV/IPV services for to LBT women. An overview of the included articles is presented in Table 2.

Table 2. Summary of included evidence across the eight data-extraction categories

Article	*Country or region*	*Study population*	*Training intervention*	*Methodology or design*	*Reported impact*	*Enablers*	*Barriers*
Barrett and Stephens (2012)	Australia	Health and human-service organisations serving GLBTI clients	How2 organisational inclusion programme	Programme report and case examples	Improved organisational awareness and inclusive-practice planning	Leadership commitment, champions, consumer consultation, partnerships, action planning, and policy review	Equal-treatment assumptions, weak accountability, limited consultation, and slow trust-building
Mayfield et al. (2017)	United States	Medical students	Three-hour LGBTQ-inclusive sexual-history curriculum using prework, lecture, standardised patients, and debriefing	Pre-post curriculum evaluation	Improved comfort with inclusive sexual-history taking	Experiential practice, structured debriefing, and implicit-bias reflection	Short intervention, self-reported outcomes, and limited evidence of sustained behaviour change
van Roessel (2025)	Canada	GBV-sector workers addressing 2SLGBTQI+ survivors' needs	Co-designed trauma- and violence-informed e-learning module	Participatory co-design study	Produced contextually relevant curriculum content and identified service needs	Co-design, organisational support, compensation, time allocation, and cross-organisational collaboration	Structural stigma, policy constraints, confidentiality risks, and resource limitations
Lelutiu-Weinberger and Pachankis (2017)	Romania	Mental-health professionals	Two-day LGBT-affirmative practice training	Pre-post acceptability and preliminary-efficacy study	Improved perceived clinical skills, knowledge, comfort, and affirmative attitudes, with reduced homonegative and transnegative attitudes	Locally adapted content and a supportive learning environment	Highly stigmatising context, self-selection, self-reported outcomes, and limited long-term evidence
Ali et al. (2025)	Pakistan	Health providers and relevant stakeholders	Life-skills-based GBV training using role-plays, simulations, case studies, mobile networking, and mentorship	Intervention evaluation with stakeholder engagement	Significant improvements in provider and stakeholder knowledge and skills	Experiential learning, institutional support, NGO and health-department involvement, mentorship, and referral coordination	Patriarchal norms, underreporting, stigma, limited legal protection, constrained infrastructure, and no specific LBT focus

Transformative sensitisation training emerges as a promising strategy for improving provider confidence, knowledge, attitudes, and practical skills (Mayfield et al., 2017; Lelutiu-Weinberger & Pachankis, 2017; Ali et al., 2025). However, the evidence also shows that training alone is insufficient unless it is embedded within broader organisational change (Barrett & Stephens, 2012; van Roessel, 2025). The most effective interventions combine didactic learning with experiential methods, structured reflection on bias, survivor-centred principles, case-based practice, referral mapping, leadership support, ongoing mentorship, and mechanisms for accountability (Mayfield et al., 2017; Ali et al., 2025). For a study focused on LBT women in LMICs, this means that a training intervention should not simply add LBT-specific content to an existing GBV curriculum. Rather, it should adapt survivor-centred GBV practice to account for the specific forms of invisibility, stigma, risk, and exclusion that LBT women face when seeking support (van Roessel, 2025; Ali et al., 2025).

Theme 1: From Equal Treatment to Equity-Oriented and Affirming Care

Barrett & Stephens (2012) critique the assumption that inclusive care can be achieved by "treating everyone the same". The authors' account of the *How2 programme* demonstrates that this belief often functions as a barrier because it obscures the specific needs of GLBTI clients and prevents organisations from identifying exclusionary practices (Barrett & Stephens, 2012). In SGBV-IPV services, this finding is particularly important for LBT women because services may still operate with heterosexual and cisgender assumptions about survivors, perpetrators, relationships, family structures, disclosure, risk, and safety planning. A provider may believe that they are being fair by avoiding questions about sexual orientation or gender identity, yet this avoidance can make LBT women's relationships, violence experiences, and unique needs invisible. LBT women may experience IPV in same-sex or gender-diverse relationships, may fear being outed when seeking help, may have had prior discriminatory encounters with health or justice systems, and may anticipate disbelief because dominant GBV frameworks often assume male perpetrators and heterosexual female survivors (van Roessel, 2025).

This theme also appears in the Mayfield et al. (2017) article, which focuses on LGBTQ-inclusive sexual history taking and implicit bias awareness. Although the study is located

in a medical education context rather than an SGBV service setting, it offers an important lesson: provider competence requires more than factual knowledge about LGBTQ populations; it requires practice in asking inclusive questions, recognising assumptions, and responding without judgement (Mayfield et al., 2017). The use of standardised patients[3] and structured debriefing is especially relevant for LBT-inclusive SGBV-IPV training because providers must be able to practise difficult conversations before they are expected to respond to LGBTQ+ survivors of SGBV and IPV in real service settings.

Implications for Training Intervention: Equity-oriented care must explicitly acknowledge difference rather than erase it. This includes inclusive intake language, careful confidentiality practices, non-assumptive risk assessment, recognition of LBT-specific coercive tactics such as outing, and referral pathways that do not expose survivors to further stigma. Training interventions should help providers move from a general commitment to non-discrimination toward affirmative and specific practice to ensure that LBT women are not only not stigmatised but that their unique needs are addressed and they are not left more vulnerable or further traumatised.

Theme 2: Training Improves Knowledge and Confidence, but Skills Require Practice

Evidence shows that training can improve providers' knowledge, confidence, comfort, and perceived competence (Mayfield et al., 2017; Lelutiu-Weinberger & Pachankis, 2017, and Ali et al., 2025). An evaluation of a three hour sexual history taking module including prework, lecture, and standardised patient encounter followed by debriefing with second and third year medical students found statistically significant improvements in students' comfort taking sexual histories with patients of diverse sexual orientations and identities (Mayfield et al., 2017). Similarly, a two-day LGBT-affirmative mental health practice training in Romania improved mental health professionals' self-assessed clinical skills, knowledge, comfort, affirmative attitudes, and reduced homonegative and transnegative attitudes (Lelutiu-Weinberger & Pachankis, 2017). A life-skills-based GBV

[3] Standardised patients are people trained to act as patients in realistic healthcare scenarios so that providers can practice and be assessed on the knowledge, comfort, confidence and quality of care that would be rendered to prospective patients ''(Kwan et al, 2019).

training in Pakistan showed significant improvements in healthcare provider and stakeholder (i.e. government officials, civil society representatives and community leaders) knowledge and skills, supported by experiential methods such as role plays, simulations, and case studies (Ali et al., 2025).

An important finding is that training approaches that rely only on lectures may increase awareness but are less likely to produce practical changes in provider behaviour. In contrast, the most promising interventions used applied learning strategies that require participants to rehearse communication, respond to realistic cases, reflect on bias, and receive feedback (Mayfield et al., 2017; Lelutiu-Weinberger & Pachankis, 2017; Ali et al., 2025). This is important for SGBV-IPV service provision because providers are not simply transmitting information; they are managing disclosure, safety, distress, confidentiality, referral, and trust. For LBT women, the stakes of provider communication may be especially high because one insensitive question or heteronormative assumption can confirm fears that the service is unsafe (van Roessel, 2025). Feelings of insecurity or discomfort around engaging with SGBV/IPV providers and systems may lead some LBT women to avoid or withdraw from available survivor support services due to experiencing varying degrees of secondary victimisation within SGBV/IPV systems, lack of trust, or assessing that they are more risky than beneficial.

Implications for Training Intervention: pilot training should, thus, prioritise active, participatory and experiential learning rather than relying primarily on lecture-based delivery. Additionally, the training should also include follow-up support (such as mentorship, peer-learning or mobile networking groups) to reinforce learning after the initial workshop and help providers apply new skills within their service environments.

Theme 3: Organisational Readiness and Supportive Leadership Are Core Facilitating Factors

Sensitisation training is most effective when organisations are ready to support change through creating organisational systems and physical spaces (Barrett & Stephens, 2012; van Roessel, 2025; Ali et al., 2025). Even well-trained providers may struggle to provide adequate care for LBT survivors of IPV/SGBV if they lack private consultation space,

referral options, supportive supervisors, inclusive documentation systems, or organisational permission to adapt protocols (Ali et al., 2025).

Sustained commitment of senior leadership to integrate LGBTQI+ inclusive practices throughout organisational structures and systems (this can include, organisational champions (i.e. organisational staff that advocate for the broader inclusion and integration of gay, lesbian, bisexual, transgender and intersex affirming practices across organisational systems and operations), action planning, community engagement, and partnerships are key enablers of GLBTI-inclusive practice (Barrett & Stephens, 2012). The *How2* case examples show that training becomes more meaningful when it is tied to organisational audits, policy review, community engagement, and accountability mechanisms (Barrett & Stephens, 2012). Organisational support, time allocation, compensation for participation, and cross-organisational collaboration are essential for effective service provider strengthening (van Roessel, 2025). Institutional support from health departments and NGOs, as well as the inclusion of stakeholders beyond frontline providers are critical for sustainably strengthening survivor-centred and fully inclusive and affirming SGBV/IPV service delivery (Ali et al., 2025).

Implications for Training Intervention: managerial support that oversee inclusive organisational practices via clearly articulated protocols, intersectoral referral coordination, trained empathetic staff, continuous adaptation training, and supportive supervision are important facilitating factors of inclusive and affirming IPV/SGBV services for LBT women in LMICs. For the proposed training intervention, organisational readiness should be treated as both a condition for implementation and an intervention target. Before training, participating services may need a readiness assessment that examines policies, referral pathways, confidentiality procedures, staff attitudes, leadership support, data systems, and existing links with LBT or broader LGBTQI+ organisations. During training, managers and frontline staff should be engaged together so that individual learning is connected to practical organisational change.

Theme 4: Structural Stigma and Sociocultural Context Shape Service Access

The role of stigma and structural violence also emerged as a theme in this desk review (Lelutiu-Weinberger & Pachankis, 2017; van Roessel, 2025). LGBT-affirmative training can be acceptable and promising even in a highly stigmatizing national context (Lelutiu-Weinberger & Pachankis, 2017). This finding is particularly useful for LMIC settings where legal, religious, cultural, or political conditions may constrain open discussion of sexual orientation and gender identity. The Romanian study suggests that stigma does not make training impossible; rather, it makes careful adaptation, a supportive training environment, and locally relevant case discussion even more crucial (Lelutiu-Weinberger & Pachankis, 2017).

The Canadian co-design study deepens this point by framing 2SLGBTQI+ survivors' service needs through trauma- and violence-informed care (van Roessel, 2025). It shows that barriers are not only interpersonal but also structural, including homophobia, transphobia, cisnormativity, heteronormativity, and organisational policies that may conflict with individualised care (van Roessel, 2025). A study in Pakistan similarly demonstrates that GBV training must contend with patriarchal norms, underreporting, stigma, limited legal protection, and constrained health infrastructure (Ali et al., 2025). Although this study does not focus on LBT women, it provides important LMIC-specific evidence that GBV service training must be context-sensitive and must address the cultural and institutional conditions that shape disclosure and help-seeking (Ali et al., 2025).

For LBT women, structural stigma can intensify barriers to SGBV-IPV care in several ways. Survivors may fear being disbelieved because their abuse does not fit dominant cisgender, heteronormative SGBV/ IPV scripts. They may avoid reporting if police, health workers, shelter staff, or community leaders are perceived as hostile to or ignorant of LGBTQI+ people and their needs and experiences. They may also experience compounded stigma and legal risks when violence occurs in contexts where same-sex relationships are criminalised, socially condemned, or rendered invisible.

Implications for Training Intervention: Training must then therefore help providers distinguish between general SGBV structural barriers and LBT-specific structural barriers and needs, while avoiding the assumption that LBT women are a homogenous group. Moreover, it is important that the training intervention have an intersectional approach in identifying LBT-specific structural barriers. That is to say that structural barriers based on one's sexual orientation and gender identity should be read in tandem with the understanding of how other intersecting positionalities (such as ones' class, race, geographic location , disability, age, religion, gender expression, health and migration status) scaffold exposure to violence, access to care, and additional related risks of marginalisation.

Theme 5: Co-Design, Community Engagement, and Trust-Building Are Essential

Another facilitating factor identified in the reviewed articles is meaningful engagement with the communities the intervention seeks to serve (Barrett & Stephens, 2012; van Roessel, 2025). Barrett and Stephens show that client consultation, partnerships, and community engagement helped organisations build credibility with GLBTI communities (Barrett & Stephens, 2012). The case examples also show that trust-building can be slow, particularly where GLBTI clients have prior experiences of exclusion or where confidentiality is fragile (Barrett & Stephens, 2012). The van Roessel (2025) study makes this principle more explicit by involving GBV-sector workers in developing curriculum content that reflected their practice realities and perceived learning needs around 2SLGBTQI+ survivors (van Roessel, 2025). Providers need to understand that LBT women may test service safety before disclosure, may disclose selectively, or may avoid naming a partner's gender if they fear judgement. The intake process is therefore a critical intervention point (van Roessel, 2025).

For a training intervention focused on services for LBT women in LMICs, co-design is not only a methodological preference but an ethical and practical necessity (van Roessel, 2025). Training content designed without LBT women's input may reproduce the same invisibility it seeks to address. LBT women and LBT-led or LGBTQI+ community organisations can help identify locally specific risks, appropriate language, unsafe

referral points, trusted service providers, and examples of affirming practice (Barrett & Stephens, 2012; van Roessel, 2025). At the same time, co-design must be conducted carefully to avoid extracting unpaid labour from marginalised communities or exposing participants to risk. This means ensuring confidentiality, compensation where possible, safe participation options, and clear boundaries and articulations around how lived experience will be used (van Roessel, 2025).

Implications for Training Intervention: Trust-building, via a participatory LBT women co-design process, should also be treated both as a training competency skill and integrated throughout training design and implementation processes. As such, sustainably employing trust-building should place the lived realities of LBT women and LBT-led advocacy organisations at the centre of the intervention through the continued inclusion, participation and leadership of LBT women in all steps of intervention design, piloting and assessment. Furthermore, providers need to understand that LBT women may test service safety before disclosure, may disclose selectively, or may avoid naming a partner's gender if they fear judgement. The intake process is therefore a critical intervention point (van Roessel, 2025). Training should include practical exercises on introducing confidentiality, asking about relationships without assuming gender, responding to disclosure, assessing safety without outing the survivor, and making referrals that preserve dignity and choice.

Theme 6: Designing and Grounding Training Interventions in Conceptual Frameworks

The findings show that the interventions were guided by frameworks that shaped different aspects of their design, delivery and intended change. Ali et al. (2025) drew on life-skills and experiential learning, translating knowledge into applied competencies through role-plays, simulations, case studies, mentorship and stakeholder engagement. van Roessel (2025) used trauma- and violence-informed care to centre safety, choice, collaboration and attention to the structural conditions affecting 2SLGBTQI+ survivors; this framework also supported participatory co-design so that curriculum content reflected practice realities and service users' needs. Mayfield et al. (2017) integrated implicit-bias awareness into an LGBTQ-inclusive curriculum, combining reflection on

assumptions with standardised-patient encounters and debriefing to help learners recognise how bias can influence communication and clinical decisions. Lelutiu-Weinberger and Pachankis (2017) used affirmative mental-health practice principles to strengthen providers' knowledge, skills and comfort while directly addressing homonegative and transnegative attitudes in a highly stigmatising context. Barrett and Stephens (2012), although not presenting a conventional individual-level training framework, used an organisation-wide inclusion approach that linked staff development to leadership commitment, policy review, community consultation, organisational champions and action planning. Together, the studies indicate that frameworks influenced not only curriculum content but also teaching methods, stakeholder participation, organisational supports and the levels at which change was expected to occur.

For the proposed study, an integrated framework could combine survivor-centred GBV response, trauma- and violence-informed care, intersectionality and LBT-affirmative practice. Survivor-centred GBV principles would orient the intervention towards safety, confidentiality, dignity, informed choice and appropriate referral. Trauma- and violence-informed care would guide facilitators and providers to avoid retraumatisation and recognise how past and ongoing structural violence shapes disclosure and service engagement. Intersectionality would support analysis of how sexual orientation and gender identity interact with rural location, class, race, disability, age, religion, health and migration status to produce different risks and barriers to care. LBT-affirmative practice would move the training beyond generic non-discrimination by building providers' ability to recognise diverse relationships, challenge heteronormative and cisnormative assumptions, use inclusive language and respond to LBT-specific forms of coercion and exclusion. Used together, these frameworks would connect immediate provider competencies with the organisational and structural changes required for safer and more inclusive services.

Implications for Training Intervention: The design and approach of a training intervention should be explicitly anchored in the study's Theory of Change, which locates the exclusion of LBT survivors across interconnected individual, institutional

and societal levels. The reviewed articles discussed mechanisms for activating these three pathways so that the intervention makes links between actions and changes in each pathway. This can take the shape of: assessing provider and organisational gaps an barriers through surveys; service mapping; co-design approaches that ensure a locally relevant, LBT-affirmative and trauma- and violence-informed curriculum; participatory, skills-based training; strengthen inclusive procedures and referral pathways. Lastly, The Theory of Change should remain a living framework, with evaluation findings, participant feedback and dialogue with affected communities used to refine training content, implementation support and organisational action plans.

Theme 7: Intervention Evaluation Methodology and Data Collection Tools

The reviewed studies used different methods for developing and evaluating training interventions indicating significant gaps in the evidence base for this research question. van Roessel (2025) used participatory co-design to develop contextually relevant curriculum content but did not test training effectiveness. Barrett and Stephens (2012) reported organisational case examples and implementation processes rather than measured participant outcomes. Mayfield et al. (2017) and Lelutiu-Weinberger and Pachankis (2017) used pre-post evaluations that identified short-term changes in self-reported knowledge, comfort, attitudes and perceived skills. Ali et al. (2025) assessed changes in provider and stakeholder knowledge and skills and incorporated stakeholder engagement and post-training support. Across the studies, self-reported measures were more common than observed practice, organisational change or survivor outcomes. The evidence therefore supports conclusions about training acceptability and short-term learning more strongly than conclusions about sustained service transformation. Further, practical constraints affecting implementation and evaluation included staff turnover, limited time and resources, difficulty releasing providers from service duties, political or cultural resistance, participant self-selection and limited follow-up. These findings indicate the importance of more investment in evidence building to improve and transform SGBV/IPV services for LBT women.

Recommendations for the intervention

Based on the findings and the implications identified across the themes, the proposed training intervention should take the following actions into consideration:

- Use participatory and experiential learning methods, including case discussions, role-plays, simulations, reflective exercises, and opportunities to practise inclusive communication and safety assessment. Note that these approaches take time and brief trainings are not effective.
- Integrate LBT-affirmative content into survivor-centred GBV practice rather than treating LBT inclusion as an optional add-on to existing training.
- Include content on specific vulnerabilities and risks that LBT women are navigating and emphasise confidentiality, fear of outing, non-assumptive relationship questions, LBT-specific coercive tactics, secondary victimisation, referral safety, and the limits of “treating everyone the same”.
- Engage managers and frontline providers together so that individual learning is connected to organisational change, including protocols, documentation, referral pathways, supervision, and accountability mechanisms. Provide opportunities for training participants to identify individual actions and organisational changes that will support inclusive and affirmative care for LBT women who have experienced SGBV/IPV.
- Include LBT women and LBT-led or LGBTQI+ organisations in intervention design, piloting, and feedback processes in ways that protect confidentiality, avoid tokenism, and recognise community expertise.
- Build in follow-up support, such as mentorship, peer learning, or mobile networking, to help providers apply and continuously strengthen training in practice and sustain learning beyond the initial workshop.
- Use evaluation tools that capture more than participant satisfaction with trining by assessing changes in knowledge, attitudes, confidence, skills, practices, and organisational improvements where feasible.

Reflection on the Theory of Change

The findings support strengthening the intervention's Theory of Change by making the links between individual, organisational, and structural change more explicit. At the individual level, the intervention should build providers' knowledge, confidence, attitudes, and practical skills. At the organisational level, it should support services to review procedures, referral pathways, confidentiality practices, documentation systems, and supervision arrangements. At the structural level, it should recognise how stigma, rurality, resource constraints, and broader social norms shape whether LBT women experience services as safe, accessible, and trustworthy. The Theory of Change should therefore remain a living framework that is refined through formative findings, participant feedback, and dialogue with affected communities and service providers.

Final Reflections

The findings of this desk review show that service provider training is necessary but not sufficient on its own to improve SGBV/IPV services for LBT women. Across the included studies, training was most promising when it was linked to organisational systems, supportive leadership, clear protocols, referral pathways, participatory learning methods, and credible commitments to inclusion. The review also shows that stigma—whether expressed through homonegativity, transnegativity, heteronormativity, cisnormativity, patriarchal norms, or structural violence—remains a central condition shaping both LBT women's access to services and providers' ability to respond safely and affirmingly.

A key reflection is the limited evidence base directly addressing service-provider interventions for LBT women experiencing SGBV/IPV in LMICs. Because only a small number of studies spoke directly to the review question, the desk review had to draw on adjacent evidence from broader LGBTQI+ service inclusion, GBV training, health-provider education, and high-income contexts. This limits the strength of conclusions that can be drawn, but it also highlights the importance of this study's formative research and pilot intervention in contributing to the limited evidence base.

The synthesis suggests that effective interventions need to bridge two fields that are often treated separately. General GBV training may improve understanding of violence, disclosure, safety planning, and referral, but may not address the invisibility of LBT relationships, fear of outing, discriminatory service encounters, or assumptions that IPV is always heterosexual. Similarly, general LGBTQI+ sensitisation may improve attitudes, but may not equip providers to manage acute SGBV/IPV risk, trauma, safety planning, or referral coordination. The proposed intervention therefore needs to combine survivor-centred GBV practice with LBT-affirmative, trauma- and violence-informed, and intersectional approaches.

Reference List

Ali, T.S., Merchant, A., Qamar, W., Memon, Z.A., Barolia, R. and Bhutta, Z.A. (2025) 'Enhancing health workforce capacity through life skills-based interventions: evidence from Pakistan on reducing gender-based violence', *BMC Health Services Research*, 25, article 1044.

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19–32.

Barrett, C. and Stephens, K. (2012) *Beyond: 'we treat everyone the same': A report on the 2010–2011 program How2 create a gay, lesbian, bisexual, transgender and intersex inclusive service*. Melbourne: Gay and Lesbian Health Victoria.

Kwan A, Daniels B, Bergkvist S, Das V, Pai M, Das J. Use of standardised patients for healthcare quality research in low- and middle-income countries. BMJ Global Health. 2019;4:e001669. https://doi.org/10.1136/bmjgh-2019-001669

Lelutiu-Weinberger, C. and Pachankis, J.E. (2017) 'Acceptability and preliminary efficacy of a lesbian, gay, bisexual, and transgender-affirmative mental health practice training in a highly stigmatizing national context', *LGBT Health*, 4(5), pp. 360–370. doi: 10.1089/lgbt.2016.0194.

Mayfield, J.J., Ball, E.M., Tillery, K.A. et al. (2017) 'Beyond men, women, or both: A comprehensive LGBTQ-inclusive, implicit-bias-aware, standardized-patient-based sexual history taking curriculum', *MedEdPORTAL*, 13, article 10634. doi: 10.15766/mep_2374-8265.10634.

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., et al. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Annals of Internal Medicine, 169*(7), 467–473.

van Roessel, L.H. (2025) *The co-design of a trauma- and violence-informed care e-learning module for the gender-based violence sector: The unique service needs of 2SLGBTQI+ survivors*. Master's thesis. Southern Ontario.