CHAPTER 10
GENDER-BASED VIOLENCE

10.1 INTRODUCTION

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.

The term "gender-based violence" (sometimes referred to as "sexual and gender-based violence") highlights the gendered dimension of these types of acts. In other words, this term highlights the relationship between females' subordinate status in society and their increased vulnerability to violence. Women and girls are the most affected by GBV and thus the term "gender-based violence" is often used interchangeably with the term "violence against women." However, violence against men and boys may also be gendered and/or sexual in nature, particularly when they are subjected to torture,

detainment, or forced participation as child soldiers. Additionally, the term GBV may also be used to refer to violence targeting lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQIA) persons who face risks as a result of being seen as defying a society's established sexual and gender norms, otherwise referred to as gender non-conforming.

GBV includes:

- Sexual violence, including rape, sexual abuse, sexual exploitation and forced prostitution
- Domestic and intimate partner violence
- Child, early, and forced marriage
- Harmful traditional practices such as female genital cutting, so-called "honor" crimes, and widow inheritance
- Human trafficking, including sex trafficking, child trafficking, and labor trafficking
- Denial of resources and lack of opportunities based on gender, sexual orientation, and/or gender identity
- Harmful acts based on sexual orientation and/or gender identity

BOX 10.1: GENDER-BASED VIOLENCE: SOME DEFINITIONS

SEXUAL VIOLENCE (SV)

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. Sexual violence includes:

- ***Rape/attempted rape***
  Rape is an act of non-consensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Efforts to rape someone that do not result in penetration are considered attempted rape
- ***Sexual abuse***
  Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions
- ***Sexual exploitation***
  Any actual or attempted abuse of a position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another

DOMESTIC VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)

Domestic violence takes place between current or former intimate partners (spouses, boyfriend/girlfriend) as well as between family members (e.g., mothers-in-law and daughters-in-law). Domestic violence may include sexual, physical, and psychological abuse. Other terms used to refer to domestic violence perpetrated by an intimate partner include "spousal abuse" and "wife battering."

FEMALE GENITAL CUTTING

FGC constitutes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. These practices are sometimes referred to as "female circumcision" or "female genital mutilation."

FORCED EARLY MARRIAGE

This occurs when parents or others arrange for and force a minor to marry someone. Force may occur by exerting pressure or by ordering a minor to get married and may be for dowry-related or other reasons. Forced marriage is a form of GBV because the minor is not allowed to, or is not old enough to, make an informed choice.

Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many forms of GBV are illegal and criminal acts in national laws and policies, although these may differ in both content and implementation from country to country. Although responsibility for GBV falls to the protection cluster, prevention of sexual violence, particularly in facilitating safe access to health care and care for survivors of sexual violence, and other medical and mental health care, are under the remit of the health sector/cluster.

The consequences of GBV can be immediate or long-term, resulting directly from violent acts or secondary long-term effects:

- The physical consequences range from relatively minor injuries to severe injuries leading to death or permanent disabilities and impairments, unintended pregnancies, unsafe abortion, adverse pregnancy outcomes, including miscarriage, low birth weight, and increased rates of fetal death and neonatal and infant mortality, sexually transmitted infections (STIs), including HIV, pelvic inflammatory disease, infertility, and chronic pain syndromes, and urinary tract infections
- Psychological consequences include anxiety, including post-traumatic stress disorder (PTSD), depression, feelings of inferiority, inability to trust, fear, increased substance use and abuse, sleep disturbances, eating disorders, sexual dysfunction, and suicide or self-harm

BOX 10.2: GENDER-BASED VIOLENCE IN HUMANITARIAN SETTINGS

- In the Democratic Republic of the Congo during 2013, the United Nations' Children's Fund (UNICEF) coordinated with partners to provide services to 12,247 GBV survivors; 3,827, approximately 30%, were children, of whom 3,748 were girls and 79 were boys
- In Pakistan following the 2011 floods, 52% of surveyed communities reported that privacy and safety of women and girls was a key concern. In a 2012 protection rapid assessment with conflict-affected internally displaced persons (IDPs), interviewed communities reported that a number of women and girls were facing aggravated domestic violence, forced marriage, early marriages, and exchange marriages, in addition to other cases of gender-based violence
- In Afghanistan, a household survey in 2008 showed that 87.2% of women reported one form of violence in their lifetime and 62% had experienced multiple forms of violence
- In Liberia, a survey of 1,666 adults found that 32.6% of male combatants experienced sexual violence while 16.5% were forced to be sexual servants. Of a sample of 388 Liberian refugee women living in camps in Sierra Leone, 74% reported being sexually abused prior to being displaced; 55% experienced sexual violence during displacement
- Of 64 women with disabilities interviewed in post-conflict Northern Uganda, one third reported experiencing some form of GBV and several had children as a result of rape
- In a 2011 assessment, Somali adolescent girls in the Dadaab refugee complex in Kenya explained that they are in many ways 'under attack' from violence that includes verbal and physical harassment, sexual exploitation and abuse in relation to meeting their basic needs and rape, including in public and by multiple perpetrators. Girls reported feeling particularly vulnerable to violence while accessing scarce services and resources, such as at water points or while collecting firewood outside the camps
- In Mali, daughters of displaced families from the North (where female genital cutting is not traditionally practiced) were living among host communities in the South (where FGC is common). Many of these girls were ostracized for not having undergone FGC; this led families from the North to feel pressured to perform FGC on their daughters
- Domestic violence was widely reported to have increased in the aftermath of the 2004 Indian Ocean tsunami. One NGO reported a three-fold increase in cases brought to them. Studies from the United States, Canada, New Zealand and Australia also suggest a significant increase in intimate partner violence related to natural disasters
- Research undertaken by the Human Rights Documentation Unit and the Burmese Women's Union in 2000 concluded that an estimated 40,000 Burmese women are trafficked each year into Thailand's factories and brothels and as domestic workers
- The Gender-Based Violence Information Management System (GBVIMS), initiated in Colombia in 2011 to improve survivor access to care, has collected GBV incident data from 7 municipalities. As of mid-2014, 3,499 females (92.6% of whom were 18 years or older) and 437 males (91.8% of whom were 18 years or older) were recorded in the GBVIMS, of whom over 3,000 received assistance

- GBV also has a large impact on the social health of the individual and the community in terms of stigma, isolation, and rejection of survivors and children born as a result of rape (including by husbands and families), losses in women's income potential, interrupted education of adolescents, and homicide (e.g., so called "honor" killings and female infanticide)

Although GBV is a global issue the nature and extent of specific types of GBV vary across countries and regions. GBV is often underreported, but various forms of GBV have been documented during humanitarian crises and it should be assumed that GBV is occurring from the start of a crisis regardless of whether prevalence data are available.

Gender-based violence may occur throughout and across the life cycle (see Fig. 10.1). Some people are more vulnerable than others based on their membership in different identity groups.

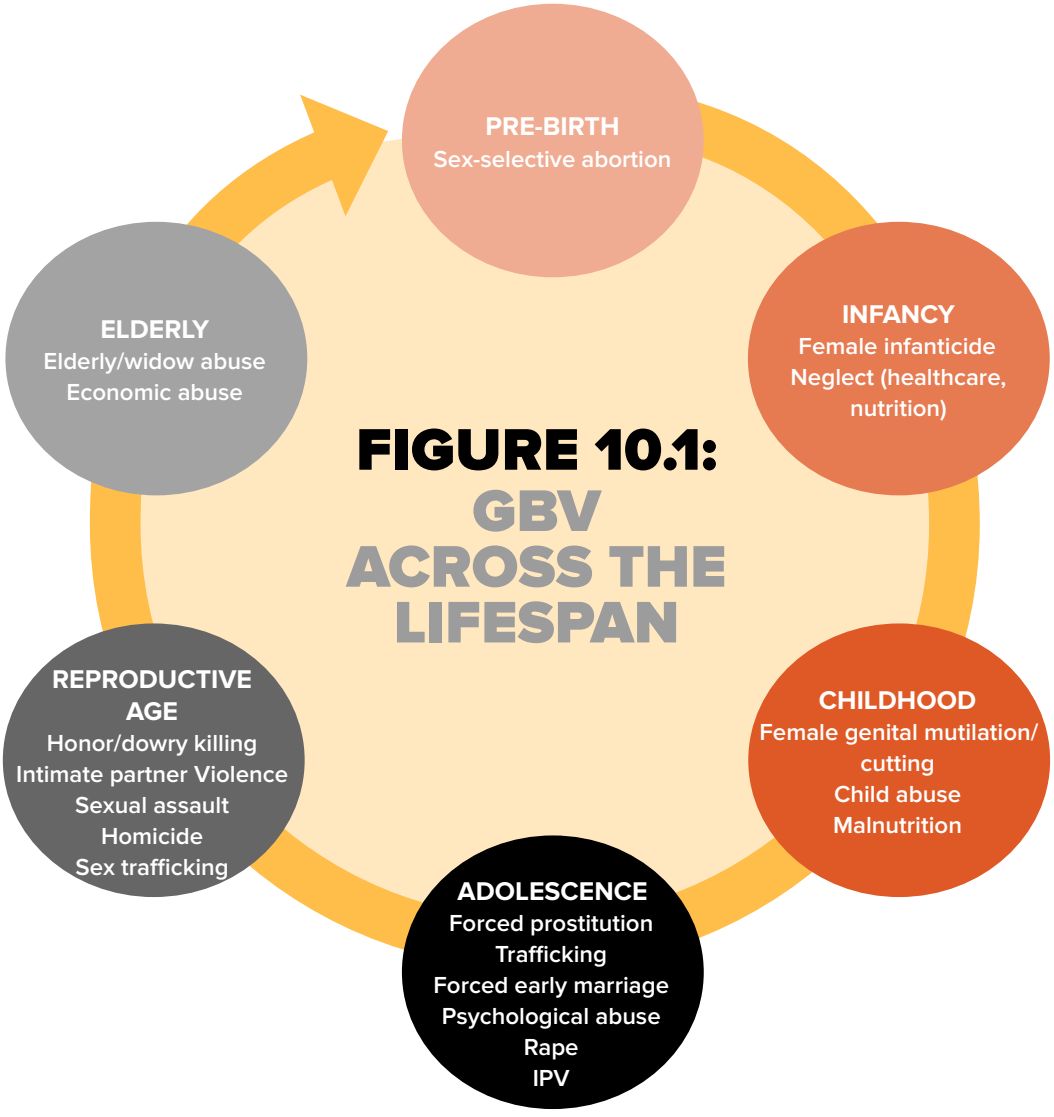

FIGURE 10.1: GBV ACROSS THE LIFESPAN

10.2 OBJECTIVES

This chapter focuses on the responsibility of sexual and reproductive health (SRH) Coordinators, health program managers, and service providers in preventing and responding to GBV-related health consequences. The objectives of this chapter are to assist them to understand:

- How GBV can take a range of forms and affect different subpopulations
- The roles and responsibilities of the health sector in responding to GBV in humanitarian settings

- The multi-sectoral approach to prevent and respond to GBV
- How to support the integration of GBV prevention and response elements into the health sector/cluster

10.3 GENDER-BASED VIOLENCE PROGRAMMING

10.3.1 Minimum Initial Service Package implementation

Health services are often the first - and sometimes the only - point of contact for survivors seeking assistance for GBV. From the earliest stages of an emergency, health actors must work to prevent and provide clinical care for survivors of sexual violence per the Minimum Initial Service Package (MISP). Preventing sexual violence and responding to the needs of survivors is a core objective of the MISP. Priority activities center on: 1) Working with other clusters, especially the protection or gender-based violence sub-cluster, to put in place preventive measures at community, local, and district levels including health facilities to protect affected populations, particularly women and girls, from sexual violence; 2) Making clinical care and referral to other supportive services available for survivors of sexual violence; and 3) Putting in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.

As soon as possible, health sector actors should be equipped to provide clinical care to survivors of all types of GBV and make referrals as necessary to other relevant services. Crucial to providing accessible and quality healthcare services for GBV survivors, is ensuring their delivery in a safe, confidential, dignified and non-discriminatory manner that considers the survivor's gender, age, and any specific needs.

10.3.2 Needs assessment

While assessments are an important foundation for program design and implementation, they are not a prerequisite for putting in place some essential GBV prevention, mitigation, and response measures prior to or from the onset of an emergency. Many risk-reduction interventions can be introduced without conducting an assessment. For example, health sector actors can implement the MISP at the onset of every emergency.

Integrate GBV considerations into needs assessments for comprehensive SRH service planning. Within the multi-sectoral framework, SRH Coordinators and health program managers are part of the Health sector/cluster and must collaborate with other sector/cluster actors involved in GBV programming to collect the following information:

AT THE COMMUNITY LEVEL

- Level of awareness about the health consequences of GBV and when and where to access relevant health services
- Level of awareness of GBV-related services and resources among populations at-risk

AT THE PROGRAM LEVEL

- International and local actors working on GBV
- The existence of national, multi-sectoral and interagency operating procedures, protocols, practices, and reporting forms
- Location and type of services providing care for survivors of GBV (health, community support, social, psychological, legal)
- The extent of adherence to ethical and safety standards in health services (safety, privacy, confidentiality, respect)
- SRH program staff and healthcare provider training needs
- Availability of supplies to care for survivors of sexual violence, including emergency contraception (EC), post-exposure prophylaxis (PEP), and medicines and manual vacuum aspiration (MVA) equipment for safe abortion care to the full extent of the law
- GBV data collected at the facility-level

AT THE NATIONAL LEVEL

- National protocols related to GBV medical care and referral

- National laws related to GBV and types of GBV mentioned
- National plans/policies to eliminate GBV. What types of GBV does the plan target?
- The legal definition of rape. The legal age of consent for sexual activity. Does it differ for boys and girls?
- Mandatory reporting laws for cases of sexual abuse and sexual assault
- National laws on abortion in the context of rape and incest
- Cadres of health service providers authorized to collect forensic evidence and the range of forensic evidence admissible in courts of law

It is generally accepted that GBV, and in particular sexual violence, is underreported almost everywhere in the world. Survivors fear potentially harmful social, physical, psychological, or legal consequences if they disclose the event. In settings characterized by instability, insecurity, loss of autonomy, breakdown of law and order, and widespread disruption of community and family support systems, disclosure is even less likely. Any available data, in any setting, about GBV reports from police, legal, health or other sources will represent only the small proportion of survivors who choose to self-report and should not be used to establish prevalence or incidence or to make conclusions about common types of GBV.

Any inquiry into sexual violence and other forms of GBV must be designed and carried out with an understanding of the situation and take into consideration how the information will be used, who will see it, how the information will be reported, to whom and for what purpose and who will benefit from it. Consider ethical and safety issues at all times when involved in collecting, analyzing and reporting on GBV information.

BOX 10.3: SAFETY, ETHICAL, AND METHODOLOGICAL RECOMMENDATIONS FOR DOCUMENTING AND SHARING INFORMATION ON GBV CASES REPORTED TO SRH SERVICES

WHEN DOCUMENTING INFORMATION

- Basic care and support for survivors must be available before commencing any activity that may involve individuals disclosing information about their experiences of GBV
- The safety and security of service providers involved in gathering information about GBV is of paramount concern and in humanitarian settings in particular should be continuously monitored
- The confidentiality of individuals who provide information about GBV must be protected at all times and they must give informed consent before their information is documented
- SRH service providers caring for GBV survivors must be carefully selected and receive relevant and sufficient specialized training and ongoing support
- Staff must be trained on and held accountable for adhering to data protection protocols
- Additional safeguards must be put into place if children (i.e., those under 18 years) are involved

WHEN SHARING DATA

- Keep in mind the audience and possible use of the data and offer guidance on interpretation of the data
- Provide the context for all reported data. If known, and safe to do so, provide information on the camps/clinics/districts from where cases are reported. Be specific, e.g., "reported cases from X number of health facilities"
- Only share a comprehensive description of the incident if this cannot be linked back to individual survivors (precise date and location, information on the victim, ethnicity, age, sex, medical findings, should only be included when safe to do so)
- Provide additional information that may have contributed to changes in the number of reported cases from the previous reporting period. For example, more services available, public information campaigns, upsurge in violent attacks. Whenever possible, information on when incidents took place should be collected and the information reported along with aggregated numbers
- Label all tables and reports appropriately to avoid the information being taken out of context

10.3.3 Programming considerations for GBV survivors

Health programming approaches to prevent, mitigate, and respond to GBV must be adapted to the changing nature of emergencies, including the increasing urbanization of internally displaced, migrant, and refugee populations, protracted emergencies especially in fragile states, as well adaptions to both slow and sudden onset emergencies. Furthermore, strategies for coverage and access for non-camp settings, rural areas, and more inaccessible settings (e.g., areas under siege, high security contexts) must be considered and addressed. Table 10.1 presents key actions for preventing and responding to GBV at different stages of emergency.

TABLE 10.1: KEY ACTIONS FOR HEALTH ACTORS TO PREVENT AND RESPOND TO GBV

KEY ACTIONS	PREPAREDNESS	RESPONSE	RECOVERY
Ensure women and adolescent girls have immediate access to priority reproductive health services as outlined in the MISP at the onset of an emergency		X	
Ensure GBV survivors have access to high-quality, life-saving health care, including post-rape treatment and clinical care for other forms of GBV		X	X
After the immediate onset and during transition phases, re-establish comprehensive reproductive health services, including GBV treatment and referral systems			X
Involve women, adolescent girls and other at-risk groups in the design and delivery of health programming (with due caution where this poses a potential security risk or increases the risk of GBV)	X	X	X
Pre-position trained staff and appropriate supplies to implement clinical care for GBV survivors in a variety of health delivery systems (e.g., medical drugs, equipment, administrative supplies, mental health and psychosocial support, referrals, etc.)	X	X	
Develop and/or standardize protocols and policies for GBV-related health programming, in partnership with Ministry of Health, as feasible, and civil society actors including women's rights groups, to ensure integrated, quality care for survivors	X	X	X
Enhance the capacity of health providers to deliver quality care which is age, gender and culturally appropriate to survivors through training, support and supervision on GBV prevention and clinical care for sexual assault and other forms of GBV. Ensure a clear focus on clinical and attitudinal competencies for child-friendly care and to promote access and recovery for both male and female survivors	X	X	X
Promote integration of available health services in GBV standard operating procedures and/or referral pathways; promote quality of care assessments as context allows	X	X	X
Assess and address the accessibility of health and reproductive health facilities that integrate GBV-related services (e.g., provide safe and confidential escorts to facilities, make opening times convenient, ensure universal access for persons with disabilities, eliminate service fees, etc.)	X	X	X
Implement strategies that maximize the quality of survivor care at health facilities (e.g., implement standardized guidelines for the clinical care of sexual assault; establish private consultation rooms; maintain adequate supplies and medical drugs; provide follow-up services, etc.)		X	X
Ensure information sharing and coordination between health and GBV working groups, including identifying joint actions to address GBV risks and ensure protection for women, girls and other at-risk groups and provide quality health services to GBV survivors		X	X
Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a focal point to regularly participate in GBV working group meetings		X	X
Identify, collect and analyze a core set of indicators - disaggregated by sex, age, disability and other relevant vulnerability factors - to monitor GBV risk-reduction activities throughout the program cycle	X	X	X

SRH Coordinators and health program managers must ensure that service providers are trained to provide competent, confidential, and compassionate clinical care for survivors of sexual violence and that they have the supplies to do so. This section outlines different types of GBV and their SRH consequences as well as specific prevention and response strategies.

SEXUAL VIOLENCE

Sexual violence takes many forms and includes rape, sexual harassment, forced pregnancies/abortions, sexual exploitation, and sex-trafficking. Sexual violence is often referred to as any non-consensual sexual act, attempt to obtain a sexual act, unwanted sexual comments, or advances directed against a person's sexuality.

Individuals displaced, living in conflict and other emergency settings face increased vulnerability to sexual violence. For these populations, violence may occur within the context of war or conflict, during transit and displacement, and in the camp/settlement setting. Due to the breakdown of family and social structures and changes to law enforcement and protective structures, loss of secure housing, limited economic opportunities and instability, conflict- or crisis-affected populations face an increased risk of opportunistic sexual violence by both known or unknown perpetrators. Moreover, in some conflict or post-conflict settings, sexual violence is used as a tactic of war. It is estimated that more than 1 in 5 women/girls experience sexual violence during displacement in their lifetime. This is likely an underestimate due in part to lack of awareness of available services and stigma associated with reporting these violations.

At a minimum, health facilities in humanitarian settings are expected to establish basic clinical care according to the MISP guidelines and referral for psychosocial and protection services for survivors of sexual violence. Typically access to these services for survivors requires that survivors or family members and communities seek out services and disclose the sexual abuse. Some of the barriers survivors face are lack of knowledge around available services and the importance of timely care. Furthermore, the survivors need to trust in the confidentiality, privacy, and compassion of the health provider at facility level. These are some of the reasons why sexual violence continues to be under-reported, services under-utilized, and victimization of sexual violence survivors continues in humanitarian settings.

Impact on health

Sexual violence is among the most pervasive forms of violence and is a major public health concern. It is a traumatic experience that may have a variety of negative consequences on women's psychological, physical, sexual, and reproductive health.

The negative health impacts of sexual violence may be both short- and long-term and may include:

- Physical injury
- Psychological disorders
- STIs including HIV
- Unintended pregnancy and unsafe abortion
- Fistula and chronic pain
- Death

Death may result directly as a result of violence or as the result of suicide after the event. Further, sexual violence survivors may also be at risk of being killed by family members or members of the community, a practice that is sometimes referred to as an "honor killing."

Sexual violence diminishes the ability of women and girls, along with other at-risk populations, to meaningfully participate in development, peacekeeping, educational opportunities, and economic activities. Entire communities suffer deeply due to the multi-layered impacts of sexual violence.

SRH response

The health sector's responsibilities when responding to sexual violence are to:

- Ensure that health facilities are equipped and staffed and that high quality, life-saving health services including post-rape care are available
- Enhance the capacity of health providers at all levels to respond to survivors through training, support, and supervision in a non-discriminatory, confidential, and safe manner

- Through training, support, and supervision, providers should be sensitized to address issues such as counseling for and providing emergency contraception and comprehensive safe abortion care, virginity testing as medical malpractice, and caring for girls, boys, men, LGBTQIA individuals, and other marginalized groups
- Ensure the health sector actively participates in the development and continual update of a functional and comprehensive referral pathway that takes all needs of survivors into account
- Ensure that standards and protocols for prevention and treatment of consequences of sexual violence including documentation and information sharing in a confidential manner are in line with international guidelines and that these are properly and consistently implemented

Healthcare providers frequently come into contact with survivors of sexual violence and are in a unique position to create a safe and confidential environment for survivors to disclose their experiences of violence. Sometimes the survivors will need clinical care to prevent or treat consequences of sexual violence and in some cases the appropriate support will be referral to other resources and services depending on the survivor's needs and wishes. Irrespective of the circumstances, healthcare providers who come into contact with survivors need to be sensitive to signs and symptoms of sexual violence and act appropriately.

DOMESTIC AND INTIMATE PARTNER VIOLENCE

The World Health Organization (WHO) defines IPV as any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Intimate partner violence is considered one form of domestic violence, which also includes other forms of violence that takes place in the home or family, such as child or elder abuse and abuse from other relatives. Globally, 1 in 3 women is beaten, coerced into sex, or otherwise abused by a past or current intimate partner in the course of her lifetime.

Economic coercion is a form of IPV where one partner, typically the male partner in a heterosexual relationship, controls vital resources and assets of the other partner compelling that individual into some course of action. Frequently, economic coercion limits a woman's ability to leave an abusive relationship and fosters dependence. This is particularly true in emergencies where social and economic systems are destabilized, as well as in camp settings where access to and control of resources is important.

Impact on health

Domestic and intimate partner violence impacts the survivor in a myriad of ways. These can include, but are not limited to:

- Physical injury, including breaks, bruises, sexual assault, and other forms of trauma
- Psychological disorders, including depression, PTSD, and suicide
- STIs including HIV
- Miscarriage and pregnancy loss
- Forced pregnancy, unintended pregnancy, and unsafe abortion
- Death

SRH response

Service providers and healthcare personnel can play a strategic role in detecting, referring, and caring for women living with violence. The response steps below are a minimum response, to be expanded quickly to comprehensive care as soon as possible. It is also important that care be provided in a sensitive way, meeting the needs of increasingly vulnerable populations (women, adolescents, young boys, elderly persons, persons with disabilities, LGBTQIA people, etc.).

Detection

Abused women often seek health care, even when they do not disclose the violent event. Thus, interventions by SRH providers can potentially mitigate both the short- and long-term health effects of GBV on women and their families.

Train all SRH providers to recognize signs of domestic and intimate partner violence and how to respond to suspected or reported abuse. If abuse is suspected (for example if

the provider sees unexplained bruises or other injuries), SRH professionals may probe for more information in a private, caring, and nonjudgmental manner. For example: "Has your partner or another person important to you ever hurt or physically harmed you in any way (such as hitting, kicking or burning you)?" or "Are you afraid of your partner?" Maintain confidentiality because the survivor and/or other relatives could be subjected to further harm. Make sure the survivor has a safe place to go to. If she has to return to the abuser, retaliation may follow. If a safe place is not immediately available, work with the survivor to develop an alternative safety plan.

In collaboration with Health Coordinators, ensure that:

- All clinic and reception staff are aware of domestic and intimate partner violence
- All staff understand and apply the four guiding principles of safety, respect, confidentiality, and non-discrimination
- Posters and leaflets that condemn violence and information on support groups are displayed

Referrals

Train all SRH providers to refer cases of domestic and intimate partner violence by doing the following:

- If the abuser learns that the matter has been reported, help the survivor to assess her present risk for harm: "Are you or your children in immediate danger?" "Do you feel safe to go home?" "Would you like some help with the situation at home?"
- Offer information and referral for legal advice, social support, or other services. Help her to identify sources of support such as family and friends, local women's groups, shelters, and legal services. Make it clear to the survivor that she is not alone
- Refer her for post-rape services or other medical treatment as needed
- Refer her to psychosocial services and mental health support if available

Care

Domestic or intimate partner violence often includes sexual violence and survivors should receive care accordingly. In addition, care for domestic and IPV survivors should include:

- Providing first line support using a survivor-centered approach
- Being equipped to provide 24/7 emergency care and treating acute injuries
- Referring to appropriate and available mental health services

HARMFUL PRACTICES

The term "harmful practices" may refer to various abuses of the rights of women and girls including, but not limited to, female infanticide, child, early, and forced marriage, female genital cutting (FGC), and so-called "honor" crimes. Harmful practices can be understood as social conventions upheld by deeply-rooted discriminatory gender, social, and cultural norms and inequalities, beliefs relating to women's position within the home and society, women's sexual morality, and, in some cases, marriageability. Conflict or crisis settings exacerbate the risk of some of these harmful practices. Due to their high prevalence globally and specific impact on the SRH of women and girls, this section focuses on the issues of FGC and child, early, and forced marriage.

FEMALE GENITAL CUTTING

It is estimated that over 200 million girls and women have undergone some form of FGC and 3 million girls are at risk of being subjected to the practice each year. The majority of these girls and women live in Africa, although the practice is also prevalent in certain countries in the Middle East and North Africa, Asia, and other regions. SRH Coordinators and health program managers must be aware that FGC and health consequences related to FGC may be common among the population in the setting in which they work. FGC, regardless of the type (see Box 10.4), constitutes an extreme form of discrimination against women and is a violation of human rights. Approximately 10% of women and girls who are subjected to FGC undergo Type III, the most severe form.

BOX 10.4: FGC CLASSIFICATIONS ACCORDING TO THE WHO

TYPE I	**Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce**
TYPE II	**Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)**
TYPE III	**Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)**
TYPE IV	**All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization**

FGC is often performed by traditional practitioners with limited knowledge of anatomy and medicine, who may be unable to effectively respond when complications arise. Professional medical practitioners may also be asked to perform FGC, out of a belief that it will make the procedure safer. The WHO urges health professionals not to legitimize the practice by performing any form of FGC, including re-infibulation, which is the sewing of the external labia back together after a deinfibulation, or opening of the labia, has been performed to allow for sexual intercourse or child birth.

BOX 10.5: KEY MESSAGE

The medicalization of FGC - willful damage by health professionals to healthy organs for nontherapeutic reasons - is a misguided and unethical step that fails to address the fundamental injustice of FGM.

Impacts of FGC on SRH

There are no health benefits to girls and women from FGC and those who experience it are at risk for a number of immediate and long-term health consequences that may impact them throughout the course of their lives.

Immediate complications include:

- Hemorrhage (one of the most common complications), pain, shock
- Infections, including local infections, abscess formation, septicemia, genital and reproductive tract infections, urinary tract infections, and transmission HIV or other infections from the use of unsanitary tools
- Urine retention
- Issues with the wound healing
- Injury to neighboring organs, such as the urethra, vagina, or rectum
- Death

Long-term complications include:

- Menstrual difficulties, including dysmenorrhea, irregular menses, and difficulty passing menstrual blood
- Pain and/or difficulty in passing urine
- Recurrent urinary tract infections
- Chronic pelvic infections which may increase the risk of ectopic pregnancy or infertility
- Abscesses and cysts
- Possible increased risk of transmission of HIV
- Reduced sexual sensitivity and painful intercourse

Problems during pregnancy and childbirth are common in women who have undergone Type III FGC. Obstetric complications include prolonged or obstructed labor,

caesarean section, obstetric lacerations, hemorrhage, and infection. The causal relationship between prolonged and/or obstructed labor and obstetric fistula suggests that some forms of FGC may also lead to an increased risk of fistula. These various complications are also associated with higher incidence of stillbirth and neonatal death, as well as fetal asphyxiation.

The trauma of FGC may have long-term psychological impacts. The procedure, and the physical health consequences resulting from it, are associated with issues such as anxiety, depression and post-traumatic stress disorder. The physical and psychological impact of FGC may for some also contribute to the development of problems in sexual relationships.

It is important to remember that not all women who have undergone FGC will experience any particular related health problem. On the other hand, women may be unaware that the health problems they suffer are the result of FGC.

SRH response

SRH service providers must be able to interview and conduct a physical examination of women who have undergone FGC, recognize and provide appropriate information, counseling, support, treatment and/or referral for further management of the complications of FGC in a confidential, private, and non-judgmental manner (see Chapter 9).

Maternal and newborn health

Ensure SRH service providers who have midwifery duties are trained to assess and manage women with complications due to FGC during pregnancy, labor and delivery, and the post-partum period. This includes deinfibulation and infant resuscitation at delivery.

Deinfibulation

In settings where Type III FGC is common, SRH Coordinators and health program managers must ensure that service providers are trained in deinfibulation (opening up an infibulation) when indicated, or know when and where to refer for this procedure. In addition to being performed to allow for intercourse, this procedure is recommended for preventing and treating obstetric complications, facilitating childbirth, and preventing and treating urologic complications, including urinary tract infections and urine retention. Providers should ensure clients undergoing deinfibulation for childbirth or other reasons have information on the health consequences of re-infibulation (procedure to narrow the vaginal opening in a woman after she has been deinfibulated) and the benefits of not re-infibulating. Deinfibulation, performed with informed consent, may also be viewed as an attempt to restore a woman's right to the highest attainable standard of health.

Contraception

Contraception is as appropriate for girls and women with FGC as it is for any other client. Women who have undergone Type III FGC may have difficulties in using a method that has to be inserted vaginally, such as an intrauterine device (IUD), female condoms, or vaginal rings. This highlights the importance for contraceptive counseling and method mix.

CHILD, EARLY, AND FORCED MARRIAGE

Each year approximately 15 million girls globally are married before their 18th birthday. Although child marriage occurs in communities around the world, the majority of these marriages are concentrated in developing countries, where 1 in 3 girls is married before 18 and 1 in 9 is married before age 15. There is increasing evidence to suggest that child marriage often increases during times of crisis.

In addition to gender or cultural norms, socioeconomic factors, including dowries, bride price, or a lack of resources to care for daughters, often also play a role in families' decisions to marry off girls. During humanitarian emergencies families often experience loss of livelihoods and may struggle to provide the food and other resources needed to take care of children, amplifying the economic factors that lead to child marriage. Furthermore, some families may seek to marry off girls to those they feel are better able to provide for them during the crisis, or perceive marriage as a means of protection from other forms of violence, including sexual violence, which increases during emergencies. Preventing and responding to child, early, and forced marriage requires an inter-sectoral response.

Impact of child, early, and forced marriage on SRH

Child, early, and forced marriage violate a number of

human rights, including the right to the highest attainable standard of health.

Early pregnancy

Young brides often face pressure to prove their fertility by becoming pregnant soon after marriage. This pressure, exacerbated by the unequal power dynamics within early marriages, limits girls' decision-making, and a lack of information about the contraception options that are available to them often leads to early pregnancy. The stress of pregnancy, labor, and delivery on the bodies of adolescent girls who have not yet reached physical maturity heightens their risk of complications, including miscarriage, pre-term birth, post-partum hemorrhage, prolonged and/or obstructed labor, obstetric fistula, and death. Maternal mortality is the second leading cause of death among adolescent girls between the ages of 15-19 worldwide.

HIV/STIs

Married girls are often significantly younger (often more than 10 years younger) than their husbands, who may have had more sexual partners and therefore have a greater risk of carrying and passing on sexually transmitted infections, including HIV, to their brides. Power differentials that may exist between husbands and wives, due to gender norms, and inequality are also often compounded by age differences and as a result girls may be unable to refuse sex or negotiate safer sex.

Increased risk of other forms of violence

In addition to child marriage being a form of gender-based violence, evidence has shown that girls who marry at a young age are more likely to experience sexual or physical violence within the home.

SRH response

As married adolescent girls are frequently isolated at home, they are often hard to reach with information and/or services (which are typically tailored to older women or unmarried adolescents) despite their need (see Chapter 6).

Antenatal and obstetric care

Adolescent girls, regardless of marital status or other factors, are often less likely to seek antenatal care (ANC) than those in their twenties or thirties. However, ANC can help to identify pregnancy complications early, including anemia and hypertension, and provide young girls (and family members) experiencing their first pregnancy the opportunity to learn to recognize the signs of complications.

Due to the high risk of delivery complications, including prolonged and/or obstructed labor, adolescent girls should be urged to, if at all possible, deliver with the assistance of a skilled birth attendant.

Contraception

Married adolescents have the same right as other women and girls to access family planning information services, including a full range of contraceptive methods. Providers should ensure that adolescent girls are made aware of these services and how to access them. Post-partum contraceptive planning counseling can provide an opportunity to inform girls of the benefits of family planning and birth spacing. As with other services respectful and confidential care is vital.

HUMAN TRAFFICKING

BOX 10.6: HUMAN TRAFFICKING IN HUMANITARIAN CONTEXTS

Among the factors that increase trafficking risks for refugees are their physical insecurity; social, economic and political marginalization; victimization by smugglers facilitating refugee movement; experience with sexual violence; social isolation or other negative consequences resulting from sexual violence; pressure to engage in survival sex; severe disruptions to family structure; and lack of legal protection.

Human trafficking is an additional risk facing women and girl refugees in urban and camp settings. Unaccompanied children who are refugees are at a greater risk of abuse and human trafficking. According to the United Nations (UN), human trafficking is the "recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving

of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation." Sex trafficking has the most direct relation to sexual and reproductive health, although other forms of trafficking (i.e., forced labor) may also negatively impact overall health status.

Reliable data on human trafficking is difficult to obtain and verify, due to variations in definitions, invisibility and illegality of the activity itself, and conflation with other activities, such as sex work.

Based on current, reliable evidence, those who are trafficked into the sex industry and as domestic servants are more likely to be women and children. Reports on trafficking of males indicate that men and boys are more commonly trafficked for various other forms of labor, and that these trafficking sectors generally differ by country or region.

Impacts on health

Many of the SRH implications of human trafficking are due to sexual violence. However, other impacts that have consequences for SRH include forced or coerced use of drugs or alcohol, social restrictions, and/or emotional manipulation.

SRH response

If a person has been trafficked, chances are SRH care will be responsive rather than preventive. People who have been trafficked should be provided with a full range of SRH services, as needed and as warranted by the circumstances, as well as psychosocial supports. It is essential that service providers offer non-stigmatized physical care and examinations.

10.3.4 Psychosocial support considerations for GBV survivors

Many survivors experience long-lasting psychological and social effects, although the impact of GBV can vary from person to person. The psychological consequences of GBV can inhibit a survivor's functioning and well-being, not only personally, but in relationships with family members, and can even extend to the wider community.

Social stigma, isolation, and rejection, including by intimate partners, spouses, and families, are serious consequences, often making emotional recovery difficult due to withdrawal from day-to-day activities and from social support. Most societies blame victims of sexual violence for the incident which can socially isolate them and prolong or prevent recovery, the effects of which can be compounded across generations, especially with children born as a result of rape. Furthermore, IPV, early marriage, FGC and other harmful practices are socially normalized in many communities and societies. Therefore, survivors of GBV or those not complying with these harmful social practices may face exclusion and risk different forms of emotional and physical violence.

The range of psychological consequences for individual survivors vary across anxiety and fear, depression, anger, self-blame, flashbacks and nightmares, feelings of powerlessness, sexual problems, and mood swings. For most survivors, these experiences are normal emotional responses to trauma. These psychosocial effects can last for years, causing prolonged suffering, and may sometimes lead to self-harm or even attempted suicide. With social and emotional support, many survivors learn to cope and the distress decreases over time. However, ongoing professional psychosocial and mental health care can be very important for survivors and if possible, all survivors should be offered to be referred to trained counselors who can provide professional psychological evaluation and care.

THE SURVIVOR'S HEALING PROCESS BEGINS FROM THE FIRST VISIT TO THE CLINIC

SRH service providers must ensure close coordination between clinical and psychosocial support services to enable staff to provide the survivor with referral to psychosocial or mental health services. Psychosocial support should begin from the very first encounter with the survivor. Providers at all health and community services must be trained to listen and provide emotional support whenever a survivor discloses or implies that she has experienced GBV, give information, provide options for psychosocial referral and help the survivor to start to regain a sense of dignity and control.

BOX 10.7: KEY MESSAGES WHEN PROVIDING CARE TO SEXUAL VIOLENCE SURVIVORS

- The survivor is not to blame for the assault
- The survivor may experience a series of confusing emotions that may take some time to go away
- The survivor's response is normal and understandable given what has happened to her/him/them
- Early medical care will help prevent serious physical problems
- The survivor is not alone. Talking about the experience often helps people
- Let the survivor know what sources of support are available to her/him/them and that it is her/his/their choice to access these support services
- Ensure that the survivor knows the information about the assault will be kept confidential and that she/he/they do not need to share the story to access services

The behaviors and attitudes of health staff that the survivor comes into contact with can play a significant role in the survivor's recovery. It is essential that health staff are trained to provide rights-based and compassionate care for survivors which includes dispelling myths and misconceptions surrounding sexual violence and other forms of GBV. This includes practically addressing victim-blaming, and other practices (i.e., invasive techniques not medically indicated such as speculum examination or virginity testing) that can re-traumatize survivors. Multiple and intrusive interviews about the incident can also re-traumatize the survivor and should not be required to access services. Survivors should be protected from having to repeat their story to multiple staff members from within the same service or different organizations. They should also be protected from participating in coerced interviews with media or different government authorities. Health staff must be trained in child-friendly techniques for providing quality care to child and adolescent survivors. Furthermore, non-discrimination and stigma reduction training must be integrated into clinical capacity building for all staff working with female and male survivors, persons engaged in sex work, LGBTQIA populations, persons with disabilities, and other marginalized groups.

In most cultural settings, the support of family and friends is likely to be a key factor in overcoming the trauma of violence. Providers must facilitate participation and integration of survivors in the community. Community-based activities that can be appropriate are:

- Identify and train appropriate existing resources in the community, such as traditional birth attendants, midwives, women's groups, religious leaders, and community services programs to know how to support survivors
- Develop women's support groups, including providing training to or specific support for integrated or marginalized community self-help groups such as persons with disabilities or LGBTQIA persons. In some contexts it may be appropriate to have support groups specifically designed for survivors of sexual violence and their families; however, great care must be taken not to increase social stigma by singling out one group of people
- Create special drop-in centers and spaces for survivors where they can receive confidential and compassionate care
- Provide material support as needed via health or other community services
- Encourage use of appropriate traditional resources. If feasible, collaborate with traditional healers or clergy who, respectively, may conduct meaningful cleansing ceremonies or prayer for sexual violence survivors. Many such practices can be extremely beneficial; however, ensure that they do not perpetuate blaming-the-victim or otherwise contribute to further physical or psychological harm to the survivor

These activities must be culturally appropriate and must be developed after consultation (and if possible in cooperation) with community members. They will need ongoing financial and logistical support and, where appropriate, training and supervision.

Psychosocial supports are also needed for survivors of FGC and women who were forced into early marriage. The organization and labelling of such support must be adapted because FGC and early marriage are often

socially sanctioned and people may not see themselves as survivors.

10.3.5 Coordinating and making linkages

True comprehensive care to survivors comes from 4 separate sectors including health, police and justice, social services, and coordination and governance. Protection, health, GBV, and wider service institutions must work in a coordinated way to provide survivor-centered care for those impacted by GBV.

To date, the multi-sectoral programming model forms the "best practice" for prevention of and response to GBV in humanitarian settings. Key characteristics of the multi-sectoral model include full engagement of the affected community, interdisciplinary and inter-organizational cooperation and collaboration and coordination among health, psychological, legal, and security services when responding to the needs of survivors of GBV.

The underlying principle of this model recognizes the rights and needs of survivors of GBV as paramount in terms of access to respectful and supportive services, guaranteed confidentiality and safety, and the ability to determine a course of action for addressing the GBV incident, based on the individual survivor's needs and wishes.

Because of the importance of multi-sectoral collaboration in GBV programming, SRH Coordinators and health program managers must actively participate in a process to clarify roles and responsibilities and collaboration within and among sectors to prevent and respond to GBV. The outcome of this process is sometimes referred to as standard operating procedures (SOPs) for GBV. Developing agreed-upon SOPs must be a collaborative process that occurs through a series of consultations with key stakeholders and actors in the setting.

While all sectors/clusters have a role to play in prevention of and response to GBV, at a minimum, this process should include representatives from health, psychosocial, safety/security and legal/justice/protection sectors (UN agencies, national and international NGOs, community-based organizations, and relevant government authorities when appropriate).

Representatives from other sectors/clusters (including education, food and nutrition, camp management/shelter/site planning and water/sanitation) should also participate in the development of SOPs.

Within the multi-sectoral model, the responsibilities of the heath sector/cluster include:

- Provide clinical care to men, women, and child survivors of sexual violence and other types of GBV
- Ensure drugs (emergency contraception) and supplies (post-rape kits and medicines and MVA equipment to support safe abortion care to the full extent of the law) are available and staff has been properly trained in the health facility
- Document findings in an objective and non-judgmental manner in standard intake forms according to WHO recommendations
- Collect forensic evidence where appropriate (see Chapter 3) and if informed consent is given
- Provide testimony in cases where a survivor chooses to pursue legal action
- Identify survivors of various types of GBV and offer referral to appropriate services
- Conduct GBV awareness sessions at community and facility levels

10.3.6 Advocacy

In order to prevent GBV from occurring, SRH Coordinators and health program managers must work in close collaboration with local stakeholders, particularly women's non-governmental organizations, as well as professional organizations, aiming at a joint decision by the community to abandon these practices. Organize discussion and information sharing in the community aimed at empowerment, realization of girls' and women's human rights, and providing information on impacts on women and girl's health and rights and the harmful consequences of the practices and the benefits of abandoning them.

All agencies should advocate for the enactment and/or enforcement of national laws against GBV in accordance with international legal obligations, including prosecution of offenders and the implementation of legal measures to protect and support the survivor.

10.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

GBV is a violation of fundamental human rights and can be a serious impediment to the realization of human rights and fundamental freedoms. These include the rights to:

- Life, liberty, and security of the person. This right is at risk when a person is subjected to GBV forms including SV, IPV, and FGC
- The highest attainable standard of physical and mental health. For example, this right may be restricted if a person is denied access to appropriate medical care following rape or if a girl child is forced into early marriage
- Freedom from torture or cruel, inhuman, or degrading treatment or punishment
- Freedom from all forms of discrimination, including on the basis of sex, gender, gender identity and expression, and sexual orientation. This right may be threatened when laws fail to protect women and girls from GBV and/or where they must be accompanied by a husband or father to obtain medical treatment after rape. All forms of violence against women are a manifestation of gender-based discrimination against them
- Enter into marriage with free and full consent and the entitlement to equal rights to marry, during marriage and at its dissolution. Forced marriage is a denial of this right as is marital rape

PROGRAMMATIC EXAMPLE 10.1: BARRIERS TO SRH CARE AND EXPERIENCES OF UNINTENDED PREGNANCY AMONG YOUNG WOMEN IN NICARAGUA

ORGANIZATION: Center for Humanitarian Emergencies, Emory University

LOCATION: Nicaragua

INTRODUCTION: Over 89% of Nicaraguan women experience physical, sexual, or psychological abuse in their lifetimes. In addition, there is a high unmet need for SRH services, with over half (65%) of pregnancies among women 15-29 unintended. The 2006 Nicaraguan "total ban" on abortion creates penalties for women who obtain abortion under any circumstances, as well as for providers, resulting in a chilling effect. Complications from unsafe abortion contribute to the country's high maternal mortality ratio.

PROJECT DESCRIPTION: We conducted 10 in-depth interviews with women aged 16-23 who had experienced an unintended pregnancy. Topics included pregnancy and family planning history, circumstances surrounding unintended pregnancy, and experiences with abortion.

RESULTS: All of the women had only been pregnant 1 time and 5 had gotten pregnant between the ages of 14-17. Four considered an unsafe abortion and 2 became pregnant as a result of nonconsensual sex. One woman, Ana Maria* received an unsafe abortion.

Ana Maria was 19 when an older man in her village, her brother's best friend, raped her. She didn't tell anyone what had happened, not even her family. She was a virgin and knew little about pregnancy or how to prevent it. But sometime after her assault she began to suspect she was pregnant. Her fears were confirmed by a home pregnancy test and later by blood test at a community clinic. Desperate, Ana Maria told her rapist that she was pregnant. He coerced her to see a "natural medicine" practitioner and gave her the money to have an abortion. Ana Maria travelled to see the woman who terminated the pregnancy by inserting a long rod into her vagina. The woman told her she would experience some cramping and be fine in a few days. Hours later Ana Maria felt feverish and began passing dark fetid clots of blood. Her brother, seeing that she was ill demanded, that she tell him what had happened. When she did, he helped her to get to a nurse. Although many health providers are reticent to provide post abortion care because of the legal limits on abortion, one nurse helped Ana Maria. She received treatment for a perforated uterus – a common complication from unsafe abortion. As a result of her experience, Ana Maria reported feelings of depression and isolation.

QUESTIONS TO CONSIDER: What were the missed opportunities related to SRH prior to and following Ana Maria's assault? Aside from the rape itself, what other forms of GBV did Ana Maria experience? What are the human rights issues that arise from the case of Ana Maria?

**A pseudonym has been used*

- Right to decide freely the number and spacing of children. Reproductive coercion is a violation of this right
- Freedom of movement, opinion, expression and association. These are restricted when someone is trafficked, subjected to forced confinement or is prohibited by a husband or parent from accessing health or other services. The later constitutes of a form of psychological intimate partner violence
- Right to information. Preventing young girls and women from accessing information about ways to prevent unintended pregnancies and manage their reproductive choices is a violation of this right

Girls are particularly at risk of GBV due to their sex, as well as their young age. The Convention on the Rights of the Child states that children have the right to protection from all forms of physical or mental violence, including from sexual abuse, whether the abuse takes place in the family or in institutions, as well as from organized sexual abuse. Children also have the right to be protected from harmful practices, such as FGC, and to safely prevent unintended pregnancy, including by using emergency contraception.

Gender-based violence survivors have the right to seek medical treatment without cumbersome procedural requirements. Therefore, preventing the survivor from accessing and obtaining medical treatment by requiring her to present a marriage certificate, have the authorization of the husband or file a police report is a denial of this right. Where adolescents are involved, States should ensure legal provisions that provide for the possibility of medical treatment without parental consent for adolescents.

10.4.1 Guiding principles

Reproductive health managers or service providers in different contexts are likely to face similar dilemmas. The key to providing safe and ethical care for GBV survivors is ensuring practical adherence to the guiding principles and by implementing four inter-related approaches:

- ***A survivor-centered approach*** means that the survivor's rights, needs and wishes are prioritized when designing and developing GBV-related programming
- ***A rights-based approach*** utilizes international human rights norms and principles to analyze and address the root causes of discriminatory practices and violations
- ***A community-based approach*** is essential to empower individuals, families and communities with the knowledge, skills and resources to change harmful social norms perpetuating GBV.
- ***A systems approach*** analyzes GBV-related issues across an entire organization, sector, and/or humanitarian system to design systematic and context-specific solutions to improve GBV prevention and mitigation efforts in the short-term and in the long-term

The survivor-centered approach can guide professionals - regardless of their role - in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which a GBV survivor's rights are respected, safety is ensured, and the survivor is treated with dignity and respect. The approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person's capacity to make decisions about possible interventions.

Guiding principles for SRH service providers:

- ***Safety:*** The safety and security of the survivor and others, such as her/his/their children and people who have assisted her/him, must be the number one priority for all actors. Individuals who disclose an incident of GBV or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them
- ***Confidentiality:*** Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment
- ***Respect:*** The survivor is the primary actor, and the role of helpers is to facilitate recovery and provide resources for problem-solving. All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor
- ***Non-discrimination:*** Survivors of violence should

receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation or any other characteristic

A key component of the survivor-centered approach is "informed consent". For SRH staff this involves providing accurate information in a neutral manner to GBV survivors about all services available, the benefits and possible consequences of accessing these services and sharing information to enable the survivor to make an informed decision that is best for him/her. Survivors should never be coerced into accessing a service against her/his/their wishes. Furthermore, SRH service providers must let the survivor know that they can retract their consent for the service or information sharing at any time (even during service provision or after sharing information about the incident).

BOX 10.8: INFORMED CONSENT

This refers to approval or assent, particularly and especially after thoughtful consideration. Free and informed consent is given based upon a clear appreciation and understanding of the facts, implications and future consequences of an action. In order to give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given and be able to evaluate and understand the consequences of an action. They also must be aware of and have the power to exercise their right to refuse to engage in an action and/or to not be coerced. Children are generally considered unable to provide informed consent because they do not have the ability and/or experience to anticipate the implications of an action, and they may not understand or be empowered to exercise their right to refuse. Service providers working with children must facilitate assent (for older children) or get consent from the designated adult guardian or caregiver. There are also instances where consent might not be possible due to cognitive impairments and/or physical, sensory, or intellectual disabilities.

10.4.1 Challenges and opportunities

At times, SRH Coordinators, health program managers, and service providers may face difficult decisions when providing care for survivors of GBV. They may find that national legislation or social or cultural norms place restrictions on the provision of certain services or in certain circumstances. For example:

- In some societies, it is common in cases of sexual violence for the family and/or the authorities to force unmarried female survivors to marry the perpetrator (double-victimization).
- In communities where a woman's virginity at the time of marriage is considered very important, the family of a survivor may ask service providers to conduct a "virginity test"
- If patient confidentiality is compromised, services provided to the survivor can put the survivor at risk of reprisals and continued violence
- Health service providers' attitudes and behaviors often reflect the discriminatory attitudes of affected communities, including victim-blaming, which may create a barrier for survivors to access services and effect their recovery
- A service provider may suspect or know that the perpetrator of violence is someone related to or close to the survivor and may feel that the survivor's safety is not guaranteed, particularly in the case of children

In these cases, the SRH Coordinator, health program manager, or service provider may:

- Talk to their supervisor
- Discuss options with their client
- Discuss advocacy options and strategies within their organization or clinic structure
- Explore linkages with and referrals to local organizations that might be able to help the client
- While respecting the confidentiality of their client, discuss with colleagues how to avoid such situations/handle them in the future
- Raise these concerns/challenges in health coordination meetings

10.5 MONITORING AND EVALUATION

Monitoring and reporting on cases of GBV, information sharing, incident documentation, and data analysis must be agreed upon as part of the SOP. Collecting and analyzing information on GBV can provide valuable information if it is conducted and shared appropriately.

Indicators to be collected at the health-facility level:

- Number of reported cases of sexual violence reported to health services (per month).
- Timing of EC provision (percentage of eligible rape survivors presenting to the health services within 120 hours who receive EC)
- Timing of PEP provision (percentage of eligible rape survivors who present to the health services within 72 hours and receive PEP)
- Number of women and girls who receive safe abortion care (SAC) to the full extent of the law

Indicators to measure annually:

- Number of health workers trained in providing clinical care to survivors of sexual violence (see Chapter 3 for details)

10.6 FURTHER READING AND ADDITIONAL RESOURCES

Anderson, M., Wheaton, W., & Evans, D. P. (n.d.). *Protection in Health in Humanitarian Settings: Principles and Practice for Public Health and Healthcare Practitioners*. (D. Townes, Ed.).

Foreign and Commonwealth Office. (2014). *International Protocol on the Documentation and Investigation of Sexual Violence in Conflict: Basic Standards of Best Practice on the Documentation of Sexual Violence as a Crime under International Law* (1st ed.). United Kingdom. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319054/PSVI_protocol_web.pdf

IASC. (2015). *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery.* Retrieved from: https://gbvguidelines.org/wp/wp-content/uploads/2016/10/2015_IASC_Gender-based_Violence_Guidelines_full-res.pdf

IASC. (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva, Switzerland. Retrieved from: http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

IASC Sub-Working Group on Gender & Humanitarian Action. (2008). *Gender-based Violence Resource Tools: Establishing Gender-based Violence Standard Operating Procedures (SOP Guide)*.

IRC, & UNICEF. (2012). *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings* (1st ed.). Retrieved from: https://www.unicef.org/pacificislands/IRC_CCSGuide_FullGuide_lowres.pdf

RHRC Consortium, & Women's Commission for Refugee Women & Children. (2004). *Gender-based Violence Tools Manual for Assessment & Program Design, Monitoring & Evaluation in conflict-affected settings*. Retrieved from: https://reliefweb.int/sites/reliefweb.int/files/resources/FC881A31BD55D2B3C1256F4F00461838-Gender_based_violence_rhrc_Feb_2004.pdf

UN Action Against Sexual Violence in Conflict. (2008). *Reporting and interpreting Data on Sexual Violence from Conflict-Affected Countries: Do's and Don'ts*. Retrieved from: http://www.stoprapenow.org/uploads/advocacyresources/1282164733.pdf

UNFPA. (2015). *Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies*. Retrieved from: https://www.unfpa.org/sites/default/files/pub-pdf/GBVIE.Minimum.Standards.Publication.FINAL_.ENG_.pdf

UNHCR. (2004). *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons. Revised Edition*. Retrieved from: http://www.unhcr.org/protection/health/403a0b7f4/clinical-management-rape-survivors-developing-protocols-use-refugees-internally.html

WHO. (2001). *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of Nursing and Midwifery: A Teacher's Guide*. Geneva, Switzerland. Retrieved from: http://apps.who.int/iris/bitstream/10665/66857/1/WHO_FCH_GWH_01.3_eng.pdf?ua=1

WHO. (2005). *Multi-country Study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses*. Geneva, Switzerland. Retrieved from: http://www.who.int/reproductivehealth/publications/violence/24159358X/en/

WHO. (2007). *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*. Retrieved from: http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

WHO. (2013). *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines*. Retrieved from: http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf

WHO. (2014). *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook - Field Testing Version*. Retrieved from: http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf?ua=1

WHO. (2016). *WHO Guidelines on the Management of Health Complications from Female Genital Mutilation*. Retrieved from: http://apps.who.int/iris/bitstream/10665/206437/1/9789241549646_eng.pdf

WHO. (2017). *Responding to Children and Adolescents who have been Sexually Abused*. Retrieved from: http://apps.who.int/iris/bitstream/10665/259270/1/9789241550147-eng.pdf?ua=1

WHO, War Trauma Foundation, & World Vision International. (2011). *Psychological First Aid: Guide for Field Workers.* Retrieved from: http://apps.who.int/iris/bitstream/10665/44615/1/9789241548205_eng.pdf

Women's Refugee Commission. (2014). *The Intersection of Sexual and Reproductive Health and Disability: Research from Kenya, Uganda and Nepal*. Retrieved from: https://www.womensrefugeecommission.org/disabilities/resources/1084-srh-disabilities-uganda-2014

Women's Refugee Commission. (2015). *"I See That It Is Possible" Gender-Based Violence Disability Toolkit ": Disability Inclusion in Gender-Based Violence Programming*. Retrieved from: https://www.womensrefugeecommission.org/

Women's Refugee Commission. (2016). *Mean Streets: Identifying and Responding to Urban Refugees' Risks of Gender-Based Violence*. New York, NY. Retrieved from: https://www.womensrefugeecommission.org/gbv/resources/1272-mean-streets

Women's Refugee Commission, & IRC. (2015). *I See That It Is Possible: Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings*. Retrieved from: https://www.womensrefugeecommission.org/disabilities/resources/document/945-building-capacity-for-disability-inclusion-in-gender-based-violence-gbv-programming-in-humanitarian-settings-overview