ADDRESSING VIOLENCE AGAINST WOMEN AND GIRLS IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES: A REVIEW OF KNOWLEDGE ASSETS

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List of acronyms and abbreviations

ASRH	Adolescent sexual and reproductive health
ARV	Anti-retroviral
CDC	Centers for Disease Control and Prevention (U.S.A.)
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DHS	Demographic and Health Survey
FGM/C	Female genital mutilation/cutting
GBV	Gender-based violence
GRB	Gender-responsive budgeting
HPV	Human papilloma virus
IASC	Interagency Standing Committee
ICPD	International Conference on Population and Development
ICRW	International Center for Research on Women
ICW	International Coalition of Women Living with HIV/AIDS
IGWG	Interagency Gender Working Group (USAID)
ILO	International Labour Organization
IOM	International Organization for Migration
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IPV	Intimate partner violence
MCH/FP	Maternal and child health/family planning
MISP	Minimum Initial Service Package
NGO	Non-governmental organization
OHCHR	Office of the United Nations High Commissioner for Human Rights
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother to child transmission
SGBV	Sexual gender-based violence

SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
UNTERM	United Nations Multilingual Terminology Database
USAID	United States Agency for International Development
VAW	Violence against women
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

I. INTRODUCTION AND KEY CONCEPTS

A. DESCRIPTION OF THIS KNOWLEDGE ASSET

This report reviews literature on the integration of activities to address gender-based violence (GBV) – specifically violence against women and girls – into sexual and reproductive health (SRH) services. It is designed to provide guidance to health-sector programme designers and managers.

This first chapter provides basic definitions (with additional definitions in Annex I); introduces key principles of human rights-based programming, gender mainstreaming and culture; discusses the evidence that provides a strong foundation for recommendations on integrating SRH and GBV; and provides information on the most basic resources for the programme planner.

B. DEFINITIONS

1. Violence against women

The following definition of violence against women (VAW) is from the United Nations General Assembly's 1993 Declaration on the Elimination of Violence Against Women (A/RES/48/104):

> "Article 1: For the purposes of this Declaration, the term 'violence against women' means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.
>
> "Article 2: Violence against women shall be understood to encompass, but not be limited to, the following: (a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs."

2. Gender-based violence

Gender-based violence is defined in UNTERM, the United Nations Multilingual Terminology Database, as physical, mental or social abuse (including sexual violence) that is attempted or threatened, with some type of force (such as violence, threats, coercion, manipulation, deception, cultural expectations, weapons or economic circumstances) and is directed against a person because of his or her gender roles and expectations in a society or culture. In circumstances of GBV, a person has no choice to refuse or pursue other options without severe social, physical, or psychological consequences. Forms of GBV include sexual violence, sexual abuse, sexual harassment, sexual exploitation, early marriage or forced marriage, gender discrimination, denial (such as education, food, freedom) and female genital mutilation. This phrase is used extensively in this review with regard to GBV as practiced against women and girls.

3. Sexual and reproductive health

The Programme of Action of the International Conference on Population and Development (ICPD), Cairo, 5-13 September 1994, includes definitions related to reproductive health and reproductive rights. These definitions (United Nations Population Fund, 1996, paragraphs 7.2 and 7.3) appear also in the Platform for Action of the Fourth World Conference on Women. Beijing, 4-15 September 1995 (United Nations, 1996, paragraphs 94 and 95.

> "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."
>
> "…[R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence. …full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality…."

Additional definitions of terms used in this review appear in Annex I.

C. KEY PRINCIPLES

1. Basic prerequisites to address gender-based violence in the health sector

Health organizations have an ethical obligation to do no harm when they address GBV. They must be able to ensure basic precautions to protect women's lives, health and well-being before they begin to address GBV systematically through the routine screening of patients. These basic precautions are the following (adapted from Interagency Gender Working Group of USAID, 2008, 26):

- Ensuring the woman's safety as the primary concern of all interventions. Providers must be trained to assess danger and provide safety planning for women in danger. This principle is closely related to the principles of privacy and confidentiality.
- Protecting women's privacy and confidentiality, including not engaging in mandatory reporting without the woman's consent.
- Ensuring that health-care providers have adequate knowledge, attitudes and skills to offer the following:
    - A compassionate, non-judgemental response that clearly conveys the message that violence is never deserved and women have the right to live free of violence.
    - Appropriate medical care for injuries and health consequences, including sexually transmitted infection (STI) and HIV prophylaxis and emergency contraception post-rape, with referral systems for medical conditions that the facility cannot address.
    - Information about legal rights and any legal or social service resources in the community.

Some sources in the GBV literature recommend that certain prerequisites be in place in order to begin to screen women for GBV in health services. These prerequisites include well-functioning referral networks to legal and social services and to security systems in the community. However, there is considerable disagreement about this recommendation, as these resources are unavailable in many settings. UNFPA views the prevention of GBV and attention to survivors as part of the essential reproductive health package.

2. Integration of human rights, gender mainstreaming and cultural sensitivity

Mainstreaming gender and cultural sensitivity are essential components of an integrated approach to the promotion and fulfilment of human rights. As a recent UNFPA internal concept note states, the achievement of human rights includes gender equality and culturally sensitive delivery of affordable and accessible services that "contributes to a tangible demonstration of attainment of human rights, particularly reproductive rights, …by all women…." (UNFPA 2010, 3). Legal changes are necessary, but not sufficient, to achieve realization of women's rights – including freedom from GBV – in the communities where they live. "Therefore, the objective of an integrated approach is to build ownership of the human rights agenda within communities…." (UNFPA 2010, 3). See box 1.

Box 1.

Integrating human rights, gender mainstreaming and cultural sensitivity

An integrated approach provides a "reality check", through an analysis of the human rights situation, which includes:

- Identifying and analysing the specific gender inequalities constraining development progress in the areas at the core of the UNFPA mandate: reducing maternal mortality, preventing HIV/AIDS, preventing violence against women, ensuring adolescent SRH and integrating population dynamics in development processes.

- Identifying not only which cultural factors (actors, customs and interpretations) exacerbate or counter these inequalities but also recognizing those that support empowerment and foster enjoyment of rights.

- Promoting dialogue with cultural gatekeepers in "safe spaces", identifying the positive elements inherent in the culture which can facilitate and encourage change in behaviour and/or attitudes.

- Taking into account the international legal frameworks relevant to the situation at hand and assessing the extent to which national laws and institutional frameworks support or hinder the realization of these human rights.

Source: Adapted from UNFPA Concept Note (internal), 2010. "Integrating Gender, Human Rights and Culture in UNFPA Programmes." p. 5.

a. Culturally sensitive approaches

Culturally sensitive approaches seek elements in the surrounding culture that support efforts to eliminate GBV, while also seeking to transform norms that violate women's and girls' human rights. The basic prerequisites listed above derive from human rights principles, and employ culturally sensitive approaches by recognizing that providers may come from cultural settings that condone GBV and that special training may be needed to transform these cultural norms and to reinforce those norms that would help eliminate GBV.

b. Guidance on human-rights based approaches

United Nations policy and programme guidance mandates that all development programming follow human rights-based approaches. As defined in Session Three of the United Nations Common Learning

Package on Human Rights-Based Approaches, the basic principles are the following: (See http://www.undg.org/index.cfm?P=531 for the full training package.)

- The development process is normatively based on international human rights standards and principles.

- It recognizes human beings as rights-holders and establishes obligations for duty-bearers.

- It focuses on discriminated and marginalized groups, such as sex workers.

- It aims at the progressive achievement of all human rights.

- It gives equal importance to the outcome and process of development.

- It recognizes the interdependence of rights, so that achievement of any one right (health, freedom from violence) depends on comprehensive strategies that address linked rights. For example, economic discrimination against women makes them more dependent on families and intimate partners and thus more vulnerable to both SRH risks and GBV.

The implications of applying human rights-based approaches in GBV integration include the following:

- Working with women and girls to empower them to demand rights and services, and with duty-bearers (health-sector officials and professionals) to develop capacities to respond effectively.

- Ensuring that health services do not violate women's and girls' human rights and become perpetrators of violence. Amnesty International published a basic resource on this topic in 2006: *Caring for human rights: Challenges and opportunities for nurses and midwives.* Many of the topics covered in the guide relate to harmful practices within the SRH sector that constitute violence against women or girls, including forced sterilization and abortion, mistreatment of women/girls undergoing abortions, FGM/C and virginity testing.

- Ensuring that women and girls participate in programme and policy design, monitoring and evaluation.

- Creating a political and socio-cultural environment in health sector services that condemns and strives to eliminate GBV.

- Staying up to date with standards and guidance on VAW originating in the international human rights system, with evidence from programme evaluations.

- Ensuring that SRH services:

    - Reach the most vulnerable and marginalized for SRH problems and HIV.

    - Promote understanding among health providers of underlying vulnerabilities for GBV, SRH problems (including HIV) and the linkages among them.

3. Mainstreaming gender-based violence and culturally sensitive approaches in sexual and reproductive health policies, programmes and services

"Gender mainstreaming" or "*incorporating a gender perspective"* are terms that can be used interchangeably to mean programming that furthers gender equality. The goal of gender mainstreaming is to integrate and promote gender equality and women's empowerment in programmatic activities. This implies taking into account women's and men's perspectives, needs and rights, and opportunities and challenges at all stages of developing, implementing, monitoring, and evaluating policies and programs.

Gender-based violence and sexual and reproductive health risks share a common root -- gender inequality. Gender norms – the socially constructed ideas and rules about correct male and female behaviour and characteristics -- include culturally entrenched beliefs and social rules related to male and female sexuality, so that gender mainstreaming demands attention to culture and the application of culturally sensitive approaches. The link between gender norms and sexuality drives many SRH issues, from the HIV pandemic, unsafe abortion and maternal mortality to the unmet need for family planning. For example, in many cultures gender norms promote early marriage, in which girls under age 18 are married to older, sexually experienced men. This traditional harmful practice puts girls at high risk for HIV infection, and the ensuing early pregnancies increase their risk of maternal mortality and morbidity, including obstetric fistula.

The structures of most societies discriminate against women and girls, leading to unequal opportunities and power differences between men and women. These inequalities, combined with strict norms governing sexuality, are at the root of many forms of GBV, including intimate partner violence (IPV), beating during pregnancy, sexual harassment, rape as a tactic of war, and honour killings. Women's and girls' unequal status in their families and communities has roots in and is reinforced by political, economic and social discrimination, strongly reducing women's autonomy, their ability to exercise reproductive rights, their ability to protect themselves from unwanted pregnancies and HIV, and their ability to leave abusive situations. This gendered system of discrimination and cultural norms in many societies leads to widespread acceptance – even by women -- of violence against women (UNFPA 2008b, 3).

Social factors stemming from gender inequalities – including cultural norms denying women knowledge of sexual health, the threat of physical violence, and women's fear of abandonment or loss of economic support -- make women especially vulnerable to being infected with HIV by their partner; these factors make it difficult for women to negotiate condom use or safe sex.

Discriminatory beliefs regarding gender and sexuality are pervasive in most cultures. Hence, the task of integrating attention to GBV in SRH services is a long-term enterprise that involves changes in policies, plans, protocols and infrastructure, as well as training and supervision. In particular, one-off training efforts are insufficient to address the underlying social and cultural predispositions of health-care personnel. Mainstreaming gender demands an investment in cultural transformation among all those working in the health system.

Health providers need to apply culturally sensitive approaches, understanding that structural and cultural factors contribute to women's and girls' vulnerability to GBV and SRH risks and that many of these factors are related to gender inequalities. Without this understanding, they easily fall into the common cultural perceptions of GBV that blame the victim, whereas an understanding of these factors helps providers give care that is compassionate, comprehensive and effective. Therefore, a prerequisite for mainstreaming gender in SRH and GBV programmes is gaining an understanding of how gender issues are manifested in a particular context.

The prevention of GBV in communities demands gender-transformative programming – an approach that seeks to transform gender roles and promote more gender-equitable relationships between men and women. Such programmes seek to reflect critically about, question or change institutional practices and broader social norms that create and reinforce gender inequality and vulnerability for both men and women. Social science researchers can help health promotion programmes to identify specific cultural beliefs that are discriminatory and test messages to transform them.

Ultimately, the elimination of GBV and reduction of SRH risks require the elimination of key aspects of discrimination against women. Therefore, "gender mainstreaming" is an essential component of all efforts to prevent both GBV and sexual and reproductive ill-health, and to support to women and girls affected by GBV, HIV and other SRH risks.

D. The Evidence Regarding gender-based violence, sexual and reproductive health and HIV Policies and Programmes

Addressing and preventing GBV in SRH programmes is a key strategy to help achieve the MDGs, in particular those related to women's empowerment and gender equality, maternal health, child health and HIV. The United Nations Secretary-General's Campaign – UNITE to End Violence Against Women – will be active through 2015. It is tied to the deadline for achievement of the MDGs, thus affirming "the importance of addressing violence against women and girls if progress is to be made on poverty reduction and development" (United Nations Secretary-General, 2009a) . SRH programmes address all three of the health MDGs: child survival in prenatal care, maternal health in prenatal, childbirth, post-natal, family planning, and abortion services, and STI or HIV/AIDS services, including the prevention of mother to child transmission (PMTCT).

1. Diverse health consequences of gender-based violence

GBV, particularly IPV and sexual violence, has been shown to be a risk factor for diverse and severe physical and mental health consequences, including serious SRH consequences. GBV is linked to many serious health problems for women, both at the time violence occurs and throughout life. GBV is increasingly viewed as a risk factor for a variety of diseases and conditions and not just as a health problem in and of itself. Health consequences include injuries, gynaecological disorders, mental health problems, adverse pregnancy outcomes, and STIs (Campbell, 2002). The World Health Organization (WHO) multi-country study confirms a strong association between IPV and many forms of poor health, including mental health and suicidal tendencies (Ellsberg, 2006). Ellsberg and another recent overview (García-Moreno and Stöckl, 2009) identifies the following conditions as associated with a "history of physical or sexual abuse": irritable bowel syndrome; sexually transmitted diseases; gastrointestinal disorders; gynaecological problems, including vaginal bleeding and vaginal infections; urinary tract infections; chronic pelvic pain; and serious mental health problems as depression, anxiety, post-traumatic stress disorder and risk of suicide.

Both GBV and the associated health consequences are costly for societies and their health systems. Evidence generally suggests that women who experience or have survived GBV have more health problems and use physical and mental health services more than other women. Heise conducted the first major study on the costs of these health consequences in Disability Adjusted Life Years (DALYs) and other standard measures (Heise,1994) followed by another World Bank study in 2004 (Morrison and Orlando, 2004). The list of ill health consequences generated by the WHO multi-country study and other sources mentioned above provides a basis for costing studies, but health-service statistics can help to improve costing estimates where universal screening is implemented. A team from The International Center for Research on Women examined 30 studies, mostly from industrialized countries, showing that the economic costs of IPV are "enormous," but suggesting a different costing framework that focuses on household and community costs for developing countries (Duvvury, Grown and Redner, 2004).

2. Gender-based violence as a factor in sexual and reproductive health and HIV-related morbidity or mortality

- Violence during pregnancy is as common, or more so, than many conditions that are usually screened for in antenatal care. Recent studies from dozens of countries found the prevalence of physical abuse during pregnancy at about 3 per cent to 11 per cent in industrialized countries and approximately 4 per cent to 32 per cent in developing countries (Ellsberg, 2006). This is a compelling rationale for the integration of GBV into antenatal care, with universal screening for GBV in these services. The possibility has been raised that the GBV rates appear higher among pregnant women because they use health services more often than non-pregnant women, thereby increasing the rate of detection of GBV (Cook and Dickens, 2009). However, this hypothesis simply points out the key role of the health sector in detecting women and girls who are abused and providing them with support.

- Violence during pregnancy has been associated with adverse pregnancy outcomes, such as low birth weight, premature labour, preterm delivery, miscarriage and foetal loss (Campbell, García-Moreno and Sharps, 2004; Ellsberg and others, 2008; García-Moreno, 2009). In a recent study using Demographic and Health Survey (DHS) data in Cameroon, women and girls exposed to spousal violence were 50 per cent more likely to experience foetal loss compared with women not exposed to abuse. Recurrent foetal mortality had the strongest association with emotional violence. These findings support policies of routine prenatal screening for IPV and the establishment of IPV-prevention programmes to reduce infant mortality as well as improve women's health and well-being (Alio, Nana and Salihu, 2009).

- Violence against pregnant women is also a cause of maternal mortality (Campbell, García-Moreno and Sharps, 2004. A study in Mozambique notes that violence was the fourth largest cause of maternal death (Glasier and others, 2006). IPV has also been associated with increased rates of pregnancy termination in both developed and developing countries (Ibid.) and where abortion is illegal, these procedures are apt to be unsafe.

Gender inequalities and GBV are among the key factors in SRH vulnerabilities for women and girls

- There is a growing body of evidence on the linkages between HIV and GBV: Multiple literature reviews (Program on International Health and Human Rights, 2006; Program on International Health and Human Rights, 2009; World Health Organization, 2003, 2009a) have analysed the evidence of two-way links between GBV and HIV risks. There is a consensus that addressing GBV is an essential component in all HIV programmes. See box 2.

- The linkages between GBV and SRH risks are bidirectional. Gender inequalities and GBV are among the key factors in SRH vulnerabilities for women and girls; at the same time, SRH issues such as HIV infection or unwanted pregnancies can increase GBV risks and serve to compound the effects of other aspects of gender discrimination (Program on International Health and Human Rights, 2006). Some illustrations are:

    - GBV leading to SRH risks: IPV lessens women's ability to negotiate condom use with their partners, thus increasing their risk of HIV infection. GBV may interfere with the ability to access HIV treatment and care and potentially the ability to maintain adherence to anti-retroviral (ARV) treatment.

- SRH risks leading to GBV: For women, testing positive for HIV or STIs may constitute a risk factor for experiencing GBV, with studies finding an increase in violence following disclosure of HIV status or even following disclosure that HIV testing has been sought.

- GBV and SRH risks compounding other types of gender discrimination: GBV disempowers women in multiple ways. With less autonomy due to the control exerted by their partners, women may not be free to seek employment and education or to assume leadership in their community.

IPV serves as a barrier to contraceptive and condom use, denying women their reproductive rights and right to sexual health.

Most often, IPV serves as a barrier to contraceptive and condom use, denying women their reproductive rights and right to sexual health. IPV lessens women's and girls' autonomy, increases the risk of forced sex, and makes them unable to insist on condom use by reinforcing unequal male-female power dynamics (Program on International Health and Human Rights, 2009). Jealousy is often a motive for men to engage in IPV as well as to oppose a partner's family planning use, so that women who have access to services need to use methods such as hormonal injections that allow their use of contraception to remain hidden (Cripe and others, 2008; Gee and others, 2009).

One recent country study shows a different kind of link, suggesting that women who suffer IPV might be less apt to want more children and more apt to use modern contraception where methods are readily available that are not easily detectable by male partner‘s or family members (Alio and others, 2009).

Some situations or life experiences lead to heightened risks for both GBV and HIV infection.

- HIV vulnerability is especially high for all sex workers and is significantly influenced by GBV in their working environment. Many settings offer little or no promotion of safer sex, and provide little or no control over clients' behaviour. Threats of violence or actual violence from gangs and establishment owners compromise safer sex negotiations. (See also chapter V, E,on sex workers page 72)

- Conflict and emergency situations affect the intersections of GBV and HIV. In conflict situations, rape and sexual violence are often reported to be high and interventions to address GBV, HIV or their intersections sorely lacking.

- Individuals who have survived sexual coercion and assault early in life exhibit increased patterns of sexual risk-taking later in life, including unprotected sex with multiple partners and transactional sex, which increase their risk of acquiring HIV later in life.

- Children and adolescents who experience sexual violence are also more likely to experience, tolerate or perpetrate sexual or domestic violence as adults, fuelling a cycle of violence and increased health consequences.

3. Reasons for integrating gender-based violence and sexual and reproductive health programmes

Box 2. Key messages on linkages between gender-based violence and HIV

GBV and the Risk of Acquiring HIV

- Physical and sexual GBV have been associated with HIV transmission.
- Economic violence may increase the risk of acquiring HIV by deepening gender inequalities and increasing vulnerability.
- GBV or the threat of violence may prevent women from being able to practice safer sex.
- Experiencing GBV may be associated with engaging in "HIV risk behaviours," such as unprotected sex and transactional sex.
- Male perpetrators of violence may engage in "HIV risk behaviours," such as not using condoms with multiple casual sexual partners.

Child Sexual Abuse and the Risk of Acquiring HIV

- Child sexual abuse is an important facet of GBV with implications for HIV risk and vulnerability.
- Individuals who have been sexually assaulted in childhood may later exhibit a pattern of sexual risk-taking.
- Individuals who experience coerced sex in their childhood may have an increased risk of acquiring HIV or other STIs later in life.

HIV Seropositivity and the Risk of Experiencing GBV; GBV and Adherence

- HIV seropositivity may be associated with the risk of experiencing violence.
- GBV or fear of GBV may potentially delay a woman's decision to disclose her HIV status.
- GBV may negatively influence adherence to treatment regimes because, for example, it may hinder women from accessing health services.

Substance Use, GBV and HIV

- GBV may be linked to substance use.
- Substance use may be linked to an increase in HIV risk behaviours and GBV, even as the exact pathways are not yet entirely clear.
- Gender differences in substance use may impact the ways in which GBV and HIV intersect.

GBV and HIV in Conflict/Emergency Situations

- Conflict and emergency situations may affect the intersections of GBV and HIV. In conflict situations, rape and sexual violence are often reported to be high and interventions to address GBV, HIV or their intersections sorely lacking.

Source: Program on International Health and Human Rights, 2009, box 2.

Sexual and reproductive health services offer the main entry point for identification of and support for women who have been or are currently subject to GBV.

- Women who experience GBV – especially IPV -- are unlikely to report it to authorities, but they are very likely to use a health service, especially for antenatal care (Colombini, Mayhew and Watts, 2008).

- The common element among clients of SRH services -- antenatal, pregnancy testing, maternal and child health/family planning (MCH/FP) (a large proportion of clients), STI and HIV – is that the women and girls have had unprotected sex. About 12 per cent of "typical" condom users (who are not using condoms correctly or not using them 100 per cent of the time) may get pregnant. "Perfect" use rates are 2-5 per cent. Condom users who become pregnant were possibly exposed to STIs and HIV. (See discussion of use rates at: http://www.goaskalice.columbia.edu/2219.html [accessed 30 October 2009]. Evidence from DHS data and the WHO multicountry study on women's health and domestic violence(Ellsberg and others, 2008) shows that a significant percentage of women and girls who have had unprotected sex – a large percentage in some countries – are in a violent or coercive intimate relationship.
- Therefore, a significant percentage of clients attending all SRH services are apt to suffer from or be survivors of IPV or sexual gender-based violence (SGBV). Clients of SRH services often report higher rates of experiencing IPV or sexual coercion/violence than do respondents in population-based surveys (Luciano, 2007, 7).
- Health care–based sexual assault treatment settings attract more sexual assault survivors than do forensic-based settings (Martin and others, 2007).

Integration helps both SRH and GBV programmes serve their clients better and be more effective in the promotion of health and well-being:

- In HIV and SRH programmes, addressing GBV effectively will reduce SRH and HIV risks, because of the linkages described above.
- The women served by GBV programmes have high SRH risks, which GBV programmes need to address through efficient referral systems to SRH services to meet the full range of survivors' needs.
- Training in GBV issues will help SRH providers understand and address the gender issues underlying SRH risks. Understanding the factors in women's and girls' vulnerabilities to GBV is highly relevant to the gender discrimination and power imbalances that are implicated in SRH risks.

Integration builds on the existing strengths and requirements of both types of programmes. Services related to GBV, SRH and HIV all require similar abilities among providers: to pay strict attention to privacy and confidentiality; to recognize and counter cultural norms that discriminate against women and their sexuality; and to interact non-judgmentally and compassionately with women and girls on issues related to sexuality and intimate relationships.

4. Evidence and recommendations on strategies for integration

Evidence on factors in successful integration of GBV into SRH services is scarce. The body of literature on the integration of GBV refers mainly to family planning and HIV services, and not to the broader range of SRH services such as prenatal care, maternal health care and reproductive cancer screening. Peer-reviewed journal articles are more apt to focus on the demographic and epidemiological evidence on the nature of the linkages between GBV and SRH, especially HIV, and not on programme evaluations. Also, much of the evidence on integration and the literature to guide health providers are from northern industrialized countries, where conditions are much more favourable to successful integration than in developing country and/or emergency settings. Northern settings tend to have more adequate health infrastructure and human resources; lower prevalence of extreme poverty; better protection from the legal/judicial system; and more supportive legal and community resources for women and girls experiencing GBV.

Literature evaluating how "successful" services integrated GBV is scarce and tends to be found in "gray" unpublished literature, which is difficult to scan systematically (Program on International Health and Human Rights, 2009).

Guidance on the implementation of integration between HIV services and GBV is relevant to other sexual and reproductive health issues. Much of the content of the WHO manual on the integration of GBV in HIV services (World Health Organization, 2009a) is relevant to all other SRH services. In cases where GBV is detected, no matter what kind of SRH service, the needs and rights of the women and girls in their interactions with the health sector are similar. The major exception is that HIV and STI testing and disclosure raise the level of threat of additional IPV, and HIV infection may occasion stigma and discrimination leading to GBV.

- The most up-to-date resources on the integration of GBV into HIV programmes are the recently published WHO manual: *Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs* (World Health Organization, 2009a). This manual was based on a mapping of some of the unpublished literature and service protocols. Another study forthcoming in 2010, *Gender-Based Violence and HIV*, Program on International Health and Human Rights, Harvard School of Public Health, 2009, is an extensive search of the unpublished literature and has the most up-to-date evidence.
- A 2009 literature review of the evidence on linkages between GBV and HIV/AIDS found much evidence on why it is important to forge the linkages, but very little evaluation evidence on how to do so (Program on International Health and Human Rights, 2009). Authors highlight the importance of:
    - Building skills and strategies that empower women and girls both economically/socially and in terms of gaining control over their sexual experiences.
    - Focusing on vulnerable groups.
    - Engaging men as agents of change.

  However, the specifics of what it would take to carry out relevant interventions in any given context are generally lacking.

The basic guidance contained in much of the GBV literature pertains to all types of GBV and all types of health services. A fuller explanation of the points below is contained in the following sections:

- The physical and mental health consequences of GBV must be addressed. (See chapter II, D, 2)
- Systems for universal or selective screening for GBV must be set up. (See chapter III, A, Screening)
- The health providers must be trained on gender issues and GBV, with ongoing systems for training. (See chapter II, D. Developing capacity among health-care providers)
- Special precautions must be taken to ensure privacy and confidentiality. (See chapter III, C, Privacy and Confidentiality procedures)
- Non-judgemental and culturally sensitive screening must be provided on site, and counselling provided on-site or through referrals. (See chapter III, B, Counselling)
    - Counselling should include information on human rights and legal rights, safety planning, help with decisions on disclosure of HIV/STI testing results (if relevant) and legal action, and information on resources available in the community.
- Referral systems to legal and psychosocial support services in the surrounding community need to be established and available in a timely fashion to reduce delays in receiving the necessary constellation of care and services for survivors of GBV. (See chapter III, D. Referrals and Coordination with Other Sectors.)

E. BASIC RESOURCES: MANUALS, BASIC REFERENCES AND WEBSITES

The most comprehensive and up-to-date resources clearly directed to health-sector providers, including websites that are kept up-to-date, are summarized below. Manuals related to integration of HIV and GBV are cited here because most of the guidance is pertinent to other SRH programmes as well.

Many more resources are available than those listed here. Manuals of more limited topical scope are cited only under the topic.

1. Manuals and basic references

- International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) produced a training manual and video that was tested with numerous affiliates, all of which focus on sexual and reproductive health services. The manual (Bott and others, 2004), *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries* may be downloaded at http://www.ippfwhr.org/files/GBV_Guide_EN.pdf, and a video, *¡Basta! The Health Sector Addresses Gender-Based Violence*, may be watched at http://www.ippfwhr.org/en/node/269. This resource is pertinent to the broad range of SRH programmes and concentrates specifically on SRH services.

- *Gender-based Violence Training Modules: A Collection and Review of Existing Materials for Training Health Workers (Murphy and others, 2006).* This review describes a variety of training resources for health workers on GBV. The reviewers screened the training modules for accuracy, content areas covered (e.g., GBV awareness, IPV and childhood sexual abuse), skills covered and quality of instructional design. The review recommends whether modules are most appropriate for pre-service or in-service training and provides links to the actual modules. The materials are categorized into modules that are applicable for developing-country contexts and those modules that are useful but less current or less applicable to developing contexts. This resource may be downloaded at http://www.hrhresourcecenter.org/node/581 .

- *Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs* (World Health Organization, 2009a). An important reference for health personnel, this guidance covers all major topics and types of services related to HIV/AIDS and GBV, with many tools and protocols. It incorporates the latest thinking and evidence on key components and integrates attention to GBV throughout.

- Interagency Gender Working Group (IGWG) of USAID, *Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers* (Interagency Gender Working Group (IGWG) of USAID, 2008) 2nd edition. The guide states basic principles and health policy and provides guidance for many types of programmes, including youth, service delivery, community mobilization, behaviour change communications and humanitarian programmes. The working group also produced a guide to incorporating gender issues in general into SRH programmes, with issues of GBV highlighted throughout the manual: *A Manual for Integrating Gender into Reproductive Health and HIV Programs: from Commitment to Action*. 2nd edition (Caro, 2009).

- D. Luciano. *A Manual for Integrating the Programmes and Services of HIV and Violence Against Women* (Luciano, 2009). This manual is another basic resource on integration of HIV and VAW, sponsored by the United Nations Development Fund for Women (UNIFEM). It includes discussion of the integration of GBV in HIV prevention, voluntary counselling and testing (VCT), PMTCT, and care, treatment and support. It also includes a number of tools to help in design and a tool for prioritizing integrated services. Other topics are the WHO strategic approach to integration, planning for capacity-building of personnel and the rapid assessment of data collection methods.

- *Department of Health United Kingdom. Responding to Domestic Abuse: A Handbook for Health Professionals, 2005.* *http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4126619.pdf [accessed November 2009].* The content in this manual is geared primarily to the United Kingdom context; however, it contains much useful guidance and sample forms that could be adapted to other contexts.

- *IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings Focusing on Prevention of and Response to Sexual Violence in Emergencies* (Interagency Standing Committee, 2005). The guidelines provide humanitarian actors with a set of minimum interventions in all sectors to prevent and respond to GBV In emergencies. Although the guidelines recognize that other forms of GBV occur, especially after the acute phase of emergencies, the emphasis is on sexual violence as "the most immediate and dangerous type of gender-based violence occurring in acute emergencies."

- *IASC Gender Handbook* is based on and should be used in conjunction with the *Guidelines*. Probably the most up-to-date reference on gender in humanitarian settings, the *Handbook* is available by chapter on the Internet. The chapters on gender basics, gender and health, and gender and participation are especially relevant to health-sector work in these settings (Interagency Standing Committee, 2009).

- The UNFPA *A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Manager*s (UNFPA, 2001) is based on experiences in developing-country settings and focused on SRH and GBV integration. It provides guidance on barriers to talking about GBV, project design, the role of the facility and staff, and start-up issues. It includes sample planning checklists, facility assessments, short screening tools, in-depth GBV assessment tools, safety planning guides and other tools for providers to adapt to their cultural context.

2. **Websites**

The main United Nations-sponsored comprehensive website related to VAW is the new UNIFEM "Virtual Knowledge Centre to End Violence Against Women and Girls," at **http://www.endvawnow.org/.** This section briefly describes websites specifically geared to the health sector's response to violence against women and girls, and/or to specific SRH topics such as sexual violence. Other websites with topic-specific content are cited in the relevant sections, with the links in the References section at the end of this document.

- The WHO website on GBV has numerous resources aimed at the health sector as well as introductory materials on gender and health that would be useful for training health sector personnel. http://www.who.int/gender/violence/en/.

- UNFPA. Many UNFPA resources are linked to the health-sector response, in particular, providers of SRH services, although resources on the website also provide guidance and examples for comprehensive, multisectoral approaches. The Gender-based Violence page http://www.unfpa.org/gender/violence.htm leads to UNFPA and partner publications and websites and contains links to resources on FGM/C, women in emergencies, trafficking, GBV and HIV and harmful practices.

- The Sexual Violence Research Initiative website is a one-stop resource on the subject, with access to many guidelines, journal articles and reports on a wide range of topics connected with SGBV, including HIV, human rights, conflict settings, trafficking, disabilities, harmful practices, masculinity, medico-legal, prevention, advocacy and restorative justice. http://www.svri.org/index.htm.

- The Eldis Development Gateway website has links to numerous publications and articles, with many references related to health-services response, SRH and GBV in the gender-based violence section http://www.eldis.org/go/topics/resource-guides/gender/gender-based-violence, including the following:
    - Sexual violence: http://www.eldis.org/go/topics/resource-guides/gender/gender-based-violence/sexual-violence
    - Domestic violence (including IPV, forced marriage): http://www.eldis.org/go/topics/resource-guides/gender/gender-based-violence/domestic-violence
    - Manuals and toolkits: http://www.eldis.org/go/topics/resource-guides/gender/gender-based-violence/manuals-and-toolkits

II. ADDRESSING VIOLENCE AGAINST WOMEN AND GIRLS THROUGH SEXUAL AND REPRODUCTIVE HEALTH POLICIES AND PLANNING

This section addresses overall policy and planning issues when integrating GBV with SRH programmes in the health sector, discussing mainly the health sector's key role in secondary (screening for early intervention) and tertiary (intervening to minimize the severity of long-term abuse) prevention of GBV (UNFPA, 2001). Primary prevention – acting to reduce and eventually eliminate all instances of GBV – is a multisectoral effort in which the health sector often plays a role and is discussed briefly in section E, page 33.

Because SRH programmes – prenatal care, family planning, childbirth services and other reproductive health services such as cervical cancer prevention – exist at all levels of the system, from community-based primary-care outreach to hospitals, this chapter discusses all these levels. The following chapters address issues that are specific to each type of service or to especially vulnerable populations of women and girls.

A. BASIC ELEMENTS IN ADDRESSING GENDER-BASED VIOLENCE IN ALL SEXUAL AND REPRODUCTIVE HEALTH SERVICES

All SRH services can and should play the following roles in addressing GBV, provided that the minimum conditions to ensure women's safety and to do them no harm are met. (See discussion on "3. Minimum prerequisites for the integration of services addressing gender-based violence " page 24).

- Prevention of GBV through educating clients. Culturally specific educational materials or videos that can be handed to all clients or shown in waiting rooms are now available in most countries, along with materials referring them to GBV-related services available in their community.
- Screening. in chapter III, A, page 38. When clients do not disclose GBV in routine screening, most SRH services offer the opportunity during the physical exam to note signs of violence on the body, including the genital area, and give clients a second chance to disclose GBV and receive support (see Chapter III, A, Screening, for details).
- Provision of the appropriate SRH and other medical services that are integrated and as convenient as possible. Women living with violence may need treatment for injuries and mental health services as well as SRH services such as STI and HIV testing, prenatal care, contraceptive counselling and provision of methods. Non-coordinated provision of related services by different providers creates unnecessary delays and displacement, increasing women's time and cost of travelling to different locations, as well as the emotional costs incurred by recounting the full story of their traumatic experiences to several professionals who have not communicated with one another. The lack of integration and associated delays thus serve as a barrier for women to get the SRH and GBV services they need.
- Referral to social or legal services**.** Cooperation agreements should facilitate quick access to the needed services.

B. Basic Planning Issues

1. A systemic approach to gender-based violence

Two decades of experience in integrating GBV into health services have shown that interventions must go beyond training health-care providers, adapt training curricula to the local context and utilize a system-wide approach, including changes in policies, procedures and increased attention to privacy and confidentiality (Heise, Ellsberg and Gottemoeller, 1999), (Ellsberg, 2006), (Jacobs and Jewkes, 2002). Box 3 describes this approach as applied to GBV services.

Box 3. A systemic approach to gender-based violence services

Reforms involving a systemic approach to improving GBV services typically include:

- Changes in norms, policies and protocols.
- Infrastructure upgrades to ensure private consultations.
- Training of all staff (including managers) on screening for GBV, safety planning for victims and provision of emotional support.
- Increased availability of emergency voluntary testing and counselling services (HIV, STI, pregnancy) as well as HIV post-exposure prophylaxis (PEP), treatment of STIs, emergency contraception and treatment for other common health consequences of GBV.
- Strengthening of referral networks with other GBV-related services such as legal services, psychosocial support and shelter.

Source: (Sarah Bott, Andrew Morrison, and Mary Ellsberg, 2005; Myra Betron and Lucia Fort, 2006.

Health-sector interventions alone will not eliminate GBV or SRH risks. Multisectoral strategies encompassing diverse prevention initiatives as well as health care are necessary. Providers must work together with other sectors, particularly at the community level, to strengthen local networks for support of survivors of violence and also to engage in health promotion and violence prevention.

The adoption by States of multisectoral national action plans or strategies on violence against women, as recommended by the Declaration on the Elimination of Violence against Women, has become increasingly common. Ideally, the health-sector services and programmes that address VAW would be integrated into a national action plan that provides the health sector with a framework for cooperation, a division of labour and referral networks. The components of national plans that affect the health sector reflect a range of support services for victims/survivors, including medical treatment, psychosocial support, safety planning and referral systems to legal services, community GBV programmes and alternative housing. In these plans, the health sector forms partnerships to engage in educational outreach for GBV prevention and to acquaint women with their rights and the resources available to them. The health sector would also engage in capacity-building for staff and officials. National plans would also include judicial and security-sector plans aimed at prosecution, punishment and rehabilitation of perpetrators (World Bank, 2002).

2. What is integration?

The basic principle of integration of SRH and GBV services is to make as many of the necessary services as possible conveniently available to women, without undue waiting times, delays or multiple visits. When women are in danger or arrive in emergency rooms with severe injuries or post-rape, providing the constellation of needed services as quickly as possible –including counselling and safety planning -- can be a matter of life and death. A recent review (Colombini, Mayhew and Watts, 2008) examined the evidence from developing countries for three models of integration and identified good practices within each model:

- Selective provider and/or facility-level integration (same site): a few selected services are integrated into existing services by the same provider and/or on one site.
- Comprehensive provider and/or facility-level integration (same site); a wide range of services are integrated into existing services by the same provider or at same site.
- Systems-level integration (multi-site linkages) in addition to the facility-level integration. Coordination with other sectors establishes solid referral systems, typically for psychosocial counselling, legal aid, social support, police investigations, hotline services and shelter.

> "Overlooking the health implications of violence against women is not just a missed opportunity. Women sometimes disclose intimate partner violence, rape or sexual abuse to heath-care providers, and providers who respond by blaming the victim may inflict severe emotional trauma. Providers . . . may fail to provide holistic care, to recognize women in danger or to provide necessary, even life-saving care, such as STI prophylaxis. Moreover, health systems that do not protect patient confidentiality may put women at risk of additional violence from partners or other family members."
>
> (World Bank, 2002, 2).

Basic decisions about the type of integration need to be made based on available resources and the context. For post-sexual violence visits in particular, there is a crucial 72-hour period in which emergency contraception and HIV post-exposure prophylaxis (PEP) are possible, strongly arguing for 24-hour availability of services, use of facility-level integration and "one-stop services."

3. Minimum prerequisites for the integration of services addressing gender-based violence

The primary concern of any health-care provider must be women's health and safety. Therefore, the first task of the health system, programme or facility when addressing GBV is to determine whether the minimum conditions are met – or could be met through some additional investment in resources, system improvements and training – to ensure that providers do no harm and that their intervention promotes health and safety. In resource-poor settings, all of the recommended components of a GBV service may not exist. For example, legal services or shelter programmes may be unavailable; the backup from the judicial system may be extremely weak; or there may be no trained counsellors to provide psychosocial support. Even in the lowest resource settings, the following resources and interventions should be possible with a minimum of initial investment:

- Basic reference materials on health and legal aspects of GBV available for providers.
- Educational materials on GBV available for those in waiting rooms, including audio-visual materials in local language if possible.
- Providers trained to treat the health consequences of GBV, to be compassionate and non-judgmental, and to conduct danger assessment and safety planning.
- Privacy and confidentiality systems in place.

- Contact information for any social or legal support services in the community posted and/or available;
- For post-sexual violence services, availability of HIV PEP and emergency contraception.

4. Guidance on basic components of gender-based violence and sexual and reproductive health services

Basic components include the minimum requirements described on page 9. This section expands on the minimum requirements to describe the recommended interventions and investments needed to integrate GBV with SRH services, from primary to tertiary level. Although much of the literature reviewed addresses the integration of GBV with HIV programmes, most of this content is relevant to all SRH programmes and services, and to health-sector establishments from the primary-care level to the tertiary-care level of referral hospitals.

1. Assessments to understand the profile of GBV and SRH in the service/programme setting. (See resources section below).

2. Infrastructure or strategies, such as to guarantee privacy.

3. Systems and protocols to guarantee confidentiality.

4. Training of staff to provide gender-sensitive and rights-based care and basic counselling for all forms of GBV, including sexual violence. (See section 1. Capacity development systems for the integration of gender-based violence in health services page 30).

5. Components related to integration within a health facility: coordination, referrals systems.

6. Screening policies and protocols, including tools to identify women and girls at high risk of GBV and women and girls who are in danger. (See section on screening page 38).

7. Protocols for each type of provider when a women or girl who has been abused is identified (paediatrics, prenatal care, childbirth, women's health, HIV services, etc).

8. Referral networks for services not available on-site, including counselling and peer support groups.

9. Service components, equipment, and supplies related to post-rape services and medico-legal requirements (See chapter IV, C, Post-sexual violence services, page 55).

Box 4 presents a schematic view of these basic components of a systemic approach to integration of GBV, organized by the levels in the health system, from individual providers up to the Ministry of Health.

Box 4.

TABLE 1. Ways of addressing inimate partner violence, according to type of provider

Nurse/health worker	Clinic/care setting	Hospital	Ministry of Health
Being informed about the types, extent and underlying causes of violence	Developing policies on violence against women	Accepting referrals and acting as a reference point for clinic/case facilities implementing policies to address violence against women	Publicly condemning violence against women
Screening for abuse during reproductive health consultations	Ensuring private space is available when needed for consultations	Developing protocols on the management of rape, child sexual abuse and other forms of violence	Being informed about types of violence, underlying causes and consequences
Supporting women emotionally by validating their experiences, and by being nonjudgmental and willing to listen	Displaying posters/leaflets condemning violence against women	Ensuring staff are appropriately trained to handle rape, child sexual abuse and other forms of violence	Supporting the development of policies and protocols on different forms of violence against women
Providing appropriate clinical care (e.g., emergency contraception, pregnancy testing, and STI/HIV testing and treatment)	Supporting staff interested in helping women who have experienced violence, and promoting staff access to appropriate training	Developing statements on the unacceptability of violence	Incorporating specialized curricula on violence against women into health worker training
Documenting the medical consequences of violence	Supporting staff who have experienced partner violence	Supporting staff interested in helping women who have experienced violence, and promoting staff access to appropriate training	Monitoring and evaluating initiatives to address intimate partner violence
Maintaining confidentiality	Creating links with other local organizations working to address gender violence	Being active in multisectoral initiatives on intimate partner violence	Being active in multisectoral initiatives on intimate partner violence
Referring women to community services and resources, if they exist			

Source: Watts and Mayhew, 2004a, Table 1, p. 210.

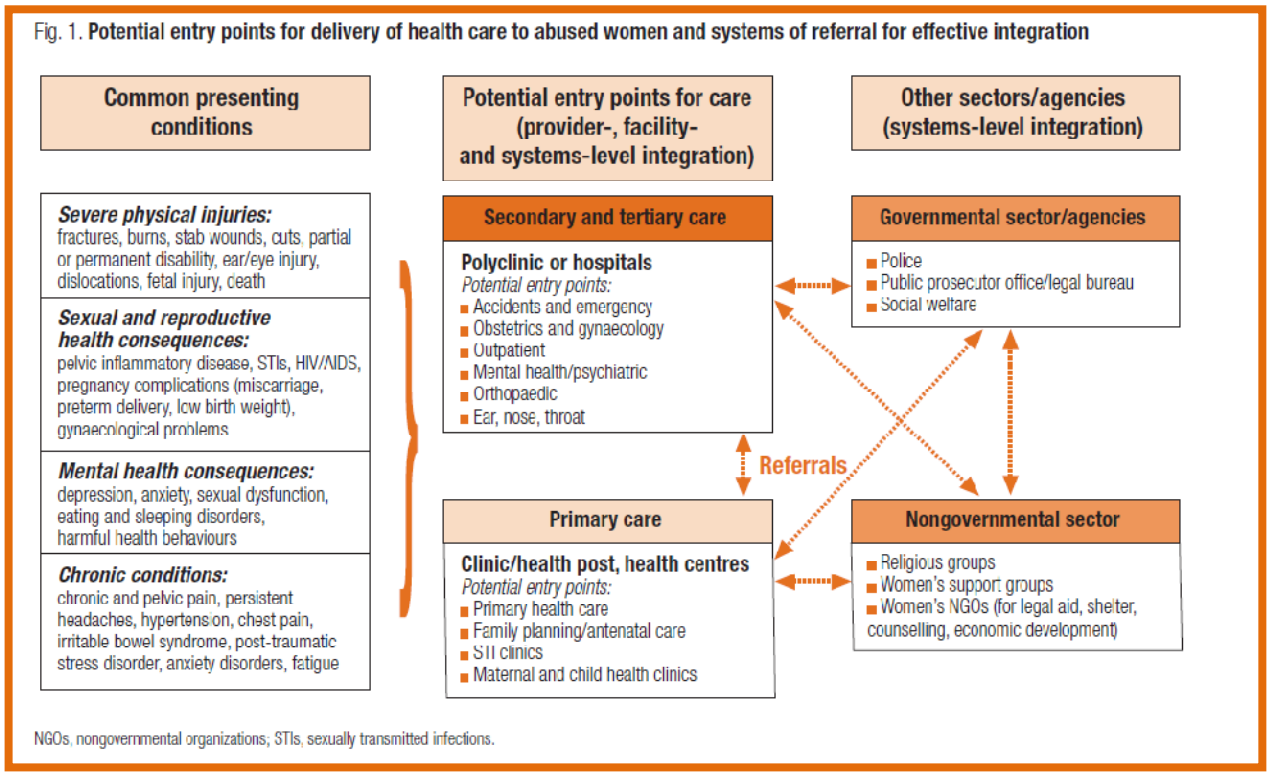
Many aspects of this integration are a challenge in settings where there is a shortage of health providers, facilities, equipment and supplies overall, especially at the primary-care level. Even in these settings, and without overloading community health volunteers and health workers who are addressing multiple issues, some basic interventions are still possible to enable the health sector to support women affected by GBV or survivors of GBV.

5. Entry points into the health system for women affected by gender-based violence

This section will comment on some of the main entry points. More detailed discussions are to be found in sections on the main types of SRH services: HIV/AIDS and STI services (page 51); post-sexual violence services (page 55); maternal-child health services (page 61); other reproductive health services, including family planning, abortion, infertility, and gynaecological services (page 62); and paediatric services (page 64).

The most common entry points to the health system were summarized in a recent literature review, (Colombini, Mayhew and Watts, 2008), which provided the diagram in Figure 1 showing the common presenting conditions of women experiencing GBV, the potential entry points at different levels of the system and the referral networks needed.

Source: Manuela Colombini, Susannah Mayhew and Charlotte Watts. 2008, Figure 1, p. 639.



a. Emergency rooms

Emergency rooms most often identify GBV when violence results in severe physical injuries. SRH services in emergency rooms become essential when post-sexual violence services are linked with the juridical and legal system. Evidence suggests that most women and girls experiencing rape will go to a hospital before going to the police and may be reluctant to go to the police for safety (fear of retaliation) and economic reasons (fear of loss of financial support). Women and girls also want non-stigmatized services -- that is, they do not want others in the waiting room to know they are using a post-sexual violence service. In settings with high community awareness of the rights of rape victims, women come to emergency rooms aware of their legal rights with the intention of ensuring that the required medical evidence is collected for legal purposes.

b. Primary care

In most countries, MCH primary-care services have the highest national coverage of all types of health services, often reaching hard-to-reach and highly vulnerable women and girls in rural areas and those living in extreme poverty in urban areas. As such, MCH services offer a unique opportunity to detect and prevent GBV among women who otherwise have little access to health services. Because the incidence of GBV seems to rise in pregnancy, it is imperative that providers are alert for signs of GBV.

Prenatal and MCH services are the main entry point to reach girls in early marriage, at the time of the first pregnancy. Pregnancies in girls under 18 carry high risks for both mother and infant, and early marriage is a harmful practice associated with multiple violations of girls' rights. (See chapter V, B, discussion and references on early marriage on page 80).

The health consequences of GBV may be a presenting condition, as in Figure 1 above, but in prenatal or MCH services, women typically will not disclose their experience of violence unless asked. The policies and protocols for inquiry then become a crucial component of GBV integration, with decisions on

whether to implement universal screening or screening only in selected services, such as HIV VCT, family planning and the emergency room

c. HIV and other sexual and reproductive health services

SRH and HIV services are key entry points for detecting women experiencing GBV or at high risk of GBV, as discussed earlier (see chapter I, D, 3, page 18).

6. Costing

There is considerable literature on the costs to society of GBV and the long-term health consequences of GBV. Yet little evidence seems to exist on the costs of integrating GBV into SRH services. Most studies are from industrialized countries and are not applicable to a developing-country setting, because the additional costs will vary according to the infrastructure and services already available, e.g., the extent of training of service providers in counselling and/or gender sensitivity, and whether the facility already has the capacity to provider appropriate post-sexual violence services, such as the provision of emergency contraception, STI and HIV testing, and PEP for HIV/AIDS and treatment for STIs.

The additional costs to be considered include the following one-time start-up costs. This list assumes that the normal equipment and supplies for the SRH service setting are in place.

- Any remodelling of facilities that is needed to provide the necessary privacy, usually outfitting a private room for counselling, or a room dedicated solely to the constellation of post-rape services.

- Adaptation of screening tools and protocols, which might necessitate the time of a researcher to verify culturally appropriate language and ways to surmount cultural barriers to disclosure.

- Training of health providers to apply protocols and provide initial gender-sensitive, sympathetic counselling.

- Time of health sector staff to set up the appropriate linkages and referral systems with police, judiciary and psychosocial services.

- For post-sexual violence services, coordination with the legal system demands medico-infrastructure, equipment, supplies and medicine, e.g., laboratories to take biological samples, HIV/PEP, emergency contraception, STI treatment and other items that are mandated by national law and may prove useful as evidence if legal recourse is pursued.

Some recurrent costs will be fixed; others will vary according to the number of women expected to use the service. As community-based education campaigns raise awareness about GBV and women's rights, the numbers of women using the service should increase steadily. If the service is to be sustainable, the following recurrent costs must be considered and built into budgets.

- If the facility sets up a special service for GBV that did not exist previously, there will be annual operating costs.

- The need for training and support of health personnel dealing with GBV cases is ongoing, to avoid burnout and maintain quality of services.

- Given the skills and time constraints of many of the health providers doing the initial screening for GBV, many services added psychologists to existing services. Given the human resource constraints of most public-sector health services, it is difficult to provide these additional support services, such as psychologists, without additional funding (Hainsworth and Zilhão, 2009).

- For resource-poor settings low-cost alternatives, such as peer support groups for women, are suggested when psychosocial support is lacking.

- If post-sexual violence services are added, the cost of any additional laboratory tests and standard treatments, as well as the costs of gathering of evidence for the juridical system according to national standards.

However, one review of investment in addressing violence against women in HIV/AIDS programmes (Fried, 2007) cautions that specific health-related funding is "hard to track, hard to find" and that funding mechanisms in the new aid environment seem to be making accountability for such investments even more challenging by making specific investments more difficult to track.

Only one study from South Africa gives some idea of additional costs (Kim and others, 2007). The cost of strengthening post-rape services in South Africa to improve the quality of history and examinations, the provision of pregnancy testing, emergency contraception, STI treatment, VCT and HIV PEP, as well as follow-up counselling and referrals, amounted to an additional $US17,449 annually at a rural hospital.

Worldwide, experiences of Gender Responsive Budgeting (GRB) promoted by UNIFEM and other United Nations partners might yield more information on health systems investments in GBV integration, and on costs.

- The portal sponsored by UNIFEM http://www.gender-budgets.org/ gives a variety of resources on this advocacy and accountability strategy.

- UNIFEM and UNFPA produced a training manual and annexes on GRB and SRH that includes content on violence against women. *Gender Responsive Budgeting in Practice: a Training Manual*. http://www.unfpa.org/public/op/edit/publications/pid/370 . However, with the exception of the study from South Africa cited above, more specific information on the costs of integrating GBV was not found in the literature search.

7. Planning and assessment resources

Most of the comprehensive planning resources are described under "Basic Resources" in chapter I. In particular, the following provide planning overviews:

- The IPPF/WHR manual (Bott and others, 2004) has a management checklist on pages 43-47, a comprehensive planning tool for all components of integrating GBV into SRH services. The annexes contain several assessment tools, including a provider survey, a clinic observation guide and a record review protocol.

- The Interagency Working Group Manual on the integration of gender in SRH services (Caro, 2009) provides a guide to the planning cycle in Chapter 5, "Gender Integration Throughout the Program Cycle," including the topics of assessment, strategic planning, design, monitoring and evaluation.

"Assessment" tools have several purposes, and the title of the publication does not always reveal the purpose:

- Assessing the prevalence and types of GBV in a given setting (see section C below, page 30, on surveillance systems). This data is important for planning purposes as well as for advocacy to invest in the integration of GBV.

- Assessing the capacity of health services and providers to integrate GBV. These assessments are crucial to detect and correct gaps in the ability to integrate GBV.

- Assessing GBV among women and girls within the health-care setting. This purpose overlaps with screening (see discussion page 25). For example, the United States Centers for Disease Control published *Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools* (Thompson and others, 2006) as well as *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings* (Basile, Hertz and Back, 2007). Both tools could be adapted to developing country settings.

Some of the tools are general and focus on the whole health sector; others are specialized and concern one type of GBV such as sexual violence or are geared to industrialized country settings. The following tools are geared to developing-country settings:

- The *Guide for Community Assessments on Women's Health Care* (Kidd and Orza, 2008) provides a grass-roots methodology for performing assessments of women's health applicable to a GBV assessment.

- The Sexual Violence Research Initiative published an assessment guide of health services for sexual assault survivors geared to developing-country contexts. (Christofides and others, 2006) http://www.svri.org/analysis.pdf [accessed November 2009].

C. ESTABLISHING NATIONAL SURVEILLANCE SYSTEMS AND DATA COLLECTION METHODS

Resources on this section will be made available on the UNIFEM "Virtual Knowledge Centre to End Violence Against Women and Girls," at http://www.endvawnow.org/.

D. DEVELOPING CAPACITY AMONG HEALTH-CARE PROVIDERS

Building the capacity of health-service providers to address GBV sensitively and with a rights-based approach is one of the key interventions for integration with health services and one of the minimum requirements for integration of GBV (see page 9).

In the long-term, the best and most sustainable approach to building national capacity in GBV in the health sector is to integrate training on GBV into the curriculum of medical and nursing schools. However, even if this content were part of pre-service training, reinforcement and updating of the basic skills would still be necessary. This section concentrates on the strategies used to build capacity among practising health providers, most of whom have received no pre-service training on gender issues or GBV.

1. Capacity development systems for the integration of gender-based violence in health services

Although training is often viewed as the main capacity-building strategy, it should be part a longer term process with various interventions and systems, including the following:

- Assessing the capacity strengths and gaps of health staff, according to the basic objectives outlined below, to build the capacity development plan.

- Developing a training programme to introduce providers to the basic information and skills.

- Identifying and providing reference materials, guides and protocols to support providers in the post-training period.

- Exercising strong supportive supervision and mentoring systems as providers put their skills into practice, such as regular meetings to exchange experiences and feedback.

- Establishing systems to disseminate growing evidence on how best to integrate GBV with SRH programmes and services.

- Providing periodic professional development courses to update skills.

- Establishing ongoing orientation and training systems for new and regular staff to keep pace with emerging evidence on how best to integrate GBV with SRH services.

A recent example of responding to the demand for capacity-development systems in GBV is a postgraduate medical certificate programme with the support of UNFPA Tunisia that will provide GBV training to medical doctors, nurses and other health-care providers. The curriculum for the course was developed through a consultative process involving technical experts from UNFPA and the medical field ("A new medical diploma on violence: a unique experience in Tunisia", 2009). The course integrates content on human rights-based approaches, adolescents, substance abuse and HIV as related to violence against women and girls, including guidance on providers' conduct with HIV-positive patients.

2. Capacity-building objectives for addressing gender-based violence in sexual and reproductive health programmes

The educational objectives of a capacity-development programme in GBV should include the following:

1. Understanding of the clinical and medical aspects of GBV and how to address the major physical and mental health consequences. Sexual violence merits special attention, because the accompanying SRH risks demand PEP for HIV, emergency contraception and attention to any damage to vaginal or anal tissue.

2. Understanding of basic gender inequality issues and the factors linking GBV to SRH, including how power inequalities in intimate heterosexual relationships and in the communities make women and girls vulnerable to SRH risks and GBV.

3. Understanding of the individual and community-level factors of vulnerability to GBV, HIV and SRH in the context. (See discussion of prevention, page 33). Examples might be alcohol abuse, intergenerational sex, substance abuse and other community-level factors such as extreme poverty and high levels of violence in conflict or post-conflict settings (Hainsworth and Zilhão, 2009).

4. Support to the woman, including learning to refrain from blaming the victim. The provider should learn to identify and reject stigmatizing attitudes regarding women's experience of GBV, and counter any norms that accept VAW as deserved or even desired, such as "women enjoy punishment" (Kim and Motsei, 2002). This culturally specific aspect of the training should be based on existing research into attitudes on GBV, or if necessary, on focus groups of community members in order to understand community norms.

5. Skills-building to face a highly emotional issue with empathy, understanding and without blame. Providers need to learn to accept women's and girls' emotional reactions to trauma and reassure the victims that these emotions are normal and justified.

6. Addressing possible experiences of GBV in the providers' lives, with psychosocial support to overcome trauma. Some attempts to integrate VAW into reproductive health or HIV services have been derailed when trainers could not handle the emotions of providers who had experienced GBV or were still in violent relationships (World Health Organization 2009a, 9).

7. Practising the use of a culturally adapted screening tool, preferably through role-playing and other participatory methods.

8. Learning key messages about GBV to deliver to clients based on such human rights principles as the right to live free from violence, so that GBV is never justified and never "their fault," right to refuse sex, etc.

9. Learning about local laws and GBV resources so that women and girls can be informed of their legal rights and of any women's organizations providing support.

10. Assessing of a woman's risk of danger and engaging in safety planning, especially if the counselling is linked to STI or HIV post-test counselling in which the woman has learned that she tested positive. Safety planning might include discussions of possible violent consequences of disclosure to partners and strategies to avoid violence.

11. Providing counselling for the violent partner or locating community resources that can do this if this intervention is requested by women. At a minimum, counselling the partner should have explicit anti-violence messages and inform him of laws against violence. If counselling is not possible, educational materials designed for male perpetrators could be provided, so long as they are tested in the local context. (See Annex II for an example of a Papua New Guinea leaflet directed to men.)

3. Resources for capacity development

Numerous training resources and reference tools on GBV are available and referenced throughout this site/toolkit. The most comprehensive of those that are geared to health-service providers were described in chapter I, E, "Basic Resources," including especially Murphy and others (2006) and IPPF/WHR (2003)

Box 5 shows an example of a training course from South Africa (*Vezimfilho* -- to Break the Silence) that incorporates most of these elements. Although the course focuses on VCT training for HIV/AIDS services, most of the topics that are pertinent to GBV training in all SRH services are represented.

Box 5.

BOX 1.9

Capacity-building for addressing gender-based violence through VCT (33)

Vezimfihlo! (*To break the silence*) is a training programme developed in South Africa that aims to equip counsellors who work in VCT settings to address gender-based violence. The programme explores why gender-based violence is a public health concern and how health workers can help abused patients; it also builds identification, consultation, communication and response skills. The target audience includes lay counsellors and other service providers who give VCT. Key topics in the manual include:

- the social construction of gender
- gender-based violence – a public health priority
- how the health sector can respond to gender-based violence
- attitudes to gender-based violence
- gender-based violence – causes and consequences
- experiences of gender-based violence
- identification of gender-based violence
- barriers to the identification and disclosure of violence
- the role of the health sector in ensuring safety
- asking about abuse and performing safety assessments
- consultation skills – how to improve communication
- options for abused women
- gender-based violence in VCT
- building support systems, including community resources.

Key messages for addressing violence against women in the health sector

- Gender-based violence is a health problem, so the question is not whether to engage with it but how to do so.
- Health workers in a VCT setting, and those supporting abused women, need to engage with factors that place women at risk and interfere with the ability of HIV-positive women to live healthy lives.
- The role of health workers in addressing gender-based violence is to:
  - — ask about it
  - — be empathetic and non-judgemental
  - — discuss how it can increase HIV risk
  - — discuss its effect on disclosure and living positively with HIV
  - — talk about safety and give information about options.

Source: World Health Organization, 2009a, Box 1.9, 10.

Long-distance "e-learning" resources on gender, including content on GBV, are gaining greater importance and are available to most United Nations agency staff, as well as their partners, in some cases. See reference to one of these courses related to Gender and Humanitarian Response in chapter III, D, page 50.

E. Primary Prevention of Gender-based violence and Public Health Outreach

Primary prevention of GBV aims at addressing GBV before it happens by working at policy and societal levels for changes in legal structures, judicial remedies and cultural norms. Civil society organizations typically play a leading role in primary prevention, either through advocacy to improve policies or through community-based efforts to create more favourable cultural norms. Health services engage in secondary prevention -- aimed at stopping or minimizing GBV -- through screening for GBV, to identify women and girls experiencing GBV and provide the needed support and referrals to prevent additional occurrences of GBV. Health services also undertake tertiary prevention: treatment and harm reduction for those women and girls with severe injuries and health consequences from GBV.

Many primary-prevention strategies are either community-based with direct face-to-face educational interventions or involve mass media campaigns. See the VAW virtual knowledge centre on prevention strategies for a comprehensive discussion: http://www.endvawnow.org/?start-here-programming-essentials-me&menusub=147&promoting-primary-prevention

Primary prevention involves: promoting policy and legal changes so that perpetrators do not enjoy impunity; transforming discriminatory cultural norms (shared by both men and women) that accept violence against women; addressing factors that reinforce women's subordination to men in the family and community, including economic and political discrimination; and addressing both community-level and individual risk factors (see box 6).

Box 6. Community and individual risk factors for gender-based violence

Community-level risk factors for GBV:

- Traditional gender norms that support male superiority and entitlement.
- Social norms that tolerate violence against women.
- Weak community sanctions against perpetrators.
- Poverty.
- High levels of crime and conflict.

Individual risk factors for women:

- Greater than moderate consumption of alcohol or drugs.
- Previous history of abuse.
- Becoming empowered through education or increased income (in traditional settings where men are not included in anti-GBV education).
- Poverty (especially for sexual violence).

Source: Interagency Gender Working Group of USAID, 2008, p. 7.

1. Violence prevention strategies: an overview of the evidence

The latest evidence from WHO on violence prevention, a resource linked to the Global Campaign for Violence Prevention (World Health Organization, 2009b), provides useful guidance on seven major violence prevention strategies, all of which are relevant to violence against women and girls. This list of strategies covered by the review includes comments on their pertinence to violence against women and girls:

1. Developing safe, stable and nurturing relationships between children and their parents and caregivers – a history of child abuse make men more apt to be perpetrators of GBV, and women more at risk of experiencing IPV.

2. Developing life skills in children and adolescents; comprehensive SRH and life skills education in schools are the ideal vehicle for reaching large numbers of boys and girls while their ideas about gender

TABLE 1

Overview of violence prevention interventions with some evidence of effectiveness by types of violence prevented

Intervention	Type of violence					
	CM	IPV	SV	YV	EA	S
1. Developing safe, stable and nurturing relationships between children and their parents and caregivers						
Parent training, including nurse home visitation	●			○		
Parent-child programmes	○			○		
2. Developing life skills in children and adolescents						
Preschool enrichment programmes				○		
Social development programmes				●		
3. Reducing the availability and harmful use of alcohol						
Regulating sales of alcohol			○			
Raising alcohol prices			○			
Interventions for problem drinkers		●				
Improving drinking environments				○		
4. Reducing access to guns, knives and pesticides						
Restrictive firearm licensing and purchase policies				○		○
Enforced bans on carrying firearms in public				○		
Policies to restrict or ban toxic substances						○
5. Promoting gender equality to prevent violence against women						
School-based programmes to address gender norms and attitudes		●	○			
Microfinance combined with gender equity training		○				
Life-skills interventions		○				
6. Changing cultural and social norms that support violence						
Social marketing to modify social norms		○	○			
7. Victim identification, care and support programmes						
Screening and referral		○				
Advocacy support programmes		●				
Psychosocial interventions			○			
Protection orders		○				

KEY

● Well supported by evidence (multiple randomized controlled trials with different populations)

○ Emerging evidence

CM – Child maltreatment; IPV – Intimate partner violence; SV – Sexual violence; YV – Youth violence; EA – Elder Abuse; S – Suicide and other forms of self-directed violence

are still in flux, to raise their awareness of all forms of GBV as a human rights violation, to empower girls, and to enlist boys' as their allies in combating GBV.

3. Reducing the availability and harmful use of alcohol; such use is a risk factor for men to be perpetrators or for women to be affected.

4. Reducing access to guns, knives and pesticides; conflict and post-conflict settings are risk factors for GBV because of lapses in security and also because access to small arms and weapons becomes much more widespread.

5. Promoting gender equality to prevent violence against women. (See discussion of gender mainstreaming in chapter I, C, 3, page 12).

6. Changing cultural and social norms that support violence: norms that support gender inequality as well as GBV need to be transformed. This strategy involves mass communications, community mobilization, and informal education activities to combat GBV.

7. Victim identification, care and support programmes; in this strategy, the health sector, and SRH programme in particular, can play a major role.

See the graphic (Table 1) for strategies that have evidence of effectiveness for IPV and sexual violence prevention drawn from *Violence prevention: the evidence: overview* (World Health Organization, 2009c). It is instructive that most categories of interventions for IPV prevention have only "emerging evidence," with the only interventions with "well-supported evidence being interventions for problem drinkers, school-based programmes to address gender norms, and "advocacy support" programmes. Sexual violence prevention seems particularly under researched, with no interventions that are well-supported. However, the standards for inclusion "as well-supported by the evidence" are so strict that all but one of the evaluations that passed inclusion criteria are from the United States of America or the United Kingdom, because randomized controlled trials with different populations are rare in developing countries.

Many other prevention strategies for which rigorous quasi-experimental evaluations were conducted qualify as promising and worthy of adaptation, such as the IMAGE (Barker, Ricardo and Nascimento, 2007; Pronyk and others, 2006) and Rural AIDS and Development Action Research Programme (RADAR) (Kim and others, 2007) programmes in South Africa and Program H for outreach to men and boys (Instituto Promundo). One good-practice example of an anti-GBV mass media campaign is the Breakthrough Campaign in India, http://www.breakthrough.tv/, an award-winning mass media TV campaign on sexuality and HIV as well as violence against women in India. The campaign has reached millions of Indians in their homes via broadcasts during prime-time TV. See the primary prevention section of the UNIFEM knowledge centre website for additional examples. http://www.endvawnow.org/?start-here-programming-essentials-me&menusub=147&promoting-primary-prevention . These are all multisectoral strategies in which the health sector should play a key role, and they deserve further exploration, provided that excellent monitoring and evaluation systems are in place so the multisectoral team can adjust or withdraw strategies that prove ineffective.

2. Role of sexual and reproductive health services in primary prevention

The level of involvement of the health sector in primary prevention varies among and within countries, according to the level of political will to eliminate GBV. In many countries, therefore, the first step in addressing GBV in the health sector is advocacy.

The potential role of SRH services in GBV prevention is not limited to secondary and tertiary prevention for "victim identification, care and support"; addressing GBV through SRH services is also an essential primary prevention strategy. SRH providers serve a sexually active population; prenatal care services, in particular, tend to have the highest national coverage and are most apt to reach highly marginalized and vulnerable women and girls. Therefore, SRH services are ideal channels to detect women and girls at high risk of violence and to counsel or refer them to related services to prevent a first experience of violence. SRH providers may also be able to detect instances of emotional abuse that have not yet escalated to physical abuse. Implementation of quality GBV screening and counselling in SRH services, with referrals to appropriate community services for follow-up, is thus a key component in the constellation of interventions needed for primary prevention of GBV.

The discussion below highlights the possible roles of health professionals in primary prevention, according to the elements listed earlier in this section.

- Undertaking advocacy for policy and legal changes so that perpetrators do not enjoy impunity. Health professionals often enjoy high status in many countries and thus are ideally positioned to serve as advocates, both among national planners and within their sector, for investments in eliminating GBV.
- Transforming discriminatory cultural norms - shared by both men and women -- that accept violence against women. The health sector can address these through participation in mass media or community-based awareness-raising, through educational materials and resources available in waiting rooms, examination rooms, and counselling spaces, and through messages delivered personally to female and male clients/patients.

- Addressing social, economic and political factors that reinforce women's subordination to men in the family and community. As discussed on page 18, in many settings where women and girls are isolated in their homes (or workplaces in the case of sex workers and trafficked women), health providers may be the first and only point of contact for a woman/girl experiencing GBV. As such, providers are a key source of referrals to programmes in their area that aim at empowering women and that address these socio-economic and political factors. The training of health providers in gender discrimination should raise their awareness of these factors in assessing the vulnerability of women and girls to GBV; this knowledge will help them to be understanding and compassionate and do more effective safety planning. (See discussion of danger assessment and safety planning in Chapter I, C, 1).

- Addressing individual risk factors. When screening protocols cover past as well as present GBV, health providers are well-suited to uncover a history of abuse and refer women/girls to sources of psychosocial support. Alcohol or substance use is also a risk factor for both GBV and most SRH problems, so that SRH programmes would benefit from addressing these issues.

Many primary-prevention initiatives implemented by civil society organizations or health ministries (in the case of HIV prevention, for example) are either community-based, with a wide variety of face-to-face educational interventions, or mass media campaigns. An important component of all these strategies is a referral system to health services for women/girls experiencing GBV. It is essential for health systems to facilitate and stimulate these linkages. Where the health sector engages in community outreach on SRH issues such as maternal and child health, health professionals can be directly involved in educational activities in community-based strategies.

Reaching out to men and boys and enlisting them as allies against GBV is an important element of all GBV primary prevention. When men or boys accompany their partners or wives to SRH services, the involvement of heterosexual couples creates opportunities for the health sector to play a role in both primary and secondary prevention; for the former, educating men and boys on GBV in efforts to reinforce anti-GBV norms and, for the latter, detecting possible instances of GBV and taking action to avert additional harm to the woman. See the UNIFEM VAW Virtual Knowledge Centre for comprehensive guidance and resources on working with men and boys on VAW. http://www.endvawnow.org/?men-boys

One study of a family planning service that campaigned to involve men found that male attendance at the service rose significantly through active invitations from their spouses as well as through advertising the services of an urologist. With heterosexual couples as clients, gender power dynamics along with the threat of GBV arose at times, necessitating diplomatic and creative strategies to try to avert GBV and ensure privacy and confidentiality for women (Shepard 2004).

3. Resources for gender-based violence prevention

One of the most helpful interventions that health services can make to contribute to GBV prevention is to make educational written and audio-visual materials with key messages on GBV available in waiting rooms and in providers' clinical spaces. In settings with low female literacy, audio-visual materials are especially important. Annex II shows an example from Papua New Guinea of a cultural and context-specific adaptation of the most important messages for men and women.

- See the following link for a comprehensive database of educational materials related to VAW. http://www.m-mc.org/mmc_search.php?match=violence%20against%20women&step=results&adv=mat&site=HCP&key=

- See the website http://www.preventviolence.info/ for a wide range of resources on IPV and sexual violence prevention. See also the websites listed as Basic Resources in chapter I. The website of the GBV Prevention Network, has a wide array of news, resources and publications as well as relevant web links to other sites. See http://www.preventgbvafrica.org

III. DESIGN AND IMPLEMENTATION GUIDANCE: ALL SEXUAL AND REPRODUCTIVE HEALTH AND HIV SERVICES

This guidance is designed for public, private and civil society health- service providers. At the grass-roots level, civil society organizations provide a significant proportion of SRH services and play a critical role in ensuring that services reach GBV survivors.

A. SCREENING

Screening is "asking women about experiences of violence/abuse, whether or not they have any signs or symptoms" (Bott and others, 2004, 109). Without routine screening, health services respond to GBV mainly when female clients take the initiative to disclose it or when women or girls come to the emergency room with severe injuries. Given strong cultural barriers and taboos to such disclosure in many societies, without some level of screening many women and girls experiencing GBV will not receive the information, support and protection they need. For a large percentage of women, then, screening by health providers is the bedrock on which all other interventions to address GBV are based.

However, controversies surround the benefits and risks of routine screening. Regardless of whether health services implement routine GBV screening, researchers and advocates agree that women's health care programmes have an ethical obligation to ensure that staff are prepared to respond compassionately and appropriately to disclosures of violence against women (Bott, Morrison and Ellsberg 2005, 28).

1. Evidence on screening policies

There are controversies on whether universal or selective routine screening for GBV and the disclosure of GBV is always beneficial to women. A number of key knowledge gaps related to routine screening need to be addressed through research:

> "Although there might be general agreement that health services have an important role in addressing intimate partner violence, and that asking women about abuse is generally a good thing, there needs to be greater clarity on who should ask the questions, of whom, in which settings, and after what training. Ensuring women's safety during and after disclosure is of paramount importance" (García-Moreno, 2002, 1509-1510).

Most agree that in the absence of the minimum prerequisites for integrating GBV (see page 9), routine screening of women who do not spontaneously disclose GBV should not be undertaken. The IPPF/WHR manual (Bott and others, 2004, 109-111) discusses the arguments for and against routine screening and concludes that, even without legal recourse and with little community support, abused women or girls may benefit from access to a private space where she can discuss GBV. (García-Moreno, 2002; Koziol-McLain and others, 2008)

2. Guidance on screening for gender-based violence

Screening should create a record of the main GBV issues for the woman, which, in turn, would determine what care and support she needs from the provider doing the screening and from others in the facility or the community. SRH services need to devise policies on who will be screened for GBV, protocols on how to screen women for different types of providers and situations and, through training and support, ensure that providers screen and counsel women in a non-judgemental and comprehensive way and with as much helpful information as possible.

Four main categories of routine screening exist: (Morrison, 2008)

- Ask all women about abuse at all first visits, otherwise known as universal screening.
- Screen in strategic programmes (emergency, reproductive health, HIV, mental health, etc.).
- Screen groups of women who have been identified as being at high risk of GBV. Depending on the setting, such groups often include girls in early marriages, domestic workers, girls in households without either parent, sex workers, women and girls in emergency settings, women and girls living with HIV, with mental illness, and with disabilities.
- Screen only when there are signs or indications that GBV may be occurring.

a. Recommended screening policy for sexual and reproductive health services

When the main prerequisites for women's safety and doing no harm are met, all SRH services should screen for IPV and for sexual violence because power inequalities between men and women have such a fundamental effect on sexual relationships (Hainsworth and Zilhão, 2009). SRH providers' screening protocols should be tested in context to be culturally appropriate to help guide their enquiries about GBV.

Groups of women and girls at high risk for GBV should always be screened. See list above, but in each context additional specific populations at highest risk need to be identified.

Once the decision has been made on whom to screen, the next task is to make the screening as effective as possible. The following issues and ways to make screening more effective have been documented.

b. Capturing signals that gender-based violence may be involved

Many possible warning signals might indicate that a woman is in a violent relationship. The most typical are unexplained bruises or injuries. Additionally, however, in SRH services, women often disclose information about dynamics in their relationship that should lead to further enquiries. For example, when a woman indicates that her partner is opposed to her use of family planning or that he refuses to use a condom or that she dare not disclose to him the results of her HIV test, providers' protocols should prompt them to enquire about GBV. Other types of presenting conditions should occasion similar enquiries. See figure 2 below—a summary of possible presenting conditions from a United Kingdom handbook for health professionals (Department of Health United Kingdom, 2005) as well as figure 1 under "Entry Points" (see page 26).

Figure 2.

Source: **Department of Health, United Kingdom (2005).**

c. Barriers to women's disclosure of gender-based violence

Most literature has documented that women accept and approve of screening for GBV, and that fears that women will find the questions offensive appear to be unfounded (Koziol-McLain and others, 2008) , (Population Council, 2006) . However, numerous barriers to spontaneous disclosure of GBV to health providers have been identified:

- It may be taboo to speak of GBV.
- Women suffering abuse may feel shame, and feel that GBV is their fault, posing a barrier to disclosure to the provider.
- Women may fear lack of confidentiality. If their partner finds out they have disclosed GBV to the provider, they fear being subjected to more violence.

- The questions in the protocol need to be culturally appropriate. Questions may either be too general or too specific to elicit responses. For example, a study in the Dominican Republic showed that a general initial question about how things are going with the woman's partner worked well, (Population Council, 2006), whereas a qualitative study in Kenya cited the "blurred boundaries between forced and consensual sex" as demanding more exact phrasing of questions that would elicit responses (Kilonzo and others, 2008, 188, from Abstract).

- Social science researchers can help providers to recognize cultural barriers to women's disclosure of GBV, to test screening protocols and, through findings from focus groups or client interviews, suggest ways to build confidence and trust in the interaction.

- Women may disclose more to female providers, but this could differ by culture. Studies in the United States show no differences by sex of provider (Gerlach and others, 2007).

In summary, if a provider observes signs of physical violence or other signals that a client has not verbally disclosed during the routine screening, the provider should assume that one of the above barriers is operating. Services should experiment with the most culturally sensitive and productive ways to probe with further questions or offer reassurance concerning confidentiality, so that women will feel safer and less ashamed to seek support (see box 7).

Box 7

Routine screening: Make it simple

All possible screening questions were narrowed down to four initial questions for Latin American affiliates of IPPF/WHR. These questions were tested for cultural appropriateness and for their ability to elicit both positive and negative responses from the female clients of reproductive health clinics.

- Have you ever felt emotionally or psychologically injured by your partner or another person important to you?
- Has your partner or another person important to you ever caused you physical harm?
- Were you ever forced to have sexual contact or intercourse?
- When you were a child, were you ever touched in a way that made you feel uncomfortable?

Source: A Guedes, S. Bott and Y. Cuca. "Integrating systematic screening for gender-based violence into sexual and reproductive health services: results of a baseline study by the International Planned Parenthood Federation, Western Hemisphere Region." *International Journal of Gynecology & Obstetrics* 78, no. Supplement 1 (2002): S57-S63.

The following sample screening form (box 8) from the IPPF/WHR manual is another slightly more complex example, discussing the importance of adaptation to local conditions and needs (Bott and others, 2004, 121).

Box 8.

In Practice

Screening questions developed by the IPPF/WHR initiative

IPPF/WHR developed four screening questions adapted to the needs of the regional initiative in a Latin American/Caribbean setting (specifically, the Dominican Republic, Peru and Venezuela). They had strengths and weaknesses, but over the course of several years, the participating associations found that they worked fairly well. Please note, however, that the following questions are only a translation from the Spanish original and that the English version has NOT been field-tested. Screening questions need to be carefully translated and adapted if they are going to be used in different linguistic and cultural settings.

(Translated from Spanish)

Introduction

Since abuse and violence are so common in women's lives, we have begun asking these questions of all women who come to_____(name of the clinic).

Psychological/emotional violence in the family

1. Have you ever felt harmed emotionally or psychologically by your partner or another person important to you? (For example, constant insults, humiliation at home or in public, destruction of objects you felt close to, ridicule, rejection, manipulation, threats, isolation from friends or family members, etc.)*

If Yes, → when did this happen? _____
Who did this? _____

Physical violence

2. Has your partner or another person important to you ever caused you physical harm? (Examples: hitting, burning or kicking you?)*

If Yes, → when did this happen? _____
Who did this? _____

Sexual violence

3. Were you ever forced to have sexual contact or intercourse?

If Yes, → when did this happen? _____
By whom? _____

Sexual abuse in childhood

4. When you were a child, were you ever touched in a way that made you feel uncomfortable?

If Yes, → when did this happen? _____
By whom? _____

Safety

5. Will you be safe when you return home today?
6. Are you afraid of your partner or another person causing you harm?

**Note: Each association decided to work out its own description of acts of physical and psychological violence, depending on what it felt were common practices in its country setting.*

3. Danger assessment

Danger assessment – in some countries called risk assessment – goes beyond screening for past or current GBV to assess the level of danger faced by a woman who is in a violent relationship. As such, often the questions may become more detailed. The suggestions below range from the most comprehensive – with multiple questions – to the simplest – two questions.

The following graphic (box 9) from the United Kingdom illustrates the issues that would be covered in a risk assessment (Department of Health United Kingdom, 2005, 67). If the provider detects any danger to the woman or girl, the next essential step is safety planning, discussed in section B below, on counselling.

A 15-question list is included here to illustrate other possible questions. These were developed by International Planned Parenthood Federation/ Western Hemisphere Region (IPPF/WHR) Latin American affiliates from a tool developed by Jacqueline Campbell (Bott and others, 2004, 92).
1. Has the physical violence increased in frequency over the past year?

2. Has the physical violence increased in severity over the past year?

3. Does he ever try to choke you?

4. Is there a gun in the house?

5. Has he ever forced you to have sex when you did not wish to do so?

6. Does he use drugs? [name drugs used in surrounding communities]

7. Does he threaten to kill you and/or do you believe he is capable of killing you?

8. Is he drunk every day or almost every day? (In terms of quantity of alcohol).

9. Does he control most or all of your daily activities? For instance, does he tell you who you can be friends with, how much money you can take with you shopping, or when you can leave the house?

10. Have you ever been beaten by him while you were pregnant?
(If you have never been pregnant by him, check here ____)

11. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")

12. Have you ever threatened or tried to commit suicide?

13. Has he ever threatened or tried to commit suicide?

14. Is he violent toward your children?

15. Is he violent outside of the home?

The experience of the Latin American affiliates of IPPF/WHR in using this more detailed questionnaire demonstrates the importance of adapting danger assessment tools to the local cultural context and facility. The Latin American providers found that the following two simple questions worked better (Bott and others, 2004, 92) : Will you be safe when you return home today? Are you afraid that your partner or another person will cause you harm?

4. Resources for screening

In addition to the resources highlighted in the discussion above, two additional tools could be adapted to developing country settings:

- The U.S. Centers for Disease Control (CDC) published *Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools* (Thompson and others, 2006).

- *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings* (Basile, Hertz, and Back, 2007).

B. COUNSELLING

Even in settings where there is no routine screening for GBV, there will be cases in which GBV is detected due to injuries, as well as spontaneous disclosure of GBV to health providers by women. Therefore, a wide variety of staff in a health facility should be trained to carry out a minimum level of counselling. All researchers and advocates are in agreement that the key principle in the minimum level of counselling is doing no harm: not "blaming the victim," listening with compassion, not espousing any harmful gender norms that belittle women and accept GBV, providing privacy and confidentiality, assessing danger and providing safety planning if needed.

However, most women and girls experiencing GBV or who are survivors of GBV need more than this minimum of psychosocial support, and whenever possible, SRH providers should strive to provide this or have efficient referral systems to sources of support. SRH services have an advantage over providers of other types of health services, because (ideally) they have been trained to discuss sensitive issues surrounding sexual relationships.

1. Guidance on gender-based violence counselling

Training in counselling is an ongoing effort. Building capacity in counselling is perhaps the most challenging aspect of integration of GBV in SRH services, because health providers are immersed in the cultural norms of the surrounding society. Some of these norms are positive, but others are harmful and perpetuate discrimination against women and girls. Often the gender-related attitudes and beliefs that must be transformed are deep-seated. Without adequate refresher training, mentoring and supervision to reinforce initial training, providers may belittle women, make light of their experiences of violence, exhibit judgemental attitudes with regard to women's sexuality and experience of GBV, accept GBV, and hold other harmful stereotypes when dealing with marginalized women such as commercial sex workers, women with HIV or ethnic minorities. Given the reported high turnover of health personnel in the public sector in many countries, training in GBV -- as well as SRH and HIV -- is an ongoing challenge. Counselling training and manuals that identify these prevalent, harmful cultural norms, expose them as harmful and false, and build on positive cultural values as well as human rights principles are needed. See the UNFPA website on "using cultural fluency for greater effectiveness" http://www.unfpa.org/culture/ for guidance on how to implement this principle.

Most SRH services described in the literature hired psychologists or trained selected staff in counselling or did both. In SRH services, the most cost-effective strategy is to train providers who have already proved to be good counsellors on SRH issues, so that basic elements of listening, not passing judgement and exhibiting warmth and compassion do not need to be part of the training. Thus, some providers may be limited to the barest minimum of initial screening, with referral within the facility to someone more skilled.

2. Safety planning

Safety planning with women in violent relationships is an essential component of GBV counselling. If the danger assessment determines that a woman might be in danger of further violence after leaving the health service, the health provider must help her think through her options and strategies to ensure safety. Research from the United States suggests that it is precisely when a woman is leaving a violent relationship that she is most in danger and most in need of safety planning (Bott and others, 2004, 88). Several resources include sample safety plans, but most are geared to urban or developing-country settings. Box 10 is from the WHO guidelines on gender and HIV. As for all tools illustrated here, questions need to be adapted to the cultural context.

Box 10.

BOX 2.4

Safety planning with women at risk for violence (*33, 121*)

- Ask about violent and controlling behaviours.
- Show a sympathetic attitude; do not blame or judge women.
- Inform women of their rights and the services available to them.
- Help women to make their own choices about their relationships, and discuss the implications of violence against women with regard to the risk of HIV and to living with HIV.
- In the event that a woman decides to stay with a violent partner, assist her in planning what to do if the violence increases.
- In the latter circumstance, in the event that a woman decides to leave her partner, assist her in planning what to do. This involves answering the following questions:
  - Where could she go?
  - How would she get there?
  - Is money needed? Does she need her identification documents?
  - Would she need emergency clothes, etc.?
  - Can she always keep a bag packed?
  - Would it help to agree on a signal to neighbours in order to get their help?
- Provide formal options for support, including police, social workers, community-based organizations, women's NGOs, etc., if available.
- Discuss informal options for support, including neighbours, friends and relatives.
- Key messages about disclosure to give women affected by violence:
  - Decide on the best time and place to have a conversation.
  - Choose a time when you expect that you will both be comfortable, rested and as relaxed as possible.
  - Think about how your partner may react to stressful situations.
  - If there is a history of violence in your relationship, consider your safety first and plan the situation with a case manager or counsellor.
  - Imagine several ways in which your partner might react to the news that you are HIV-positive. Write down what he might say, then think about what you might say in response.

Source: World Health Organization, 2009a, Box 2.4, 39 .

3. Resources

Most counselling guides and training manuals on GBV are related either to VCT in HIV/AIDS services, (see page 51) or to sexual violence services (see page 60).

One general guide, *Counseling Guidelines on Domestic Violence*, is written in highly accessible and non-technical language, ("Remember, a good counselor has big ears, big eyes, and a small mouth") and integrates issues related to HIV testing as well (Southern African AIDS Training Programme, 2001). The guide is an example of a culturally adapted counselling guide, with case studies highlighting situations in southern African countries.

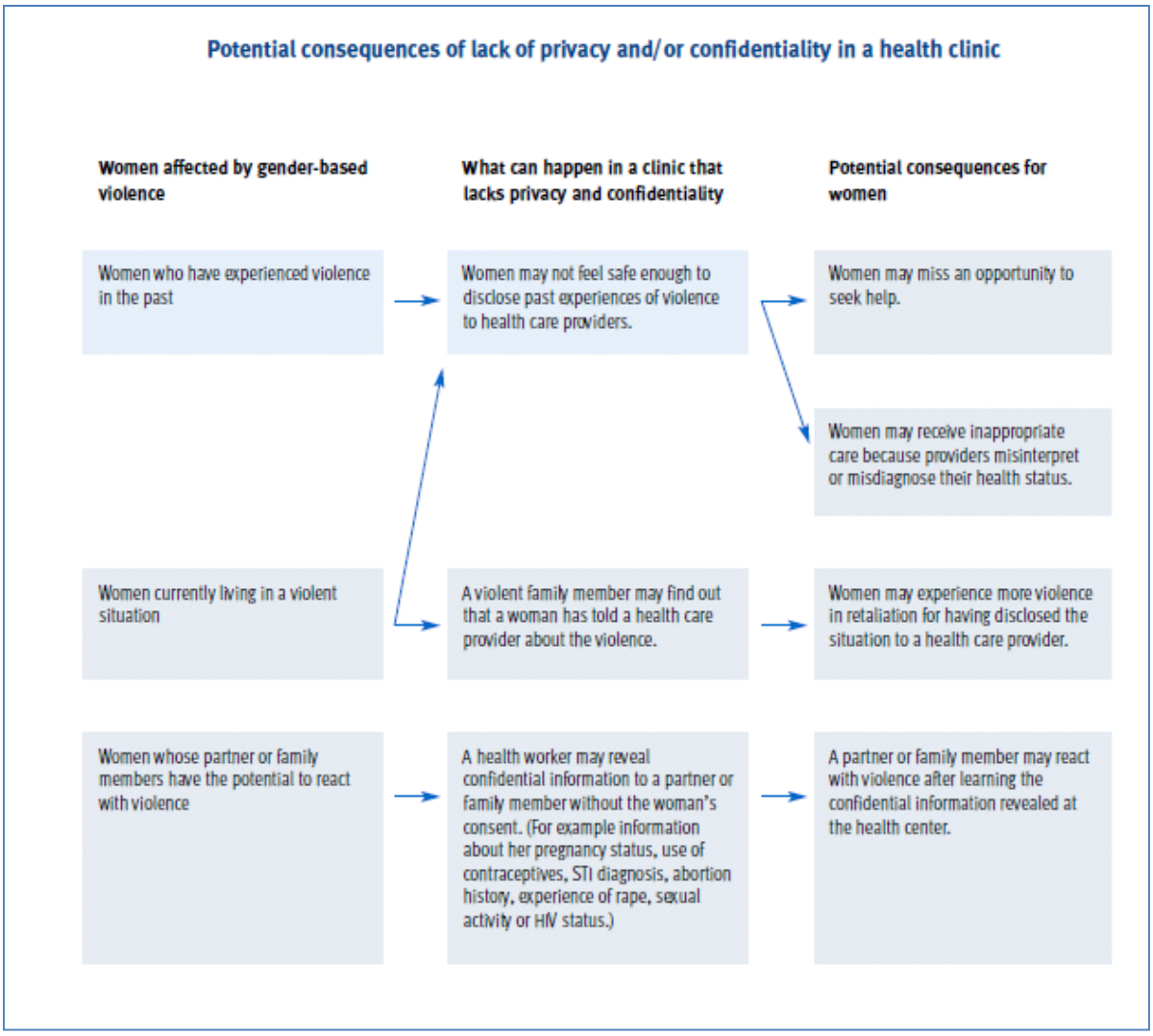
For resource-poor settings, when psychosocial support is lacking, low-cost alternatives are suggested, such as peer support groups for women. A counselling guide for peer support groups was produced in Eastern Europe: *The Power to Change: How to set up and run support groups for victims and survivors of domestic violence* (Daphne Project, 2008) (with a Portuguese translation). As with all training materials, it would need to be adapted to other cultures.

C. PRIVACY AND CONFIDENTIALITY PROCEDURES

Privacy and confidentiality procedures are essential elements of all health care, but in both SRH and GBV-related services, the consequences of failures in these procedures may be severe. In VCT services, in some circumstances, people who test seropositive for HIV face discrimination, violence and abuse. For women or girls experiencing GBV, they may face increased violence or even death if family members or others with authority over them learn that they have disclosed GBV to a health provider.

The IPPF/WHR Manual (Bott and others, 2004, 51) provides a helpful discussion of the possible consequences for women of failures to ensure privacy and confidentiality, and the following summary (see figure 3 below):

Figure 3.



The essential components of privacy and confidentiality procedures include:

- In the reception area, the woman/girl should be able to state the reason for her visit privately.
- In the conversation between the woman/girl and provider, it is important to find a way to talk to her alone, so that no one can overhear, including anyone accompanying the woman (spouse, mother-in-law, etc.) or people in the waiting room or in adjoining areas. In low-resource settings where no private room exists, measures such as walking to another part of the facility with the client or to an outdoor patio might have to be taken.
- The facility must implement secure measures to keep patient records and information confidential. However, sharing of information among the medical professionals caring for the woman is both ethical and necessary to provide a good standard of care, so long as no one else can overhear the conversation (Cook and Dickens, 2009).

The ethical and legal dilemmas in confidentiality include the following:

- Where legally mandated reporting of all or some forms of GBV exists, the provider faces ethical issues. When the safety and well-being of children are also threatened, many countries require reporting to the authorities. It is important to inform the woman of such legal mandates to help her engage in safety planning.
- In some cases, the extent of the physical abuse alarms health providers so that they feel obligated to report the offense to authorities, even if the woman does not consent. However, they may inadvertently be doing more harm than good. A woman experiencing GBV probably knows best whether reporting the perpetrator to the authorities would endanger her even more. When reporting GBV would put a woman at greater risk, providers must give highest priority to the women's safety. They have an ethical obligation to do no harm. See "Dilemmas in intimate partner violence" (Cook and Dickens, 2009) for a full discussion of the ethical issues in these situations.

D. REFERRALS AND COORDINATION WITH OTHER SECTORS

This section will be linked to and cross-referenced with the UNIFEM health-sector knowledge management asset, and the web link will be provided upon completion of this asset.

IV. ISSUES AND GUIDANCE FOR SPECIFIC SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND DELIVERY SETTINGS

A. HUMANITARIAN SETTINGS

1. Gender-based violence risks

In humanitarian settings, women and girls are at greatly increased risk of GBV, especially sexual violence, leading to increased vulnerability to HIV and AIDS, unwanted pregnancy, unsafe abortion and mental health problems. These increased GBV risks are linked to the displacement of people and families from their homes, often in traumatic events in which the social fabric of communities and traditional social controls break down. People from various communities may be all together in one place, often with insufficient shelter, clothing, food, fuel, water and other basic necessities. As in other settings of extreme poverty or deprivation, women and girls may feel compelled to engage in sex in exchange for food and other needs. Most often, young people are out of school, men are unemployed and women lose any income generation opportunities they had. Furthermore, they suffer increased burdens because they are responsible for sick, injured and/or ageing family members and usually spend much more time obtaining food and fuel. Under such stresses, violence multiplies, and women and girls are especially vulnerable (Inter-agency Standing Committee, 2009; Interagency Standing Committee 2005, 4).

In conflict settings, this vulnerability is exacerbated by much more widespread violence and access to small arms. "Militarization of a culture works against women's empowerment and gender equality, partly through the increased incidence – and acceptability – of violence" (UNFPA 2008b, 8). Rape has been used as a tactic of war to humiliate the enemy in Bosnia, Congo, Sudan and several other countries and has recently taken "egregious forms," with estimates of incidence ranging in the hundreds of thousands (García-Moreno and Stöckl, 2009). Agencies involved in humanitarian response must quickly learn about gender issues in these settings and about appropriate responses to sexual violence and other forms of GBV.

2. Basic principles and actions

Health services should screen for all types of GBV in humanitarian settings, not just sexual violence. Humanitarian and conflict settings increase risks of all types of GBV, not just rape by strangers As one study in a post-conflict setting in Uganda commented: "Intimate partner violence, sexual abuse of girls aged under 18, sexual harassment and early and forced marriage may be more common than rape by strangers" (Henttonen and others, 2008, 122, from Abstract).

For the prevention of GBV, the participation of women and girls in all aspects of designing and running a humanitarian response is essential as well as in peacekeeping and post-emergency planning (Security Resolution 1325). Women know what aspects of the setting put them at risk for GBV, such as long unprotected walks to get water. (See chapter on Gender and Participation in Humanitarian Action in the IASC Gender Handbook). (Inter-agency Standing Committee, 2009).

For a longer list of basic actions, see the table 2 below on minimum and comprehensive responses in the IASC Guidelines (Interagency Standing Committee, 2005, 6) . The table is available from the following website:
http://www.humanitarianinfo.org/iasc/documents/subsidi/tf_gender/GBV/GBV%20Guidelines%20Matrix.pdf

Guidelines for Gender-based Violence Interventions in Humanitarian Settings

Focusing on Prevention of and Response to Sexual Violence in Emergencies

Functions & Sector	Emergency Preparedness	Minimum Prevention & Response (to be conducted even in the midst of emergency)	Comprehensive Prevention & Response (Stabilised phase)
1 Coordination	• Determine coordination mechanisms and responsibilities • Identify and list partners and GBV focal points • Promote human rights and best practices as central components to preparedness planning and project development • Advocate for GBV prevention and response at all stages of humanitarian action • Integrate GBV programming into preparedness and contingency plans • Coordinate GBV training • Include GBV activities in inter-agency strategies and appeals • Identify and mobilise resources	1.1 Establish coordination mechanisms and orient partners 1.2 Advocate and raise funds 1.3 Ensure Sphere standards are disseminated and adhered to	• Continue fundraising • Transfer coordination to local counterpart • Integrate comprehensive GBV activities into national programmes • Strengthen networks • Enhance information sharing • Build (human) capacity • Include governments and non-state entities in coordination mechanisms • Engage community in GBV prevention and response
2 Assessment and monitoring	• Review existing data on nature, scope, magnitude of GBV • Conduct capacity and situation analysis and identify good practices • Develop strategies, indicators, and tools for monitoring and evaluation	2.1 Conduct coordinated rapid situation analysis 2.2 Monitor and evaluate activities	• Maintain a comprehensive confidential database • Conduct a comprehensive situation analysis • Monitor and evaluate GBV programs, gender-balanced hiring, application of Code of Conduct • Review data on prevention measures, incidence, policies and instruments, judicial response, social support structures • Assess and use data to improve activities
3 Protection (legal, social, and physical)	• Review national laws, policies, and enforcement realities on protection from GBV • Identify priorities and develop strategies for security and prevention of violence • Encourage ratification, full compliance, and effective implementation of international instruments • Promote human rights, international humanitarian law, and good practices • Develop mechanisms to monitor, report, and seek redress for GBV and other human rights violations • Train all staff on international standards	3.1 Assess security and define protection strategy 3.2 Provide security in accordance with needs 3.3 Advocate for implementation of and compliance with international instruments	• Expand prevention of and response to GBV • Provide technical assistance to judicial and criminal justice systems for reforms and effective implementation of laws in accordance with international standards • Strengthen national capacity to monitor, and seek redress for, violations of human rights/international humanitarian law • Encourage ratification of international instruments, and advocate for full compliance and effective implementation • Promote human rights, IHL and good practices • Ensure that GBV is addressed by accountability mechanisms • Ensure that programmes for DDRR include women and children affiliated with warring factions • Ensure that programmes for reintegration and rehabilitation include survivors/victims of GBV and children born of rape • Provide training to relevant sectors including security forces, judges and lawyers, health practitioners, and service providers
4 Human Resources	• Ensure SG's Bulletin is distributed to all staff and partners and trained accordingly • Train staff on gender equality issues, GBV and guiding principles, and international legal standards • Develop a complaints mechanism and investigations strategy • Minimise risk of sexual exploitation and abuse (SEA) of beneficiary community by humanitarian workers and peacekeepers	4.1 Recruit staff in a manner that will discourage SEA 4.2 Disseminate and inform all partners on codes of conduct 4.3 Implement confidential complaints mechanisms 4.4 Implement SEA focal group network	• Monitor effectiveness of complaint mechanisms and institute changes where necessary • Institutionalise training on SEA for all staff, including peacekeepers
5 Water and Sanitation	• Train staff and community WATSAN committees on design of water supply and sanitation facilities	5.1 Implement safe water/sanitation programmes	• Conduct ongoing assessments to determine gender-based issues related to the provision of water and sanitation • Ensure representation of women in WATSAN committees
6 Food Security and Nutrition	• Train staff and community food management committees on design of food distribution procedures • Conduct contingency planning • Preposition supplies	6.1 Implement safe food security and nutrition programmes	• Monitor nutrition levels to determine any gender-based issues related to food security and nutrition
7 Shelter and Site Planning, and Non-Food Items	• Train staff and community groups on shelter/site planning and non food distribution procedures • Ensure safety of planned sites and of sensitive locations within sites • Plan provision of shelter facilities for survivors/victims of GBV	7.1 Implement safe site planning and shelter programmes 7.2 Ensure that survivors/victims of sexual violence have safe shelter 7.3 Implement safe fuel collection strategies 7.4 Provide sanitary materials to women and girls	• Conduct ongoing monitoring to determine any gender-based issues related to shelter and site location and design
8 Health and Community Services	• Map current services and practices • Adapt/develop/disseminate policies and protocols • Plan and stock medical and RH supplies • Train staff in GBV health care, counselling, referral mechanisms, and rights issues • Include GBV programmes in health and community service contingency planning	8.1 Ensure women's access to basic health services 8.2 Provide sexual violence-related health services 8.3 Provide community-based psychological and social support for survivors/victims	• Expand medical and psychological care for survivors/victims • Establish or improve protocols for medico-legal evidence collection • Integrate GBV medical management into existing health system structures, national policies, programmes, and curricula • Conduct ongoing training and supportive supervision of health staff • Conduct regular assessments on quality of care • Support community-based initiatives to support survivors/victims and their children • Actively involve men in efforts to prevent GBV • Target income generation programmes to girls and women
9 Education	• Determine education options for boys and girls • Identify and train teachers on GBV	9.1 Ensure girls' and boys' access to safe education	• Include GBV in life skills training for teachers, girls, and boys in all educational settings • Establish prevention and response mechanisms to SEA in educational settings
10 Information Education Communication	• Involve women, youth, and men in developing culturally appropriate messages in local languages • Ensure use of appropriate means of communications for awareness campaigns	10.1 Inform community about sexual violence and the availability of services 10.2 Disseminate information on International Humanitarian Law to arms bearers	• Provide IEC through different channels • Support women's groups and men's participation to strengthen outreach programmes • Implement behaviour change communication programmes

IASC
Inter-Agency Standing Committee

Guidance on sexual violence services was adapted from the IASC recommendations in the Gender and Health Chapter of the new Handbook (Inter-agency Standing Committee, 2009) regarding basic actions to address post-sexual violence services. (See more comprehensive guidance on post-sexual violence services on page 55).

- Establish confidential services or referral mechanisms for health and psychosocial services for rape survivors.
- Provide 24-hour access to sexual violence services, with a system of counsellors or health providers being "on call" during hours when the services are not open.
- Train staff on the clinical management of rape.
- Train staff in the basic principles of counselling that does no harm (see page 44), with a focus on countering discriminatory norms regarding women's and girls' sexuality in the specific cultural context.
- Conduct information campaigns for men and women about sexual violence as a violation of women's and girls' human rights, about the health risks to the community from sexual violence and about national laws against sexual violence.

Adolescent girls suffer greatly increased risks of sexual violence in humanitarian settings (see chapter V, A for discussion of GBV and adolescents on page 65.

3. Resources

Resources related to sexual violence will be described under that topic on page 60.

- *IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies.* These are the basic guidelines followed by the humanitarian response committee, developed by the IASC Sub-Working Group on Gender and Humanitarian Action (Interagency Standing Committee, 2005).
- The Working Group also developed a handbook on GBV -- *Women, Girls, Boys & Men. Different Needs – Equal Opportunities* -- to help responders put the guidelines into operation, and an e-course for long-distance learning has been announced (Inter-agency Standing Committee, 2009). The handbook discusses gender issues related to all aspects of humanitarian settings, including food security, shelter, health, participation and sanitation, along with prevention strategies and post-rape services. The guidelines as well as the handbook chapters can be downloaded in separate modules from the working group's website: http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-common-default&sb=1
- UNFPA and Save the Children just developed a manual: *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. The handbook includes a fact sheet on adolescents and sexual violence and discusses adolescent-friendly services in the humanitarian context (Mitchell and others, 2009).
- The Reproductive Health Response in Conflict Consortium website includes a variety of resources and tools related to GBV. http://www.rhrc.org/resources/index.cfm?sector=gbv . One useful planning resource developed by the Consortium –*Checklist for Action: Prevention & Response to Gender-Based Violence in Displaced Settings* – was adapted from a checklist developed by the United Nations Commission on Human Rights (UNCHR) (The Gender-Based Violence Global Technical Support Project, 2004) .

- This Eldis website has a wide range of articles on GBV in emergencies: http://www.eldis.org/go/topics/resource-guides/gender/gender-based-violence/gbv-in-emergencies

B. HIV/AIDS AND SEXUALLY TRANSMITTED INFECTION SERVICES

The arguments for the integration of GBV with HIV/AIDS programmes are strong, given that all forms of GBV– including harmful practices as well as physical and sexual violence – are important drivers of the epidemic, and that disclosure of HIV infection or even engaging in VCT may put a woman at risk of GBV.

The guidance related to integration of GBV in HIV/AIDS programmes is extensive, although literature reviews still reveal the lack of sufficient evidence to guide implementation (Program on International Health and Human Rights, 2009). [The main references are described in the basic resources section on page 19, and others are referenced throughout this section and under Resources, page 55].

STIs are risk factors for HIV infection and, currently, most HIV/AIDS services include testing and treatment for STIs, so this review will not discuss them separately. For a woman, disclosing a STI diagnosis to a male partner increases risks of IPV and securing cooperation of the male partner(s) in treatment may be challenging. However, once cooperation of all partners is achieved, the health consequences and stigma related to STIs are less severe than for HIV/AIDS, because STIs are curable and treatment is less expensive and more accessible.

1. Basic human rights principles related to GBV in context of HIV/AIDS services

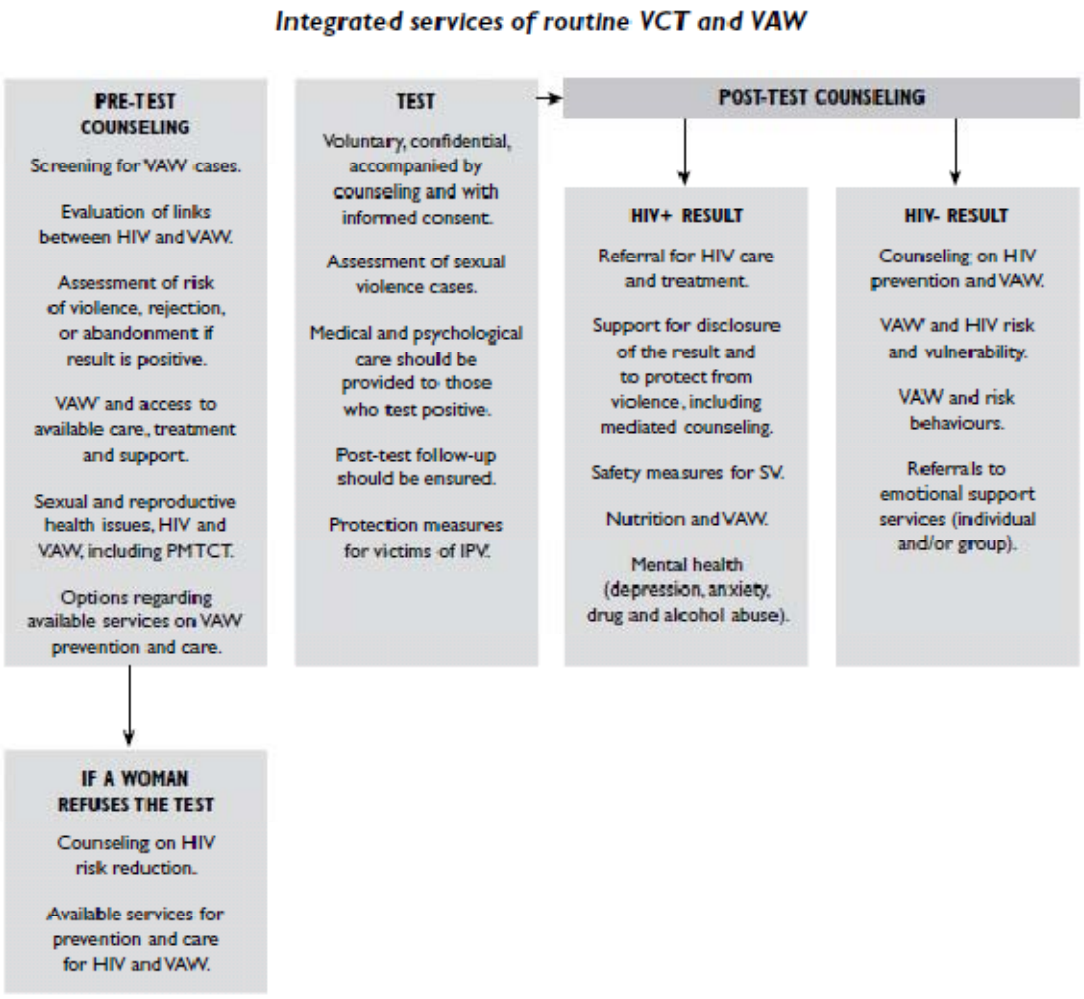
The literature on health and human rights contains a substantial focus on human rights issues in the context of HIV/AIDS services (International Reproductive and Sexual Health Law Programme, 2008; OHCHR 2006). Some of the human rights issues related to HIV and GBV stem from the stigma, discrimination, and violence sometimes suffered by those testing positive for HIV. In general, the basic prerequisites for the integration of GBV discussed earlier – concern for safety above all, privacy and confidentiality, adequate training of providers and referral networks -- address these basic human rights principles. The following guidance is specific to HIV services.

- Voluntary disclosure of HIV status: Policies must make disclosure voluntary, whether to sexual partners, family members, schools or workplaces, due to risks of ensuing violence, discrimination and harm. Danger assessment and safety planning are essential components of the counselling and planning for disclosure/partner notification.
- Coerced sterilizations and abortions of women who have tested positive for HIV are a violation of reproductive rights and a form of GBV that is perpetrated by the health sector in some countries. Reports (Ahmed and Bell, 2009) are increasing about forced sterilizations conducted on HIV+ women during Caesarean sections. Respect for the reproductive rights of women and girls living with HIV mandates that HIV-positive women have exactly the same reproductive choices as women who are HIV-negative (Titus and Moodley, 2009).

2. Voluntary counselling and testing

There is extensive guidance in on VCT services in general. Resources highlighted here provide guidance on the integration of GBV into these services. For example, a manual on the integration of VAW and HIV services (Luciano, 2009) provides a schema for VCT (see box 11) that gives an overview of the service components with integration of GBV.

Box 11.



a. Opt-out vs. opt-in models

The U.S. Centers for Disease Control and Prevention (CDC) and WHO together with the Joint United Nations Programme on HIV/AIDS (UNAIDS) recently released new guidelines for HIV testing in health-care settings. The guidelines recommend eliminating individual informed consent in favour of an opt-out approach that requires clients to actively decline the HIV test after a pretest information session. The effects of this policy on women – who use health services more than men and are often subject to routine prenatal testing -- need further study (Maman and King, 2008). In this scenario, inadequate informed choice may result from insufficient training of health personnel, or class/cultural/linguistic barriers between providers and women. Providers should be trained to discuss the right to decline HIV testing in the context of exploring the risks and benefits of HIV testing and disclosure.

When opt-out policies are linked with mandatory partner notification, they put women at risk of GBV. In these cases, the "opt-in" approach to testing may be more appropriate for women in violent relationships. Individualized informed consent, rather than routine testing, may be more appropriate for populations of women and girls who are especially vulnerable to adverse consequences upon disclosure of HIV test results, such as girls in early marriage and women or girls who have already disclosed that they are in violent relationships (World Health Organization and UNAIDS, 2007).

Pretest and post-test counselling on disclosure or voluntary partner notification must explore the risk of violence through danger assessments. Many women are at high risk of violence from their partners when they disclose HIV status, especially if they already experience violence in their relationship(s). Therefore, danger assessment should be an essential component of the service. The services may need to identify social support services available for women who are in violent intimate relationships. In settings where these are not available, safety planning involves prompting women to reflect on possible sources of support from their social and family networks, including religious leaders. A 2006 meeting (WHO, 2006) on issues of disclosure of HIV status to partners resulted in the following guidance for VCT programmes, shown in box 12.

Box 12.

Key recommendations made by the meeting participants to address violence against women in HIV testing and counselling programmes

1. **Address violence as a barrier to women accessing HIV testing and counselling services by**
   - Raising awareness of the links between HIV and violence among programme managers, counsellors and clients.
2. **Address violence as a barrier to HIV disclosure, and as an outcome of disclosure for some women by**
   - Implementing tools that counsellors can use to identify and counsel women who fear violence and other negative outcomes following HIV status disclosure.
   - Offering alternative models for HIV disclosure, including mediated disclosure with the help of counsellors.
3. **Address violence as a barrier to women implementing risk-reduction strategies by**
   - Assisting women to develop strategies to protect themselves when negotiating safer sexual relationships.
4. **Address post-test support needs of women in violent relationships**
   - Referring women to peer groups to provide ongoing psychosocial support.
   - Developing referral networks to organizations that offer services for female victims of violence.
   - Where these services do not exist, building support systems for women, including peer support models.

Source: World Health Organization, 2006.

b. Involving sexual partners in voluntary counselling and testing and "mediated disclosure"

Effective cure of most STIs requires the involvement of the intimate partner; if not, the woman will just get reinfected. HIV VCT can focus only on treatment and securing support, with requirements or protocols for partner notification. The possibility of violence as a consequence of notification, however, poses a dilemma in which the provider must give priority to the woman's consent and safety. The 2004 WHO review of studies, *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes A Review Paper* (Maman and Medley, 2004), and the latest guidance from WHO (World Health Organization, 2009a) discuss various possibilities for mediated disclosure of women's HIV status to her partner. The health provider can help women rehearse or role-play how they will disclose or decide whether it would increase safety to have a third party present. Often, women express their desire for "mediated disclosure" of positive HIV-testing results and choose either to revisit the health provider with their partner or to involve another family member or a religious leader (Maman and others, 2009). Although the literature observes that, in many cases, women's fears of violent consequences prove unfounded, it is still of paramount importance that the health provider manage the

situation with overriding concern for women's safety (World Health Organization and UNAIDS 2007, 16).

The following protocol (see box 13) indicates how counsellors could conduct danger assessment and safety planning to guide HIV disclosure strategies.

Box 13.

BOX 2.3

Protocols to address violence in counselling on HIV status disclosure (*118*)

Example 1. Counselling protocol from Dar es Salaam, the United Republic of Tanzania

In a voluntary HIV counselling and testing clinic in Dar es Salaam, researchers piloted the following protocol to raise the issue of violence during counselling on HIV disclosure. Counsellors asked women the following questions:

1. Is your partner aware that you will be tested for HIV?
2. If you told your partner you tested positive for HIV, do you think he would react supportively?
3. Are you afraid of how your partner will react if you share your HIV test results with him?
4. Has your partner ever physically hurt you?
5. Do you think that your partner may physically hurt you if you tell him that you have tested for HIV and your HIV test results are positive?

Counsellors supported women's decision to disclose if they answered positively or negatively to question 1, positively to question 2 and negatively to questions 3–5. If women answered negatively to question 2, and positively to any of questions 3–5, then counsellors proceeded with caution and explored in more depth each woman's risk of disclosure-related violence. If the counsellors determined that the risk was high, they explored alternative options, including: opting not to disclose; deferring disclosure to a time when a woman's safety was ensured; or developing a plan for mediated disclosure in which women either brought the partner to the clinic to disclose, or identified a trusted family member or friend to be present when they shared their HIV test results with their partner. If women answered negatively to question 2 and positively to questions 3–5, regardless of how they answered question 1, then counsellors explored these alternative options for disclosure.

Example 2. Family Health International (FHI): Asia-Pacific region

In the region that FHI designates as the Asia-Pacific region, FHI staff have developed the following protocol for counsellors to use when counselling clients regarding disclosure.

1. Counsellor asks: "There are some routine questions that I ask all of my clients because some are in relationships where they are afraid that their partner may hurt them. What response would you anticipate from your partner if your results came back positive?"
2. If the client indicates that she or he is fearful or concerned, then the counsellor asks, "Have you ever felt afraid of your partner? Has your partner ever pushed, grabbed, slapped, choked or kicked you? Threatened to hurt you, your children or someone close to you? Stalked, followed or monitored your movements?"
3. If the client responds affirmatively to any of these points, the counsellor then adds, "Based on what you have told me, do you think telling your partner will result in a risk to you or your partner?"

The client is then encouraged to make a decision to disclose based on a realistic appraisal of the threat.

Source: World Health Organization, 2009a, Box 2.3, 38.

3. Prevention of mother to child transmission services

Generally, PMTCT services are integrated with prenatal care services (see page 61). Guidelines for all VCT services apply for PMTCT services, since the first step is VCT. The WHO Gender and HIV guidance tool makes important points about the potential effect of GBV on pregnant women diagnosed with HIV (World Health Organization, 2009a).

- A woman may not be able to make decisions about ARV prophylaxis without the consent of family members. Hence, providers need to handle the disclosure process with concerns for the woman's safety, as discussed in the previous section on VCT.

- Women in violent relationships or who fear violence may not have disclosed their status to their families or partners and may therefore experience difficulty in adhering to ARV prophylaxis

because of concerns related to maintaining confidentiality and avoiding inadvertent disclosure of HIV-positive status. It is suggested that, if the danger assessment confirms risk of violence, safety planning with the woman include strategies for hiding the medication.

4. Resources

- Many publications and references on the integration of GBV issues in HIV/AIDS programmes exist, although evaluation evidence is still scarce on the best implementation strategies in different cultural contexts. The main two resources focused on HIV/AIDS are described more fully in chapter I, E. They are: *Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs* (World Health Organization, 2009a).
- Luciano, D. *A Manual for Integrating the Programmes and Services of HIV and Violence Against Women* (Luciano, 2009).

Other resources include content on HIV as well as other SRH issues:

- *Sexual Violence and HIV: A Technical Assistance Guide for Victim Service Providers (* National Sexual Violence Resource Center, *2008)* provides guidance on HIV for post-sexual violence services, within the setting of the United States.
- *International Guidelines on HIV/AIDS and Human Rights* (UNAIDS, 2006) provides essential guidance for HIV programmes related to human rights principles.

C. POST-SEXUAL VIOLENCE SERVICES

1. Health consequences of sexual violence

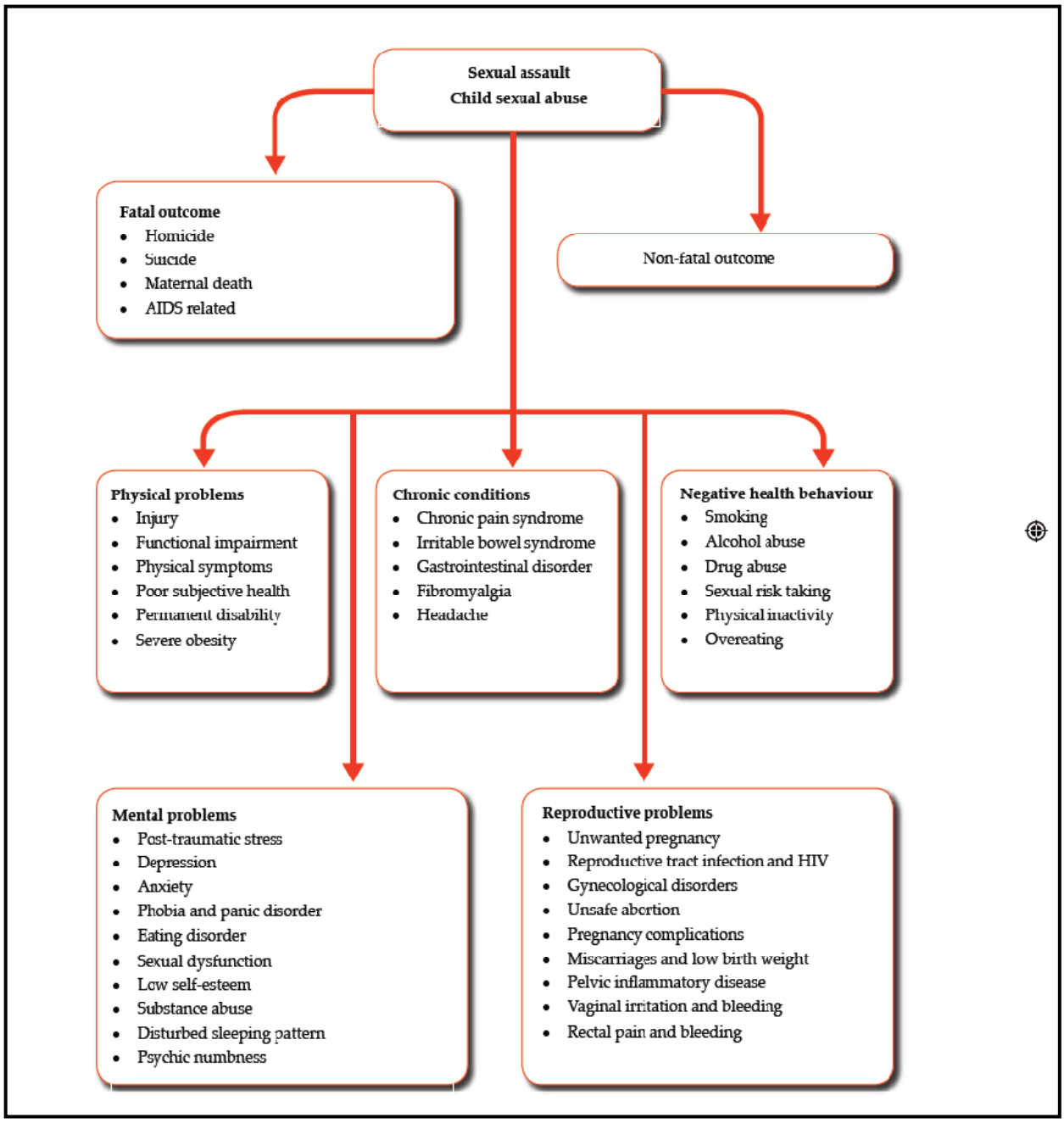
There are diverse health consequences of sexual violence with short-term and long-term physical and psychological effects, the latter of which can be especially severe (World Health Organization, 2003). A high incidence of traumatic fistula and ensuing incontinence has been associated with rape in some conflict settings (Peterman and Johnson, 2009). The WHO *Guidelines for medico-legal care of victims of sexual violence*, pages 12-17, have a full discussion of these consequences. In particular, childhood sexual abuse has been associated with increased risks of HIV infection later in life, due to a pattern of sexual risk-taking or substance abuse. It is hypothesized that this linkage is a result of the long-term psychological harm of childhood sexual abuse (Program on International Health and Human Rights, 2009).

The health consequences mainly occur from one or more incidents of sexual violence, but may be compounded by blame and violence from others after the incident. In some countries, social norms related to a family's "honour' are attached to an unmarried girl's virginity before marriage. A girl who is raped is often doubly victimized by being blamed for the attack, expelled from her family, beaten, or in worst cases, killed. See discussion of honour-based violence in chapter VI, D, page 84.

The following diagram (figure 4), from a training course for health providers in Kenya, is based on the literature on the consequences of sexual violence. (Ministry of Health Kenya, 2007, 66)

Figure 4.

Sexual violence effects



2. Basic guidance and considerations for post-sexual violence services

Strict compliance with all the minimum requirements for the integration of GBV in SRH services is essential, as summarized on page 9. This additional guidance is specifically related to sexual violence.

- Women or girls who have been raped often face severe social consequences and stigma, due to gender and sexuality norms that strictly sanction any sexual activity for women and girls outside of marriage. Health providers should be informed of the norms in the community where they are working, and take these into account in danger assessment and safety planning.

- Training providers for post-sexual violence services entails extra investment in combating attitudes prevalent in the surrounding culture that stigmatize women's sexuality. While they might be understanding about a "pure" or "faithful" woman who has been raped, they might view women who have more than one partner or are sexually active before marriage as inviting or deserving sexual violence. The need to combat prejudicial attitudes on the part of the provider is especially great in the case of sex workers who experience sexual violence. Such deeply ingrained social attitudes take extra reinforcement in training, supervision and ongoing professional development to erase. Training content needs to explicitly address and counter these attitudes.

- All sexual violence services should include HIV PEP, emergency contraception, STI testing and treatment and all other necessary medical services, including post-trauma counselling**.** Some HIV programmes include PEP for HIV but do not provide emergency contraception in the mistaken belief that emergency contraception is abortive. This omission of a necessary post-rape service is a violation of women's reproductive rights. Post-trauma counselling may be unavailable in some settings, and some services have experimented with peer support groups for survivors of sexual violence.

3. Post-sexual violence service models

Often, post-rape services are situated in emergency rooms or in rooms set aside for these services in hospitals. Where rates of sexual violence are high – as among displaced populations during armed conflicts – all health providers should be trained to provide basic medical treatment, counselling and referrals to women or girls who have experienced sexual violence. The provision of post-rape PEP for HIV and emergency contraception is essential as is training for providers in the gender issues related to sexual violence (Kilonzo and others, 2008).

a. Comprehensive approach

The following framework (box 14) describes a comprehensive approach to post-sexual violence services.

Box 14.

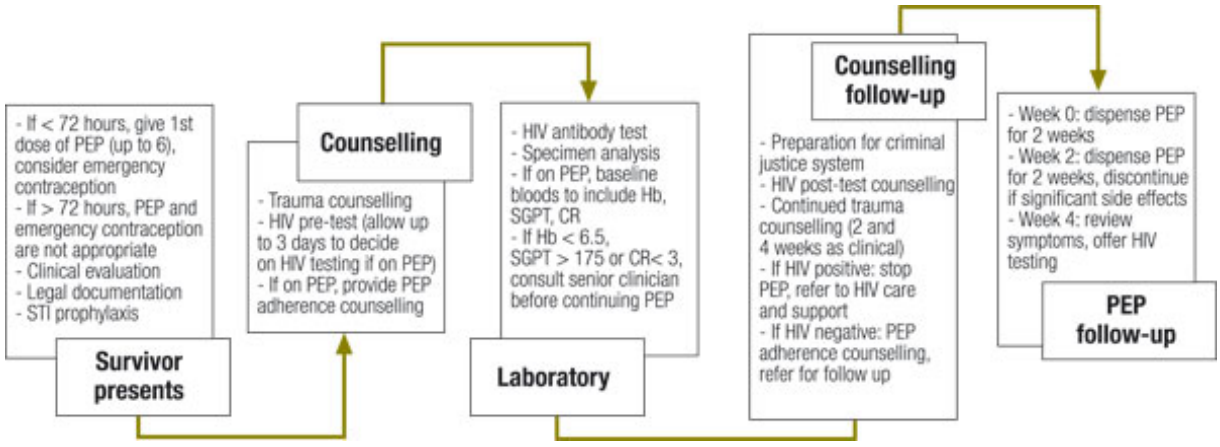
Framework for a comprehensive model of care, support and prevention of SGBV

1. Medical management of sexual violence at point of first contact with the survivors.
2. Psychological counselling of rape survivors.
3. Sensitive approaches to managing child survivors of sexual violence (of both sexes), and to encouraging and enabling presentation by male survivors.
4. Collection of forensic evidence (at health facility during medical management and/or at police station) and creation of a chain of evidence that can be used during a prosecution.
5. Strong links between police and health facility to enable incidents to be referred in either direction so that, if desired, a prosecution can be initiated. Ensure prosecutions initiated by the police are sustained through the judiciary.
6. New or strengthened community-based prevention strategies that are relevant and appropriate for the local context and that are directly linked to the nearest medical/police structures.
7. Physical (and psychological/emotional) violence between domestic or intimate partners addressed through:
   a. Messages communicated during the prevention strategies;
   b. Screening for signs and symptoms of such violence during routine health consultations.

Source: Population Council, 2008b.

Post sexual-violence services in Kenya have been evaluated extensively (Kilonzo and others, 2009; Kilonzo and others, 2008; Kim, Martin and Denny 2003; Kim and others, 2007) and provide useful evidence for service models in other developing-country settings.

Figure 5 below displays the post-rape care services algorithm developed for health facilities in Kenya (Kilonzo and others, 2009).



CR, creatinine; Hb, haemoglobin; PEP, post-exposure prophylaxis; SGPT, serum glutamic pyruvic transaminase; STI, sexually transmitted infection.

Source: Kilonzo and others, 2009.

b. One-stop centres for post-sexual violence services

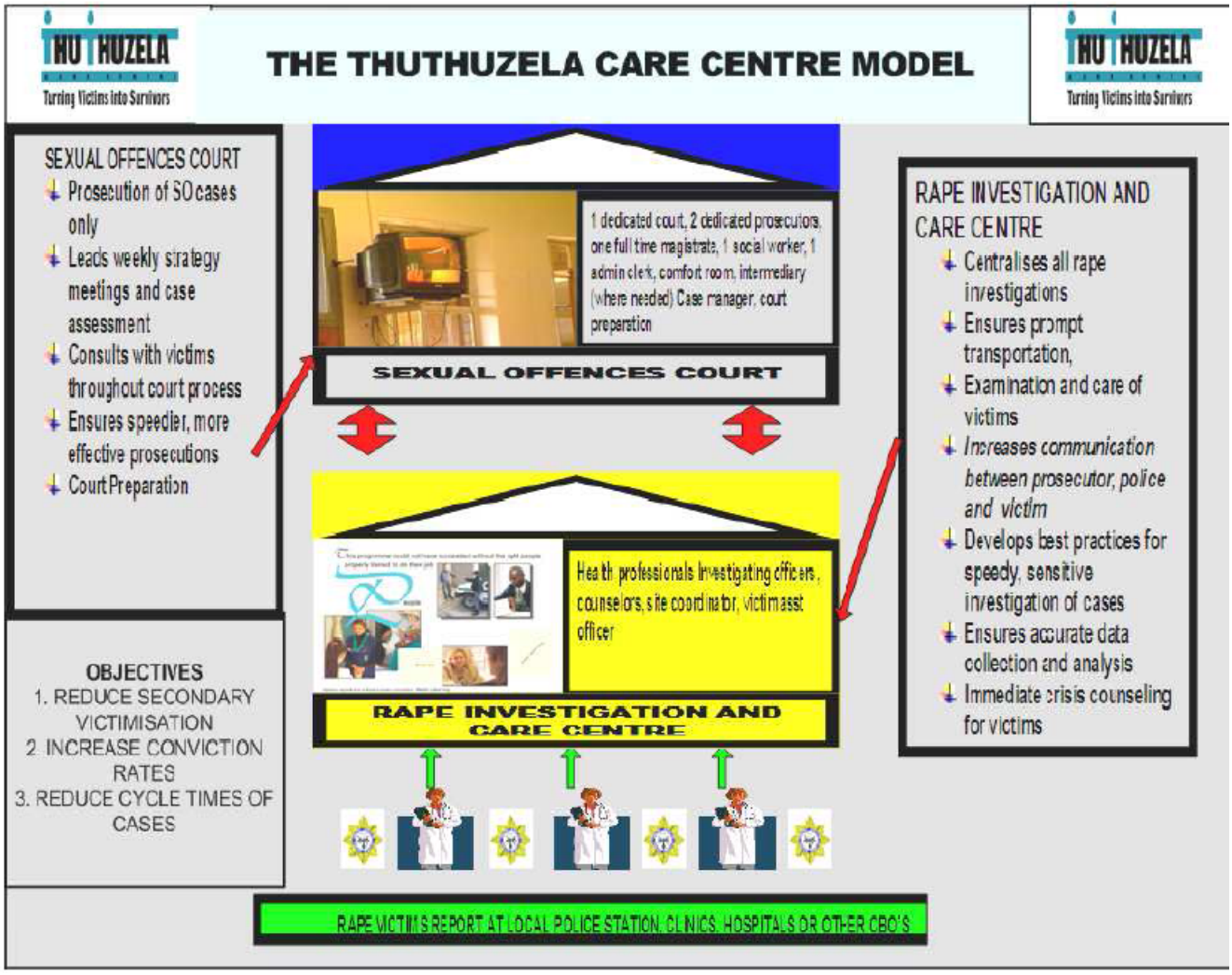
One-stop centres are an alternative model first piloted in Malaysia to help women have quick access to the full range of medical, psychosocial, police and legal services needed post-rape. Such centres generally need government or external funding, as they are rarely self-supporting. They need well-trained staff with smooth coordination among the various aspects of the services. These models are feasible mainly in large urban centres with well-functioning transport so that women or girls from a large area have geographic access to the services.

South Africa has established several one-stop centres for victims of sexual violence. The following account and graphic (figure 6) describe the model of the Thuthuzela centres.

Restoring Dignity and ensuring justice for victims of sexual violence (see http://www.unicef.org/southafrica/hiv_aids_998.html

> "Thuthuzela's integrated approach to rape care is one of respect, comfort, restoring dignity and ensuring justice for children and women who are victims of sexual violence. The rape victim is first removed from the crowds at the police station to a more victim-friendly environment before being transported by ambulance to the Thuthuzela one stop care centre at the hospital.
>
> Enroute, she receives comfort and crisis counselling from a trained ambulance volunteer and once at the centre, she is ushered to a quiet, private space, welcomed by the site-coordinator and a doctor immediately summoned to conduct a medical examination. Information on the procedures to be performed is then provided and the patient signs a consent form for medical examination and blood specimens.
>
> If the medical examination happens within 24 hours of the rape, she is offered the opportunity to take a bath or shower and to change into soft, clean clothes to help cushion bruised feelings from the incident. After that, the investigating officer on call to the centre takes the victim's statement.
>
> Thereafter, she receives appropriate medication and is given a follow-up date for further medical treatment, before being transported home. 'This process ensures that service providers are available to a rape survivor in one location, rather than her being shuttled around throughout the criminal justice system.'"

Figure 6.



4. Training resources and basic references

The "Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations" includes prevention and management of the consequences of sexual violence. Chapter Three of the Distance Learning Training Module on the MISP provides basic guidelines and a chapter quiz for health personnel. http://misp.rhrc.org/content/view/14/28/lang,english/

The *Trainer's Manual on Clinical Care for Survivors of Sexual Violence*, published by the Ministry of Health in Kenya, is another well-vetted training resource for health services in non-emergency settings (Ministry of Health, Kenya, 2007).

http://www.svconference2008.org/publications/Trainers%20manual%20on%20clinical%20care%20for%20survivors.pdf

Getting It Right! A practical guide to evaluating and improving health services for women victims and survivors of sexual violence (Troncoso and others, 2008) was developed and field-tested by Ipas and partners in developing country settings. Its emphasis is on assessing strengths and gaps in sexual violence services, along with strategies to address the gaps.

Rape: How Women, the Community, and the health sector respond (Sexual Violence Research Initiative, 2007) discusses health consequences, community responses (stigmatization as well as

support), clinical and community-based services and the effectiveness of various kinds of therapies. http://www.svri.org/rape.pdf

WHO Guidelines for medico-legal care for victims of sexual violence (World Health Organization, 2003a) http://whqlibdoc.who.int/publications/2004/924154628X.pdf provides internationally vetted clinical standards.

WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies (World Health Organization, 2007) provides important guidance on how to interview survivors of sexual violence with concern for their emotional well-being and safety. http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries by United Nations Action against Sexual Violence in Conflict (June 2008) includes "do's" and don'ts" about collecting and interpreting data from sexual violence services. http://www.stoprapenow.org/pdf/UN%20ACTION_DosandDonts.pdf

D. MATERNAL-CHILD HEALTH SERVICES

This section focuses mainly on prenatal and childbirth services. (The prevention of mother-to-child transmission (PMTCT) of HIV is discussed in section B, 3, page 54.).

1. Evidence on gender-based violence integration with maternal-child health services

The negative consequences of GBV for women and their infants, the evidence of high rates of GBV against pregnant women in many countries, and the strong linkage between vulnerability to HIV infection and GBV – all pose a strong argument for routine screening for IPV in prenatal and PMTCT services.

MCH services tend to have the highest national coverage of all types of health services. Due to underinvestment in health and severe shortages of training personnel, the coverage may not be as complete as planned and the quality may be deficient. There is insufficient evaluation evidence on strategies to integrate GBV with MCH services, with the bulk of the studies in industrialized northern countries (Program on International Health and Human Rights, 2009). The challenges posed by such integration have been studied in developing countries (Henttonen and others, 2008) as well as northern industrialized countries (Hindin, 2006) :

- Even in some settings where providers were supposedly trained and provided with protocols, the screening and counselling were sporadic or of low quality due to the culturally sensitive nature of GBV, especially sexual violence, and the shortages and high rotation of trained health personnel that have become acute in the lowest income countries.
- Prenatal care generally takes place at the primary-care level, where personnel shortages are especially acute in rural areas. Therefore, many MCH health services fail to provide basic services, much less screen for GBV, due to lack of infrastructure, training or facility-based protocols.

2. Integration of gender-based violence with maternal and child health services

- GBV screening should be universal in prenatal services, given their high coverage and ability to reach vulnerable women and girls. As for all services, the minimum requirements for the integration of GBV need to be in place. (See page 9)
- Some traditional childbirth practices constitute violence against women. (OHCHR, 2008, 10-11) OHCHR documented numerous practices, some related to obstructed labour leading to uterine

rupture, such as vaginal cuts before labour starts, forceful pressing on the abdomen and unsafe surgical procedures to extract the foetus.

3. The sexual and reproductive health and gender-based violence risks of married girls and adolescent mothers

Early marriage is a harmful practice and a form of GBV. It increases risks for GBV and HIV. (See chapter VI, B, on early marriage, page 80 for a full discussion and references.

a. Maternal health risks

Married girls under 18 will come to prenatal services when they are pregnant. These are typically very high-risk pregnancies for both mother and child, (World Health Organization, 2008). Prenatal and MCH health personnel should be trained to treat pregnant adolescents with sensitivity to their risks, vulnerabilities and needs, with the youngest girls at highest risk of obstructed labour. Often, where early marriage is frequent, girls have low status and are undernourished (OHCHR, 2008).

- In rural areas where extensive travel is needed to reach the health service, the visit may be the girls' first contact with a health provider in years. For married girls to reach health services, the health sector must engage the girls' gatekeepers — their parents, mothers-in-law or husbands. The girls are often isolated socially and may be accompanied on the visit by a member of the husband's family (Brady and Saloucou, 2007). This visit is an important opportunity to engage the gatekeeper in informing both of the risks of early pregnancy to both mother and infant, including the risk of preterm delivery, the need for adequate nutrition to avoid anaemia and the importance of access to emergency obstetric care.
- Health providers should make every attempt to support the girl and educate the family to delay a second pregnancy until she is 18 and at least 36 months have passed since the first pregnancy. Provision of family planning services post-partum – especially if local breastfeeding practices do not provide full contraceptive protection – is essential to protect girls' health.

b. HIV risks

If there is a significant age disparity with the spouse, offering voluntary testing and counselling for HIV and STIs as well as a Pap smear for human papilloma virus (HPV) is also crucial. The provider may need to explain to the girl and the family member the SRH risks of early marriage when there is a significant age disparity, so that the girl does not get blamed and run the risk of violence.

c. Gender-based violence risks

Married girls are also at high risk of experiencing GBV. With girls in early marriage facing high GBV risks, it is essential that no opportunities to screen for GBV, provide support and engage in harm reduction are lost. To screen for GBV, the provider would have to arrange a private examination or a private moment with the girl.

E. OTHER REPRODUCTIVE HEALTH SERVICES

1. Family planning services

Studies on family planning services show significant numbers of clients who have experienced SGBV (Watts and Mayhew, 2004). Many women/girls having unprotected sex do so because they are subject to threats, coercion, physical violence or sexual violence. (See discussion on page 18 on reasons for integrating SRH and GBV services). Family planning providers have an important role to play in prevention and in the care and support of women at risk of GBV or experiencing GBV.

Addressing GBV will help make family planning programmes more effective. If violence is stopped, women will have a wider range of contraceptive methods to choose from, might have greater success in persuading male partners to use condoms and, in general, will be empowered to communicate more

with partners on equal footing regarding reproductive choices. For all these reasons, it is recommended that family planning providers screen for GBV and ensure that the minimum requirements discussed in chapter 1 are met to ensure women's safety and do no harm.

2. Infertility services

Infertility services should always screen for GBV**.** In most societies, fertility is highly prized and, in many, women suffering from infertility may be subject to violence from their husbands or the husbands' family (Yildizhan and others, 2009).

3. Abortion services

Reasons for seeking abortion services vary, but in some cases GBV may be the main or one of the main reasons. Therefore, safe abortion providers should always screen for SGBV. Rape is an accepted cause for legal abortions in many countries, including childhood sexual abuse. In other cases where women do not mention violence, screening for GBV is still appropriate, since some women may seek services because they do not want more children with a violent partner or because they have experienced sexual harassment but are too ashamed to disclose it.

Forced abortions are a form of violence against women. The International Coalition of Women Living with HIV/AIDS (ICW) has conducted studies of practices of forced abortion against women living with HIV. Cases in which HIV+ women requesting an abortion are forced to be sterilized in order to obtain the abortion have also been documented (Ipas, 2008). ICW has also documented significant numbers of young HIV-positive women having been sterilized in Namibia (Ahmed and Bell, 2009). In other situations, the stigma attached to pregnancy out of marriage or son preference (see discussion in chapter VI, page 79) may lead to a partner or family forcing a woman or girl to get an abortion; providers need to be alert for signals that an abortion is being forced on a woman or girl by her partner or family and communicate the ethical, human rights, and legal implications to the family.

There is emerging evidence that bans on sex selection may have negative effects on women's reproductive rights, barring them from access to a service they need and, in some cases, leading them to seek unsafe clandestine abortions. Efforts to eliminate sex selection need to be directed mainly to changes in sociocultural norms and structural discrimination against women to eliminate son preference (Center for Reproductive Rights, 2009).

Health providers should never mistreat or perpetrate violence against women with complications from unsafe abortion. A case against Chile was brought to the Committee against Torture because providers were mistreating women and denying them treatment until they revealed the name of the person who gave them the abortion (Shepard and Casas Becerra, 2007). Widespread testimonies in Latin America attest to the mistreatment and discrimination received by women arriving in hospitals with abortion complications. This is a form of violence against women perpetrated by the health sector.

4. Gynaecological check-ups

Literature reviews show that women who have experienced physical or sexual violence from their intimate partners are, in general, three times more likely to have a symptom of gynaecological morbidity (Campbell, 2002). Since women are often ashamed to disclose sexual violence, especially with an intimate partner, training should alert providers to probe for possible sexual violence when women have repeated gynaecological issues, such as reproductive tract infections. Pelvic examinations also give providers the opportunity to note vaginal or anal lesions or bruises in the genital area and should trigger sensitive, supportive questioning to help women get support to stop the sexual violence.

Other traditional practices, such as insertion of herbs into the vagina for vaginal tightening, may cause women chronic pain from gynaecological conditions (OHCHR, 2008).

F. PAEDIATRIC SERVICES

Paediatric services are perhaps the most underutilized in preventing and treating all forms of violence to the girl child, including female adolescents. In many developing countries, paediatric services are integrated with MCH services, and children up to age 5 are seen. Girls ages 5-18 may not be seen again by a health provider unless they have a serious illness or injury or until they are pregnant. (Ideas on how to provide older girls with better access to health care and GBV screening are discussed in chapter V).

Paediatricians should be trained to screen, treat, provide initial counselling and refer for children who have been sexually or physically abused or suffer other forms of violence. Paediatricians have a key role to play in detecting these forms of violence, taking whatever measures are necessary to treat and reduce harm as well as providing counselling and education to attempt to deter the practice. The best interest of the child needs to be the overriding principle for the provider, with well-functioning referral systems so that whatever child-protection systems exist in the local context are activated. Potential roles for the paediatric services include:

1. Detecting sexual abuse of girls and boys

Paediatricians may see the most extreme cases of child rape, when severe injuries are caused, but many survivors of childhood sexual abuse remain silent, with severe consequences for their mental health. Therefore, paediatricians should screen for sexual violence when a child shows severe depression or other known consequences of childhood sexual abuse. The WHO guidelines on medico-legal care of victims of sexual violence give more detailed guidance (World Health Organization, 2003).

2. Enlisting and training female paediatric nurses and other female health technicians to examine young girls.

- Most paediatric examinations in developing countries do not include examination of the genital area for girls, especially if the provider is male, limiting paediatricians' ability to detect injuries due to sexual abuse and potential harm caused by FGM/C (see full discussion in chapter VI, C).

3. Dealing with the health consequences of son preference

Cases of female infanticide or severe neglect or malnourishment of girl children may be due to son preference in countries where this is prevalent. Malnourished female infants or girls whose physical growth is stunted may suffer mental impairment that affects their access to education and will be at high risk of obstructed labour and maternal morbidity (especially fistula) and mortality when they begin childbearing. At the least, the paediatric health provider must provide a model of giving high value to the girl child and take actions to protect her from further harm. In these cases it is urgent that the paediatrician intervene at as early an age as possible to explain the consequences of inadequate malnutrition to the family and/or to contact child protection systems (OHCHR, 2008).

V. STRATEGIES THAT REACH THE MOST VULNERABLE WOMEN AND GIRLS

This chapter focuses on suggestions for health-sector strategies to take a proactive role to reach "hard-to-reach" women and girls, who are the most vulnerable to GBV as well as SRH problems -- including adolescents, women and girls living with HIV, migrants, women and girls with disabilities, indigenous and ethnic minorities, sex workers and trafficked women and girls. Most of the guidance on addressing GBV within the context of health services applies to these women and girls; the main difference is that strategies for reaching them are different. First, all suffer problems of access to health services, so that strategies to integrate GBV have to address these access barriers first. Second, these women and girls, for different reasons, suffer from stronger discrimination than the general female population; hence, the challenge is greater in training providers to treat these women non-judgementally with respect and compassion.

Many other categories of women and girls might be classified as hard to reach and highly vulnerable in a particular context; discussed here are the main categories that cut across most regions and for whom targeted programmes exist.

A. ADOLESCENTS

Reviewing the evidence on adolescent girls reveals the underlying role of gender discrimination in the linkages between their GBV and SRH risks, including HIV infection, too-early pregnancies and maternal mortality and morbidity (Temin and Levine, 2009). The clearest example of these linkages is early marriage, which has serious and often lifelong health and psychological consequences (see full discussion in chapter VI, B, page 80). Another example is unmarried adolescent girls' lack of access to SRH education, commodities and services, which is based on strong social disapproval of their sexuality, especially before marriage. Conversely, boys may be expected to be sexually active, also putting them at risk of HIV and STIs.

1. Evidence on adolescent girls and sexual violence

Several literature reviews exist on the extent and serious consequences of sexual abuse of girls, (Jewkes and others, 2002; Murray and Burnham, 2009; Reza and others, 2009) with some rapes happening to children younger than adolescents, necessitating extensive reconstructive surgery for the child. In some cultures, girls are blamed when they experience sexual violence, resulting in further victimization due to violence against them from family or community members (Pinheiro, 2006). (See also discussion of honour-based violence in chapter VI, D, page 84).

Many authors have written about the widespread myth that having sex with a virgin will cure AIDS. Some African researchers, however, (Jewkes, Martin and Penn-Kekana, 2002) dispute that this myth is a key factor in child rapes; they cite all the factors of vulnerability for girls as the main cause in settings where the prevalence of sexual violence is high.

Worldwide, studies show that adolescent girls are at high risk of sexual violence. Much sexual violence against girls happens in the homes of parents or relatives, but girls are also at risk of sexual harassment in schools, workplaces and humanitarian response settings. This is a strong argument for routine screening for GBV in adolescent SRH services. The WHO multicountry study shows that more than 30 per cent of the women who reported sexual initiation before age 15 reported the experience as forced (World Health Organization, 2005b) . Studies in several regions show that an alarmingly high proportion of first sexual experiences for girls are forced, with high rates of 40-48 per cent in some regions and countries (Temin and Levine, 2009, 25). Research in several countries suggests that the pregnancies of the youngest adolescents (10-14) are the result of sexual abuse. For example, records at one maternity hospital found that 90 per cent of young mothers ages 12 to 16 were pregnant as the result of rape (Family Health International, 2006).

Adolescent girls are at especially high risk of sexual violence and harassment in humanitarian response settings. A new manual on adolescent sexual and reproductive health in emergency settings (Mitchell and others 2009, 29) states the following:

> "Adolescents who are faced with poverty or separation from their families or communities as a result of an emergency situation are at risk of sexual violence. They may be coerced to provide sex in exchange for food, clothing, security, or other necessities, or they may sell sex to earn money for what they or their families need. Adolescent girls, especially if they are unaccompanied or have the responsibility of caring for younger siblings, are at risk of rape and SEA [sexual exploitation and abuse] because of their dependence on others for survival, because of their limited decision-making power, and because of their limited ability to protect themselves."

In some settings, substance abuse among adolescents and young people is directly linked to GBV and often to HIV infection or unwanted pregnancy. These issues require close cooperation among various components of a health system or facility, so that SRH needs, substance abuse and GBV are all addressed. Additional human resources, such as psychologists, are often required to address this issue adequately.

2. Guidance on increasing access to sexual and reproductive health and gender-based violence services for adolescent girls

Discussion of the linkage of GBV issues with SRH programmes for adolescents must first acknowledge that sexually active adolescents – both married and unmarried -- are a hard-to-reach population for the health sector. Without complementary community-based interventions, girls in this age group have little contact with the health sector until/unless they get pregnant.

For unmarried girls, sociocultural barriers to access to facility-based SRH services remain high, especially in rural areas. Research carried out by the Population Council on youth centres that offered SRH services demonstrated these barriers (Finger, 2000) , and subsequent experiments with adolescent-friendly SRH services showed that

> "Although the projects appear to have improved the clinic experience for adolescent clients and to have increased service use levels at some clinics, the findings suggest that community acceptance of reproductive health services for youth may have a larger impact on the health-seeking behaviours of adolescents" (Mmari and Magnani, 2003, 259).

Settings in which the usage of facility-based SRH services is higher and the barriers lower include:

- University health clinics
- Clinics in dense urban areas with affordable public transportation systems so that young people have choices outside their immediate neighbourhood
- Settings in which female adolescents can leave the home unaccompanied

Multisectoral approaches are needed, due to the fragility of the health sector in many of the least developed countries: "The clear priority is to develop creative approaches to prevent and treat childhood sexual abuse. These approaches should go beyond the limits of the health system to involve community-based organisations and non-governmental organisations, including the active religious groups …. Governments must actively support such initiatives; and the first steps towards these initiatives are to face up to the extent and consequences of the problem." (Murray and Burnham, 2009, 1925)

Making SRH services "youth-friendly" is a key strategy to improve access to both SRH and GBV services. Literature on "youth-friendly" or adolescent-friendly SRH services is abundant, showing how the "supply side" can be improved by making services equitable, acceptable and accessible, and by training providers to be welcoming, non-judgemental and gender-sensitive with young clients. A 2009 literature review shows that young people rated the following factors as most important in youth-friendly

services: confidentiality, privacy, short waiting time, low cost and friendliness to both young men and young women. They did not rate as a high priority their own participation, having youth-only services or young providers (Shaw, 2009).

The WHO framework for youth-friendly health services includes the following additional characteristics: capacity to see providers without appointments, easy registration, convenience of the facility, and accompaniment by community outreach and peer-to-peer dialogue to increase coverage and accessibility (box 3.2 in Temin and Levine, 2009).

Box 15.

BOX 3.2

WHO framework for youth-friendly health services

To be considered youth-friendly, services should be equitable—all adolescents, not just certain groups, are able to obtain the health services they need; accessible—adolescents are able to obtain the services that are provided; acceptable—services are provided in ways that meet the expectations of adolescent clients; appropriate—services that adolescents need are provided; and effective—the right services are provided in the right way and make a positive contribution to the health of adolescents.

Other specific characteristics make services youth-friendly. These include procedures to facilitate easy confidential registration, short waiting and referral times, and capacity to see patients without an appointment. Their providers are non-judgmental, technically competent in adolescent-specific areas and health promotion, and backed by compassionate support staff. The facilities should be convenient and allow for privacy. And importantly, they should be accompanied by community-based outreach and peer-to-peer dialogue to increase coverage and accessibility (B. J. Ferguson, pers. comm.; WHO 2003a).

3. Models that lower barriers to access to adolescent sexual and reproductive health and gender-based violence services

Many of the following models are not adequately tested but show promise. See also discussions of paediatric services on page 64 and post-sexual violence services on page 55.

a. Use of peer education and support networks

Peer education is the most common adolescent sexual and reproductive health (ASRH) strategy used to reach adolescents who will not come to a health facility; often, the health sector forms a partnership with civil society organizations to train and support the peer

educators. A recent evaluation of *Geração Biz,* (Malahe, 2009) a multisectoral ASRH programme in Mozambique, produced useful insights on experience in the use of peer support networks to address GBV, showing training and support needs that are similar to those of adult health providers who address GBV. Among the positive outcomes of the programme were increases in community awareness and reporting of GBV.

b. Integration with primary care

In these primary-care models reaching young female adolescents, GBV screening and educational messages can be linked with HIV and SRH prevention and services (Temin and Levine, 2009).

- Vaccinations as opportunities: Two immunizations in particular are recommended for early adolescence: HPV vaccine, and tetanus booster. Where these vaccines are offered, (often in school-based services for tetanus) the moment of delivering the vaccine may be an opportunity to screen for GBV and offer SRH information.

- School-based services: Close cooperation with the educational system would allow the establishment of school-based services, usually an office within the school and a nurse. Especially in the upper-grades of primary school and in secondary schools, providers should be trained in adolescent-friendly SRH and in GBV screening, counselling and referral.

The "12-year-old check-in": The Population Council and colleagues propose "the 12-year-old check-in," which would allow integration of screening for GBV, counselling and possible referrals (box 3.3 in Temin and Levine, 2009,46). See box 16 below.

Box 16.

Check-In Wellness Components	
Health	**Social**
Physical exam	Counseling
Immunizations review and catch-up	Life-skills building
Nutrition/growth check-up	Educational assessment and support
Sexual and reproductive health information and services	Peer and social support screening and improvement
HPV vaccine (when available)	Drugs/alcohol/smoking screening and support for addictions prevention
HIV/AIDS prevention information	Family wellness and social support
Violence screening and support	Citizenship and social participation skill building and motivation
Mental health screening and support	
Injury screening and prevention	

Source: Temin and Levine, 2009, box 3.3, 46.

4. Virginity testing

In many countries, virginity testing of adolescent girls is a common request, with families bringing their adolescent daughters to the medical professional for the test (Amnesty International, 2006). This should be considered a harmful traditional practice and is a violation of girls' human rights.

As a matter of medical ethics, medical professionals should refuse to carry out virginity testing for three reasons:

- A finding of non-virginity brings life-changing negative consequences for the girl in many cultures, including ostracism, violence or even death in so-called honour killings.

- There is no way a medical exam or even an observation from a traditional midwife can determine virginity. A hymen can be broken for many reasons and can take many shapes. Also, a girl may be born without one. Since the test as practised cannot possibly test virginity, there are many false negatives with the consequences described above.

- It is discriminatory to require virginity of girls and not boys as a condition for being able to marry and for inclusion as a respected member of a community.

5. Adolescent sexual and reproductive health and gender-based violence in humanitarian settings

Adolescent girls are placed at higher risk, particularly of sexual violence, in humanitarian settings, especially in conflict and post-conflict situations. Young female combatants, girls associated with fighting forces, abductees and dependents are especially at risk of SRH consequences – including infection with HIV or other STIs, unwanted pregnancies and maternal morbidity and mortality. They are also as risk for mental health and psychosocial problems as they may have committed or witnessed acts of extreme physical or sexual violence or may themselves be survivors of sexual violence. New guidelines from Save the Children and UNFPA (Mitchell and others, 2009) are the most up-to- date resource on this topic.

6. Resources on adolescent girls and gender-based violence

- *A Study on Violence against Girls*. (UNICEF Innocenti Research Centre, 2009) http://www.unicef-irc.org/publications/pdf/violence_girls_eng.pdf contains a summary of the latest evidence and resources on GBV against girls, from a conference on the subject and from the United Nations study on Violence against Children.

- *Programme Planning Materials and Training Resources: A Compendium* (UNFPA and Margaret Sanger Center International-- Safe Youth Worldwide Initiative, 2004) http://www.unfpa.org/upload/lib_pub_file/367_filename_compendium.pdf describes and analyses a large and diverse array of resources. It focuses on youth and HIV, with substantial content related to GBV in many of the resources described.

- The Interagency Youth Working Group, a United States-based consortium, has a collection of resources on its website related to SRH and youth, with reports, tools and curricula on a wide variety of topics, including a page on gender: http://info.k4health.org/youthwg/prog_areas/gender.shtml

- A comprehensive resource for adolescent SRH programmes wishing to implement peer education programmes is available from Family Health International's Youth net Website, but GBV-related guidance would need to be added to these resources. http://www.fhi.org/en/Youth/YouthNet/Publications/peeredtoolkit/index.htm

- The Sexual Violence Research Initiative "Child" topic page http://www.svri.org/children.htm has numerous research reports as well as website links on adolescent sexual abuse.

- *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (Mitchell and others, 2009) has a strong focus on GBV, particularly sexual violence. See, in particular, the "MISP: Adolescents and Sexual Violence Fact Sheet," page 29.

B. WOMEN LIVING WITH HIV

1. Roles for health services

The violence and stigma against women living with HIV in the communities where they live and in their families has been widely documented. Given these risks, health services can play the following constructive roles:

- Health providers should assume that women and girls living with HIV are at high risk for GBV and screen accordingly.
- The role of the health sector must be to protect the human rights – including the reproductive rights - of women living with HIV in the context of health services. In some cases, the health sector has caused more harm through forced abortions or sterilizations (see chapter IV, E, 3) judgemental and hostile treatment, and failures to protect women's confidentiality and safety post-testing.
- Participate in multisectoral efforts to prevent GBV and reduce stigma and discrimination against women living with HIV in their communities.

2. Resources

The two resources listed below take a human rights-based approach, with the full participation of women living with HIV.

- *Positive Women Monitoring Change: A Monitoring Tool on Access to Care, Treatment and Support Sexual and Reproductive Health and Rights and Violence Against Women* (Population Council, 2008a) is a tool for HIV-positive women to conduct situation analyses on SRH and GBV and to monitor services, including SRH services.
- *Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: Manual for Trainers and Programme Managers*, (Engender Health and International Community of Women Living with HIV/AIDS (ICW), 2006).

C. INDIGENOUS WOMEN

In most countries, due to discrimination and exclusion as well as linguistic, geographic and cultural barriers, indigenous women and girls tend to have less access to SRH services than most of the population. Where indigenous or tribal minorities are concentrated in rural areas with poor transportation infrastructure, geography is an important barrier, so the health sector must come to the community for prevention, education and primary care. Where services are geographically accessible, they are often discriminatory, culturally insensitive or lacking translation services if needed, thus generating mistrust and rejection by indigenous women.

All these barriers complicate the health sector's integration of GBV with SRH services for indigenous women and girls. The involvement of indigenous women's organizations with SRH programmes and services is essential to help overcome these barriers and identify the most rights-based and culturally appropriate ways to increase their access to both GBV and SRH education, counselling and services. SRH services and education must empower indigenous women to be full partners in the design and oversight of the quality of services, including their cultural appropriateness. Other essential actions are:

- To address discriminatory attitudes by providers from the dominant culture through ongoing training and supervision.

- To reach out to indigenous men and boys, as in all efforts to prevent GBV, as an essential complement to the involvement of women's organizations.

In many countries, radio programmes in indigenous languages are the best way to reach indigenous women and girls to transmit public health information and messages. Minga Peru carried out a programme in the Peruvian Amazon that demonstrated the ability to reach rural indigenous women and girls through trained "radio correspondents" from the rural communities, to provide important information on HIV risks and VAW, and to change some attitudes among listeners. Partnerships with SRH services and local NGOs with roots in indigenous communities could use similar strategies in other settings. See http://utminers.utep.edu/asinghal/technical%20reports/FINAL-Revised_July-8-2008-singhal-dura-minga-UNIFEM%20report.pdf for more information.

D. MIGRANTS

1. Evidence on sexual and reproductive health and gender-based violence risks of female migrants

Both internal migrants – those who have generally moved from rural to urban areas within the same country – or external migrants from other countries are responding to the push of poverty and lack of opportunity at home and the pull of a perception of better employment opportunities in the destination city or country.

Many migrants – especially female immigrants -- (UNFPA, 2005) do not have access to adequate SRH care or any other health services for a variety of reasons, including lack of legal immigration status, lack of health insurance, cultural or linguistic barriers, lack of information about available services and poverty. Female migrants are less likely to seek prenatal services than nationals for many of these reasons. Female migrants who experience GBV – whether sexual harassment or trafficking into sex work – seldom seek medical attention out of shame or fear (Global Migration Group, 2008). (see also sections E and H below for discussions of sex workers and trafficked women).

Female migrants are at especially high risk for GBV, sexual harassment and SRH risks, even when migration is voluntary, i.e., not the result of trafficking, conflicts or other humanitarian emergencies. A large proportion of women and girl migrants end up working at low-paying unstable jobs in domestic service, service sectors such as waitressing, farm work, and sex work -- frequently unstable jobs marked by low wages, the absence of social services and often exploitative and abusive working conditions (UNFPA, 2006). Many rural to urban migrants are adolescent girls going into domestic service; in some countries, these girls are also apt to be indigenous. Female migrants of all ages working in domestic service are especially at risk for GBV and sexual harassment. A study by the International Organization for Migration (IOM) of male and female migrant farm workers in South Africa determined that the female workers were especially vulnerable to HIV infection, with the risk greatly heightened among young women (International Organization for Migration, 2009). In some countries, migrants are subject to xenophobia and racially motivated attacks, with some of these attacks taking the form of rape of women, as in the case of Somali women in South Africa (International Organization for Migration, 2009).

2. Guidance to address the risks of migrants

a. Health-sector policies

It is important that the health sector devise outreach strategies to reach women migrants. Integrated SRH and GBV services should be made available in health services near the neighbourhoods where migrants cluster and be widely publicized. In settings such as emergency settings for refugees, where high rates of sexual violence occur, extra investment in comprehensive post-sexual violence services needs to be culturally appropriate and linguistically accessible for migrant women and girls.

Health-sector policies should establish non-discrimination against migrants and educate providers to recognize the high risk of GBV among women and girls who are migrants. The *International Convention*

on the Protection of the Rights of All Migrant Workers and Members of Their Families guarantees the right of migrant workers to emergency health services and to the same access to health services.

b. Legal environment and agreements

Changes often need to be made in the legal environment facilitate access to health services for female migrants in a sustainable manner. A recent United Nations report on Violence against Women Migrant Workers (United Nations Secretary General, 2009b) notes a good practice for women migrants working in domestic services by the Government of Jordan, which developed a labour contract for non-Jordanian domestic workers. The contract guarantees the rights of migrant women to life insurance, medical care and rest days and is considered a requirement for obtaining residency, a work permit and a visa to enter Jordan.

Agreements between sending and receiving countries should guarantee migrant rights, with proper outreach to migrants to inform them of their rights, with resources if they are subjected to GBV, and with information on health services.

The Overseas Workers Welfare Administration (OWWA) in the Philippines offers returning migrant workers health services, counselling and voluntary HIV testing and counselling, along with many other services to assist with repatriation (UNAIDS, ILO and IOM, 2008). GBV screening and counselling with a focus on sexual harassment could be a routine part of such programmes for returning female migrants.

c. Involvement of migrant community organizations in prevention of gender-based violence and sexual and reproductive health risks

Migrant communities often have their own churches and small businesses that can form partnerships with the health sector to prevent GBV through educational messages, inform women of their legal rights in the country and publicize SRH services.

E. SEX WORKERS

Globally, the great majority of sex workers are women and girls. The widely varying conditions of sex work lead to the greater vulnerability of all sex workers – male, female and transgender – to SRH problems, GBV and HIV. In many countries, laws, policies and practices drive sex work underground, making it extremely difficult to reach sex workers and their clients with HIV prevention, treatment, care and support programmes. As a result, sex workers often have poor access to adequate health services and HIV-prevention measures such as male and female condoms; PEP after rape, emergency contraception, management of STIs; and drug treatment and other harm-reduction services (UNAIDS, 2009).

GBV against sex workers – whether from their controllers, clients or law-enforcement agents -- is one of the factors driving the HIV epidemic in many countries. GBV is linked to sex workers' inability to insist on the use of condoms and thus their inability to protect themselves as well as their clients. In most countries, the highest rates of HIV infection are found among sex workers due to these multiple violations of their human rights.

The many barriers to providing services for sex workers that need to be addressed include the discrimination they face from health care and social services and from law-enforcement officers. Those who have been illegally smuggled across national borders, knowingly or unknowingly, are even more vulnerable to GBV and HIV. Often their passports are seized by criminal gangs as a deterrent to escape; they lack local language skills, have no or limited access to health-care services and frequently have no support networks to provide assistance.

1. Guidance for the health sector

"Services must be available, accessible, acceptable and of high-quality, in places and at times that ensure their accessibility to sex workers and their clients. Integrated services increase the

number of entry points and expand coverage for a broader range of health and social services," (UNAIDS, 2009, Sec.1:10)

When sex workers seek assistance from health services, they often encounter barriers and hostility. When health professionals are not adequately trained, they reflect the stigma in the surrounding culture through judgemental or abusive treatment. Health services often subject sex workers to disapproval, refusal to treat their health problems, mandatory HIV testing, exposure of their HIV status and threats to report them to the authorities. Sex workers who have been raped or beaten may be blamed or have their concerns dismissed. Some doctors seeing sex workers are interested only in STIs and may even ignore their physical injuries. Barriers to seeking health care for GBV are also related to the widespread social acceptance of violence against sex workers, and their own lack of awareness of their rights (World Health Organization, 2005a).

The minimum standard to which any health service should be held is to do no harm. Therefore, it is essential for SRH services to train staff to treat sex workers with the same respect and compassion that they would treat any other person and to not denounce them to authorities. However, sex workers' high vulnerability to HIV infection and GBV, especially sexual violence, makes it essential to go beyond that minimum standard, to provide sex workers with supportive and rights-based counselling, voluntary testing and referrals to legal aid if available. (See chapter IV, C, for discussion of post-sexual violence services, page 57)

International HIV/AIDS Alliance (International HIV/AIDS Alliance, 2008) documents ways in which HIV/AIDS services can help to address GBV with sex workers by enlisting the participation of sex workers in the training of providers and development of protocols. There are HIV/AIDS projects that arrange for sex workers to conduct training for health-service providers to show them how they should address and treat sex workers in a non-abusive and non-stigmatizing way. Sex workers have also helped health services develop guidelines for history-taking and medical examination protocols that ensure confidentiality and that ask an appropriate range of questions.

2. Resources

- The UNAIDS *Guidance note on HIV and Sex Work* is an important resource, outlining basic multisectoral strategies as well as guidance for health services (UNAIDS, 2009).
- *Toolkit for targeted HIV/AIDS prevention and care in sex work settings,* produced by WHO, 2005 http://www.who.int/gender/documents/sexworkers.pdf
- *Sex Work, Violence and HIV: A Guide for Programmes for Sex Workers,* produced by the International HIV/AIDS Alliance (International HIV/AIDS Alliance, 2008)

F. ELDERLY WOMEN

The Fourth World Conference on Women, held in Beijing, China, identified elderly women as a vulnerable population, and ICPD called for elimination of all violence and discrimination against elderly people, particularly women. A proposed general recommendation concerning reporting on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) has drawn attention to the vulnerabilities of older women, especially those living in areas of conflict and displacement. The recommendation highlights age-related abuse as well as negative stereotypes of older women, older women's need for palliative care and the impact of lifelong economic discrimination against women as they age, leading to increased impoverishment (Shepard 2010, 47).

Elderly women are infrequent visitors to sexual and reproductive health services but may attend breast and cervical cancer-screening services, suffer from other reproductive cancers and seek medical care for reproductive tract infections. Because elderly women are especially vulnerable, providers should screen

them for GBV. Women suffering from senile dementia or Alzheimer's may be especially at risk for suffering violence from caretakers and family members.

G. WOMEN WITH DISABILITIES

Most studies show that women with disabilities are much more likely to experience GBV and sexual violence, putting them at increased risk of unwanted pregnancy, STIs and HIV. However, the degree of vulnerability and factors in the vulnerability vary significantly depending on the type of disability. The Center for Research on Women with Disabilities at Baylor College of Medicine (http://www.bcm.edu/crowd/?pmid=1338) points out that:

> "…violence issues, such as prevalence, risk factors, and interventions, vary to such a high degree across disability types (sensory impairment, physical impairment, psychiatric impairment, cognitive impairment), that it is best to focus on one group at a time and speak of findings for that group only. It is very difficult to generalize statistics to the population of women with disabilities as a whole."

Studies that include a wide variety of types of disabilities without disaggregating should be interpreted with caution and, ultimately, do not provide SRH services with the guidance that they need on the particular vulnerabilities for women and girls with a specific type of disability.

1. Guidance for the health sector

Women and girls with disabilities suffer high barriers to access to SRH education and services, making them very vulnerable to sexual violence. They are often isolated in their homes or in institutions, and if they do not have access to education, they may be ignorant about their bodies and SRH. Those with developmental or severe psychiatric disabilities may not realize they have been raped. Their enforced ignorance makes them especially vulnerable to sexual violence and to the services they need post-rape (Murray and Powell, 2008). The health system needs to devise strategies to reach out to women and girls with various types of disabilities and ensure they have access to SRH education and services.

Some women and girls with disabilities have caretakers who may be the perpetrators of GBV, whether they are family members, staff in institutions or paid caretakers. Screening for GBV needs to be undertaken in an initial private interview, if possible, without the caretaker's presence. Women and girls with disabilities often depend on their caretakers for survival and daily living, which makes it difficult for them to leave abusive situations (Hoog, 2003).

Health services must do no harm. Historically, SRH health services have been known to be perpetrators of violence against women with disabilities, especially those with psychiatric or cognitive disabilities, including denial of appropriate reproductive health care; forced/involuntary

sterilization and forced abortion. An association of women with a disability or a chronic and disabling disease in Antwerp (Persephone NPO, 2008) documents many of these abuses.

All health services, including SRH services, should take measures to ensure that treatment of women and girls with disabilities is respectful and sensitive. If a particular institution for the people with a certain type of disability is in the catchment area, the staff and women with disability could give input on the kind of treatment and training health providers need.

SRH services should take measures to improve accessibility, including wheelchairs and, for the deaf, interpreters on call. They should also engage local organizations of disabled people to determine what other accommodations should be made.

During emergencies, the number of adolescents with disabilities may increase due to physical or psychological injury or mental health conditions that manifest as a result of crisis (Mitchell and others, 2009). This may make young women more vulnerable to GBV, especially sexual violence, so SRH providers need to reach out to this population of young women with information, and offers of support.

2. Resources

- A "Model Protocol on Screening Practices for Domestic Violence Victims with Disabilities" (Hoog, 2003) gives practical tips on screening which should be adapted for low-resource settings.
- The website of Women with Disabilities Australia has a sexual and reproductive rights section--http://www.wwda.org.au/sexualit2006.htm -- with some resources related to SRH and VAW. Its resource manual is available only for purchase.
- The Disability and HIV Policy Brief from WHO is the most SRH-specific resource, with useful guidance for medical professionals not limited to HIV service providers. http://www.who.int/disabilities/jc1632_policy_brief_disability_en.pdf

H. TRAFFICKED WOMEN AND GIRLS

1. Guidance for the health sector

According to the Palermo Protocol, trafficking means:

…the recruitment, transportation, transfer, harbouring 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 payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs" (United Nations 2000, Art. 3).

Women and girls make up 98 per cent of those forced into commercial sexual exploitation as well as into domestic service. In addition to the use or threat of force associated with trafficking, women are placed at further risk of sexual and other violence from "owners" or clients, with exposure to damaging psychological and physical effects (Amnesty International, 2006). See table 3 below on the health risks

and consequences from trafficking.

Table 3.

Table 1: Summary of the health risks and consequences of being trafficked[9]

HEALTH RISKS	POTENTIAL CONSEQUENCES
Physical abuse, deprivation	Physical health problems, including death, contusions, cuts, burns, broken bones
Threats, intimidation, abuse	Mental health problems including suicidal ideation and attempts, depression, anxiety, hostility, flashbacks and re-experiencing symptoms
Sexual abuse	Sexually transmitted infections (including HIV), pelvic inflammatory disease, infertility, vaginal fistula, unwanted pregnancy, unsafe abortion, poor reproductive health
Substance misuse Drugs (legal & illegal), alcohol	Overdose, drug or alcohol addiction
Social restrictions & manipulation & emotional abuse	Psychological distress, inability to access care
Economic exploitation Debt bondage, deceptive accounting	Insufficient food or liquid, climate control, poor hygiene, risk-taking to repay debts, insufficient funds to pay for care
Legal insecurity Forced illegal activities, confiscation of documents	Restriction from or hesitancy to access services resulting in deterioration of health and exacerbation of conditions
Occupational hazards (see Table 2) Dangerous working conditions, poor training or equipment, exposure to chemical, bacterial or physical dangers	Dehydration, physical injury, bacterial infections, heat or cold overexposure, cut or amputated limbs
Marginalization Structural and social barriers, including isolation, discrimination, linguistic and cultural barriers, difficult logistics, e.g., transport systems, administrative procedures	Unattended injuries or infections, debilitating conditions, psycho-social health problems

Source: International Organization for Migration, 2009. *Caring for Trafficked Persons: Guidelines for Health Providers*. Geneva: IOM.

Health providers may have a unique opportunity to provide trafficked women and girls with SRH and GBV education and care, and with their consent, support for referrals to agencies that could help them.

Policies and protocols should assume SRH and GBV risks for trafficked women. Trafficked women and girls face high SRH risks and hence, it is essential to provide these groups with SRH information, counselling and services, as well as to screen and counsel for GBV.

As increased attention to ending trafficking and supporting victims of trafficking occurs through government and NGO programmes, health providers will come into increased contact with trafficked women and girls. In these cases, the woman has already disclosed her status or it has been discovered, and the health providers' main task is to provide all required care and counselling according to the same guidelines as for all women affected by GBV, but with special attention to danger assessment and safety planning.

Many trafficked women and girls are under such tight controls that they have no access to health care, despite the serious SRH risks they are subject to. When health personnel do come into contact with them, trafficked women and girls may be reluctant to disclose their situation for fear of prosecution (where sex

work is illegal) or of deportation, since they are often in the receiving country illegally (Amnesty International, 2006). They might come accompanied by the trafficker, necessitating strategies to arrange a private interview with the woman or girl. The ethical dilemmas faced by a health provider who suspects – if a client does not disclose – that their client is a victim of trafficking are considerable, if the possible consequences of disclosure are violence from the trafficker, and imprisonment or deportation for the woman. The IOM Handbook (*Caring for Trafficked Persons: Guidelines for Health Providers,* 2009a) has an action sheet on "What to do if you suspect trafficking" with crucial guidelines.

The *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women (Zimmerman and Watts, 2003)* provide important guidance in these cases, where confidentiality and concern for the woman's safety are matters of life and death. If the woman is still working for the trafficker, the safety of the provider and those she is referred to also need to be taken into account in any follow-up actions for referrals or contact with legal authorities.

2. Basic Resources on Trafficking

- The UN GIFT website has a full array of basic references, manuals and tools, and news about past and upcoming meetings on trafficking. The link relating to "best practices" is particularly useful as guidance. http://www.ungift.org/ungift/knowledge/practices.html
- In 2008, in the framework of the United Nations Global Initiative to Fight Trafficking (UN.GIFT), IOM and the London School for Hygiene and Tropical Medicine convened leading experts in health and human trafficking to gather existing research and grass-roots experiences on managing the health consequences of trafficked persons. The resulting handbook -- (*Caring for Trafficked Persons: Guidelines for Health Providers* 2009a) -- provides practical, non-clinical advice to help health providers understand trafficking, recognize associated health problems and consider safe and appropriate approaches to providing health care for trafficked persons. The guidance is also useful for meeting the health needs of women migrant workers who are victims of abuse. The "action sheets" include SRH, special considerations when examining children and adolescents, trauma-informed care, safe referral, mental health care, disabilities and medico-legal considerations.

VI. HARMFUL PRACTICES

Harmful traditional practices are forms of violence that have been committed against women in certain communities and societies for so long that they are considered part of accepted cultural practice. Several sources list the following practices: FGM/C; early marriage and early pregnancy; honour-based violence and killings; various taboos or practices that prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son preference and its implications for sex selection and neglect of the girl child; female infanticide; and dowry price (Amnesty International, 2006; OHCHR, 2008; Pinheiro, 2006) .

Four of the most widespread harmful practices are discussed here: son preference, FGM/C, early marriage and honour-based violence. These and other harmful practices have several characteristics in common:

- They are typically deeply rooted in the cultures and settings in which they are practised.
- They originate in discrimination against women and girls, including discriminatory norms related to sexuality.
- Their physical and mental health consequences for women and/or girls are often highly significant.
- They are a form of GBV as well as making women and girls more vulnerable to other forms of GBV.
- Economic systems and incentives – such as dowry practices and inheritance laws – perpetuate them.

The implication of these characteristics for all harmful practices is that strategies to address them must be multisectoral, and that purely legal and policy responses often fail to have the desired impact on the practice. Strong evidence corroborating this statement exists for sex selection, FGM/C and early marriage in countries that have outlawed the practices. Health services come into contact with women and girls suffering from harmful practices mainly due to severe physical or mental health consequences of the practices. Besides their duty to reduce harm, whenever possible, health professionals can play important roles in prevention and in advocacy to eliminate the practices.

Resources on harmful practices include the following:

- The Sexual Violence Research Initiative website has a section on traditional harmful practices http://www.svri.org/female.htm with many publications on FGM/C and early marriage in particular.
- A Holistic Approach to the Abandonment of Female Genital Mutilation/Cutting (New York: UNFPA), reviews devastating short- and long-term impacts on the lives of women and girls. http://www.unfpa.org/public/pid/407
- A UNIFEM website has a more complete discussion of the latest evidence on several harmful practices, including those in this review: http://www.unifem.org/gender_issues/violence_against_women/facts_figures.php?page=4)
- A manual for health practitioners, *Caring for human rights: Challenges and opportunities for nurses and midwives* (Amnesty International, 2006), includes guidance on addressing harmful practices for health providers: http://www.amnesty.org/en/library/info/ACT75/003/2006/en

A. SON PREFERENCE

Son preference is implicated in several forms of violence against girls and women, either directly or indirectly, and has serious psychological and health consequences (OHCHR, 2008). Some forms of violence against girls based in son preference include female infanticide, discrimination in the feeding and care of female infants, preferential investment in the education of sons and direct physical abuse of girls. In countries where son preference is prevalent, women may be at greater risk of GBV when they do not produce a male heir, either by being forced to undergo an abortion, or from physical violence from the spouse or his family. Increased risk of forms of GBV such as trafficking and early marriage may occur when sex selection leads to skewed sex ratios among young people of marriageable age. Generally there are legal, cultural and economic foundations to son preference (e.g., inheritance laws, economic discrimination against women and dowry practices). Hence, strategies that solely address attitudes and beliefs are not sufficient.

Health providers must play a key role in detecting these forms of violence; although the ultimate solutions are multisectoral, their counselling of girls, women and their families and their role in campaigns to prevent these forms of GBV are an important contribution. (See discussion under chapter IV, F. Paediatric services, page 64.)

1. Sex selection

In countries where son preference is a strong and technology is available to determine the sex of the foetus, sex selection is performed by aborting female foetuses. Traditional practices to detect the sex of the foetus also lead to efforts to abort the foetus. Sex selection is a form of discrimination against women and directly implicated in GBV risks. High social pressures to produce male offspring lead to pressures for sex selection and can lead directly to serious physical harm to women bearing female foetuses, either through IPV, forced abortion or unsafe abortions. "Illegal abortion, particularly of female foetuses, either self-inflicted or performed by unskilled birth attendants, under poor sanitary conditions has led to increased maternal mortality, particularly in South and South-East Asia" (OHCHR, 2008, 8).

The latest evidence on the long-term results of widespread sex selection indicates that it leads to situations of skewed male-female population ratios that cause a shortage of women of marriageable age and a "marriage market" in which the supply of women is significantly less than the demand. The plausible consequences of this situation in Asia include increased GBV, trafficking and discrimination (UNFPA, 2007b). Another plausible consequence would include increases in the incidence of forced and/or early marriage.

2. Responses to sex selection

Sex selection is a harmful practice with roots in both culture and in structural gender inequalities, so that reducing and eliminating the practice must be multisectoral. India's experience with outlawing the practice has shown that legal remedies are not sufficient (UNFPA, 2008a). A recent policy statement (Center for Reproductive Rights, 2009) describes the potential harm to women that could ensue from legal prohibition and takes a position against such laws.

Awareness campaigns to decrease the acceptance of sex selection as well as other structural and policy changes to address discrimination against women are essential (UNFPA, 2008a). A recent video on sex selection in India (United Nations Television, 2009) portrays the role of inheritance and dowry laws and practices as well as economic discrimination against women in sex selection, demonstrating the policy and structural interventions needed to complement legal prohibition and the current mass media campaigns.

Given the health sector's key role in enabling sex selection, it would be appropriate for health ministries to take the lead in prevention, engaging in comprehensive strategies to reduce son preference and sociocultural support for sex selection. However, in the long term, governments must address gender inequalities to eliminate the economic factors that stimulate son preference.

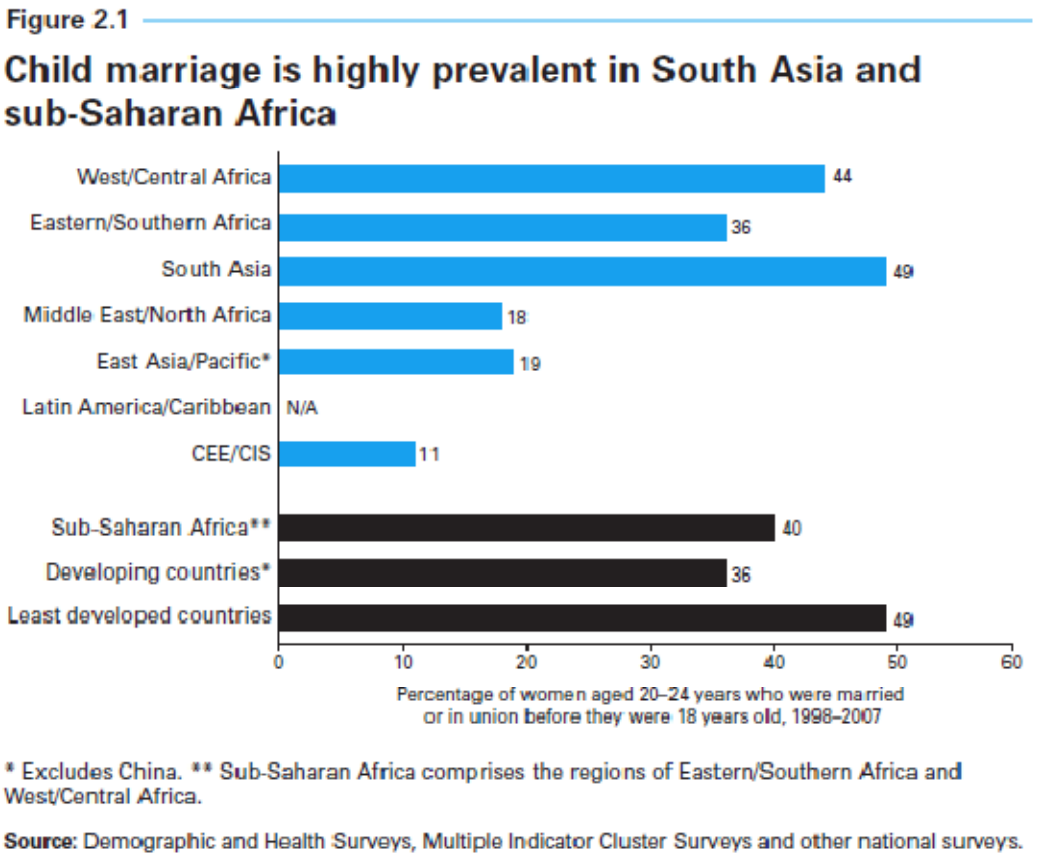
B. EARLY MARRIAGE

Early marriage is defined as marriage under the age of 18. This practice most often affects girls and is considered a violation of girls' human rights, depriving them of their right to health, development, education, participation and often survival.

1. Evidence on the prevalence and risks of early marriage

Early marriage happens more often in settings where son preference is strong. Population Council researchers estimate that approximately one third of girls living in the developing world (excluding China) are married before age 18. Council research also indicates that approximately one out of seven girls in the developing world (excluding China) marries before their 15th birthday (see website on early marriage http://www.popcouncil.org/ta/mar.html). The latest statistics show continuing high levels of child marriage, especially in Africa and South Asia (UNICEF, 2009). See figure 7 below.

Figure 7.



There is mounting evidence that married female adolescents are among the most vulnerable girls worldwide, for SRH risks and for GBV (International Center for Research on Women (ICRW), 2007).

The increased SRH risks from early marriage are well-documented, including:

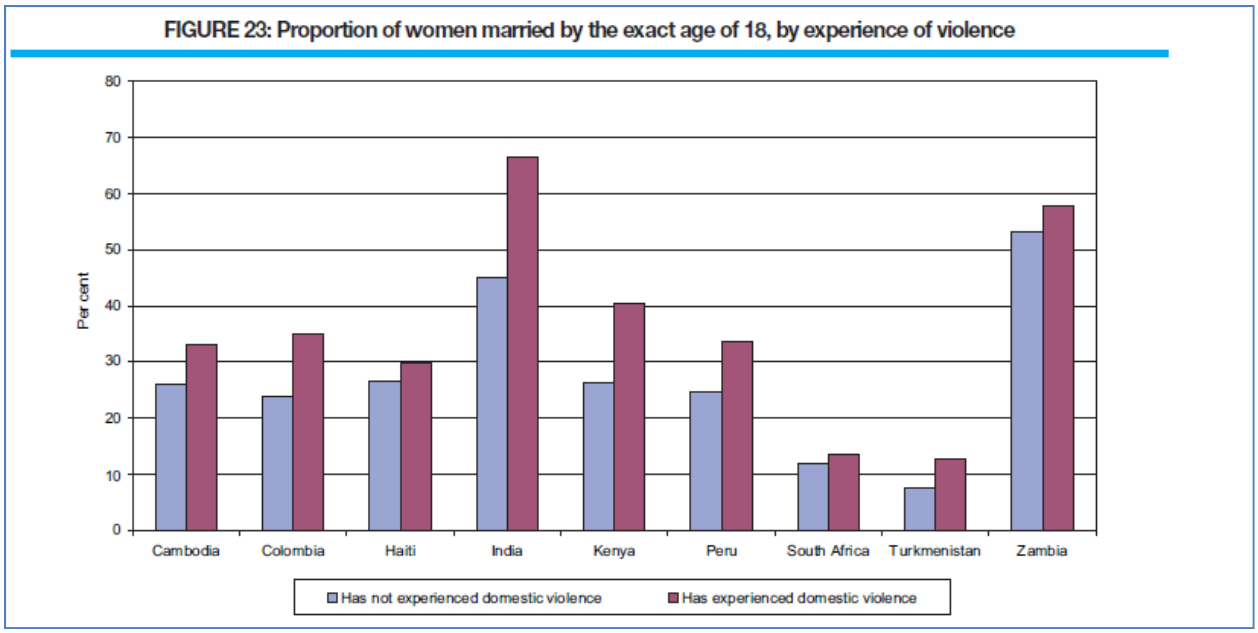
- High risk of HIV and STIs (including HPV) due to common age discrepancies between the girls and their husbands, who are apt to be sexually experienced and more likely to be infected with HIV. Forced sex causes skin and tissue damage that makes a female more susceptible to

contracting STIs from her husband. She has little or no say in protecting herself against pregnancy or diseases, although her husband may be sexually active outside the marriage. The prevalence of early marriage explains the large disparities in HIV infection rates between male and female peers in countries with generalized epidemics, with girls many times more likely to be infected. In several countries, married girls are more likely to be infected than their unmarried sexually active peers, because they are less able to negotiate safer sex (International Women's Health Coalition, 2006; World Vision, 2008).

- High maternal health risks, including obstructed labour, obstetric fistula and anaemia. Their risks are increased if they are malnourished, which is often the case due to nutritional discrimination against girls within families (Nour, 2006; World Health Organization, 2008).

Figure 8 below illustrates the high risks of GBV faced by girls married under age 18 (UNICEF, 2005, 22).

Figure 8.



Girls in early marriage are at much higher risk of GBV than are older women due to a number of factors:

- They often marry men much older than they are and move to their husband's household, reinforcing their subordination within the household.

- They are expected and pressured to have sexual relations with their husband, often against their will.

- They are under intense pressure to become pregnant, before their bodies are mature enough to withstand the risks of pregnancy.

- They are socially isolated, suffering restricted social mobility and freedom of movement outside the house, and they are often far from their family of origin, who cannot intervene on their behalf.

- They are usually deprived of the possibility of continuing their education, reinforcing their powerlessness and isolation.

2. Guidance for health services on addressing early marriage and gender-based violence

SRH providers, in particular those in prenatal and MCH services, are often the only chance married girls get for risk and harm reduction. Before their first birth, these girls rarely come into contact with the health sector. The usual first contact is in prenatal services during their first pregnancy. (See additional guidance in the discussion of prenatal services on page 61).

Sexual and reproductive health policies and programmes can help address early marriage in the following ways:

- Educate the girl and their families about the risks of early marriage, including HIV infection and risks from childbearing at such an early age, so that all can take measures to reduce the risks.
- Create protocols to ensure that prenatal and MCH services address SRH and GBV risks. (See additional guidance in the discussion of MCH services page 62).
- Use child survival and maternal health outreach and education programmes to inform the public about the risks of early marriage.
- Use service statistics to document the SRH and GBV risks from early marriage as useful data for advocacy to end the practice.

3. Resources on early marriage

- Population Council: The "Transitions to Adulthood" programme has conducted much research and programme evaluation on early marriage and programmes designed to address factors in vulnerability to early marriage. See : http://www.popcouncil.org/ta/mar.html
- UNFPA has several resources on its website, including:
  - The "Early Marriage Fact Sheet" (2005) has numerous resources, graphs, and references. http://www.unfpa.org/swp/2005/presskit/factsheets/facts_child_marriage.htm
  - *Giving Adolescent Girls the Chance to Reach Their Full Potential* http://www.unfpa.org/adolescents/girls.htm#out places early marriage within the context of the health, development and participation of adolescent girls.
- UNICEF publications with information and guidance on early marriage include the following:
  - *Early Marriage: A Harmful Traditional Practice* (UNICEF, 2005).
  - *A Study on Violence against Girls* (UNICEF Innocenti Research Centre, 2009).

C. FEMALE GENITAL MUTILATION/CUTTING

FGM/C has been shown to have both immediate and long-term health consequences, and human rights standards classify it as a "traditional harmful practice" that is a violation of the rights of the girl child and of women. FGM/C also violates numerous other rights, including the rights to health, security and the physical integrity of the person; and the right to be free of torture and cruel, inhuman or degrading treatment (OHCHR and others, 2008). The practice is an obstacle to achieving the MDGs on child survival, maternal health and HIV/AIDS, because the more severe forms often lead to obstructed labour and haemorrhage, and most forms increase susceptibility to HIV infection. See box 17 below for a description of the forms of the practice (Population Reference Bureau, 2008) .

Box 17.

Box 2

Types of Female Genital Mutilation/Cutting

Female genital mutilation/ cutting (FGM/C) refers to a variety of operations involving partial or total removal of female external genitalia. The female external genital organ consists of the vulva, which is comprised of the labia majora, labia minora, and the clitoris covered by its hood in front of the urinary and vaginal openings.

In 2007, the World Health Organization classified FGM/C into four broad categories:

Type 1 or Clitoridectomy: Partial or total removal of the clitoris and/or the clitoral hood.

Type 2 or Excision: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type 3 or Infibulation: Narrowing of the vaginal orifice with creation of a covering seal by cutting and placing together the labia minora and/or the labia majora, with or without excision of the clitoris.

Type 4 or Unclassified: All other harmful procedures to the female genitalia for nonmedical purposes, for example, pricking, piercing, incising, scraping, and cauterization.

Note: Current questionnaires used in the Demographic and Health Surveys do not differentiate between Types I and II, but only between whether a girl or woman has been cut, whether tissue has been removed, and whether tissue has been sewn closed.

Source: World Health Organization, *Eliminating Female Genital Mutilation: An Interagency Statement,* OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO (Geneva: WHO, 2008): 23.

1. Current recommendations on FGM/C in the health sector

A universal policy prohibiting all medical professionals from performing any form of FGM/C should be absolute. In some countries, in a significant proportion of cases medical professionals carry out FGM/C and even of reinfibulation after childbirth. Some may do this for financial gain, while others may erroneously believe that it is a harm-reduction strategy. The following statement represents the consensus of many United Nations agencies (OHCHR and others, 2008,12).

> "There is no evidence that medicalization reduces the documented obstetric or other long-term complications associated with female genital mutilation. Some have argued that medicalization is a useful or necessary first step towards total abandonment, but there is no documented evidence to support this. There are serious risks associated with medicalization of female genital mutilation. Its performance by medical personnel may wrongly legitimize the practice as medically sound or beneficial for girls' and women's health. It can also further institutionalize the procedure as medical personnel often hold power, authority, and respect in society."

MCH and paediatric services constitute an important opportunity to prevent FGM/C and to reduce harm for girls who have been excised or infibulated.

- Providers should educate parents on the harm caused by FGM/C to prevent its occurrence. In most countries where FGM/C is prevalent now, local health ministries or NGOs have culturally appropriate educational materials available to distribute.

- In settings where FGM/C is practised, protocols for examining girls (paediatric services) and women (SRH services) should include screening for FGM/C, either verbally or when conducting pelvic examinations..

- Health policies should mandate reporting of FGM/C by type when it is observed, in order to collect national data on prevalence.

  Protocols should prompt the provider to engage in harm reduction, to reduce maternal, HIV and other health risks due to FGM/C, including detecting infections or other potential harm due to FGM/C. If a physical exam is possible, the provider should treat to mitigate harm from the most severe forms so that blockage of menstrual blood and obstructed labour will not cause illness or death later in life.

2. Resources

- *Eliminating Female Genital Mutilation: An Interagency Statement* discusses all aspects of FGM/C, including health consequences and evidence on strategies to eliminate the practice (OHCHR and others, 2008).
- The Population Reference Bureau published a wall chart on data and trends in FGM/C that describes the various forms of the practice, prevalence of the practice in various countries, the percentages of traditional vs. medical performances of FGM/C and the ages at which the practice is performed (Population Reference Bureau, 2008).
- The website www.stopfgmc.org has a variety of resources and documents from international organizations, governments, NGOs and other organizations.
- The Population Council website on "Female Genital Mutilation/Cutting: Ten Lessons to Bring About Change" summarizes the main lessons learned from the FGM/C studies in the Frontiers project. http://www.popcouncil.org/topics/fgmc.asp#/Resources (accessed November 2009).
- See also UNFPA_(2007a). A Holistic Approach to the Abandonment of Female Genital Mutilation/Cutting. New York; UNFPA.

D. "HONOUR"-BASED VIOLENCE

The United Nations classifies honour-based violence as a traditional harmful practice because it stems from long-standing cultural norms that discriminate against women and girls and cause harmful consequences, including death. As defined by UNICEF, honour crimes are those committed against girls and women who are perceived to have contravened accepted social norms of behaviour and have therefore brought shame to their families (UNICEF Innocenti Research Centre, 2009). Reasons for honour-based violence range from rape to accusations of involvement in inappropriate sexual behaviour, rejection of a family's marriage plans or being seen alone with an unrelated man (Amnesty International, 2006, 34). Honour killings are described in the *World Report on Violence Against Children* (Pinheiro, 2006, 77) : "suspected loss of virginity of a female member of the family, including as a result of rape, is perceived as compromising family honour, and may lead to her murder by family members." UNFPA estimates that as many as 50,000 girls are killed in honour-based violence each year, reliable statistics on this form of GBV are not available (UNICEF Innocenti Research Centre, 2009).

Where survivors of such violence enter the health-care system, issues of security of the survivor and the security of staff and other patients arise, as well as the particular challenges of providing care for the traumatized woman. Instances have been reported of family members entering health facilities in pursuit

of their daughter or sister, putting both providers and the female patient at risk (Amnesty International, 2006, 34).

SRH, humanitarian response, and emergency-room health personnel treating girls and women post-sexual violence must include culturally adapted questions related to honour-based violence in their danger assessment, especially in countries and among populations where honour-based violence is known to exist. In these cases, the danger may not be from the rapist(s) but from family members.

Where the danger of honour-based violence is detected, safety planning should focus on prevention of violence from family members, possibly through mediation by health personnel or other services or leaders in the local community. Finding such allies to help mediate with family members and prevent violence is greatly facilitated by community-based and mass-media prevention programmes that seek to increase opposition to the practice.

Health providers should deliver messages countering cultural norms that support honour-based violence to family members of women and girls in danger of such violence, orally and through educational materials adapted to the language and literacy level of the family. They should also document all instances of honour-based violence, so that the dimensions of the practice can become public knowledge and used in advocacy and prevention campaigns to end the practice.

VII. MONITORING AND EVALUATION

Resources on this section will be made available on the UNIFEM "**Virtual Knowledge Centre to End Violence Against Women and Girls," at http://www.endvawnow.org/.**

ANNEX I: ADDITIONAL DEFINITIONS

Gender-based violence (GBV): Physical, mental or social abuse (including sexual violence) that is attempted or threatened, with some type of force (such us violence, threats, coercion, manipulation, deception, cultural expectations, weapons or economic circumstances) and is directed against a person because of his or her gender roles and expectations in a society or culture. In circumstances of GBV, a person has no choice to refuse or pursue other options without severe social, physical or psychological consequences. Forms of GBV include sexual violence, sexual abuse, sexual harassment, sexual exploitation, early marriage or forced marriage, gender discrimination, denial (such as education, food, freedom) and female genital mutilation/cutting.(UNTERM).

Sexual and gender-based violence: Although the definition of GBV includes sexual violence, this phrase is often used to make the sexual forms of GBV more explicit. The following definition is from the UNTERM database, "A term which encompasses a wide variety of abuses, including rape, sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, involuntary prostitution (sexual bartering), torture, unwanted or noxious insertion of objects into genital openings, and attempted rape. Some have also considered female genital mutilation and other traditional practices (including premature marriage, which increases maternal morbidity and mortality) as forms of sexual and gender-based violence" (UNTERM).

Forms of violence against women: The Secretary General's "In-Depth Study on all forms of violence against women" (United Nations Secretary General, 2006) describes the following forms of violence against women, with additional comments on how multiple forms of discrimination make certain groups of women more vulnerable to specific types of violence:

- In the family, including IPV and traditional harmful practices;
- In the community, including femicide, sexual violence, sexual harassment and trafficking;
- Violence perpetrated or condoned by the State, including custodial violence, abuse by health-sector personnel, forced sterilizations and SGBV by uniformed personnel in armed conflict.

Intimate partner violence: IPV is a pattern of assaultive and coercive behaviour, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners (UNTERM).

Sexual violence: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality, using coercion, 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 (WHO, 2002).

- Women's rights related to sexuality: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences." United Nations. Platform for Action of the Fourth World Conference on Women, Beijing, 4–15 September 1995. New York, United Nations, 1996 (UN Doc. A/CONF.177/20), paragraph 96.
- A WHO expert meeting in 2002 elaborated definitions on sex, sexuality, sexual health and sexual rights. These are not official WHO definitions but represent the consensus of the experts convened. See http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/ [accessed October 2009]
    - Sex refers to the biological characteristics that define humans as female or male.

While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.

- Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

- Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

- Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

    - the highest attainable standard of sexual health, including access to sexual and reproductive health care services
    - seek, receive and impart information related to sexuality
    - sexuality education
    - respect for bodily integrity
    - choose their partner
    - decide to be sexually active or not
    - consensual sexual relations
    - consensual marriage
    - decide whether or not, and when, to have children; and
    - pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

- Sexual and reproductive health services include: family planning services; pregnancy-related services, including skilled attendance at delivery, emergency obstetric care, safe abortion where it is legal and post-abortion care; STI and HIV prevention and diagnosis, STI treatment, and HIV care and treatment; prevention and early diagnosis of reproductive organ cancers; prevention of gender-based violence and care of survivors; and essential commodities for each component (UNFPA, Report of the Secretary General to ECOSOC, 2009,27). Mental health and psychosocial support must be integrated as part of existing SRH services. This definition was derived mainly from the UNFPA Sexual and Reproductive Health and Reproductive Rights Framework, with the addition of HIV care and treatment and safe abortion services, since this knowledge asset covers HIV and all other SRH services. ICPD adds that this constellation of services should be available in humanitarian response situations.

WE MUST WORK TOGETHER TO STOP WIFE-BEATING

Wife-beating is spoiling our communities and our country.
This is not a private family matter. We must all help to stop it.

WHAT CAN MEN DO?

Do not hit your wife or children.

Learn how to **"Take it Easy"** and control your temper (see next section).

Tell people in your community about the problems that wife-beating causes, and that it is against PNG's laws.

Help stop wife-beating when you see it happening.

Offer help to women whose husbands hit them, like a safe place to stay for a while.

Take strong action against men who hit their wives.
Get a **Preventive Order** from the Village Court, or District Court, or report to police.

"Take it Easy"

When you feel yourself starting to get angry, STOP and THINK!

Go away until you feel calm again.

DO something to cool down, like go walking, talk with someone you respect, dig the garden, or read the Bible.

Do NOT drink alcohol.

Come back and talk with your wife.
LISTEN to each other.

Remember:

A real man does not hit women. He knows how to deal with problems by talking.

Hitting only causes more problems.

Information for Men

MEN HAVE THE POWER TO STOP WIFE-BEATING

WIFE-BEATING HURTS OUR FAMILIES

Department of Health

WIFE-BEATING HURTS CHILDREN

In families where the father hits the mother, health workers find that the children's health suffers, and they do not grow so well.

The children are worried, their school work suffers, and they may have behaviour problems.

Wife-beating teaches children to accept violence as normal, and to be violent themselves.

If the mother is hit when she is pregnant, it will hurt the unborn baby, and it can affect the birth.

WIFE-BEATING HURTS WOMEN'S HEALTH

Injuries to the woman's body mean she cannot look after herself or the family properly.

If she is hit on the head, this can cause brain damage, or it can make her become deaf or blind.

It affects her mental health. She is afraid and worried, and may lose interest in life.

Wife-beating is against the Law

Men and women have the same rights under the National Law of PNG.

Paying brideprice does not give a man the right to hit his wife.

WIFE-BEATING HURTS FAMILIES

Wife-beating causes families to break up.

If the man forces the woman to have sex, she may have children too close together. This makes the woman and the children weak.

If the man has an STI (sexual sickness from having sex with other people) he can give it to his wife if he makes her have sex. This can stop her from having children.

If the man has the HIV or AIDS sickness and has sex with a woman, she will get it too. The baby can also get the sickness.

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