PRIMARY HEALTH CARE PROJECT

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Guidelines for Management of Gender-Based Violence in Iraq

Guide to Health Workers and Volunteers working with IDPs and Refugees

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PRIMARY HEALTH CARE PROJECT

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Guidelines for Management of Gender-Based Violence in Iraq

Guide to Health Workers and Volunteers working with IDPs and Refugees

This document was prepared by USAID/Primary Health Care Project in Iraq implemented by University Research Co. LLC based on gender-based violence interventions and guidelines in humanitarian settings developed by Inter-Agency Standing Committee (ISAC) in 2005 and URC resources as well as technical inputs of IDPs Technical Working Group and Health Promotion Specialists and Advisors in Iraqi Ministry of Health.

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Background

The internally The Internal Displacement Monitoring Centre (IDMC) estimates that there are at least 2,300,000 internally displaced Iraqis since the beginning of the year fleeing their homes from the ongoing violence across the country).[1] [2] The current deterioration of the security environment in other governorates (e.g. Ninawa and Salah ad-Din) since June 2014 added additional burdens in the upcoming months. All these events have placed a great strain on the Governorate's public services - education, health care, and infrastructure.

The Ministry of Health (MoH) stresses the importance of community partnership and a strengthened community health workers and local health committees as active partners in the provision of comprehensive primary health care (PHC). There is growing awareness that community participation in PHC programs is an active and innovative manner of improving health status, especially for most vulnerable groups like IDPs and refugees. Organized and aware communities can improve health indicators significantly, especially those related to immunization coverage, use of health water, maternal and child health, TB and communicable diseases control and promotion of all other healthy life styles.

From its inception, the USAID-funded Primary Health Care Project in Iraq (PHCPI) has been designed to strengthen the Iraqi health sector's capacity to benefit the population as a whole; increasing access to health coverage for key vulnerable populations such as children under five, pregnant women as well as IDPs. As part of these efforts, in 2012, the Primary Health Care Project in Iraq conducted a field survey on some of the displaced populations in collaboration with the MoH and the Ministry of Migration and Displacement to gain a better understanding of the health-related needs of this population.

The intention was to take an overview of the requirements, health and social services for this population group. Based on the survey results, PHCPI has worked to increase IDPs' knowledge and access to quality reproductive and child health care services with the goal of reducing short- and long-term maternal and child morbidity and mortality (United Nations Millennium Development Goals 4 & 5). Additionally, according to the results obtained from the survey mentioned above, it appears that there is a rise in the rate of mortality and among these populations, especially among vulnerable groups such as mothers and children and increased cases of gender-based violence (GBV), especially among women and girls. MoH emphasized responses to GBV as among the critical issues to be considered by all health stakeholder and government agencies as well as ministries that work with the IDPs to strive to improve the environmental services provided so as to be on par with services provided to the other Iraqis.

[1] OCHA Iraq situation report December 2014.

[2] IOM Iraq Report/ Governorate Profile: Baghdad, 2014

Introduction

At least one in three of the world's female population has been either physically or sexually abused at some time in her life. Although in most countries little research has been conducted on the problem, available data suggest that in some countries nearly one in four women may experience sexual violence by an intimate partner, and up to one-third of adolescent girls report their first sexual experience as being forced. [3] There is a great deal of evidence and increasing acknowledgement that gender-based violence (GBV) is a serious risk factor for health and social problems. Various studies conducted primarily in the United States and other countries (e.g. Africa) show an increased risk of diseases among women survivors of gender based violence. This relationship has grave consequences for global health and human development, especially with regard to adult women, adolescents, and girls, who are most affected by sexual violence. Despite these evidences, many health professionals do not recognize the links between violence and women's health, often because violence against women remains a "silent epidemic", under-recognized by society and rarely included in the professional training of medical staff.

Gender-based violence (GBV), is a serious, life-threatening protection issue primarily affecting women and children. It is well documented that GBV is a widespread international public health and human rights issue, and that adequate, appropriate, and comprehensive prevention and response are inadequate in most countries worldwide. GBV is especially problematic in the context of complex emergencies and natural disasters, where civilian women and children are often targeted for abuse, and are the most vulnerable to exploitation, violence, and abuse simply because of their gender, age, and status in society.

During a crisis, institutions and systems for physical and social protection may be weakened or destroyed. Police, legal, health, education, and social services are often disrupted; many people flee, and those who remain may not have the capacity or the equipment to work. Families and communities are often separated, which results in a further breakdown of community support systems and protection mechanisms. To save lives and maximize protection, a minimum set of activities must be rapidly undertaken in a coordinated manner to prevent and respond to GBV from the earliest stages of the crisis. Survivors/victims of GBV need assistance to cope with the harmful consequences. They may need health care, psychological and social support, security, and legal redress. At the same time, prevention activities must be put in place to address causes and contributing factors to GBV in the setting. Providers of all these services must be knowledgeable, skilled, and compassionate in order to help the survivor/victim, and to establish effective preventive measures. Prevention and response to GBV therefore require coordinated action from actors from many sectors and agencies.

[3] http://www.icrc.org/Web/Eng/siteeng0.nsf/iwpList571/2437B7A5BFC8EE31C1256D5C00393846

Purpose of the Guidelines

Since 2003, local and international media has reported the rising death toll in Iraq due to security situation. A few have reported the increase in gender-based violence (GBV), especially against women and girls. Government, UN and human rights organizations failed to provide reports on incidence of GBV in Iraq. No disaggregated data is available. Without details on who is being targeted and the nature of the violence, it is difficult to analyze the crisis accurately or to optimize the protection response. There is no published statistics about GBV. Crimes against women and girls are not reported in Iraq because of stigma, fear of retaliation/re-victimization ('honor killing'). There is no doubt that Iraqi men and boys face enormous risk of violence, they are less likely to be targeted because they are males. Where data is available, it is reasonable to assume that the actual number of women who are attacked, abducted, raped and killed is much higher than the data indicates. According to lessons from other countries, IDPs crisis increases the potential for more GBV against women and children.

This guideline is designed, as a first step, to create awareness and sensitization among health care professionals and community workers who interact with those impacted by GBV, especially IDPs and refugees, and have a position in which they can contribute to the assistance of survivors of GBV and help prevent it in the community.

This guideline highlight important thematic issues which are urgent for the lives of IDPs. The specific objectives of this guideline include:

- To educate health personnel and community workers about the epidemiology of GBV, including the magnitude, patterns of the problem, and the direct and indirect consequences of violence on women's health.
- To ensure that health personnel are sensitized to recognize key signs and symptoms.
- To reassure providers and community workers that discussing violence is a legitimate use of time during a medical consultation.
- To provide information and knowledge of appropriate clinical care, counselling, and medico-legal processes in the management of sexual violence survivors.

USAID's Commitment to Addressing Gender-based Violence

"It is vital to promote the rights of all individuals and reduce gender-based violence while mitigating its harmful effects on individuals and communities. Unless women, girls, men, and boys fully enjoy their human rights and are free from violence, progress toward development will fall short. For many decades, USAID has partnered with non-governmental organizations, faith-based organizations, and host government institutions to increase awareness of the scope of the problem and its impact, improve services for survivors of violence, and strengthen prevention efforts." **USAID**

Target audience of this guideline is frontline health care workers involved in providing patient care at health facility and outreach: Doctors, Nurses, Clinical Officers, Counsellors, Lab personnel, Community Health Workers; and Health Facility Managers. The present guidelines is designed as an awareness building activity around GBV issues for a wide range of audience.

Story from Iraq: Women in Iraq Struggle to Survive

IOM reports that displaced Iraqi female-headed families that have returned to Iraq are still facing livelihood challenges. The survey found that:

- *74% had a hard time providing enough nutrition for their families, and that they faced delays in government food rations*
- *Iraqi women also had health and social problems that prevented 40% of those surveyed from finding jobs. 71% are unemployed.*
- *40% were depending on relatives, neighbors, NGOs and religious groups to meet their needs*
- *More than 25 percent had a family member with a chronic disease*
- *One in four lacked access to healthcare*
- *Domestic violence against women had increased in the past five years due to displacement: one in five Iraqi women were subject to violence, and a third to psychological violence*

"The oppression against women is still continuing in Iraq… The plight of the displaced women has not been dealt with seriously. They need adequate houses to preserve their dignity, schools for their children, electricity and drinking water… I do believe that we need a special program to spread awareness among women about their rights and support them on how to start a project that can secure a steady income for their families without relying on anyone."

Source: http://www.irinnews.org/report/91310/iraq-displaced-women-still-struggle-for-survival

Part I: Important concepts/definitions

Gender is a social construct that defines differentiated roles of men and women, boys and girls. Gender refers to the economic, social, political, and cultural attributes and opportunities and constraints associated with being women and men. The social definitions of what it means to be women or men vary among cultures and change over time. It is also the socio-cultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality such as homosexuals and transsexuals.

Sex is a biological classification of females and males, defining physical differences between them.

Gender roles are defined as social expectations of what men and women should do in different environments, based on the cultural ideas of masculinity and femininity. Gender roles are culturally determined and are learned. They differ from one society to another. Some gender norms enforce unequal power imbalances that negatively affect women, men, girls and boys.

Gender equality is where men and women are seen to be equal, such as women and men having equal access to education.

Survivor/victim Person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably. "Victim" is a term often used in the legal and medical sectors. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency.

What is GBV?

Definition: Physical, mental, or social abuse (including sexual violence), which is directed against a person because of his or her gender or gender role in society or culture. GBV is a major cause of death and disability among women in the world and constitutes one of their most serious health problems. Common examples of forms of violence that affect women disproportionately are rape, sexual exploitation and domestic exploitation. Sexual violence and exploitation of girls and women is increasing globally, especially in conflict areas. Rape is often used as a weapon in war.

> "GBV is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females."

The following table outlines the common types of violence experienced by women over their lifespan.

Phase	Type of Violence
Prenatal	Prenatal sex selection, battering during pregnancy, coerced pregnancy (rape during war)
Infancy	Female infanticide, emotional and physical abuse, differential access to food and medical care
Childhood	Genital cutting; incest and sexual abuse; differential access to food, medical care, and education; child prostitution
Adolescence	Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, forced prostitution
Reproductive	Abuse of women by intimate partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities
Old Age	Abuse of widows, elder abuse (which affects mostly women)

Source: Heise, L. 1994. Violence Against Women: The Hidden Health Burden. World Bank Discussion Paper. Washington. D.C. The World Bank

What are the **forms of GBV?**

GBV includes, but is not limited to:

1. Domestic Violence (DV) by an intra-family member and Intimate Partner Violence (IPV) including physical, sexual or psychological harm by a current or former partner or spouse;
2. Sexual Violence (SV) including rape, sexual abuse, forced pregnancies and prostitution;
3. Traditional harmful practices including female genital mutilation (FGM), honour killing and forced marriage; and
4. Human trafficking.

Domestic violence (also known as domestic abuse, intimate partner violence or spousal abuse) occurs when a family member, partner or ex-partner attempts to physically or psychologically dominate another.
Domestic violence occurs in all cultures; people of all races, ethnicities, religions, social class.
Domestic violence is perpetrated by both men and women.
Violence is hidden and occurs both in public and private
1 out of 4 women globally is exposed to violence domestically or from close intimate partner.

Sexual violence
World Health Organization defines **sexual violence** as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work".

Prevalence of GBV
While the prevalence of different kinds of gender-based violence varies from setting to setting, epidemiological evidence demonstrates that physical and sexual violence against women is a public health problem in virtually every part of the world. The prevalence and incidence rate of GBV varies depending on the type of violence and the population included in the study. Most studies focus on DV, IPV, or SV.

What triggers GBV?

- Crises, emergencies and natural disasters
- Position of women in the society and marriage
- Lack of bodily autonomy
- Sex as marital obligation
- Rigid notions of masculinity
- Traditions and norms- polygamy, bride price, widow inheritance: harassment or killing of widows to gain control over deceased husband's property; forced marriage to male relative of deceased husband
- Economical dependency, lack of property rights
- Poor enforcement of human rights
- Poor access to information
- Poverty, Alcohol and drug use

Why women do not tell?
Abused women are less likely to seek for health services.

- Think that violence is normal or not serious enough.
- Fear from consequences – abandonment, stigma, blame.
- Fear that they would not be believed and helped- Victims of GBV often have severe feelings of guilt
- Social and legal systems are often stacked against victims of GBV: blame the victim. May be more dangerous for the victim to report the assault – or pursue it in the legal system – than to ignore it.
- Domestic violence is often considered to be a family matter
- Needs of family well-being are often prioritized before women's health.
- Both women and men often condone man's violence

What are health effects of GBV?

Immediate consequences include injury, homicide, risk of sexually transmitted infections and pregnancy, and experience of anxiety. **Secondary** effects include severe depression and long-term impacts on children being raised in homes with intimate partner violence.

The following table outlines the potential physical, reproductive health, psychological and behavioural consequences of sexual and gender-based violence:

Why should Health Service Delivery programs address GBV?

- Health programs can be more effective if they recognize health implications of GBV. Health providers who do not ask about gender-based violence may misdiagnose survivors, offer inappropriate care, or even endanger them by giving poor advice.

- Providers may be the first point of contact for women. Although most survivors/victims of sexual violence do not disclose the abuse to anyone, some will talk with a health provider if health services are physically/ geographically accessible, confidential, sensitive, accommodate private consultations, and of good quality. Providers can assist women, rather than inadvertently putting women at further risk.

- Healthcare organizations can raise awareness of GBV as a public health problem. Health centres may serve as a first "neutral" location to provide information and counselling on women's and girls' health. Women may be more able to access this type of information if it is within the context of basic health care, and not provided by specialty or separate programmes.

> "All humanitarian actors must take action, from the earliest stages of an emergency, to prevent sexual violence and provide appropriate assistance to survivors/victims".

- Situations of sexual abuse may lead to psychosomatic problems that become only clear when the patient is interviewed tactfully and sensitively. When patients come for help under the disguise of a medical problem, it is important to find out what possible psychosocial problems (including possible GBV) exist. To be able to structure the patient's complaints and guide them to what is relevant, the health worker needs knowledge of GBV and its effects.

Non-fatal outcomes			Fatal outcomes
Physical injuries and chronic conditions	Sexual and reproductive sequelae	Psychological and behavioural outcomes	
▪ Fractures ▪ Abdominal/thoracic injuries ▪ Chronic pain syndromes ▪ Fibromyalgia ▪ Permanent disability ▪ Gastrointestinal disorders ▪ Irritable bowel syndrome ▪ Lacerations and abrasions ▪ Ocular damage	▪ Gynaecological disorders ▪ Pelvic Inflammatory disease ▪ Unsafe abortion ▪ Unwanted pregnancy ▪ Pregnancy complications ▪ Sexual dysfunction ▪ Miscarriage / low birth weight ▪ Sexually-transmitted infections, including HIV	▪ Depression and anxiety ▪ Eating and sleep disorders ▪ Drug and alcohol abuse ▪ Phobias and panel disorder ▪ Poor self-esteem ▪ Post-traumatic stress disorder ▪ Psychosomatic disorders ▪ Self harm ▪ Unsafe sexual behaviour: ✓ high-risk views on sexual violence & HIV infection ✓ less likely to use condoms & contraceptives	▪ Femicide ▪ Suicide ▪ AIDS-related mortality ▪ Maternal mortality

Sources: Adapted from Heise and Garcia Moreno, 2002; and Heise, Ellsberg and Gottemoeller, 1999.

What are the key barriers to address GBV in health care delivery settings?

- ***Programmatic barriers:***
    - Limited resources (Human and Financial resources) to support efforts against GBV. There is great burn out in health service providers.
    - Lack of proper guidelines, protocols, health care workers training or sensitization and supervision.
    - Limited resources to refer women to
    - The culture of silence surrounding GBV which makes reporting and collection of data on this sensitive issue particularly challenging.

- ***Health care provider related*:**
    - Providers may fail to recognize violence as the cause of or contributing factor behind injury, infection, and chronic conditions.
    - Health care professionals believe that violence against women is a social problem that is not relevant to their daily practice
    - Providers may think that the woman must have done something to deserve it, feel judgmental
    - Providers fear getting involved because of potential harm from the perpetrators of violence against them
    - Providers underestimate the risk of future injury and even death. They may miss the opportunity to provide adequate medical care and reduce risk. Even more serious, they may compound women's suffering by minimizing the problem, expressing negative attitudes toward victims, or by taking actions that put women's safety at risk.

What is health care provider's responsibility?

The health care provider's responsibility is to provide appropriate medical care to survivors of GBV based on guidelines. This includes collection of any forensic evidence that might be needed in a subsequent investigation either during or post crisis period. In cases of sexual violence, it is not the responsibility of the health care provider to determine whether a person has been raped. That is a legal determination. However, all health care providers must be aware of relevant laws and policies governing health care providers in cases of sexual violence.

What are health and community services provided?

- 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

Part II: Identify and support survivors of GBV

How to identify **abuse**?

- The two most important things a health care provider can do about gender-based violence are asking about abuse and supporting women/persons who disclose violence or abuse.

- The best way to uncover a history of abuse is for the health care provider to ask about it. Asking about abuse has to be done with great sensitivity.

- Screening for physical or emotional GBV can be carried out in two ways: 1) in response to situations where signs of abuse are present or 2) routine screening for all clients of a particular service. Routine screening will identify more women facing violence than if services wait for women to disclose abuse.

- Services that focus on emergency care, psychiatry, gynaecological care, sexual and reproductive health, and maternal and child health are most likely to see women who have been abused and thus provide a good opportunity to incorporate routine screening.

Screening questions

Three brief questions to screen for gender-based violence:

- Have you ever been hit, kicked, punched or otherwise hurt by someone within the last year? If so, by whom?
- Do you feel safe in your current relationship?
- Is there a partner from a previous relationship who is making you feel unsafe now?

The screening questions may be introduced directly to the patient, or indirectly, depending on the circumstances.

Identify “high risk” women

If health care providers can recognize signs and symptoms of abuse, they can help identify and screen at least 'high risk' women even when the health facility is busy and providers have very limited time.

The following have been identified as 'red flags' that should alert a health care provider to the possibility that the patient is a victim of violence or sexual abuse:

- chronic vague complaints that have no obvious physical cause;
- injuries that do not match the explanation of how they occurred;
- a male partner who is overly attentive, controlling or unwilling to leave the woman's side;
- physical injury during pregnancy;

- late entry into prenatal care;
- a history of attempted suicide or suicidal thoughts;
- delays between injuries and seeking treatment;
- urinary tract infection;
- chronic irritable bowel syndrome; and
- Chronic pelvic pain.

Additional issues to consider regarding Children

- Child survivors of GBV/sexual assault are often "groomed" by the perpetrator to deny that abuse has occurred. Health workers/counsellor should be aware of this and have a strategy for making the victim feel comfortable with reporting what really happened. However, children are also very susceptible to suggestion, so may agree that sexual assault occurred to please or avoid angering the counsellor – feel threatened to provide the answer they think the counsellor wants.

- Mothers or female guardians are sometimes enablers of sexual assault of their children by male family members or refuse to recognize that it is occurring / has occurred. This makes the presence of a female relative of the victim a double-edged sword: in most cases, it would make the child feel less threatened and uncomfortable being examined/questioned by strangers, but in some cases it might also intimidate the child into refusing treatment or not being truthful in relating what has happened to them.

- Honour killings may also be a threat in some settings (eg. Rural areas)

Supporting survivors

Violence involves physical and psychological trauma. Survivors/victims may experience an array of psychological consequences, such as sadness and depression; self-blame; somatic distress; sexual problems; mood swings, anger and anxiety-related problems (sleeplessness, fearfulness, stress, and fear of "going crazy"). For most survivors, these experiences are normal emotional responses to trauma. Especially with social and emotional support, many survivors learn to cope and the distress decreases over time

The very act of asking a woman about abuse and listening to her disclosure without judgment and with empathy and sensitivity is an act of support. It helps the woman feel that the violence is not her fault and can be the beginning of a process of changing her situation.

Three types of supportive actions include the following:

Medical support

- taking a complete history;
- detailed assessment of current and past violence;
- Gentle physical examination; and treatment of all injuries.

Emotional support

- confidentiality;
- directing the partner to leave the room;
- listening carefully; and
- Reassuring the woman that the abuse is not her fault and validating her feelings of shame, anger, fear and depression.

Practical support

- telling the patient that spouse abuse is illegal;
- providing information and telephone numbers for local resources such as shelters, support groups and legal services;
- Asking about the children's safety; and helping the patient begin safety planning.

Developing safety plan

- Support and counselling on post-treatment safety– not going back into abusive situation and preventing additional assaults

- Temporarily staying away from the abusive partner may not make the violence stop, but could help prevent serious injury or death to the woman and/or her children.

- Developing a safety plan could prove much more difficult in the case of low-income women, especially those from rural or ethnic minority communities, who may not have the resources to leave the abuser and may not have access to or even be able to afford temporary stays in safe havens.

- The health provider may have to find out if there are affordable safe places that the woman can go to, such as homes of friends or relatives.

- They may be directed to women's shelters or women's organizations that can help them, in places where such facilities exist.

- Community-based women's groups, such as self-help and microcredit groups, have the potential to provide both financial and psychological support to a woman who wishes to leave a violent relationship.

- Health facilities could take the initiative to network with such groups and harness their support to help women experiencing intimate partner violence. In the absence of shelters or women's groups and organisations, the health provider may be in a difficult situation, wanting to help but having limited possibilities to do so.

- Lessons to date however indicate that, in all circumstances, it is worthwhile to at least talk to the woman, acknowledge and document her situation of abuse and provide whatever help is within the provider's means.

Developing a safety plan

- Identify one or more neighbours you can tell about the violence, and ask them to help if they hear a disturbance in your house.
- If an argument seems unavoidable, try to have it in a room or an area that you can leave easily.
- Stay away from any room where weapons may be available.
- Practice how to get out of your home safely. Identify which doors, windows, elevator or stairwell would be best.
- Have a packed bag ready, containing spare keys, money, important documents and clothes.
- Keep it at the home of a relative or friend, in case you need to leave your home in a hurry.
- Devise a code word to use with your children, family, and friends and neighbours when you need emergency help or want them to call the police.
- Decide where you will go if you have to leave home and have a plan to go there (even if you do not think you will need to leave).
- Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he wants to calm him down. You have the right to protect yourself and your children.
- Remember, you do not deserve to be hit or threatened.

Part III: Mental Health & Psychological Support for Sexual & Gender-based Violence against Refugees & Internally Displaced Persons in Iraq

The term "gender-based violence" (GBV) refers to violence that targets individuals or groups on the basis of their gender. The United Nations' Office of the High Commissioner for Human Rights' Committee on the Elimination of Discrimination against Women (CEDAW) defines it as "violence that is directed against a woman because she is a woman or that affects women disproportionately", in its General Recommendation 19.

Sexual violence and armed conflict

Sexual violence is an important problem associated with armed conflict (see Box 1 for definition). There are great variations in the extent, scale, type, and targeting, intent, profile of perpetrator and population impact of conflict-related sexual violence.

Definition of conflict-related sexual violence

Conflict-related sexual violence includes "rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence . . . against women, men, girls or boys. Such incidents or patterns occur in conflict or post-conflict settings or other situations of concern (e.g. political strife). They also have a direct or indirect nexus with the conflict or political strife itself, i.e. a temporal, geographical and/or causal link" (UN Action against Sexual Violence in Conflict. *Analytical and conceptual framing of conflict-related sexual violence*, p. 3).

Health and social consequences

- Sexual violence can have multiple physical, psychological and social effects on survivors, their social networks and their communities.
- Sexual and reproductive health consequences include sexually transmitted infections, including HIV, unwanted pregnancies, unsafe abortions, gynecological problems and physical injuries.
- Psychological/mental health consequences include non-pathological distress (such as fear, sadness, anger, self-blame, shame, sadness or guilt), anxiety disorders (including posttraumatic stress disorder, PTSD), depression, medically unexplained somatic complaints, and alcohol and other substance use disorders, as well as suicidal ideation and self-harm.
- Social consequences include stigma and its sequelae – including social exclusion, discrimination, rejection by family and community, and further poverty.

General principles of humanitarian programming

- Mental health and psychosocial supports are essential components of the comprehensive package of care and aim to protect or promote psychosocial well-being and/or prevent or treat mental disorders among survivors of sexual violence.
- Interventions must be conducted in accordance with existing humanitarian guidance. All interventions and supports should be based on participatory principles and implemented together with communities. They should be based on assessment of capacities and needs, and build and strengthen existing resources and helpful practices. They should promote human rights and protect affected populations from violations of human rights; humanitarian actors should promote equity and non-discrimination.
- Mental health and psychosocial support planners should ensure that programs do no harm. This requires alertness to possible adverse effects during program planning, and measuring and recording unintended negative consequences through monitoring and evaluation. Unintended consequences of programs include cultural, economic, political, psychological, security and social aspects. Some avoidable causes of harmful outcomes of particular relevance to sexual violence programming are presented in Box2.

Potential harmful humanitarian practices relevant to sexual violence programming (from Wessells, 2009)

- ✓ **Poor coordination**
- ✓ **Discrimination and excessive targeting**
- ✓ **Too much or too little attention to severe problems**
- ✓ **Undermining of existing supports**
- ✓ **Services that heighten vulnerability or victimize**
- ✓ **Stigmatizing labelling**
- ✓ **Emphasis on pathology and deficits**
- ✓ **Medicalization of complex problems**
- ✓ **Aggressive questioning**
- ✓ **Fragmentation of systems**
- ✓ **Poor-quality counselling, with little training and supervision**

General principles of conflict-related sexual violence programming

- A range of supports for improved mental health and psychosocial well-being should be inclusive of – and not exclusively target – survivors of sexual violence. While the needs of survivors of sexual violence must be addressed by programs, specific targeting of survivors of sexual violence should be avoided as it risks a range of further problems such as stigma, discrimination and violence.
- Mental health and psychosocial support programming for survivors of conflict-related sexual violence should, as far as possible, be integrated into general health services, as well as a range of other services and community supports, including reproductive health, antenatal care, infant and young child nutrition, gender-based violence prevention and response, child protection, microfinance initiatives, and existing community-support mechanisms.

- Interventions should be rights based and contextualize violence against women and girls. The interest of the survivor and respect for her or his decisions is of primary importance; all actions must always be guided by a survivor-centered approach and the principles of confidentiality, safety and security, respect and non-discrimination.

Key principles for conflict-related sexual violence programming

- ✓ Avoid specific targeting of survivors of sexual violence
- ✓ Integrate supports into wider systems (e.g. general health services; existing community support mechanisms)
- ✓ Adhere to the principles of confidentiality, safety and security, respect and non-discrimination

Community-focused interventions

Community-focused interventions

- ✓ Community-based psychosocial programming is an important element of the mental health and psychosocial response to sexual violence in most conflict-affected settings.
- ✓ Community-focused interventions in the acute emergency can include community-mobilization activities and establishment of safe social spaces for women and children.
- ✓ As the situation stabilizes, these interventions need to be expanded, and socioeconomic-empowerment activities for women, such as village savings and loans associations, may be introduced.

- Community-focused psychosocial supports seek to respond to identified needs, as well as to potentially play a role in protecting dignity, promoting psychosocial well-being and preventing mental health problems associated with sexual violence (see Box 4).

- Interventions should aim to be socially inclusive and address stigma and its negative consequences; members of the stigmatized group must be involved in design, delivery and evaluation. Anti-stigma actions include educational interventions to address misconceptions. Care must be taken when designing interventions, to ensure that harmful outcomes, such as increased stigma do not arise.

- Safe social spaces can be organized around a physical space such as a community center or a women's center, or can be an adhoc social space. Safe spaces are places where women, adolescent girls and (other) child survivors can go to receive compassionate, caring, appropriate and confidential assistance. Examples include women's activity groups, wellness centers, support groups, drop-in centers, and child-friendly spaces. They are not limited to women's shelters, which may increase risks for women.

- Relevant community-mobilization activities include women's and men's support groups, dialogue groups and community education and advocacy. Supports should be socially inclusive and engage local leadership (women, men and young people). Possible aspects of

psychosocial support for survivors of sexual violence include: building a protective environment; addressing stigma; and changing norms around gender-based violence and promoting existing protective norms. Community mobilization may initially not be concerned explicitly with sexual violence by armed groups.

- Socioeconomic-empowerment initiatives can be implemented in all post-acute emergency phases of humanitarian response, and, if present prior to the crisis, can be supported to continue during the emergency phase. Examples include village savings and loans associations that rely on collective pooling and sharing of financial resources, which may support the mental health and psychosocial well-being of survivors of sexual violence and potentially reduce stigma.

Person-focused interventions

- There should be an emphasis on building the capacity of local staff (such as primary health-care workers or social workers), lay workers and other professionals who can sustainably carry this on in subsequent phases. Clear guidance needs to be provided on minimum skills, training, supervision and resources, as well as the type of interventions that can be delivered by workers with no professional experience (such as psychological first aid and basic referral).

- Training should be participatory and based on active learning principles; it should be well designed and focus on sexual abuse and sexuality, as well as skills in self-care and stress management for help providers. Training should also incorporate communications skills, and self-reflection on the provider's own experiences and attitudes (particularly towards gender-based violence and women's empowerment). Training needs to be modified to the level of education and skills of trainees and the operational context. Ongoing structured supervision, including technical and emotional support, should be provided by skilled mental health workers. Linkages between mental health, primary health, social services, protection and gender-based violence services should be developed and strengthened.

- A phased approach to delivering person-focused interventions is recommended, so that, as a minimum, all survivors of sexual violence have access to psychological first aid, even in the initial phase of response. In addition, some may require further psychological and specialized mental health care (depending on the time since the event, the severity of symptoms and degree of functioning). As the situation stabilizes and the response matures, more complex interventions can be delivered.

THINGS TO DO in community-based psychosocial support

Assessment

- DO coordinate with other stakeholders to gather existing information to identify gaps in response.
- DO assess the nature, causes, context, and impact of sexual violence and available resources in the community to inform what kind of community-based psychosocial response may be needed.
- DO ensure that assessment is action-oriented and backed by a commitment to implementing a response.
- DO design programs that offer survivors and other vulnerable women and girls the opportunity to participate in non-stigmatizing community-based activities that reduce their isolation.

Program Planning and Implementation

- DO provide women and children survivors with useful, accurate information on available services that is easily understood, presented in the relevant local language, and delivered with compassion.
- DO train and support first responders to provide a safe, calm environment; listen supportively; demonstrate compassion and non-judgment; provide reassurance without making false promises; and promote access to medical care and other support.
- DO identify a first contact or appropriate case manager - who is trained in case management and psychological first aid - who can provide basic support and help survivors access needed services.
- DO consider establishing or supporting safe spaces for women, girls, and boys to promote interaction, education, and referral to relevant services.
- DO consider whether and how to establish or link with livelihoods and economic supports that support survivors' recovery.
- DO seek to strengthen access to clinical mental health care, ensuring that clinical referral services are available for those whose distress is so overwhelming that it interferes with their ability to carry out usual work, school, or domestic activities.
- DO work with communities to spread anti-stigma messages, enabling discussions of how to prevent and respond to sexual violence, engaging women's and men's support groups, dialogue groups, and linking with community education and advocacy efforts.
- DO engage women and men, girls and boys affected by sexual violence in decisions about the design, delivery, and evaluation of interventions.
- DO consider how programming can be culturally sensitive and promote positive gender and cultural norms, while also challenging potentially harmful attitudes and practices.
- DO ensure that all relevant actors in your community know what their specific role and responsibilities are in ensuring that their particular interventions are implemented in a manner that protects the safety and security of women and children.

THINGS Not TO DO in community-based psychosocial support

Assessment

- Do NOT conduct unnecessary or duplicate assessments.
- Do NOT accept preliminary data in an uncritical manner, or assume that assessment information is not needed.
- Do NOT undertake assessments that could increase stigma or endanger the respondents or researchers.

Program Planning and Implementation

- Do NOT assume that all survivors have the same psychological and social needs following sexual violence.
- Do NOT set up new social interventions and supports without considering how they link with and build on existing community groups and processes.
- Do NOT assume that particular interventions (e.g. safe homes) are appropriate in all settings or that they should always be set up in the same way.
- Do NOT design, deliver, and evaluate psychosocial interventions without consulting those affected by, and at risk of, sexual violence.
- Do NOT focus only on survivors' identified problems while disregarding their strengths and capacities (e.g. assets, coping and resilience).
- Do NOT set up supports for survivors of sexual violence associated with the armed conflict that exclude people suffering from inter-personal violence or other forms of abuse not related to armed conflict.
- Do NOT raise expectations by providing referrals to support programs that may be unsustainable (e.g. unsustainable livelihood activities) or ineffective.
- Do NOT assume that all caregivers (e.g. family members) have the necessary skills to work safely and effectively with survivors of sexual violence or to meet children's special needs.
- Do NOT assume that service providers across response sectors are skilled in ethical and safe survivor-centered response.
- Do NOT advocate against the need for clinical care of those survivors who have a mental disorder or whose needs are not met by basic psychosocial supports.

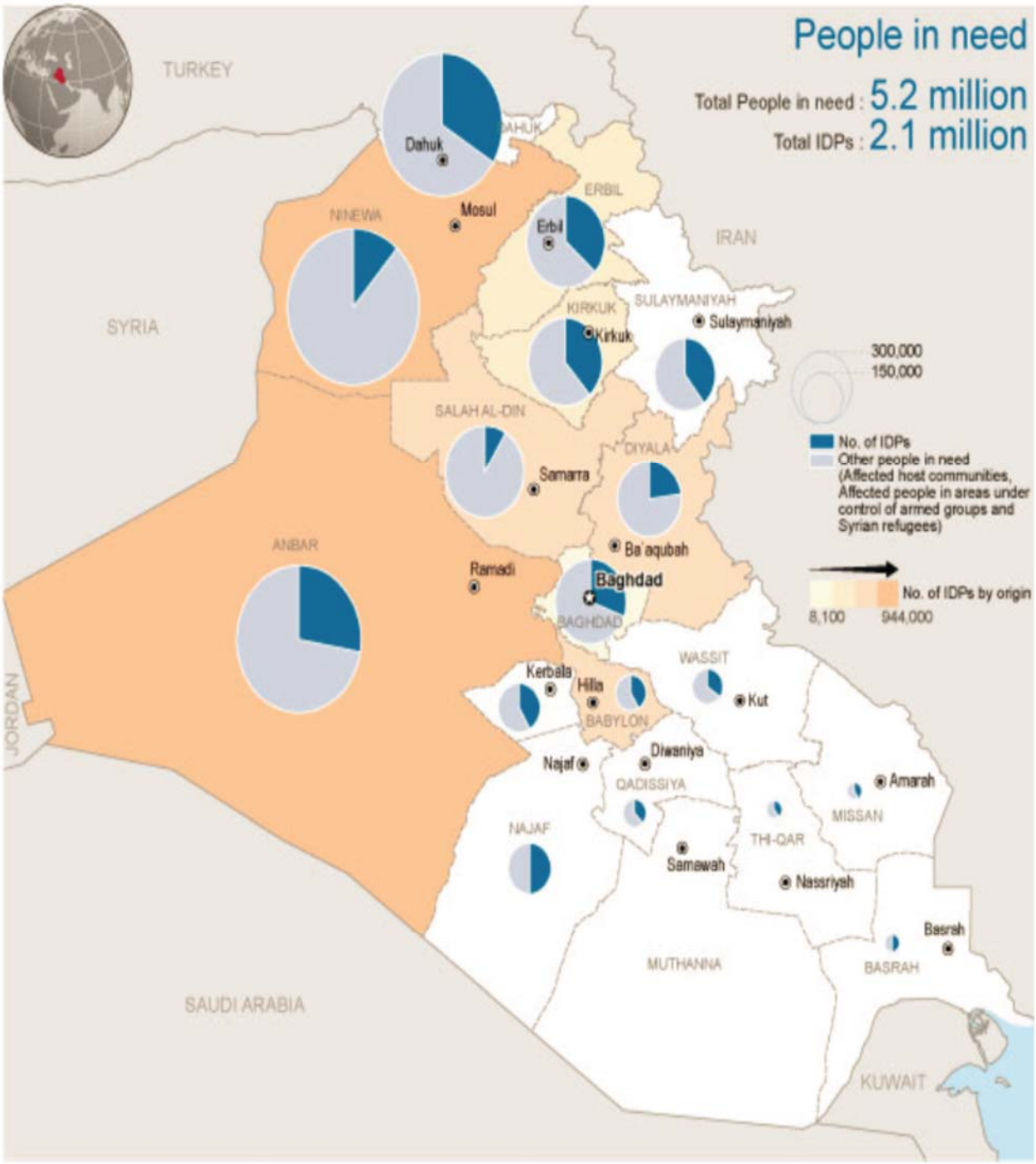
Annex I: Reports on GBV in Iraq

- It is extremely difficult to get accurate data on the number of incidences of rape and sexual violence in Iraq due to the fact that statistics are not maintained by the medical or judicial authorities; that there are only a handful of shelters for women outside of Iraqi Kurdistan; and that survivors do not report to the medical centers or the police for fear of reprisal by their families. However, despite this, a review of reports from human rights and women's organizations and newspaper articles for the period March 2003- May 2008 gives some indication of the magnitude of the problem.
- One report states that between March 2003 and May 2006, there were approximately 400 cases of rape reported in Iraq. Another report puts the figure for the period for April 2004 to September 2005 at approximately 400 rapes of females and 35 rapes of males. Yet another report states that between February and June 2006, approximately 60 females were raped in Baghdad alone while another 80 were "sexually abused in other ways". Between 2004 and May 2008, there were approximately 1,270 reports of honour crimes in Iraq. In light of the security, social and cultural context, as well as experience in other conflict situations, it is more than reasonable to assume that the number of incidences is significantly under-reported.
- Violence in the family in Iraq goes mostly unreported. According to an Amnesty report, tradition all too often serves as a pretext for acts of brutality against women for daring to choose how to lead their lives. The few existing reports on the subject show that violence against women is widespread. A report by Physicians for Human Rights surveyed 2,000 families in the south, 50% of which reported household violence in the form of beatings, torture or murder23. According to the Iraq Family Health
- Survey 2006/200724, 83.1% of the survey group reported at least one form of marital controlling behavior; 33.4% reported at least one form of emotional or psychological violence and 21.2% reported experiencing physical violence. In this latter regard, there are marked differences between Kurdistan (10.9%) and South/Centre (22.7%)
- While abductions and kidnappings occur to both men and women, the difference is that the trauma of abduction for many women does not end upon their escape or release; the shame associated with the disappearance of a female member of the family causes many families not to report the kidnapping. The resulting stigma of sexual impurity means that, even if the girl should return, she may be rejected by her family. It is further reported that some families will negotiate with the captor to marry the victim so as to restore her honor; a solution sanctioned by the law.
- Because abduction is associated with the stigma of rape or sexual assault – real or perceived – the incident is under-reported. Despite this, an examination of reports from human rights and women's organizations, as well as newspaper articles for the period mid-2003 to May 2008 shows that at least 29 women were abducted, some of them raped, tortured and killed.

- Reports with accurate and reliable data on the extent and the nature of prostitution and trafficking in Iraq are scant. The ABA/ILDP Report (December 2006) says that the Organization for Women's Freedom in Iraq estimates that nearly 3,500 Iraqi women have gone missing since 2003 (to December 2006) and it suspects that a large number of those women have become victims of sex-trafficking. In addition, in an IRIN report of 8th August 2005, suggests that there could be as many as 4,000 male commercial sex workers, who are regularly assaulted and exploited by gangs and pimps.[4]
- Recent comprehensive surveys show that:
  - 4.5 percent of married women reported they had been subjected to psychological violence (humiliation, intimidation, threat and control of her behaviour) by their husbands in the past 12 months (Iraq Woman Integrated Social and Health Study, I-WISH 2011).
  - 46 percent of girls between the ages of 10 and 14 reported that they had been beaten or humiliated by a family member in the past month (I-WISH 2011).
  - 43 percent of women aged 15-49 in the Kurdistan Region of Iraq reported they had been subjected to some form of female genital mutilation (compared to 1 percent in the rest of Iraq) (Multiple Indicator Cluster Survey MICS 2011).
  - 56 percent of men believe they have the right to beat their wife if she disobeys (I-WISH 2011).

[4] Institute for War and Peace Reporting (IWPR), Iraqi Crisis Report, No 251 dated March 28, 2008

Annex II: International Laws and conventions that protect women's human rights

- Charter of the United Nations (1945)
- United Nations Universal Declaration of Human Rights (1948)
- Office of the United Nations High Commissioner for Human Rights (OHCHR) International Covenant on Economic, Social and Cultural Rights (1966)
- OHCHR Declaration on the protection of Women in Emergency and Armed Conflict (1974)
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979)
- The Nairobi Forward-looking Strategies for the Advancement of Women (1985)
- UNHCR Policy on Refugee Women (1990)
- UN Vienna Declaration and Programme of Action (1993)
- UN Declaration on the Elimination of Violence Against Women (1993)
- Beijing Declaration & Platform for Action (1995)
- Optional Protocol to CEDAW (1999)
- Windhoek Declaration: The Namibia Plan of Action on 'Mainstreaming a Gender Perspective in
- Multidimensional Peace Support Operations' (2000)
- UN Security Council Resolution on Women, Peace and Security (2000)
- European Parliament Resolution on Gender Aspects of Conflict Resolution and Peace-building (2000)

Annex III: Iraq Map- Number and location of IDPs and People in need