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A Review of Health Systems Capacity in the Quality Management of Gender Base Violence Including Highlights in Crisis from a Feminist Perspective

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Abstract

In the lifetime of women and girls, 1 in 3 women experience gender-based violence (GBV). About 35% of women experience intimate partner violence either from an intimate or non-intimate partner. Although both women and men could be survivors of GBV, women are more vulnerable to violence due to factors related to patriarchal customs, cultures and financial resources. Resulting in a higher prevalence of violence against women. The healthcare system plays an essential role in ensuring the quality management of GBV as it is often if not only the first point of contact of survivors. This is the reason why governing bodies such as the World Health Organization have developed a multisector response to GBV victims within the health system. The multisector response supports other services such as psychosocial support, social services, legal aid, shelter/housing services or livelihood support. From literature, there are procedures outlined for each sector to ensure the quality management of GBV survivors. Reviews show that High Income Countries (HIC) are more advanced in scaling up guidelines for quality response to GBV as compared to Low and Middle Income Countries (LMIC). Whereas these guidelines have been adopted by many LMIC. The LMIC's that are advanced in responding to quality management of GBV often benefit of support from national funds and international donors. Models such as "One Stop Centers" have been set up at health facilities of some LMIC's to ensure multisector response at a single site with limited referrals. Shortcomings in the response to GBV in LMIC's consist of limited number of providers trained at health facilities, focus is most often

only on sexual forms of violence, high staff turnover at facilities, insufficient documentation and cultural interference. The prevalence of violence against women in situations of crisis such as the COVID-19 and Ebola pandemics and conflict of wars increases. The surge in violence during pandemics is promoted by laws of quarantines and lockdown. Quality management of GBV in situations of pandemics uses the multisector approach often starting with health care as the first point of contact. During pandemics, the community is implicated to help identify survivors and report. There is also extensive use of online and telephone service. The most common form of violence in the context of war is rape/sexual violence. Managing GBV survivors that result from wars remains a challenge due to under reporting of cases and services are not sort for by survivors. Health care professionals, epidemiologists and surveyors working in war areas are in position to take action to recognize, identify and address GBV towards women.

Keywords

Health System, Gender-Based Violence, Response, Crisis, Wars

1. Introduction

Gender-based violence (GBV) is recognized as a public health issue because of the numerous negative impacts on the mental, physical and social well-being of the survivor (Garcia & Watts, 2011). In addition, GBV also has its effects in the reproductive health of its survivors with consequences of sexually transmitted infections including HIV, unintended pregnancy sometimes accompanied with complications, and sometimes leading to death ultimately (WHO, 2013a). According to World Health Organization (WHO) reports in 2013, women are 1, 5 times more likely to get infected with HIV infection and 1, 6 times more likely to contract a sexually transmitted infection such as syphilis in a situation of IPV. Reports from the World Bank show that Intimate partner violence has resulted to 38% of women murdered globally. Addressing GBV within the health care system appropriately is crucial to improve the quality of life of the survivors who are most often women, girls, and other groups at risk. The reason is that healthcare providers at health facilities are often among the first if not the only points of contact of GBV victims. Since the response to GBV is multi-sectoral, the healthcare providers do not only need to offer medical attention and first-line support to survivors, but will also serve as an interface to link survivors to other services such as psychosocial support, social services, legal aid, shelter/housing services, or livelihood support (WHO, 2021a). Due to the important role of the health system, the WHO, has set up requirements for health systems to provide quality response to GBV. The requirements are essentially centered on increasing health workers and managers awareness of the problem through capacity-building activities, as well as putting systems in place at the facility level to integrate linkage of survivors to

other sectoral services while ensuring traceability through monitoring and evaluation (WHO, 2021a). In order to sustain support of GBV services, capacity building of health care workers offering services has to consider the concept of the Alma Ata Pyramidal structure of a primary healthcare system that includes national, regional and primary levels (WHO, 2021a; Panjwani & De, 2020). This implies health providers at all levels of the health pyramid need to be trained for optimal management.

For more than 30 decades, there has been much progress done to fight against GBV especially violence against women (VAW) as GBV was not recognized as a public health problem until the 1980's (Goicolea, 2023). The United Nations International and Children's Fund (UNICEF) and United Nations High Commission for Refugees (UNHCR) for example, have been working to prevent gender–based violence (GBV) and promote gender equality (UNICEF, 2019; UNHCR, 2020). The policies put in place by these international bodies do not only fight to prevent VAW but also recognize that boys and men could also be survivors of GBV and this is outlined in the UNHCR policy (UNHCR, 2020). Yet the focus is still directed towards women due to vulnerability to GBV as a result of divers factors. In most societies around the world patriarchal customs have placed men in a position of dominance over women. Some societies accept VAW as normal and should be concealed by the woman. Also, most women lack of financial resources to sort for alternatives putting women in positions of vulnerability (Fawole, 2008). Although countries have made progress since the 1995 Beijing Declaration and platform for action adopted at the 4th world conference on Women, yet there is suboptimal representation of women in positions of power and politics (GeED, 2010). This means that they have fewer opportunities to shape the discussion and to affect changes in policy, or to adopt measures to combat gender-based violence and support equality. Generally, the factors that cause GBV against women consist of context of conflict, crisis and displacement, lack of physical security, poverty and other economic challenges, discriminatory social, cultural laws, norms and practices, ineffective legal protection and inadequate political representation (Wanjiru, 2021; Concern Worldwide, 2023).

The high prevalence of VAW could be higher due to the aforementioned factors. In their life time 1 in 3 women are affected by GBV. About 35% of women experience intimate partner violence either physical and/or sexual from an intimate partner or a non intimate partner. Intimate partner violence has resulted in 38% of women being murdered globally. Female genital mutilation has been practiced on an alarming 200 million women worldwide (The World Bank, 2019). Across the six regions of the WHO, the prevalence rates of IPV against women vary for 20% in the Western Pacific to 33% in the African and South East Asia Regions (WHO, 2021b). Women are disproportionately affected by GBV and this has been identified as a violation to human rights (WHO, 2013a). However, there are legislations protecting women from gender-based violence that have been ratified both by developed and developing countries although legislations are more

effective in developed countries.

Of recent, attention has been given to the management of GBV situations of conflicts and crisis such as wars and epidemics such as COVID-19 and Ebola. There are studies that have shown that situations of conflicts and wars tend to increase the rates of GBV (Mervyn et al., 2011; John et al., 2020). In response, guidelines have been developed by the Inter-Agency Standing Committee (IASC) for Non-Governmental Organizations and United Nation Agencies in humanitarian settings to coordinate the management of GBV in situations of conflict (IASC, 2005). On the other hand, the WHO has also developed guidelines on the management of GBV in situations of epidemics (WHO, 2019).

With the recognition of GBV as a concern of public health with long lasting negative effects. Countries across the world have been busy strengthening their health systems to tackle GBV appropriately, based on the guidelines put in place by governing bodies of global health systems such as WHO and the United Nation (UN) (Sikder et al., 2021). This paper intends to review how health systems need to be and are being strengthened across some countries for quality management of GBV including situations of conflicts.

2. Multi-Sectoral Collaboration in the Management of Gender Base Violence

The health sector especially at the operational level of health facilities plays a central role in responding to GBV. Therefore, it is essential for comprehensive services to be rendered to survivors of GBV. Healthcare workers who are most often the first point of contact can serve as reliable agents not only to offer medical attention but also to link survivors to obtain legal, social, and psychological support. In addition, healthcare workers can be very influential in changing harmful cultural norms and behaviors that promote GBV in communities due to the fact that they easily gain trust from people but also due to their wide coverage and access to communities (Kim, n.d). However, most often the traditional model of attending to survivors is isolated offering uncomprehensive services, which do not meet the needs of the survivors, thereby compromising the quality of care (UNFPA, 2015). A multi-sector approach in responding to GBV entails a coordinated correlation between a variety of bodies that cover at a minimum area of psychosocial welfare, law enforcement (police, prosecutors, and justice departments), and health. The Istanbul Convention which was the first legally binding instrument to protect women from violence, gives further guidance on what sectors can come into play as concerns violence against women. The four major themes of the Istanbul convention consist of prevention, protection, prosecution, and monitoring (Convention on Preventing and combating violence against Women and Domestic violence.11). A holistic and coordinated approach of health facilities integrating other relevant institutions/services, will improve the quality of services provided to GBV victims/survivors. According to the United Nations Fund for Population (UNFPA, 2015) the coordinated response to GBV in a health system that

covers psychosocial welfare, law enforcement (police, prosecutors, and justice departments), and health consist of the following six elements; Intervention/services Procedures Roles and responsibilities of service providers, Reporting and referral, Training programs, Documentation, reporting, transmitting and data analysis, Prevention and awareness raising, Coordination.

Interventions and services for survivors of GBV assemble a variety of actions that aim to prevent, protect and support them. Interventions in case management follow four main steps. It starts with identifying the case as a survivor of GBV, then an appropriate evaluation is done by the health care provider to detect existing or potential risks from the social, familial and individual context of the survivor. The next two steps are about service provision and follow-up and close-up, where intervention plans to protect survivors and make perpetrators accountable are outlined by a team of healthcare providers who ensure linkage to other services. Outcomes of the interventions planned are evaluated routinely with adjustments made where necessary and close–up occurs when interventions have been successfully attained. The principles of safety, privacy, confidentiality, informed choice, respect, and non-discrimination form the bases of the services provided to survivors. Safety is a priority and health care workers should ensure the safety of survivors. This can be done by identifying possibilities of experiencing further violence, developing a safety plan, and actively linking survivors to other services if need be. When health professionals are dealing with survivors of GBV, rules on privacy, confidentiality, and respect have to be strictly applied. Discussions with victims should be one on one behind closed doors and all written information should be stored behind well-locked closets. Sharing information with other services has to be done with the informed consent of the survivor. A non-judgmental attitude has to be adopted by the healthcare provider while respecting the rights of the survivor. Healthcare providers should offer equitable care to all victims despite of their sex, ethnic group, or skin color for example (UNFPA, 2015). While it is the survivor's right to choose to report a situation of GBV, some countries have laws and policies in place which put health providers in a situation of mandatory reporting of such cases to the police or any legal system. In such cases, health providers will be in a conflicting decision. Whatever the case, the health provider should inform the survivor about the procedures in place and obtain consent. Integrating a referral system at the level of the health facility responds to the multiple needs of the survivor and this can be done by having the contact details of all institutions concerned in the management of cases at the level of the health facility who is responsible for linking and following up cases. The five stages of referring consist of information, obtaining informed consent, complete information and decision, the referral note, and finally the accompaniment of the survivor. The information for referral answers the question *"Who? What? and where?"* and a narrative about the predicaments of the survivor. Managing cases of GBV is sensitive and complex hence, service providers from all sectors involved have to be trained to ensure the quality management of cases. The training on

GBV can target service providers under continuous professional education as well as final year health care personnel (doctors and nurses). Other service providers could include police workers, social workers, psychologists, legal counselors, and forensics. The contents of the training should cover the theory of GBV with practical roles, and responsibilities of service providers from various sectors. Documenting and reporting data about cases of GBV by different institutions provides the basis for decision-making at different levels of response. Information about GBV is collected using standardized forms or charts at different service provision sectors. The information collected about a situation of GBV should essentially have the type of violence, type of services provided, who made the referral, legal steps initiated or undertaken, relation between victim/survivor and perpetrator, victim/survivor's and perpetrator's profile, space where violence took place (home, workplace, public space, other). Identifying the causes and contributing factors of GBV occurring in societies are strategic points to fight against the phenomenon. Strategies to bring about changes in cultural, social, and political norms that promote violent behaviors against women will be put in place. Also, raising awareness about the negativity of GBV to the survivors and the perpetrators as well as the services available, will impact demand of available services and also reduce incidence. Raising awareness can be done using all communication strategies. Multi-sectoral response to GBV is a complex system involving several institutions/organizations and implementing partners. Coordinating interaction between these programs is therefore necessary for a successful response. A coordinating body can be set up where members are at least one representative of all stakeholders fighting GBV in a given country. The coordinating body will have to meet regularly set up strategies and evaluate progress on the work plan (UNFPA, 2015).

3. Procedures for the Quality Management of GBV in Multi-Sectors

3.1. Heath Sector

Define abbreviations and acronyms the first time they are used in the text, even after they have been defined in the abstract. Abbreviations such as IEEE, SI, MKS, CGS, sc, dc, and rms do not have to be defined. Do not use abbreviations in the title or heads unless they are unavoidable. As part of a multi-sectoral response, there are procedures that need to be applied in health care settings, police services and psycho-social services for quality response to GBV.

Standard operating procedures in a health care setting provide detail descriptions about what health care providers have to do routinely when faced with a survivor of GBV. As women and girls are more often affected by different forms of GBV with divers levels of severity, frequency and consequences compared to men, priority focus for standard care is directed towards women (Michau et al., 2015). In the 57th Commission on the Status of Women for elimination and prevention of all forms of violence against women and girls, agreed conclusions called

for action to:

"*Address all health consequences, including the physical, mental and sexual and reproductive health consequences, of violence against women and girls by providing accessible health-care services that are responsive to trauma and include affordable, safe, effective and good-quality medicines, first line support, treatment of injuries and psychosocial and mental health support, emergency contraception, safe abortion where such services are permitted by national law, post-exposure prophylaxis for HIV infection, diagnosis and treatment for sexually transmitted infections, training for medical professionals to effectively identify and treat women subjected to violence, as well as forensic examinations by appropriately trained professionals.*" (Commission on the Status of Women, 2013; 57th session).

Given that the Health care system and health providers play an essential role in the identification, assessment, treatment, crisis intervention, documentation, referral, and follow-up of GBV cases, the interventions for quality management of survivors are centered on the following objectives:

- Contribute in effective identification of GBV victims/survivors;
- Ensure the victim/survivor's safety at all stages of the intervention;
- Provide quality and consistent services;
- Facilitate improved and coordinated data collection and documentation of GBV cases;
- Ensure confidentiality of the services provided to GBV victims/survivors;
- Facilitate effective referral of GBV victims/survivors within health sector and to other service providers; and
- link the health care facilities with the other services provided to GBV victims/survivors.

In order to ensure better outcomes in the implementation of standard operating procedures (SOPs) in the management of GBV survivors, minimal training of health providers on how to use the SOPs is required. Ideally, training could be part of a comprehensive pre-service training program/curriculum that integrates prevention and awareness of GBV, response to GBV by healthcare providers, and sections on multi-sectoral response to GBV. There are five core elements identified as essential for a comprehensive and effective clinical health service response to women and girls who have experienced GBV (UNFPA, 2015). They include:

1) First-line support which can include referrals;
2) Care of urgent medical issues and injuries;
3) Examination for sexual assault and treatment;
4) Assessment of mental health;
5) Management of stress management.

The management and the provision of health care services to victims of GBV should include the following step-by-step procedures: identification, evaluation, health care service delivery (with the five core elements), collection of evidence, documenting GBV, and referral. However, the order of steps may be interchangeable when handling a case of GBV except for the identification step which is

unavoidably the first step.

3.1.1. Interaction with a Gender-Based Violence Victim

Asking about GBV is sensitive and can sometimes be embarrassing for any service provider. There are recommendations that can boost healthcare provider confidence when inquiring about GBV and also control re-victimization (UNFPA, 2001).

- Initiate questions about violence—instead of expecting the woman to bring it up. This shows that you take professional responsibility for patient situation, and it helps to build trust.
- Avoid asking about GBV in the presence of a family member, friend, or children.
- Keep in mind that in crisis the patient may have contradictory feelings. Therefore, exercise patience with GBV victims/survivors. Do not put pressure on the victim/survivor to disclose. If she/he does not disclose, tell her/him what made you think about violence.
- Interruptions when the patient is speaking should be avoided. Only ask questions for clarification when the patient has completed his/her account.
- Practice active listening and not giving validation comments. This can give the patient the impression that the health provider does not believe them or that they are on the wrong, and the perpetrator is right. Listen attentively to their experience and reassure patients that their feelings are justified.
- As much as possible, the language used by the victim should be used by the provider. If the victim and the provider do not speak the same language, requests for a provider who speaks the same language as the victim should be made or an interpreter to assist the provider with the consent of the victim.
- Avoid using professional jargon and expression that might confuse the victim/survivor. Adapt language and words that are used and understood by the victim/survivor.
- Questions and phrases should be Formulated in a non-judgmental manner, using a sympathetic voice. Do not ask questions starting with "why", which tends to imply blame of GBV victim/survivor instead use open-ended questions.
- Do not blame the blame the patient by avoiding questions such as "Why do you stay with him?", "Did you have an argument before violence happened?", "What were you doing out alone?", "What were you wearing?" Instead, support the fact that GBV should not be tolerated by anyone.
- When the patient is giving an account of what happened, use supportive statements, such as "I am sorry that this happened to you" or "You have been through a lot", this will encourage the patient to provide more information.
- Reiterate to the patient that the cause of violence is not their fault but solely that of the perpetrator who is responsible for it.
- Reassure the victims/survivors that the information they provide will remain confidential and their consent will be obtained in case any information

provided has to be shared with other services.

- Avoid multitasking but give full attention to the victim/survivors when they are talking and keep your eyes focused on them.
- Be conscious of body language. How the provider stands and hold their arms and head, the nature of their facial expression, and the voice tone contribute in conveying a clear message to the patient about how the health provider perceives the situation. Validate what the victim/survivor is saying I a non-judgmental and supportive manner. Body language that show disgust, anger, unbelief or hatred in what the victim/survivor is saying should be avoided.
- The victim/survivor's religion or culture should not be a prejudice to response to GBV or be a cause of being judgmental.

3.1.2. Identification

In a healthcare setting, the health provider has to have the capacity to identify cases of GBV against women. Even when the patient does not openly report being a victim of GBV, some conditions and behaviors are usually associated with GBV that can help health providers identify cases. Injuries such as lacerations, bruises, bites, wounds, and burns on the arms and face with explanations that are not founded and often covered by clothes, are signs to suspect GBV. Unexplained gastrointestinal and reproductive health symptoms. Reproductive health symptoms can include chronic pelvic pain, unintended pregnancies, adverse birth outcomes, and repeated urinary and sexually transmitted infections. At the level of the central nervous system, there can be signs of hearing loss, cognitive problems, frequent headaches, depression, anxiety, post-traumatic stress disorder (PTSD), sleep disorders, or repeated consultations with no clear health issues. Sometimes the victims would miss their health appointments without tangible reasons and when they do report to the health facility after follow-up, an intrusive partner or husband usually accompanies them. The woman is afraid to express herself in front of her partner or accompanying adult or appears submissive when in front of her partner or husband (UNFPA, 2015).

Identification in the healthcare setting is usually from the provider's skills to detect a case of GBV, reporting by another person, and self-disclosure of the victim. In healthcare settings, two approaches: universal screening and case finding facilitate the disclosure of GBV. Universal screening, also known as routine inquiry, requires asking all women presenting in health settings about their exposure to GBV while case finding, or clinical inquiry, refers to asking women about GBV, in case they present certain clinical symptoms/history and (if appropriate) to examine the women. The approach of case finding is more effective than the universal screening approach because it is based on selective and careful clinical considerations especially when the health care provider is specially trained in how to best respond and refer cases. Whereas universal screening can be burdensome in healthcare settings, especially when there is suboptimal capacity for effective response, little or no referral options and overloaded resources/providers. When victims are identified, the integrity of the victims should be a priority and patients

with severe conditions are immediately sent for treatment. Ensuring a safe and effective identification of GBV victim/survivor requires the following operational steps (UNFPA, 2015):

- Greet the person in a manner that shows that he/she is welcomed.
- Introduce yourself to the client and briefly explain the services offered in the facility.
- In a kind manner, ask the person to introduce herself/himself (if there is no health condition that limits this).
- Ask the patient if he/she prefers to be examined by a doctor who is of the same sex (especially in cases of sexual violence).
- Chances should be provided to the patient to ask any question about what consider important.
- Consider the needs of special population groups (e.g. persons with physical or mental disabilities, religious persons, and ethnic minorities) and address them where necessary.
- The environment should be confidential and compassionate, listen to the patient actively and give validating messages.
- Be alert and vigilant to asking questions about GBV behind curtains (especially in hospital-based health care); a third person may hear the conversation.
- In order to avoid transforming the exanimation into another traumatic experience, before examinations, inform and explain to the patient what it includes, why it is done, and how.
- Sometimes the accompanying person might be the perpetrator itself. Inquiring about GBV may put the victims/survivors in an unsafe situation. Therefore, you have to determine if it is appropriate to ask about GBV exposure to the victim.
- If determined that there is no risk, ask about exposure to GBV to improve diagnosis/identification and subsequent care and referral.
- If identification is positive for GBV, verify the medical history of the victim/survivor if possible or ask if certain conditions repeat from time to time.
- Avoid leaving the victim/survivor alone, especially when suicidal attempts or thoughts and self-injuries are suspected or the risk for it is present.

3.1.3. Evaluation

After the identification of a GBV victim/survivor, the healthcare provider will evaluate the situation and determine what step follows based on the severity of the case. The evaluation will form the baseline for decisions on medical care and follow-up. For all services that will follow, consent has to be obtained. Consent is obtained from parents in case where the victims/survivors are minors (children). In the context where the victim/survivor cannot read or write, verbal consent is obtained and documented in the patient file. The victim/survivor has to be told that he/she has the right to decide which information to disclose or to keep confidential i.e. the right to limited consent. When obtaining consent, the implications of sharing the information with other services/institutions have to be

made known to the victims/survivors. Educate the victim about GBV and its negative consequences on health. All actions should be geared towards helping the victim/survivor. If the case of GBV is being disclosed by the victim/survivor themselves, provide an opportunity for them to recount what happened while talking about the type of violence and the perpetrator. Based on what has been recounted, the needs and the resources available to respond to the GBV case will be evaluated while considering the social, familial, and individual situation of the victim/survivor context. The appropriate support to be provided is determined based on the needs evaluated such that the GBV victim/survivor is protected (UN Women, 2014).

3.1.4. Service Provision

Service provision is all about healthcare providers offering medical examinations and care to the GBV victim/survivor. The healthcare provider considers the fact that the victim/survivor is in an emotional state when offering care. First-line support is the first intervention or service offered to the victims/survivors of GBV. Validation is given to what the victim/survivor is saying in a supportive and non-judgmental manner. When history about violence is being recounted, the provider listens attentively without intruding. The victim/survivor should be facilitated on how to obtain legal services and other resources that the victim may think is necessary. Help victim/survivor to increase safety measures for themselves and their children wherever there is risk. The victim/survivor should be connected to social service support. Service provision is offered in privacy and confidentiality while notifying victims/survivor that confidentiality is limited due to the obligations of reporting (UN Women, UNICEF, UNFPA, 2015).

First line support is followed by interventions of obtaining medical history and examinations. After asking the victim/survivor to recount in their own words what happened, a detailed documentation of the violence is documented informing about the date and time of the incident, any weapons that were used, the place, and the duration. The health care provider can also check for symptoms such as malnutrition and dehydration that can indicate the type of GBV. After obtaining the history, a complete physical examination is conducted by the healthcare provider according to WHO recommendations from head to toe and genitalia in cases of sexual violence (WHO, 2013a; Recommendation 11). When offering physical exams, the following principles have to be respected;

- Explain the medical examination, what it consists of, the reason it is done and how it will be done. This will avoid the exam itself of becoming another traumatic experience. The patient is given a chance to ask questions.
- Find out if the patient if they wish to have a same sex doctor (especially in cases of sexual violence).
- Avoid leaving the patient alone especially when they are waiting to be examined.
- Patients are asked to completely undress and wear a hospital gown, so as to detect any hidden injuries.

- During physical examination, start by examining the uncovered parts then sympathetically and empathetically ask the victims/survivors to uncover the other parts that are covered by cloths and hair one at a time for physical examination. This avoids a humiliating situation of nudity for the victim/survivor.
- Even if the victim/survivor reports experiencing only sexual violence, the whole body is examined including the genitals and the abdominal area.
- Examination for emotional and psychological symptoms should be examined including both minor and serious injuries.
- Always inform the patient about what you plan to do next and obtain permission throughout the examination process. The patient should know where and when you are examining especially when touching. Show them the instruments that will be used and the sample collection materials. This is because patients may refuse all or part of the examination so they need to have some degree of control over the examination which is helpful for their recovery as well.

After completing a physical examination, the care for apparent injuries and urgent needed medical care follows. Any severe injuries such as cuts and wounds are cleaned as treated appropriately on the spot. Medications such as antibiotics can be provided to avoid infection, medications to relieve pain, anxiety and insomnia and anti-tetanus vaccination. In a situation of sexual violence, the capacitated health care provider should provide (WHO, 2013a; Recommendation 11):

- Prescription to diagnose any ongoing pregnancy for women. Or prevent unwanted pregnancy by prescribing or offering emergency contraception within 3 days of sexual assault an example of a recommended medication can be a single dose of 1.5 mg levonorgestrel is recommended. Another option of emergency contraceptive is the combined estrogen progesterone regimen which can be offered, along with anti-emetics. In situations where the oral contraception is not available, another option can be the insertion of a cooper-bearing intrauterine device (IUDs) that can be inserted up to 5 days after sexual assault to medically eligible GBV victims/survivors. If sexual assault happened in more than 5 days, and emergency contraception fails, GBV victims/survivors should be offered safe abortion, under national law.
- Risk of contracting HIV should be reduced by administering post-exposure prophylaxis for GBV victims/survivors presenting within 72 hours of a sexual assault according to protocols used by the national health system.
- Also prophylactic treatment for sexually transmitted infections (chlamydia, gonorrhea, trichomonas, syphilis) is offered or prescribed. The choice of drugs and regimens should follow national guidance.
- If a blood sample from patient shows that there are no hepatitis B immune globuline and that the patient does not have hepatitis B, the first dose of the vaccine should be administered.

Mobilize social support services after obtaining consent from the victim. Work with the victim to develop a safety plan that will include children if available. Take

dispositions for follow up care where applicable (UNFPA, WAVE, 2014).

More psychological and mental health attention is given to victims/survivors of intimate partner and sexual violence. Immediate psychological support consists of: Not intruding while providing practical care and support; evaluating needs and concerns in order to help patients to address basic needs (for example, food and water, information); listening to patients attentively, but not putting pressure to get them to talk; reassuring and helping patients to feel calm; facilitating linkage to information, services and social supports; protecting patients from further harm; and provide written information on coping strategies for dealing with severe stress. Psychological follow-up support should cover a period of at least 3 months and has to be watchful, especially for cases where suicidal thoughts are identified as well as alcohol and drug abuse issues. If the victim/survivor presents signs and symptoms of mental health problems, they should be referred to specialist health care providers for psychological/mental interventions (UNFPA, 2015).

Collecting evidence of GBV should be done by a well-trained provider in a confidential context. The victim/survivor has to be reiterated the importance of collecting evidence, especially in the context of sexual violence. The type of evidence collected consists of both medical and forensic evidence. The collection of both medical and forensic samples should be done in the same place and by the same person as this reduces the number of examinations that the patient has to undergo and can ensure that the needs of the patient are addressed more comprehensively. Before collecting any type of evidence, first obtain the consent of the victim/survivor. In the case where the victim/survivor accepts to share an evidence, they should be told how to handle the evidence material in order to preserve/not to destroy the evidence (e.g. not to wash, change clothes). After collecting the evidence, ensure that it is documented in the patient records (UN Women, 2014).

Risk assessment and management interventions are important in reducing risk levels during service provision. A safety plan is developed taking in consideration risk factors and resources available. Establishing a safety plan is part of the case intervention which is essential in preventing future violent incidents or avoiding escalation or exposure to extreme situations. List the friends or neighbors of the victims who can provide shelter to the victim/survivor incase of an emergency. Neighbors can also serve as witnesses to confirm is they hear violent noises or disturbances in the house of the victim/survivor. A safety bag should be packed and kept in a place that can easily be taken for escape in case of emergency. The victim/survivor will also practice simulations on how to go out of their homes quick and safe. The survivor has to be told to make use of their sense of judgment especially in cases where the abuser can become very hysterical. In this case for the safety of you and your children, give the abuser what they want in order to calm them down. Risk factors that can initiate the development of a safety plan include situations where the victim/survivor, their children or family member has previous acts/incidents of GBV with history of convictions from the police.

Violent behavior outside the family can also be considered a risk factor. The process of separation or divorce increases chances of violence. The perpetrator has more power when other family members are in agreement with abusive attitude. Illegal or legal possession of weapons are tempting to use in situations of violence. When perpetrators consume drugs and alcohol, it can cause them to reason and act irrationally and violent with regrets after effect of alcohol. If the victim/survivor experiences threats of murder, provision of a safety plan should be taken very seriously. Situations that can lead to threats of murder are changes in relationship for example. Extreme patriarchal attitudes and culture, having a possessive and jealous partner, , stalking of the victim/survivor by the perpetrator and non-compliance with police restraining order are risk factors that need to be considered when establishing a safety plan (UNFPA, 2015).

3.1.5. Documentation of Gender-Based Violence

Demographic information about the victim is registered in the patient record and then entered into a data base which is very confidential. Information includes an account of the incident, the medical history, results of the physical examination, tests and their results, treatment plan, medications given or prescribed, victim/survivor education and information offered, referrals. Details of any apparent injury is documented with precision using additional forms and drawings of body maps for more accurate representation. Full details on the type of GBV experienced by the victim/survivor, their relationship with the perpetrator, the type of weapons used with evidence, the availability of witnesses, and history of other previous incidents. What the victim/survivor discloses is documented in their own words by the health care provider. Any emotional and psychological symptoms are also noted. All information about GBV is documented after obtaining consent from the victim while précising that it is possible to use the information for other services (UN Women, 2014).

3.1.6. Referral of Gender Base Violence Victims/Survivors

The response needs of GBV victims/survivors are complex as they require the involvement of multiple sectors. Therefore, an effective response to GBV requires a comprehensive set of services available through a multi-sectoral coordinated response that can be ensured by an effective referral. Most often, healthcare professionals are the first to get in contact with the GBV victim/survivor. This implies that they are in the better position to refer victims for appropriate health care services intra and extra health facilities and/or to other services (police, specialized services, social protection). On the other hand, health care providers can also have to assist GBV victims/survivors referred by other service providers and other specialized services. Effective referral require that health care providers able to, identify victims/survivors of GBV; offer the victims/survivors first line support; assess any risk factors that can hamper the safety of the victims/survivors; be knowledgeable about the protection laws against GBV for which the victim/survivor has the right to benefit and are able to obtain consent for any step of the process. The

steps below should be followed to ensure an effective referral (WHO, 2013a; UN Women, UNICEF, UNFPA, 2015):

- Keep up to date a directory of institutions/organizations, which provide services for GBV victims/survivors. The directory must include institution's name, contact person, address, other contact details, list of services provided.
- Evaluate what referral may be useful for the GBV victim/survivor, according to the assessed needs and wishes.
- Inform the victim/survivor about the possibility to be referred to other service providers, as requested and/or needed.
- Obtain the consent of the victim/survivor to make the referral, prior any further step.
- Clarify with the victim/survivor what information will be shared to other service providers and what information will be kept confidential (specify if there are any legal regulation/limitation).
- Give to the victim/survivor complete and correct information about service providers, following the 3W scheme described below:

WHO—which institution/organization provides services to GBV victims/survivors, adding contact information of a person (name, telephone number) that can be reached as an entry point to that service.

WHAT—what sort of assistance they can expect to receive from a specific service provider, adding cost information related to that service.

WHERE—where exactly is the place (the exact address) of the indicated services.

- Make the referral according to the victim/survivor's choice.
- Accompany the referral by a short written report and a telephone discussion with the other service provider, as a method for avoiding the situation when the victim/survivor has to repeat the story and answering the same questions during multiple interviews, passing again through the psychological trauma caused by the GBV incident.
- Encourage the victim/survivor's autonomy by empowering her/him to do the referral by itself.
- Accompany the victim/survivor to the referred service provider, if needed and possible.
- Explain to the victim/survivor that she/he can come back for further assistance. Bring up the issue at the next appointment.
- Explain to the victim/survivor about medical condition follow-up plan. ν Share contact detail for follow-up.
- Close the assistance either when the best possible outcome has been attained (the victim/survivor is referred to other service providers), or the needs/wishes of the victims/survivors change.
- Have agreements and protocols about the referral process with relevant services/institutions, including clear responsibilities of each service.
- Ensure that procedures between services/institutions for information sharing

and referral are consistent and known by staff (UN Women, UNICEF, UNFPA, 2015).

3.2. Standard Procedures for Police Service Provision

The conditions and behaviors of victims associated to GBV in a law enforcement station such as a police station are slightly different from those in a health care setting but similar for the most part of it. In a law enforcement setting, most GBV Victim/survivors change their minds from making a complaint upon arrival although it is possible to identify signs of GBV when observing the victim/survivor. Cases can also be identified from disclosure by a neighbor or relative. Some of the hindrances that cause the victims/survivors not to make their complaints are:

- Sub optimal cognitive functioning accompanied by mental or physical disability.
- Limited information about GBV and the different types.
- Fear of the perpetrator especially when the victim/survivor is financially dependent on the perpetrator and they have no place to go.
- In traditional and religious communities the victim/survivor portrays shame, fear of social consequences.
- Joint investments in common business and properties.
- Lack of culturally appropriate services and fear that they will not be believed due to the culture.
- Perception that services will not be able to offer effective assistance.

In addition to the conditions and behaviors that can indicate a situation of GBV in a health care setting, other behaviors that the victim puts up that could be a signal to the police are: substance abuse, anxiousness of being in danger always with fear of everything accompanied by trembling physical reactions. Attempts to justify the abuser with the belief that the abuser will change. When the victim is not consistent in saying what happened believing that things are under control especially when the partner refuses to leave the presence of the victim/survivor when being interviewed. Also when the victim/survivor is indecisive and says that "it is normal for people to be abusive. Another strong condition is when the victim/survivor does not have a phone (UNFPA, 2015).

When asking about GBV at the time of interaction with the victim/survivor in a police station, there are some specific actions that should be done to avoid revictimization. The police officer should keep the gun aside in order to avoid revictimization of the victim/survivor. Apart from keeping the gun away, the same way you interact with the victim/survivor in a health care setting is the same way the service provider in the police station has to behave with a GBV case.

Even in a police setting, victim/survivor autonomy and confidentiality is important after ensuring security. The victim/survivor in a police setting has to get the impression that the law enforcement officers are committed to safety and manage the situation seriously at the initial contact. The procedures to be carried out when faced with a GBV victim/survivor are: identification, evaluation, legal

assistance/investigation, collect evidence, documentation, and referral.

Identification at an institution of law enforcement can be through self-disclosure by the victim/survivor or through a health provider or a relative. On the other hand, the law enforcement officer may meet the victim/survivor at the premises after a phone call. After an emergency phone call during intervention, the police officer has to (UNODC, 2010, UNFPA, 2015).

- Address safety concerns of the victim/survivor and their children if available as soon as they make contact. This can be done by separating the victim/survivor from the perpetrator.
- Remove the perpetrator from the scene and isolate under observation if present.
- Seize any weapons identified to ensure the safety of everyone present. Observe the scene for vehicles, people and objects to identify any possible threats.
- If there are severe injuries, seek emergency medical assistance.
- Report vital information to other police officers, as well as any possible language barriers.
- Secure the crime scene, especially in cases where there was physical violence with severe injuries or sexual violence, to ensure evidence is preserved and not contaminated.
- Whenever appropriate, solicit support and assistance from other specialists (e.g. the prosecuting attorney, field evidence technicians, and crime laboratory personnel).

When the victim/survivor reports to the police premises asking for assistance or has been referred from other institutions/services:

- A victim/survivor seeking for assistance is an indication that they are in crisis. Usually in this situations, the victim/survivor's behaviors can show signs of crying, rage, hysteria, calmness, and unresponsiveness. In this case, avoid judging or disregarding any victim/survivor.
- Be welcoming during reception.
- Introduce yourself to the client and briefly explain the services offered in the institution.
- In a kind manner, ask the person to introduce herself/himself (if there is no health condition that limits this).
- If the is any life threatening health need to the victim/survivor and children if available, make it a priority to refer for medical emergency treatment before any further investigation.
- Find out if the victim/survivor wish to have a same sex police officer assist them (especially in cases of sexual violence).
- The victim/survivor is given the chance to ask questions about anything.
- The police officer should do everything to win victim/survivor's trust to increase accuracy of information needed for the prosecution/investigation.
- If the victims/survivors are peoples with physical/mental disabilities, ethnic minority and religious persons, ensure that their needs are addressed.

- The environment should be confidential and compassionate, listen to the patient actively and give validating messages.
- Avoid making the victim/survivor to meet many people in the process.
- Avoid asking about GBV in the presence of another person.
- Avoid leaving the victim/survivor alone, especially when suicidal thoughts are suspected. The police officer should be aware of the possible link of GBV with other crimes. For example, missing persons due to homicide or fugitive from home due to domestic abuse or child marriage.

After identification, the next steps which consist of legal assistance/investigation, collection of evidence, documenting GBV, and referral, should be determined by the police officer after carrying out an evaluation. The procedures for evaluation in a police or law enforcement setting is the same as in the health care setting apart from specific exceptions. For all services that will follow, consent has to be obtained. Consent is obtained from parents in case where the victims/survivors are minors (children). In the context where the victim/survivor cannot read or write, verbal consent is obtained and documented in the patient file. The victim/survivor has to be told that he/she has the right to decide which information to disclose or to keep confidential i.e. the right to limited consent. When obtaining consent, the implications of sharing the information with other services/institutions have to be made known to the victims/survivors. All actions should be geared towards helping the victim/survivor. If the case of GBV is being disclosed by the victim/survivor themselves, provide an opportunity for them to recount what happened while talking about the type of violence and the perpetrator. Reduce the number of times a victim/survivors have to recount their story as much as possible. Based on what has been recounted, the needs and the resources available to respond to the GBV case will be evaluated while considering the social, familial, and individual situation of the victim/survivor context. Phrases should be formulated towards the victim in a non-judgmental manner, using a sympathetic voice. The victim/survivor should be given the opportunity to express their expectations from the law enforcement service for any assistance or intervention. The assistance/intervention to be provided should be that should be provided to be tailored according to the expectations to protect the GBV victim/survivor (UN Women, 2014).

The interventions or service provision to a GBV victim/survivor is very crucial because it enables the identification of evidence to support the report statements of the victims/survivors. Most GBV occurs in private behind closed doors and usually the victims/survivors statement is the only testimony available for law enforcement officers. Meanwhile, the police officers cannot depend only on the report statement of the victim/survivor to build a solid case against the suspect or the perpetrator. Collecting evidence is crucial to support the prosecution file and prove that the perpetrator is guilty. As such, the police or justice will have a grounded right to issue and enforce protection orders for the victim/survivor (UNODC, 2010). During investigation, the police officer follows these steps.

- Tell the victim/survivor about their legal rights and the different ways that they can apply them. Inform them that they have the right to make a case and have a trial in court for the offence caused. It should be clear to the victim that filling a report statement against GBV is not a criminal action.
- Educate the victim/survivor of the different options of assistance available and any decision to help them to make a decision.
- The victim/survivor should be informed about the law enforcement mandate and the possible actions/interventions that can be made by law enforcement institutions.
- Explain the mandatory legal actions for certain crimes especially those specific to GBV situations and that this is usually accompanied by opening a case file regardless of the victim/survivor's complaint. Offer guidance as may be necessary for procedures in the mandate limit. Avoid situations that will waste time or promote re-victimization.
- After educating the victim/survivor on the different options, clearly explain the next steps which will include the legal procedures and how to obtain counselling and shelter. When explaining the next steps in the process, avoid using legal terminology as much as possible because the victims/survivors may not understand legal terms and they can get confused.
- The victim/survivor's complaint is recorded in the registration book and attributed a registration number for future follow up.
- The law enforcement officer should have in mind that the following type of questions may be asked by the victim/survivor: For how long will I be here today? Will I need to come back frequently? Will the perpetrator be informed about my report? Will my family and I be safe? How long will the investigation take? Do you think there will be a trial? Who takes the decision to go for a trial? If there is eventually a trial, what will I have to do? How long does a trial usually last? What does a trial situation look like?
- Reassure the victim/survivor that all information/evidence provided will be confidential and he/she will be informed in case it has to be shared.
- In a police setting also, the victim/survivor tells in their own words what happened, while providing information about the perpetrator, types of violence and severity. But sometimes this information is already available if this information is provided by another provider.
- Assess the needs and resources as this helps to understand the social, familial and individual context that influences the victim/survivor's situation.
- Seek for social support if judged that it is necessary or at the victim/survivor's request.
- Assist the victim/survivor in establishing a safety plan, to increase where needed. Sometimes, if the mandate at the law enforcement setting requires that the safety of the victim/survivor should be ensures during the investigation process, this should be applied.
- Whenever applicable, a case file is opened and all relevant documents are sent

to the judiciary.

- Make sure all what the victim/survivor disclose using their own words is documented. And ensure all records are kept in a secure and confidential place.
- Make sure that the victims/survivors are informed about the possible usage of the records judiciary reasons, although confidential.
- As required, a follow up plan should be established.
- Any confrontation with the perpetrator should be avoided as much as possible.
- Penalties to perpetrators should be applied according to the law.
- propose for arresting the perpetrator, according to the police mandate.
- Continue the investigation for submitting the file to the court for trial.
- Follow-up on the outcome of submitting a file to the Judicial Department.

In a crime scene, collecting evidence is done by forensic scientists or crime scene technicians. Professional examination from forensic scientists or crime scene technicians, increases the likelihood that injuries will be properly documented and strong evidence collected to support the investigation and prosecution of the perpetrators. During medico legal examination, other officers are not present except the professional forensic examination staff. Medico legal examinations are conducted in a prompt and gender sensitive manner that respects the dignity of the victim/survivor (UNODC, 2010); Everything done during the medico legal exam is documented. The officer explains the process of collecting evidence to the victim/survivor guided by the following steps;

- The victim/survivor has to be told not to wash cloths that carry evidence of abuse. Any other material of evidence should be preserved and not destroyed.
- Tell the victim/survivor the reason for which the evidence material is being collected. And obtain the consent of the victim/survivor if they will like the evidence of violence to be collected.
- If the forensic service office is outside of the law enforcement office, refer the victim/survivor to the nearest facility that can collect forensic evidence while explaining to them the clear information of what type of services they will benefit from in this matter.
- Upon request by the victim/survivor, they can be accompanied to the forensic service.
- Reiterate the importance of collecting evidence especially to victims/survivors of the sexual form of GBV.

Officers shall protect the integrity of the evidence and guard the chain of custody by making sure they are: properly marking, packaging, and labelling all evidence collected which can include:

- The clothes worn during the time of the abuse, especially in case of sexual assault.
- If injuries are available, photographs and/or videotapes of the victim/survivor's and perpetrator injuries and the crime scene prior to processing. It is recommended that same sax officers with the victim/survivor should be the one photographing and at the same time be sensitive about where the injuries

are located on the victim/survivors body.

- The crime scene is also drawn on a diagram.
- In case of a sexual abuse case, having evidence for DNA plays a crucial role in the investigation. In addition to the cloths of the victim/survivor's and perpetrators as well as their injuries, many other sources such as door handles, condoms, sheets, blankets, pillows, and can carry biological evidence such as blood, sweat, tissue, saliva, hair, and urine. There are officers in charge of properly collecting DNA evidence internal standard operating procedures, if mandated.

In a law enforcement setting, risk assessment and management also have to be carried out in order to come up with a reliable safety plan just as in a health setting. The identification of risk factors enables the establishment of a safety plan and these are the same as in a health care setting. Risk assessment and management interventions are important in reducing risk levels during service provision. A safety plan is developed taking in consideration risk factors and resources available. Establishing a safety plan is part of the case intervention which is essential in preventing future violent incidents or avoiding escalation or exposure to extreme situations. List the friends or neighbors of the victims who can provide shelter to the victim/survivor incase of an emergency. Neighbors can also serve as witnesses to confirm is they hear violent noises or disturbances in the house of the victim/survivor. A safety bag should be packed and kept in a place that can easily be taken for escape in case of emergency. The victim/survivor will also practice simulations on how to go out of their homes quick and safe. The survivor has to be told to make use of their sense of judgment especially in cases where the abuser can become very hysterical. In this case for the safety of you and your children, give the abuser what they want in order to calm them down. Risk factors that can initiate the development of a safety plan include situations where the victim/survivor, their children or family member has previous acts/incidents of GBV with history of convictions from the police. Violent behavior outside the family can also be considered a risk factor. The process of separation or divorce increases chances of violence. The perpetrator has more power when other family members are in agreement with abusive attitude. Illegal or legal possession of weapons are tempting to use in situations of violence. When perpetrators consume drugs and alcohol, it can cause them to reason and act irrationally and violent with regrets after effect of alcohol. If the victim/survivor experiences threats of murder, provision of a safety plan should be taken very seriously. Situations that can lead to threats of murder are changes in relationship for example. Extreme patriarchal attitudes and culture, having a possessive and jealous partner, stalking of the victim/survivor by the perpetrator and non-compliance with police restraining order are risk factors that need to be considered when establishing a safety plan (UNFPA, 2015).

Documentation of a GBV incident in the police service is done using a specific form which varies across countries. The form is structured in such a way that it

captures information about the victim/survivor and perpetrator during first contact, interviewing, investigation and the final step when the police officer summarizes the complete case. Documenting GBV incidents in a police service should have the following information;

- Information on collection of evidence i.e. the type of samples, the place of evidence collection, the professional/provider who collected the evidence, etc).
- The things that were observed at the crime scene.
- The behavior of the victim/survivor and that of the perpetrator.
- Details of the incident as well as evidence to support the alleged offence.
- Information on the type of violence.
- How weapons were used and the type of weapons used.
- A note based on the judgment of the officer on whether the perpetrator planned the incident.
- The level of severity of the victim/survivor's physical and/or emotional injuries.
- Document history of previous incidents even those with previous partners.
- Information if threats were made before or after the incident.
- The type of relationship between the victim/survivor and perpetrators.
- Information of the witnesses that were present during the incident, especially if children were present.
- Information on dependent family members especially the children.
- Information about the safety plan that has been established.
- Follow up plan measures that have been taken.

The police officer may need to refer the victim/survivor for other services after assessment or upon request by victim/survivor (UN Women, UNICEF, UNFPA, 2015). The procedures for referral at the law enforcement office are the same as in the health care setting. During referral the police officer has to consider the following steps;

- Keep up to date a directory of institutions/organizations, which provide services for GBV victims/survivors. The directory must include institution's name, contact person, address, other contact details, list of services provided.
- Evaluate what referral may be useful for the GBV victim/survivor, according to the assessed needs and wishes.
- Inform the victim/survivor about the possibility to be referred to other service providers, as requested and/or needed.
- Obtain the consent of the victim/survivor to make the referral, prior any further step.
- Clarify with the victim/survivor what information will be shared to other service providers and what information will be kept confidential (specify if there are any legal regulation/limitation).
- Give to the victim/survivor complete and correct information about service providers, following the 3W scheme described below:

WHO—which institution/organization provides services to GBV victims/sur-

vivors, adding contact information of a person (name, telephone number) that can be reached as an entry point to that service.

WHAT—what sort of assistance they can expect to receive from a specific service provider, adding cost information related to that service.

WHERE—where exactly is the place (the exact address) of the indicated services.

- Make the referral according to the victim/survivor's choice.
- Accompany the referral by a short written report and a telephone discussion with the other service provider, as a method for avoiding the situation when the victim/survivor has to repeat the story and answering the same questions during multiple interviews, passing again through the psychological trauma caused by the GBV incident.
- Encourage the victim/survivor's autonomy by empowering her/him to do the referral by itself.
- Accompany the victim/survivor to the referred service provider, if needed and possible.
- Explain to the victim/survivor that she/he can come back for further assistance. Bring up the issue at the next appointment.
- Explain to the victim/survivor about medical condition follow-up plan. ν Share contact detail for follow-up.
- Close the assistance either when the best possible outcome has been attained (the victim/survivor is referred to other service providers), or the needs/wishes of the victims/survivors change.
- Have agreements and protocols about the referral process with relevant services/institutions, including clear responsibilities of each service.
- Ensure that procedures between services/institutions for information sharing and referral are consistent and known by staff (UN Women, UNICEF, UNFPA, 2015).

Legislation for Preventing Gender-Based Violence

There are declarations and conventions that have been developed to mitigate violence against women. The development of legislations against GBV especially violence against women originates from the Universal Declaration of Human Rights of 1948 that forms the most basic international foundation for combating violence. It lays out principles of equality, security, liberty, integrity, and dignity for all people, including women. In 1993, the United Nations (UN) World Conference on Human Rights in Vienna paved the way for the integration of women's rights in both public and private spheres. another UN Declaration on the Elimination of Violence Against Women (DEVAW) was adopted by the General Assembly, calling on states to "exercise due diligence to prevent, investigate, and punish violence against women, whether those acts are perpetrated by the state or by private persons" (UN Women, 2012). The Beijing Declaration and Platform for Action adopted at the 4th World Conference on Women in 1995 set strong terms for the elimination of VAW. A major step in establishing rights for women

was the 1979 Convention on the Elimination of All Forms of Violence Against Women (CEDAW), which has been ratified by 188 nations (Klugman, 2017). In addition, the Istanbul Convention that applies in both times of peace and armed conflict, has been recognised as the most powerful legally binding set of comprehensive standards for preventing and combating violence against women in Europe and beyond (CETS 210-Council of Europe, 2011). These declarations and conventions developed to prevent and protect from violence done against women are used and ratified by many nations of both developed and still developing countries. More recent dispositions consist of the United Nations 2030 Sustainable Development Goals, where "all forms of discrimination against women and girls have to be eliminated".

3.3. Standard Procedures for Psycho-Social Service Provision

Psycho social service delivery to victims/survivors of GBV is a component of social services that ensure their rights, safety and wellbeing. Psycho social services include provision of helpful information on legal rights, hotlines for help and safe accommodation. Psycho social service providers are most often considered as counsellors who provide assistance to GBV victims/survivors. The objectives of the standard operating procedures to offer care to GBV victims/survivors are the same as in a health care setting and in the police service. The objectives in psycho social service provision also constitute linking the victim/survivor to other services. For the standard operating procedures to be implemented properly, minimal training of service providers is needed. However, what is better is for the standard operating procedures to be part of a more comprehensive training that includes sections on multi-sectoral response to GBV, specific response to GBV of psycho-social services and prevention and awareness. Basic psycho social service provision must be supported by core elements which include: informed consent and confidentiality, accessibility, referral, risk assessment and management, appropriately trained staff and workforce development, monitoring and evaluation, and system coordination and accountability (IASC, 2005; UNFPA, 2001). The social services provided to GBV victims/survivors should cover:

- Information during crisis;
- Counselling services during crisis;
- Help through hot line services;
- A safe accommodation;
- Financial and material support;
- Replacement, creation and recovery of identity documents;
- Information about legal rights including advice and representation;
- Services on counselling and psycho-social support;
- Women-centred support in case victim/survivor is a woman;
- Children's services for any child affected by violence incident;
- Information about community outreach activities and education on community services;

- Services towards economic independence and recovery;
- Data collection and information management.

Effects of GBV on victims/survivors are most often chronic and may sometimes end up with psychopathologies. Psychological conditions/behaviors that might occur in situations of GBV include:

- Feelings of guilt, shame, anger, sadness, despair, helpless, hopelessness, emptiness, powerless, suffocation;
- Constant feeling of danger (always feeling on the alert);
- Fear of everything;
- Failure to take care of themselves and others;
- Difficulty in concentrating;
- Profound loneliness (alienation);
- Loss of ability to make plans;
- Lack of initiative, fear of facing life alone, meaning of and interest in life;
- Lack of self-esteem;
- Agitation, nervousness;
- Tachycardia;
- Phobic behaviour;
- Gastrointestinal disorders;
- Sleep disorders Eating disorders;
- Headaches;
- Muscular pain;
- Substance abuse;
- Isolation in order to avoid people, places, activities, behavior and attitudes that the perpetrator/batterer dislikes (as a defense from escalating the violence);
- Change of jobs very often;
- Reducing social and leisure activities;
- Avoidance of people, places or situations which remind the victim/survivor of the event;
- Loss of the ability to protect themselves and underage children in case of women;
- Indecisiveness;
- Denial and minimizing of the event and the consequences.

Some psychological effects specific incase of the sexual form of GBV violence include:

- Rumination;
- Intrusive thoughts (the memory of the trauma suddenly comes back in a disturbing manner);
- Physical reactions (trembling or fainting upon remembering the traumatic event);
- Flashbacks;
- Nightmares.

The interaction with a GBV victim/survivor when offering a psycho social

service is the same as in a health care setting and in a law enforcement setting. What is peculiar about services in a psycho social service is that environment where the social service is being offered gives an impression on the victim/survivor. This affects the way the victim/survivor will provide information and be open to the social service counsellor. Sometimes the victim/survivor may not have food due to limited funds. Therefore, the environment where social services are offered should always take dispositions to secure refreshments, snacks and water to the victim/survivor. After physical needs are met, the counsellor can now proceed with addressing the upper layers from Maslow's hierarchy of needs (Robert, 2009). At the moment of discussion with a GBV victim/survivor avoid putting a table in between counsellor and victim/survivor as this can hinder communication. The sitting position with the victim/survivor should be such that it creates equality in power. A round table discussion is more appropriate or better still a no table in between. Also the counsellor should avoid having face-to-face and eye ball to eye ball watching the victim as this can give an impression of confrontation which can hinder communication.

When offering psycho social services, the security of the victim/survivor is a priority followed by the confidentiality of anything discussed. The aim of offering social services is to help the victim gain control of their lives and have more self confidence by applying actions to reduce isolation or alienation, improve family integration, obtain legal services and supporting economic independence. Similar to a health care setting and a police setting, the steps in the procedures of responding to a GBV case in a psychosocial service consist of identification, evaluation, intervention, documenting GBV, referral, and case management coordination. The steps can follow any order but it is primordial to start with the identification step.

Identification in a psychosocial service can be done through referral or by self disclosure. Before starting to implement any response interventions, first obtain consent of the victim/survivor. Ensure that the victim/survivor is safe and information provided is confidential. Quickly address any urgent physical needs or life threatening conditions. The counsellor attempts to gain the trust of the victim/survivor prior to addressing any psycho-social needs. The steps for identification are almost the same as in a health care setting and in a police or law enforcement setting aside certain particularities;

- Greet the person in a manner that shows that he/she is welcomed.
- Introduce yourself to the client and briefly explain the services offered in the facility.
- In a kind manner, ask the person to introduce herself/himself (if there is no health condition that limits this).
- Ask the patient if he/she prefers to be examined by a doctor who is of the same sex (especially in cases of sexual violence).
- Chances should be provided to the patient to ask any question about what consider important.

- Consider the needs of special population groups (e.g. persons with physical or mental disabilities, religious persons, and ethnic minorities) and address them where necessary.
- The environment should be confidential and compassionate, listen to the patient actively and give validating messages.
- Especially for those suffering effects of physical violence, avoid sudden movements or any physical contact with the victim/survivor or accompanying persons. This can trigger stress.
- Avoid leaving the victim/survivor alone because in some cases they can self-inflict pain.

The evaluation steps includes information about the psychological needs and the physical needs of the victim/survivor as well as the social life, relationships and economic status. Based on these, the evaluator will then decide on the appropriate or priority next steps in the procedure that the victim/survivor has to benefit from. The evaluation process is similar to that of a law enforcement setting and a health care setting. Consent is obtained from parents in case where the victims/survivors are minors (children). In the context where the victim/survivor cannot read or write, verbal consent is obtained and documented in the patient file. The victim/survivor has to be told that he/she has the right to decide which information to disclose or to keep confidential i.e. the right to limited consent. When obtaining consent, the implications of sharing the information with other services/institutions have to be made known to the victims/survivors. Educate the victim about GBV and its negative consequences on health. All actions should be geared towards helping the victim/survivor. If the case of GBV is being disclosed by the victim/survivor themselves, provide an opportunity for them to recount what happened while talking about the type of violence and the perpetrator. Based on what has been recounted, the needs and the resources available to respond to the GBV case will be evaluated while considering the social, familial, and individual situation of the victim/survivor context. The appropriate support to be provided is determined based on the needs evaluated such that the GBV victim/survivor is protected (UN Women, 2014). Other particularities when evaluation is being done in a psycho social service consist of the following steps;

- Assess the level of danger and set corresponding rules for self-protection.
- Find out if there are any consequences of GBV in her/his life of the victim/survivor.
- Verify the psycho-physical-social condition of the victim/survivor and children if available.
- Obtain information about the background of the victim/survivor.
- Obtain information about the primary and secondary social network.
- Assess victim/survivor's and family's economic situation, dependency or independency, and their living/housing conditions.
- Find out if the victim has made previous efforts to resolve the violent situation like coping strategies and attempts to run away from abuse in the home for

example.

- Asses the status of the children relating to GBV and their relations with parents.
- Attempt to explore the victim/survivor's feelings about what happened and note it.
- Find out what are the expectations and wishes of GBV victim/survivor and what urged them to seek for help.

All psycho-social service provision are offered to GBV victims/survivors in a manner that is adaptable, sustainable, holistic and multi-sector. The interventions are aimed to reduce the negative effects of GBV by establishing an individualized plan that addresses the needs as identified during evaluation. Crisis counselling can be offered in person, via telephone, mobile phone, e-mail and in various locations and diverse settings. The aim of crisis counselling is to achieve immediate safety, make sense of their experience, reaffirm their rights and alleviate feelings of guilt and shame. In extreme cases, there are long term psychosocial services such as psychotherapy which can be offered. During crisis counselling the following actions are offered by the counsellor;

- Address basic physical needs such as sleepiness, hunger and thirst.
- The victim/survivor say in their own words their opinions about the outcomes, resources and strategies with which they can cope. As such the counsellor can collaborate with the victim/survivor to identify ways of solving the situation.
- Immediately offer support services to address the psychological needs of GBV victim/survivor.
- Offer divers choices to the victim/survivor such as access to safe accommodation; access to emergency health care services; and the choice to re-contact the service, in any circumstances/choice.
- Wherever applicable, explore with the victim/survivor the possibility of obtaining a restraining/protection order.
- Assist work with the victim/survivor in establishing a safety plan, to increase safety for herself themselves and their children, if applicable.
- Agree on a long-term plan with the victim/survivor and share contact detail for follow-up.

Long term psycho social and counselling services can either be formal or informal. These services could include support groups, individual counselling, and a 24-hour hotline. Within the community, informal counselling services could be support groups of victims/survivors as well as faith based and community based group interventions. These services are effective in addressing the psychological needs of victims/survivors who are experiencing depression, anxiety, and/or post traumatic stress disorders. The services take into consideration the following actions;

- Empowering the victim/survivor to make choices independently.
- Develop plans and actions after evaluating and identifying the victim/survivor's personal needs and points of view and examining the possibility of not doing anything and leaving things as they are. Collaborate with the

victim/survivor in developing an intervention plan.

- Offer social support.
- Implement actions that will alleviate the victim/survivor's suffering, alienation/loneliness and social distances, boost self-esteem.
- Re-enforce self-protection mechanisms and coping strategies, by building on the victim/survivor's resources and capacities, to handle future violent or vulnerable situations without feeling powerless.
- Consider the possibility of failure of the intervention and or undertaken actions make this known to the victim/survivor. Facilitate reflection on the consequences if failure occurs.
- Find out if there are any other subjects that the victim/survivor wants to discuss about.
- Review what has been agreed on the intervention plan and what actions are in the responsibility of the victim/survivor.
- Develop a follow-up plan and share contact detail with victim/survivor.
- During follow-up sessions, explore the changes in the victim/survivor's situation, effectiveness of coping strategies, results of any actions undertaken by the victims/survivors. On the other hand, explore the difficulties occurred and help the victim/survivor to address them; redefine the problem, plan and further actions.

Sometimes, when victims/survivors leave their homes of danger, they need immediate accommodation services as a place of safety and refuge for them and their children if any. Psycho social services need to implement the following actions;

- Provide safe and secure emergency accommodation until the immediate danger is rolled out.
- Ensure that location is confidential and security measures are in place with security personnel, and security system.
- Basic accommodation needs are made available.
- Provide other services, according to victim/survivor's needs and choices: psychological support/counselling, legal advice, support for social reintegration, etc.
- If there are children, ensure that the safety and needs of accompanying children are addressed.

Other support services provided during psycho social response to GBV victims/survivors consist of;

- Providing material and financial assistance such as emergency transport, food, safe accommodation, basic personal and health care items, cash for certain expenditures (e.g. forensic certificate fee, taxi transfer to and from other services).
- Assisting victims/survivors to establish their identity by helping them to recreate, recover or replace their identity documents.
- Providing legal information to GBV victims/survivors on their rights and the diverse options available such as divorce, child custody, guardianship,

restriction/protection measures, and migration status.

- Providing services for children in line with international standards which are appropriate, child sensitive and child-friendly.
- Providing telephone hotlines that are toll-free for 24 hours a day, 7 days a week preferably including weekends and holidays. Ensure that staff answering help lines have appropriate knowledge, skills and are adequately trained. Ensure that the hot lines have protocols connecting them with other social services, and health and justice services to respond to individual circumstances of victims/survivors.

Risk assessment and management of GBV victims/survivors in a psycho social service setting is the same as in a law enforcement setting and a health care setting. Identification of risk factors help in the establishment of an adequate safety plan. The risks factors that can draw the attention of the psycho social service provider consist of; situations where the victim/survivor, their children or family member has previous acts/incidents of GBV with history of convictions from the police. Violent behavior outside the family can also be considered a risk factor. The process of separation or divorce increases chances of violence. The perpetrator has more power when other family members are in agreement with abusive attitude. Illegal or legal possession of weapons are tempting to use in situations of violence. When perpetrators consume drugs and alcohol, it can cause them to reason and act irrationally and violent with regrets after effect of alcohol. If the victim/survivor experiences threats of murder, provision of a safety plan should be taken very seriously. Situations that can lead to threats of murder are changes in relationship for example. Extreme patriarchal attitudes and culture, having a possessive and jealous partner, stalking of the victim/survivor by the perpetrator and non-compliance with police restraining order are risk factors that need to be considered when establishing a safety plan (UNFPA, 2015).

Documentation about GBV during psycho social service provision is done using standardized forms, charts and registers. It should be noted that the guidelines across countries will determine how comprehensive the information should be. The information collected provides a comprehensive summary about the GBV incident. Data collected is useful for monitoring and reporting purposes about GBV as well as a baseline to evaluate the multi sectoral response of GBV in a nation. Information document in a psycho social service includes;

- Collect and document information about GBV victim/survivor/case, that covers information about demography i.e. name, age, sex, marital status, number of children in custody, any antecedent psychiatric conditions, drug abuse, family members, information about socio-economic statute of victim/survivor/family.
- Document details of the GBV incident and history of violence. This should include: evidence to support the offence committed; incidents from previous partners; the relationship between victim/survivor and perpetrator; The type of violence and frequency of events; if weapons were used document the type and how they were used; document any witnesses present during the incident

even if they are still children.

- Document any physical, psychological and social consequences of the violence.
- Document factors of risk in the environment of the victim and protective measures.
- Document the actions planned to handle the violent situation.
- Document information about the evolution of the case during follow up counselling sessions.
- Document what the victim/survivor discloses in their own words.
- If any doubts are perceived by the counsellor, document them with back up reasons.
- Inform the victims/survivors the possibility of using the information provided for other services and obtain the consent backed up with documentation.
- All information documented should be in a safe and confidential place.
- Enter data into a data collection system to reporting and evaluation.

The referral system should be effectively coordinated with other services to ensure prompt and safe response to the needs of the victim/survivor. The service providers should be aware of the referral system between institutions and/or organizations and have the contact details of the different service providers. Offering referral services in a psycho social service is similar to that of a law enforcement setting and a health care setting but has certain peculiarities (UNFPA, 2015).

During referral in a psycho social setting, the provider should do the following actions:

- Based on the assessment needs identified and wishes expressed, identify the referral that will be profitable to the GBV victim/survivor.
- Ensure that when offering psycho social services, the victim is informed that there is possibility that they can be referred to other service providers, as requested and/or needed. By so doing, ensure that consent has been obtained from the victim/survivor before engaging any further step. Make sure that the referral is according to the victims/survivors choice and not coercive.
- Make it clear to the victim/survivor what information will be shared with other service providers and what information will be kept confidential. This is also based on the legal regulation of the country.
- Ensure that the victim/survivor has complete and correct information about the different service providers, following the 3W scheme described below:
    - WHO—the institution/organization that provides services to GBV victims/survivors, including the contact information of a person (name, telephone number) that can be reached as an entry point to that service.
    - WHAT—The type of assistance they can expect to receive from the service provider they are being referred to, including information about the related cost to that service.
    - WHERE—Specify the exact place/address of the indicated services.
- The referral service is accompanied by a brief report and a telephone encounter with the other service provider. This prevents re-traumatizing the victim/survivor

by making them to repeat the story and answering the same questions during multiple interviews and be psychologically affected.

- Encourage autonomy by empowering and sending the victim/survivor's for the referral service. However, if there is need, accompany the victim/survivor to the referral service provider.
- When evidence is available, explain the purpose for use of the evidence and obtain consent from victim/survivor. Remind the victim/survivor why it is particularly important to collect evidence especially for situations of violence while explaining to the victim how they should preserve the evidence article.
- Essential services that could provide support for GBV victims/survivors are:
  - nearest health facility to assist her/him in collecting evidence and also for medical care.
  - The police to deposit an official complaint.
- Ensure the availability of an up to date a directory of institutions/organizations which provide services for GBV victims/survivors. The directory should have the institution's name, contact person, address, other contact details, list of services provided.
- There should be established agreements and protocols about the referral process with relevant services/institutions, with responsibilities of each service. Information shared within the services should be consistent and known by all staff involved.

4. Status in the Rollout of GBV Guidelines

Governments have been putting up structures and systems in place for appropriate response to GBV. The interventions were determined mostly based on evidence of reviews performed from different countries, centered on the development of policies and guidelines to respond to GBV, national budget allocation, development of standard protocols, and setting up systems at health facilities to respond to GBV. The guidelines from the WHO in response to intimate partner violence also facilitate countries in the development of what is needed for an optimal response (WHO, 2013a). However, most of the reviews were based on data obtained from high-income countries as there are more investments about issues on GBV in high-income countries compared to LMICs (Coll et al., 2020). Some literature has highlighted the need to engage a quest for evidence of the context in Low and Middle-income countries (LMICs) in order to appropriately address GBV in these settings (Garcia et al., 2015; Ellsberg et al., 2014).

However many countries in the WHO regions including LMIC have adopted the guidelines developed by WHO and many other health governing bodies such as UNFPA. These countries have been working to operationalize the guidelines for standardized responses to GBV. A study carried out by Sikder et al., 2021, comprehensively evaluated the response to GBV focusing on VAW within 5 LMICs (Nepal, Sri Lanka, Bangladesh, Brazil and Rwanda), from the period of 2015 to 2020. It was found that with support from national funds and donors from

international organizations, remarkable progress had been to improve response to GBV survivors. National protocols had been developed to respond to GBV in a multisectoral approach, mainly at the ministries of health as well as other sectors such as the ministry of women and social affaires and that of justice. All countries had scaled up training of staff at the levels of health facilities on how to screen and manage GBV survivors. The One Stop Center (OSC) model aimed at providing acute services to survivors of violence was implemented in four out of 5 countries. This model which originated in Malaysia in 1994 has been rolled out in many other countries to support the provision of multi-sectoral case management for survivors, including health, welfare, counseling, and legal services with the intention of minimizing referrals and creating opportunities for traumatizing of survivors. The country that did not implement the OSC model (Brazil), integrated the package of services offered by OSC into facility medical care. Most often OSCs are located within the hospital structure with a team of trained health providers, while in some settings they appear as standalone services (Sikder et al., 2021; Olson, García-Moreno & Colombini, 2020).

According to Sikder et al., 2021, in spite of all these efforts made to improve response to GBV, some key issues or shortcomings were identified that needed attention for improvement. The training of providers at the level of the health facilities did cover many different types of health providers limiting entry points for the identification of violence cases. Health providers mostly recognized and documented only sexual violence neglecting other forms of violence such as emotional and economic violence. In some situations, health providers were influenced by their culture to blame survivors thereby traumatizing them although this attitude was reduced among health providers with meetings and follow-up from supervisory bodies. High staff turnover among those who were trained was a big challenge. Data and documentation of violence in the health management information system were sub-optimal. In addition, there was no data measuring the impact on attitudes and practices of staff after trainings. In addition based on assessment reports from the United Nation Fund for Population Activities (UNFPA), some countries are resistant to implementing the approach of responding to GBV via the health sector. Reports also highlight that it is challenging to implement a standard and efficient response within countries experiencing conflict (UNFPA, 2010).

5. Management of GBV during Crisis and Conflict

Statistics have shown that 1 in 3 women are victims of a form of GBV known as IPV at the hands of their partners (WHO, 2013b). This situation even gets worse in situations of crisis such as pandemics and or during war and conflict (Mittal & Singh, 2020). Studies have shown that outbreaks such as Ebola and Cholera have led to an increase in domestic violence. Women and girls tend to be more vulnerable to violence because of their inability to escape their abusers. The abusers or perpetrators who are males often escape or go unnoticed because of a breakdown in law caused by the crisis (Davies & Bennett, 2016). Before the most recent

pandemic, the COVID-19 pandemic, other outbreaks have led to a surge in gender-based violence especially against women thereby making it difficult to achieve gender equality globally (Mittal & Singh, 2020; Sikira & Urassa, 2015; Peterman et al., 2020). Similarly, during the COVID-19 pandemic, there was an increase in cases of domestic violence. The surge in domestic violence during the COVID-19 pandemic was promoted by the lockdown and quarantine that was imposed globally to deal with the pandemic. For example, during the quarantine period, China witnessed 3 times higher rates of gender-based violence. In Australia, the rates increased by 5% during the lockdown. In the United States gender-based violence increased from between 21% to 35%. The form of gender-based violence experienced during the lockdown is mostly domestic violence with an apparent increase in homicides (Mittal & Singh, 2020). Some of the reasons identified to cause an increase in gender-based violence during the pandemic are economic dependence of women to their perpetrators. During the quarantine, more women got laid off from informal jobs. In addition, more men than women have the capacity to do tele commutable jobs. This puts women more at risk of gender-based violence because of being economically dependent to the men who are potential perpetrators (Alon et al., 2020). During the COVID-19 pandemic, there are studies that show an increase in Post-traumatic stress disorders (PTSD), mental issues and increase in alcoholism which tend to increase rates of gender-based violence (Capaldi et al., 2012). Managing gender-based violence cases during a pandemic first starts by acknowledging that it is a problem that can happen easily in the context of outbreaks. Since the subject of gender-based violence is sensitive, it is possible that survivors may find it difficult to communicate or report their experiences. Some researchers emphasize on relying on community partnerships to sensitize their respective communities on how crucial it is to report cases of GBV when they occur. Online and telephonic services can also be made available to communities to report cases and obtain counselling services in a confidential manner (Campbell, 2020; Bradbury-Jones & Isham, 2020). Health-care workers also need to be trained to recognize and manage GBV issues (WHO, 2014). Some governing bodies such as the United Nations and researchers have emphasized the need for training a multidisciplinary staff in health, psychological, social and legal services to prevent and accurately manage cases of gender-based violence (Mazza et al., 2020). Using guidelines from the UNFPA and UN Women, some countries have implemented practices to reduce the rates of gender-based violence within the context of a pandemic. For instance, Australia domestic violence resource center provided specific guidance for family and friends to support those in family violence situations (Domestic Violence Resources Centre Australia, 2020). In France, warning systems were set up in highly visited places such as groceries and pharmacies to help victims of gender and family violence to alert the authorities (Guenfound I ABC News, 2020). In Beijing and in the United States, online platforms and hotlines were used to respond to gender-based violence cases during the COVID-19 pandemic.

Within the context of conflict or war, studies have shown that gender-based violence is a reality with no regard to human right which usually go underreported. Inflicting violence on vulnerable victims and exploitation of the human body is a strategic approach of domination by the perpetrators. Conflict exists whenever there is a resort to armed force between states or protracted armed violence between governmental authorities and organized armed groups or between such groups within a state as stated. Armed actors in conflict situations are most often the perpetrators of violence. Opportunistic violence especially rape is often reported in the context of conflict. While other forms of GBV such as IPV, physical and sexual violence are exacerbated during conflicts (Wirtz et al., 2014). Although context of war seem to increase rates of GBV against women, reporting still remains a problem cases are still under reported and services are not sort after by the survivors (Wirtz et al., 2014). This implies that in order to prevent and respond to GBV, actions to identify cases early enough should be engaged in a confidential manner by providers while making available quality services. Northern Ethiopia for example, experienced 2 years of devastating armed conflict during which there were cases of one thousand one hundred and seventy seven GBV cases reported to health providers. Gender-based violence was followed by its consequences. During the conflict in Northern Ethiopia, women and girls as young as 14 years old experienced gang rape. In addition, pregnant women and elderly women as old as 65 years were also sexually assaulted. Other forms of violence consisted of sexual, physical, and psychological (Tewabe et al., 2024). Occasionally, women and girls were directly assaulted on the body by burning the body with cigarettes or other weapons. Mental health, Socio-economic, physical health and reproductive health consequences of GBV on women are observed in a situation of conflict. Survivors have reported stigma, prejudice, suicide attempts, nightmares, and hopelessness. Survivors also deal with the traumatic stress by outmigration leaving their residences and or quitting their jobs, seeking care at healthcare facilities, self-isolation, being silent, dropping out of school, and seeking counseling. Physical injuries resulting from direct assaults (Tewabe et al., 2024). There are more profound consequences on the reproductive health of women and girls because of sexual assault during conflict. Thereby affecting the state of physical, mental, and social well-being related to the reproductive system and its functions. Survivors are three times more likely to have chronic pelvic pain, vaginal infections, dysmenorrhea, and dyspareunia. Sexually transmitted infections including HIV are also prevalent as the situation of IPV makes it difficult for the woman to negotiate the use of a condom. multifaceted interventions including psychological, health, and economic support are necessary to rehabilitate survivors to lead a productive life. Healthcare professionals, epidemiologists, and surveyors working in peace and war areas should work to recognize and address such atrocities towards women.

6. Status in the Rollout of GBV Guidelines

The support provided to survivors of GBV can occur in a setting where GBV

services are available and in settings where these services are not available. However, the case, humanitarian workers who fight against GBV have to investigate to have up-to-date information on available services and supports in the communities in which they work. Be it psychosocial, law enforcement, and health services. In context where GBV services are not available at least health care services can always be provided to victims. Health providers can support victims of GBV by simply offering a listening ear and letting victims express themselves in whatever way be it calm or loud. Health providers can also ask the question of how they can be of help to the victim (GBV Guidelines, 2024). When survivors of GBV are identified, information about available health services should be offered as almost if not all communities have access to some level of health care according to the Alma Atta health distribution pyramid (Panjwani & De, 2020). Health facilities can provide treatment to prevent HIV within 72 hours of an incident, and prevent unwanted pregnancy within 120 hours of an incident. Support for the safety of the survivor remains a priority. Those acting to fight against GBV should avoid giving advice but should be more in a position to provide helpful information to promote resilience, reduce risk, and support recovery. The support offered in times of pandemic crisis and conflict relies on remote means. In South Sudan for example women and girls are at risk of violence since the civil war erupted in 2013. To support survivors, community-based GBV task forces were trained to provide psychological first aid and safe referrals for survivors. These mobile teams of case workers provide services to women and girls at risk in remote areas. when face-to-face services are not possible such as during the COVID-19 pandemic assistance is provided via telephone or internet (International Medical Corps, 2024).

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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