MAIN CONTENTS

Chapter 10:

Sexual and gender-based violence

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1. Introduction

Sexual and gender-based violence (SGBV) is a major public health problem, a clinical health problem, and a violation of human rights. It is rooted in gender inequities, and further promotes them. Globally the scale is impressive, with approximately one in three women affected by SGBV. Such violence results in, or may result in, physical, sexual, or psychological harm, causing suffering and poor health.

The objectives of this chapter are to provide insight into the definition and diagnosis of SGBV, as well as evidence-based recommendations for care and treatment of those suffering from abuse.

1.1 Definition of terms

- *Sexual and gender-based violence (SGBV)* refers to any harmful act that is perpetrated against a person's will and is based on gender norms and unequal power relationships [1].
- *Gender-based violence (GBV)* is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private [2].
- *Violence against women (VAW).* The United Nations defines VAW as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" [3]. About 1 in 3 (30 per cent) of women worldwide have experienced either physical and/or sexual intimate partner violence (IPV, see *Section 1.4*) or non-partner sexual violence in their lifetime [3]. It is important to emphasize, however, that VAW includes not only physical and sexual violence, but also controlling behaviour, emotional and psychological abuse, verbal threats, and open humiliation.

Acronyms

FGM	female genital mutilation
HIV	human immunodeficiency virus
IPPF	International Planned Parenthood Federation
IPV	intimate partner violence
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
VAW	violence against women

The International Planned Parenthood Federation (IPPF) prefers the term 'sexual and gender-based violence' rather than 'gender-based violence' or 'violence against women', because it emphasizes the sexual violence component. Different organizations prefer to use SGBV, GBV, or VAW, depending on the organization's mandate and activities, but SGBV and GBV can be used interchangeably, as can VAW, when focusing on female survivors.

SGBV is a human rights violation associated with death, injury, and a broad range of negative sexual and physical health issues and socioeconomic impacts. SGBV occurs in many forms, including sexual violence, IPV, and reproductive coercion, and can be perpetrated by any individual, whether strangers, relatives, colleagues, acquaintances, or intimate partners. SGBV is an inclusive term that includes violence perpetrated against those who identify as women and girls, men and boys (including transgender women, girls, men, and boys), as well as against non-binary individuals who do not conform to predominant (binary) gender roles or identities. The most common perpetrators of violence against women are male intimate partners or ex-partners. By contrast, men are far more likely to experience violent acts by strangers or acquaintances than by someone close to them.

SGBV can affect anyone, but women and girls are affected and suffer at disproportionately higher rates with more severe and long-lasting health outcomes, including an increased risk of HIV and other sexually transmitted infections (STIs), unintended pregnancies, gynaecological disorders, obstetric complications,

depression, anxiety, and reduced uptake and use of contraceptives.

This chapter uses the terms 'survivor (of SGBV)' to refer to all individuals who have experienced a form of SGBV, in line with global practice, and 'a client who has experienced SGBV' to refer specifically to someone who is receiving sexual and reproductive health and rights healthcare. However, the 'correct' term to use when speaking directly to someone is whatever they prefer to use. Some people will use victim to refer to themselves and their experience, some might choose survivor, and others may not use either of those terms. The healthcare provider must actively listen to the language being used by the client and mirror it as appropriate.

1.2 Causes of sexual and gender-based violence

The root causes of SGBV are abuse of power, gender inequalities, discrimination, and harmful societal norms.

During emergencies such as conflicts, natural disasters, or infectious disease outbreaks such as coronavirus disease (COVID-19), the risk of violence, exploitation, and abuse is heightened, particularly for women and girls, as national systems and community and social support networks may weaken and gender inequalities are exacerbated [4]. The breakdown of these networks increases the risks of SGBV to women, girls, and at-risk groups as protection mechanisms are weakened. For more information on providing SGBV healthcare in emergency settings, see *Chapter 11: Sexual and reproductive healthcare delivery in humanitarian settings*.

1.3 Risks and vulnerabilities to sexual and gender-based violence

Anyone can experience SGBV and this underlines the issues of intersectionality. Intersectionality is a framework for understanding that people experience overlapping (i.e. intersecting) forms of oppression, discrimination, and marginalization based on their coexisting identities (e.g. discrimination based on both gender and ethnicity) [4]. Individuals are multifaceted and have different experiences, backgrounds, identities, and characteristics that are complex and overlap, which may increase their risks and vulnerabilities to SGBV.

Not all individuals will experience these inequalities in the same way. However, these inequalities profoundly impact the SGBV experiences survivors face [4].

Besides women and girls, other at-risk groups who also have a heightened risk for SGBV include:

- lesbian, gay, bisexual, transgender, intersex, non-binary, and gender-fluid people
- people with disabilities
- adolescents and children
- people living with HIV
- elderly people
- women and children heads of households
- girls and women who bear children of rape, and their children born of rape
- indigenous people, and ethnic and religious minorities
- separated or unaccompanied children, including orphans and children associated with armed forces/groups
- migrants, refugees, asylum seekers, and internally displaced people
- people without fixed housing
- people involved in forced and/or coerced sex work, including child victims of sexual exploitation
- people of all ages in detention [5]

1.4 Forms of sexual and gender-based violence

SGBV includes violent acts that are physical, emotional/psychological, and sexual, or deprivation of opportunities and access to resources. Forms of SGBV include:

- *Intimate partner violence (IPV)* refers to "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including

physical aggression, sexual coercion, psychological abuse and controlling behaviours" [3]. Indeed, most SGBV is perpetrated by a current or former intimate partner. Globally, almost one-third (27 per cent) of women aged 15–49 years who have been in a relationship report that they have experienced some form of IPV in their lifetime [3].

- *Reproductive coercion* is a form of abuse perpetrated by an individual(s) to exert power and control over another's reproductive health and choices, predominantly by men against women. Forms of reproductive coercion include pregnancy coercion (pressure to become pregnant), contraceptive sabotage (direct interference with contraception), and control of pregnancy outcomes (forcing the pregnant person to have an abortion or to continue with a pregnancy that they do not want) [6,7].
- *Homophobic and transphobic violence* refers to attacks on people because of their perceived sexual orientation or gender identity. This type of violence – which can take diverse forms – is often driven by a desire to punish or to 'cure' those who defy traditional gender norms.
- *Psychological and/or emotional abuse* refers to the infliction of mental or emotional pain or injury; for example, threats of physical or sexual violence, controlling behaviour, verbal abuse, intimidation, humiliation, forced isolation, stalking, harassment, defamation, and exploitation. Psychological abuse may include reproductive coercion (as above). Another example is technology-facilitated SGBV, which is when the internet or a mobile technology is used to harm others based on their sex or sexual orientation or gender identity.
- *Socioeconomic abuse or neglect* is the intentional deprivation of opportunities and resources that are needed for one to exercise their human rights motivated by perspectives on sex or gender identity or sexual orientation; examples include denial of food; denial of education or opportunities to work or own property; restricting access to money, healthcare, or social services.
- *Physical assault* is an act of physical violence that involves intentionally using or threatening to use physical force, strength, or a weapon to harm or injure a person (e.g. hitting, choking, slapping, strangulation, burning, cutting).
- *Sexual violence* (or sexual abuse) is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, directed against a person's sexuality using coercion or manipulation, by any person regardless of their relationship to the survivor, in any setting. Rape, sexual assault, and sexual exploitation are all forms of sexual violence.
- *Sexual slavery* is a form of enslavement and sexual violence that includes limitations on an individual's autonomy, freedom of movement, and power to decide matters relating to their sexual activity. Forced marriage, domestic servitude, and trafficking for sex work are often associated with sexual slavery.
- *Child sexual abuse* is a type of sexual violence that involves a child or an adolescent in sexual activity that they do not fully comprehend, have not or are unable to give informed consent to, and/or for which the child or adolescent is not developmentally prepared and cannot give consent, or that violates the law or societal norms.
- *Harmful traditional practices* are accepted forms of violence in a specific culture or society that have taken place over time, predominately against women and girls, and carried out in the name of tradition. Such acts include forced marriage, 'honour' killing, and female genital mutilation (FGM).
- *Female genital mutilation (FGM)* is a term that encompasses "all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons" [8]. The procedure is common in 30 countries across Africa and in some parts of the Middle East and Asia. It also exists in communities originating from these countries living in other countries.

2. Guiding principles, provider knowledge and skills

2.1 Guiding principles

IPPF acknowledges that SGBV is a key barrier to fully accessing sexual and reproductive healthcare and affects both the general health and sexual and reproductive health of survivors. IPPF advocates a human rights-based, client-centred, 'do-no-harm' approach to providing healthcare and supporting all survivors affected by SGBV.

2.1.1 Survivor-centred approach

When working with clients who have experienced SGBV, both clinical and non-clinical staff must practise a survivor-centred approach and implement the SGBV guiding principles of safety, confidentiality, respect, and non-discrimination. A survivor-centred approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect.

A survivor-centred approach is based on the following guiding principles:

- *Safety:* The safety and security of survivors and their children are the primary considerations.
- *Confidentiality:* Survivors have the right to choose with whom they will or will not share their story, and any information about them should only be shared with their informed consent.
- *Respect:* All actions taken should be guided by respect for the choices, wishes, rights, and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.
- *Non-discrimination:* Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation, or any other characteristics [4].

2.2 Provider knowledge

All staff should be aware of SGBV as a public health and human rights issue, as well as having relevant knowledge, clinical skills, and competencies. Safe and ethical care must be provided for people who have experienced SGBV by ensuring adherence to the facility's agreed procedures as well as the SGBV guiding principles for responding to the needs of survivors of sexual violence (safety, confidentiality, respect, and non-discrimination [2]), take a survivor-centred approach (see *Section 2.1.1*), and always believe the survivor.

Healthcare providers should know about and understand the wider issues related to SGBV, including:

- the political, social, and economic determinants of SGBV, both nationally and regionally
- the legal definition of SGBV, both nationally and regionally
- the legal age of consent
- the different forms of SGBV and the circumstances under which they are perpetrated, including physical, sexual, psychological, emotional, and socioeconomic violence against people of all ages, genders, and sexual orientations
- the prevalence and incidence of various forms of SGBV within local communities, including populations at risk of experiencing SGBV (see *Section 1.3*)
- the stigma and discrimination associated with SGBV in a range of geographic, social, and cultural settings
- cultural myths and misconceptions relating to the normalization of rape and sexual violence, e.g. attitudes to rape within marriage
- harmful sociocultural norms and beliefs relating to FGM, as well as common methods used and types of FGM practised in the community or country
- the national and/or regional legal and regulatory frameworks for reporting SGBV (including rape) and requirements and standards for collection of forensic evidence

- the national legislation, standards, and clinical guidelines for managing the medical consequences of rape
- appropriate referral pathways to apply, with the survivor's consent

In humanitarian or crisis settings, healthcare providers should also be trained on the Minimum Initial Service Package (MISP) [9] and the Inter-Agency Minimum Standards for Gender-Based Violence in Emergency Programming [4]. See *Chapter 11: Sexual and reproductive healthcare delivery in humanitarian settings* for more information.

2.3 Provider skills and competencies

Healthcare providers should be appropriately skilled, knowledgeable of SGBV root causes and myths, and prepared to identify, manage, and support clients experiencing SGBV; to perform screening where appropriate; and refer clients as appropriate for clinical care, psychological support, legal counselling, and shelter or protection services. Asking clients questions relating to SGBV can be upsetting and potentially dangerous for both client and provider, and therefore all screening must be carried out in an appropriate and survivor-centred manner. See International Rescue Committee [10] for further guidance and screening tools for SGBV in primary health facilities.

The World Health Organization (WHO) does not recommend screening all women who attend all healthcare settings for SGBV (i.e. 'universal screening') [11]. However, as many primary healthcare facilities, such as IPPF Member Associations' clinics, provide specialist care for sexual and reproductive health and rights, and clients presenting for many aspects of sexual and reproductive health and rights care are at higher risk for SGBV, selective screening of clients presenting for this care is recommended, provided appropriate training, facilities (such as private screening rooms and safe storage methods for sensitive data), and referral pathways are in place.

Providers must be mindful that screening is not an SGBV service, but rather a route to supporting further care and referrals. If specialized care or referral pathways will not be available, then screening of any kind should not be undertaken, as this can be harmful for survivors. IPPF does not recommend any screening in humanitarian settings (see *Chapter 11: Sexual and reproductive healthcare delivery in humanitarian settings*).

Counsellors, or anyone who will be screening or otherwise interacting with a client who has experienced SGBV, must be trained, skilled, and competent in up-to-date basic counselling techniques (see *Chapter 3: Counselling*) as well as in the provision of first-line support (an adaptation of 'psychological first aid'), i.e. the minimum level of psychosocial and emotional support that should be received by all clients who disclose abuse to the provider. First-line support includes practical care and responds to a client's emotional, physical, safety, and support needs, without violating their privacy [12]. WHO suggests that first-line support is often the most important care that a healthcare provider can provide.

In addition to the structural needs of private rooms where clients can speak without being overheard, building rapport and trust with the client is critical so that they feel comfortable and, if they choose, self-report the SGBV they are experiencing or are at risk of (see *Chapter 2: Facility requirements and client history/examination*). For survivors, disclosing this information is very personal and sensitive, therefore they may need extra time to talk and may be visibly upset. Through creation of a safe and empowering environment for the client, the healthcare provider will be able to make a clear assessment that will enable the provider to initiate appropriate and timely actions according to the survivor's wishes and consent [13,14].

As part of ensuring client safety and comfort, assumptions should not be made about gender identity or sexual orientation; use of gender-neutral language is recommended, where possible, e.g. 'partner' and they/them/their pronouns, until the client uses their own terms, in which case these should be mirrored.

2.3.1 Screening and clinical assessment

Healthcare providers must have skills and training in screening and clinical assessment relevant to SGBV, including:

- identifying genito-anal anatomy and assessing for clinical signs and symptoms of physical and sexual violence
- conducting a physical assessment and documenting injuries using standard terminology for classification
- assessing STI risks and having knowledge of the natural history of STIs and local protocols for testing and management
- providing first-line clinical care, such as emergency contraception and pregnancy testing

2.3.2 Referral

Healthcare providers must understand the criteria to be used as a basis for referral, with reference to the results of the screening and assessment for SGBV. Healthcare providers should also be aware of follow-up procedures after a client has been referred.

If healthcare providers have not been trained in screening and assessment for SGBV and/or do not have the appropriate survivor-centred attitude, then this process should not be implemented.

3. Caring for clients at risk of or affected by sexual and gender-based violence

3.1 Identifying clients experiencing or at risk of sexual or gender-based violence

Some clients will self-report experience or risk of SGBV themselves. Please note that providers must request time to speak privately with clients who are accompanied by a support person to provide an opportunity to disclose any experience of SGBV. Providers should nurture a safe space for clients to feel able to disclose their experiences and ensure that relevant healthcare, such as emergency contraception and post-exposure prophylaxis, is available regardless of a survivor's decision to disclose or not. However, the sensitivity of SGBV means that many clients may not want to share their information, and care must be taken to try to ensure that all clients have access to SGBV care and support.

Keep the survivor-centred approach in mind:

- If a client shares their worries, the healthcare provider should provide a safe environment for the client to feel safe and secure in sharing more information.
- If the client chooses not to disclose their situation or does not want to take up any interventions offered, essential SGBV information should be provided and another appointment offered, with the provision that they can come back at any time for information and healthcare.
- Only discuss SGBV when alone with the client or when there is no one else present over the age of 2 years, unless the client has requested the presence of a chaperone or a specific friend/relative.
- Maintain strict confidentiality of the client's health records, never leaving them out unattended on the desk.
- Before offering screening or asking any questions, providers must explain any mandatory reporting laws that affect their conversation or limit its confidentiality so that the client can make an informed choice about whether to disclose. Wherever possible, access to care and support should not rely on self-disclosure or screening.

The healthcare provider may be alerted to a client who has not self-reported experiencing SGBV, based on psychological or physical signs and symptoms that the client presents with. More than one factor may be present and correct identification will depend on the healthcare provider remaining vigilant and looking at the whole clinical and psychological picture. This may include clients:

- who engage in self-destructive or self-harming behaviours, such as substance misuse, acts of self-harm, or thoughts and plans about committing suicide
- with persistent anxiety or depression
- with recurring physical complaints such as physical injuries that are not well explained
- with repeated STIs (see *Chapter 6: Sexually transmitted infections*), as well as unintended pregnancies
- with chronic pain conditions or vague complaints for which no diagnosis can be found

Physical and psychological issues related to SGBV may only become apparent over a series of visits by the client. It may also take time for clients to trust a particular healthcare provider and disclose their situation, even when sensitive screening and counselling techniques are employed. Because of this, it is crucial that the information from the consultation is documented in the medical record (while ensuring data confidentiality) so that the conversation can be continued at the following visits, if the client wishes. It is important to note that screening is a method of offering clients who have experienced SGBV an opportunity to disclose, and not a list of questions that they must answer (see *Box 1* – next page).

In a country or region with a designated government agency that leads on SGBV, or in an emergency setting with an activated humanitarian coordination network (protection cluster or SGBV sub-cluster) there may already be a referral pathway available for the area. The healthcare provider should ensure that the details of their organization are correct and available so that survivors needing referrals to sexual and reproductive health and rights care can be safely referred, and that healthcare providers are fully aware of the options for outward referrals. If there is no current referral pathway then one should be developed using the example in *Appendix 1*, completing it with the contact details of each referral agency available.

3.2 First-line support

Healthcare providers should be trained and provide first-line support that is tailored to the individual client and is survivor-centred. This includes provision of essential practical care and action to support the client's immediate emotional and physical safety needs, bearing in mind that, where possible, survivors should be referred for comprehensive expert care and follow-up. Care will not be a 'one size fits all' model, and providers should ensure that their care (and referrals offered) is equally accessible to marginalized and under-served groups, such as those from indigenous communities, people with disabilities, displaced people, and people with diverse sexual orientations, gender identities and expressions, and sex characteristics. *Table 1* summarizes the key areas of initial support for a client, based on the acronym LIVES: Listen, Inquire, Validate, Enhance safety, Support. These were originally developed for women, but the wording here is gender neutral. Healthcare providers are encouraged to adapt the five tasks for all clients experiencing SGBV according to culture and local language.

BOX 1: Suggested screening questions to identify sexual and gender-based violence (SGBV)

1. Is it okay for us to ask you questions on sexual and gender-based violence? Yes/No

   If "YES" proceed to question 2. If "NO", offer further information, make it clear that help is available at any time, and respect the client's decision not to be asked about violence.

2. Are you currently in an intimate relationship with a person (e.g. spouse, partner) who physically hurts you? Yes/No

   If "YES", did this happen within the last 6 months? Yes/No

3. Are you currently in an intimate relationship with a person (e.g. spouse, partner) who threatens, frightens, or insults you, or treats you badly? Yes/No

   If "YES", did this happen within the last 6 months? Yes/No

4. Are you currently in an intimate relationship with a person (e.g. spouse, partner) who forces you to participate in sexual activities that make you feel uncomfortable? Yes/No

   If "YES", did this happen within the last 6 months? Yes/No

5. Have you ever been forced to have sex with someone that you were NOT in an intimate relationship with (i.e. not your spouse or partner)? Yes/No

   If "YES", did this happen within the last 6 months? Yes/No

Note to healthcare provider: If one or more "Yes" options are selected, after obtaining the client's consent, offer a referral for further SGBV care if they indicate that they have never been referred before. Once a referral has been given, do not ask this client these questions again.

Additional questions to identify reproductive coercion:

1. Has anyone, such as your partner or another person/ relative, ever forced you to do something sexually that you did not want to do or refused your request to use condoms or other contraception?
2. Has anyone, such as your partner or another person/ relative, ever tried to get you pregnant when you did not want to be pregnant? Or tried to get you to continue a pregnancy that you wished to end?
3. Are you worried anyone will hurt you if you do not do what they (the perpetrator) wants?
4. Does your partner support your decision about when or if you want to become pregnant?

Note to healthcare provider: Not all clients who live with reproductive coercion are affected by other forms of SGBV, but if there is coexistence, the risks to the client are higher.

Source: Adapted from Undie et al. [15], ACOG [16], and Silverman et al. [17].

TABLE 1: LIVES – First-line client-centred support for sexual and gender-based violence

Action	Key points
LISTEN Listen to the survivor closely, with empathy and without judging	Be aware of body language and what the client does not say Be sensitive about what you say and how it is said Use client-focused questions such as, "Would you like to tell me more?" Give the client time and do not interrupt; silence is fine as this gives the survivor time and space to think
INQUIRE ABOUT NEEDS AND CONCERNS Assess and respond to the client's various needs and concerns: emotional, physical, social, and practical (e.g. childcare)	Ask open-ended questions to encourage the client to talk Avoid "Why" questions Help the client to identify and express their needs and concerns
VALIDATE Validation is important for those who disclose violence Show them that you understand and believe them Reassure them that they are not to blame	Examples of what the healthcare provider can say: • "It's not your fault, you are not to blame" • "It's okay to talk" • "No one deserves to be hit by their partner in a relationship"
ENHANCE SAFETY Discuss a plan for the client to protect themself from further harm if violence occurs again This can include drafting a safety plan, which should be reviewed regularly The healthcare provider should be aware of what referral options are available if not all healthcare is provided by the facility, e.g. shelters offering respite from threats and providing targeted support from staff trained in SGBV case management	• Knowledge of the national SGBV protocol • Knowledge of local protocols including SGBV referral pathways • Knowledge of other partner organizations involved in SGBV survivor support • Knowledge of safe homes/shelters for SGBV survivors
SUPPORT Healthcare providers should prioritize the client's safety by helping to connect them to information, healthcare, and social support mechanisms For those living with reproductive coercion, contraceptive choices that are not visible (e.g. three-monthly injectables, implants, intrauterine device) can be offered (see further information in *Chapter 4: Contraception*)	Knowledge of other partner organizations involved in SGBV support in the area

Source: Adapted from WHO [14].

3.3 Assessing safety

To provide first-line clinical healthcare and psychosocial support (*Section 3.2*), healthcare providers should first assess the client's safety. If it becomes apparent that the client has concerns for their safety, the healthcare provider should establish whether the client is in immediate danger; the questions in *Box 2* can be used for this. The healthcare provider must avoid putting the client at any further risk. They may need to offer to see the client on their own or with a chaperone, friend, or family member of the client's choosing. If a specialised SGBV case management agency or other provider is operating in the area, then with the client's consent they should be involved at this stage so that they can lead on safety planning and ongoing support.

If the client is in immediate danger of violence, the provider should discuss with the client whether it is safe to go home or not. If not, appropriate referrals for shelter or safe housing should be made, or the client may know a safe place where they can go to.

If the client is not facing an immediate serious threat, the healthcare provider can support them to develop a safety plan should the situation escalate. Healthcare providers should be trained in how to support survivors develop safety plans to best minimize the risks and circumstances the survivor faces. This plan should include a safe place to go, whether or not to take the children (if any), transport, money, what to pack, and arranging for support from a neighbour who might hear sounds of violence from the client's home [14]. It is also important to assess the client's risk of suicide or self-harm, and the chance of putting themselves, and their children, at risk.

BOX 2: Screening questions to assess immediate risk of violence

Clients who answer "Yes" to at least three of the following questions may be at especially high, immediate risk of violence:

- Has the physical violence happened more often or worsened over the past 6 months?
- Has this person ever used a weapon or threatened you with a weapon?
- Has this person ever tried to strangle you?
- Do you believe this person could kill you?
- Has this person ever hit or beaten you when you were pregnant?
- Is this person violently and constantly jealous of you?

Source: Adapted from WHO [14].

3.4 Referral to other services

Once the immediate danger has been assessed, discussed, and first-line support offered, the healthcare provider should ensure that the client receives all relevant information and care available at the facility, as well as information about additional services that the client can be referred for, should they wish to access them. These include:

- social support (e.g. women's empowerment groups, women lawyers association)
- specialist psychological support
- survivor support groups
- police and legal support, as well as any internet-based (online) services that are available
- mental health services
- referral hospitals
- sexual assault referral centres where they exist

The healthcare provider should allow the client to lead the discussion and decide what further support they require. They may need time to think about their options. It cannot be assumed that the client will immediately make up their mind to go to the police, to a shelter, or seek psychological counselling. *Appendix 2* and *Appendix 3* summarize suggested pathways for care and referral for IPV and for immediately after assault.

The client should be advised that rejecting any referral support services will not affect their immediate care given by healthcare providers. If the client declines onward referral, the healthcare provider or assigned social worker should offer a follow-up contact and information on emergency contacts should they decide

to access services later. They should be made aware that if they have any questions or concerns, or if there is a chance that the violence could escalate, they can come back at any time, and they should be reassured that they will not be treated differently because they initially declined assistance. This gives the opportunity for the healthcare provider who assessed the client at the initial consultation to monitor the psychological state of the client with encouragement and reassurance.

3.5 Care and management of individuals subjected to sexual violence and rape

Any client who is a survivor of sexual violence has the right to receive all the clinical healthcare and support that they need. Healthcare providers who attend to SGBV survivors should be trained and skilled to provide clinical examination and care for rape survivors (*Table 2*).

Providers should explain clearly what is going to happen before and during the examination and obtain informed consent at every stage. This is especially important for survivors of sexual violence for whom the examination may be traumatic and remind them of their experience. Similarly, where a client experienced their consent being violated, they must be able to trust that their consent will be respected at every stage of their interaction with a healthcare provider. Providers must show empathy and be sensitive to the emotions of the client. The client should be asked if they would like a support person with them during any procedures or intimate examinations. If the client refuses physical examination, respect their choice, and suggest that it can be done as soon as the client feels better but make the client aware that some interventions are time sensitive. Provide referral if the client would prefer to be referred to another facility.

TABLE 2: Clinical examination and care for rape survivors

Examination or treatment	Perform as soon as possible, or within the time specified since the assault (0 hours = time of assault)
• Vaginal examination • General examination • Forensic examination • HIV post-exposure prophylaxis • Medico-legal documentation • STI prevention and treatment • Wound management • Tetanus vaccination	• 72 hours (3 days)
• Emergency contraception	• 120 hours (5 days)
• Pregnancy test • Hepatitis B vaccination	• 2 weeks • 6 weeks
• HIV counselling and referral • HIV testing	• 3–6 months
• Referral • Private counselling • STI prevention and treatment • Contraceptive counselling and healthcare • Safe abortion care	• Any time

3.6 Documentation and reporting

Clients have the right to know what information will be written and documented about their experiences, and to decide what information is and is not shared with others. Although IPPF does not support mandatory reporting because it undermines self-determination, providers must also inform survivors about limitations to confidentiality systems including mandatory reporting laws at the beginning of the consultation.

Consultation details including physical findings should be noted in the client's record and kept safely in a locked cabinet. Providers should use systems such as number identification to maximize confidentiality. Providers should also discuss with the client the content of any documentation that might be sent home with the client, to police, or other special services. Refer to the local or national SGBV protocol regarding documenting and reporting.

4. Female genital mutilation

IPPF's position on FGM is as follows:

- Individuals affected by FGM have experienced a harmful practice. They should not be stigmatized and they have equal rights of access to quality healthcare.
- FGM-related care must be rights-based, gender-sensitive, client-centred, evidence-based, stigma-free, universally accessible, and offered through the continuum of care.
- Medicalization of FGM* is never acceptable because it violates medical ethics.

4.1 Provider knowledge and skills related to female genital mutilation

Healthcare providers should understand that FGM may be considered an important part of the cultural and gender identity of girls and women in many communities, and healthcare must be sensitive to the specifics of each context, including:

- Existing laws relating to FGM in the local and national context and what the reporting requirements are to national authorities.
- The possibility, in the local context, for healthcare providers to work with community organizations or national bodies to identify children at risk and take appropriate action.
- Whether healthcare providers involved in healthcare provision are also part of the culture in which FGM is practised, in which case they may have experienced FGM themselves or subjected their dependents to it.

Healthcare providers should be familiar with FGM types and the associated complications (see *Sections 4.2 and 4.3*). They should know where to refer clients if additional clinical intervention is required (e.g. urogynaecology, assisted reproductive care, psychological or psychosexual care, and/or other SGBV care). They should also know where FGM clients can get help and support outside of the clinical settings (e.g. support groups).

However, healthcare providers should remember that not every individual who has undergone FGM has symptoms or clinical signs that need treatment. If the client is well and does not feel the need for any intervention, then this should be respected.

Healthcare providers should not recommend the implementation of medicalization of FGM, less harmful types of FGM, or any form of FGM. Similarly, requests for reinfibulation (e.g. the reinstatement of type III FGM after childbirth) by the client or a relative are unacceptable and healthcare providers must refuse any such request.

* Medicalization of FGM: "Situations in which the procedure (including re-infibulation) is practised by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere" [8].

4.2 Screening and classification of female genital mutilation

When clients attend for any sexual and reproductive healthcare, particularly in areas with a high prevalence of FGM, the healthcare provider can ask sensitively and in private whether they have undergone FGM. If they disclose that they have, or are not sure (or not sure of the extent), they can be offered a gynaecological examination. *Table 3* summarizes the four main types of FGM.

4.3 Sequelae of female genital mutilation

Information on the health sequelae of FGM is summarized in *Table 4*.

TABLE 3: Classification of female genital mutilation

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

Source: WHO [8].

TABLE 4: Health risks of female genital mutilation

Complications	Examples
Immediate	Haemorrhage, pain, shock (haemorrhagic, neurogenic, or septic), genital tissue swelling, infection (acute local infection, abscess formation, sepsis, genital and reproductive tract infections, urinary tract infections), urination problems (acute urine retention, pain passing urine, injury to the urethra), wound healing problems, death (due to severe bleeding or sepsis)
Obstetric	Caesarean delivery, post-partum haemorrhage, episiotomy, prolonged labour, obstetric tears/lacerations, instrumental delivery, difficult labour/dystocia, extended hospital stay, stillbirth and early neonatal death, infant resuscitation at delivery
Sexual functioning	Dyspareunia (pain during sex), decreased sexual satisfaction, reduced sexual desire and arousal, decreased lubrication during sex, reduced frequency of orgasm or anorgasmia
Psychological	Post-traumatic stress disorder, anxiety disorders, depression
Long-term	Genital tissue damage (chronic vulvar and clitoral pain), scaring and retention cyst Vaginal discharge (due to chronic genital tract infections) Vaginal itching Menstrual problems (dysmenorrhoea, irregular menses, difficulty in passing menstrual blood) Reproductive tract infections (and chronic pelvic pain) Chronic genital infections (increased risk of bacterial vaginosis) Urinary tract infections (often recurrent) Painful urination (due to obstruction, recurrent urinary tract infections)

Source: WHO [8].

4.4 Information, counselling, and referral for clients with female genital mutilation

Clients who have undergone FGM must not be stigmatized or discriminated against but must receive care and support from any healthcare provider involved in their care.

If a client is confirmed to have undergone FGM, the healthcare provider can offer information and referral to relevant healthcare, if requested or required, with the client's consent. Clients with type III FGM (infibulation) can be given information on and referred for deinfibulation (see *Section 4.5*) if they wish to have this corrected for their own well-being, to address any comorbidities, or before first vaginal sex or childbirth (see following paragraphs).

Healthcare providers should offer the same comprehensive sexual and reproductive healthcare to clients affected by FGM as for any other client, such as HIV and STI testing and treatment, hepatitis B and C testing, contraceptive counselling and healthcare, safe abortion care, and cervical cancer screening. There may be difficulty performing a speculum examination for clients with type III FGM. In these cases, contraceptives other than intrauterine devices can be offered, and alternatives to cervical smear testing can be offered for cervical cancer screening, such as DNA testing for HPV. The healthcare provider can also discuss with the client the possibility of performing a speculum examination using the smallest size speculum, if available.

Pregnant individuals or those considering a pregnancy should be counselled that they need to plan to deliver in a healthcare facility that is equipped to manage complications such as post-partum haemorrhage and perform caesarean delivery (i.e. comprehensive emergency obstetric and newborn care). Pregnant individuals with type III FGM should also be counselled on deinfibulation (see *Section 4.5*); they must be provided with information on the serious risks that they and their baby face during childbirth if deinfibulation is not performed in good time.

Healthcare providers should be aware that any client who has undergone FGM may have chronic physical and psychological complications that require specialist counselling or surgical treatment (see *Table 4* – previous page). The provider may need to enquire sensitively to establish to what extent the client's life is affected. Whether for physical, psychological, or psychosexual issues, the client should be provided with appropriate counselling, support, and treatment or referral; however, if the client does not wish to be treated or referred after information and counselling, their decision should be respected.

For clients who are engaged to be married, premarital counselling with the couple can address the psychosexual complications commonly associated with FGM. This can be achieved using a sex-positive approach that focuses on sexual pleasure rather than the negative experience of FGM [18,19].

4.5 Deinfibulation for type III female genital mutilation

Deinfibulation (repair of infibulation) is also known as anterior episiotomy. The procedure consists of cutting and opening the narrowed vaginal opening. Deinfibulation may be required before first vaginal sex or before childbirth, and it may also be needed to prevent and manage some immediate or long-term health consequences. While it is often performed during childbirth, deinfibulation can be offered in the antenatal period or at any time in the non-pregnant client, when requested.

The procedure can be performed at an approved location, such as a clinic, under local anaesthetic; however, there are risks attached, such as injury to the urethra and bleeding. It must, therefore, be performed by a trained specialist healthcare provider, and referral to a higher-level facility may be required.

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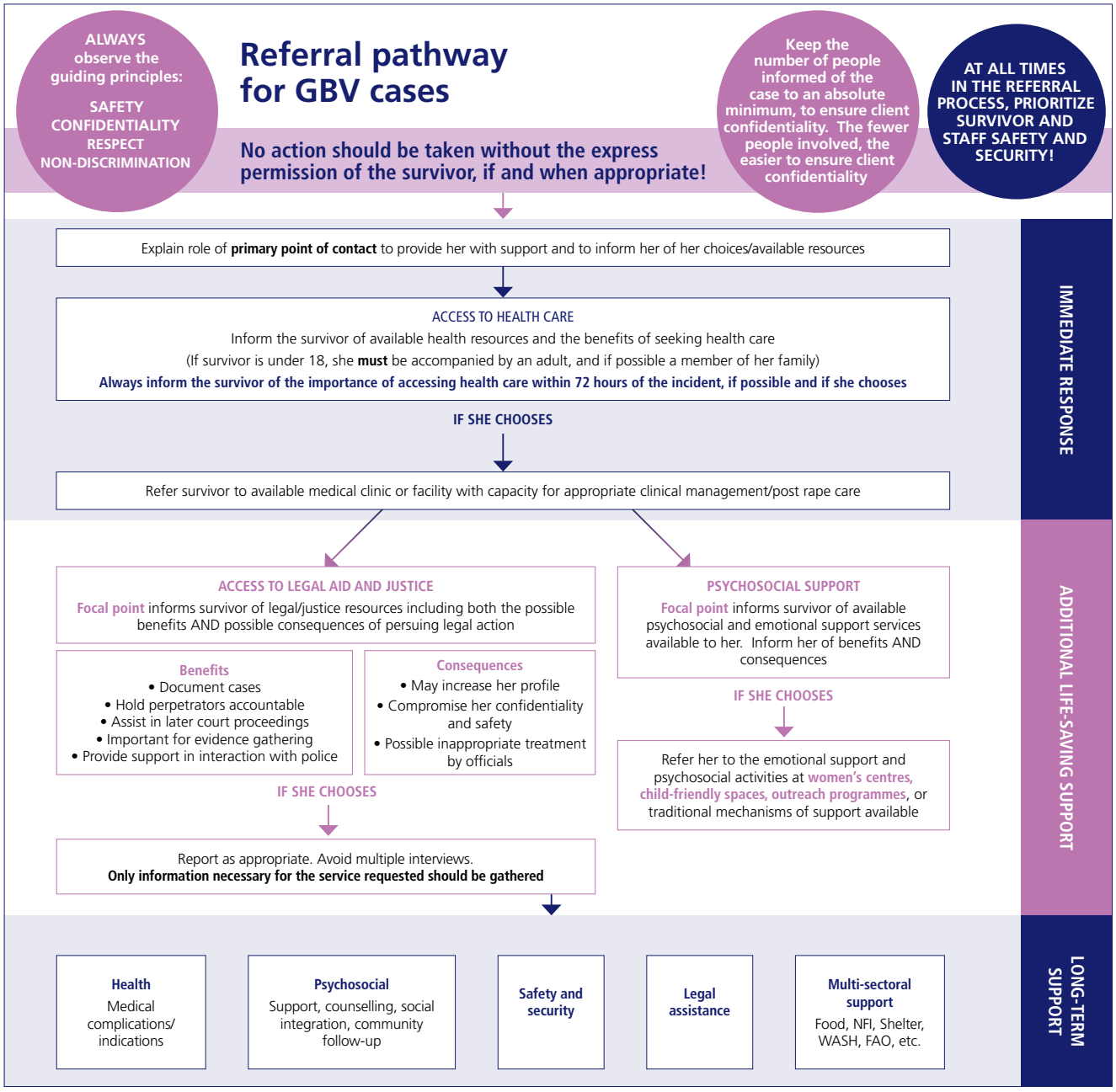
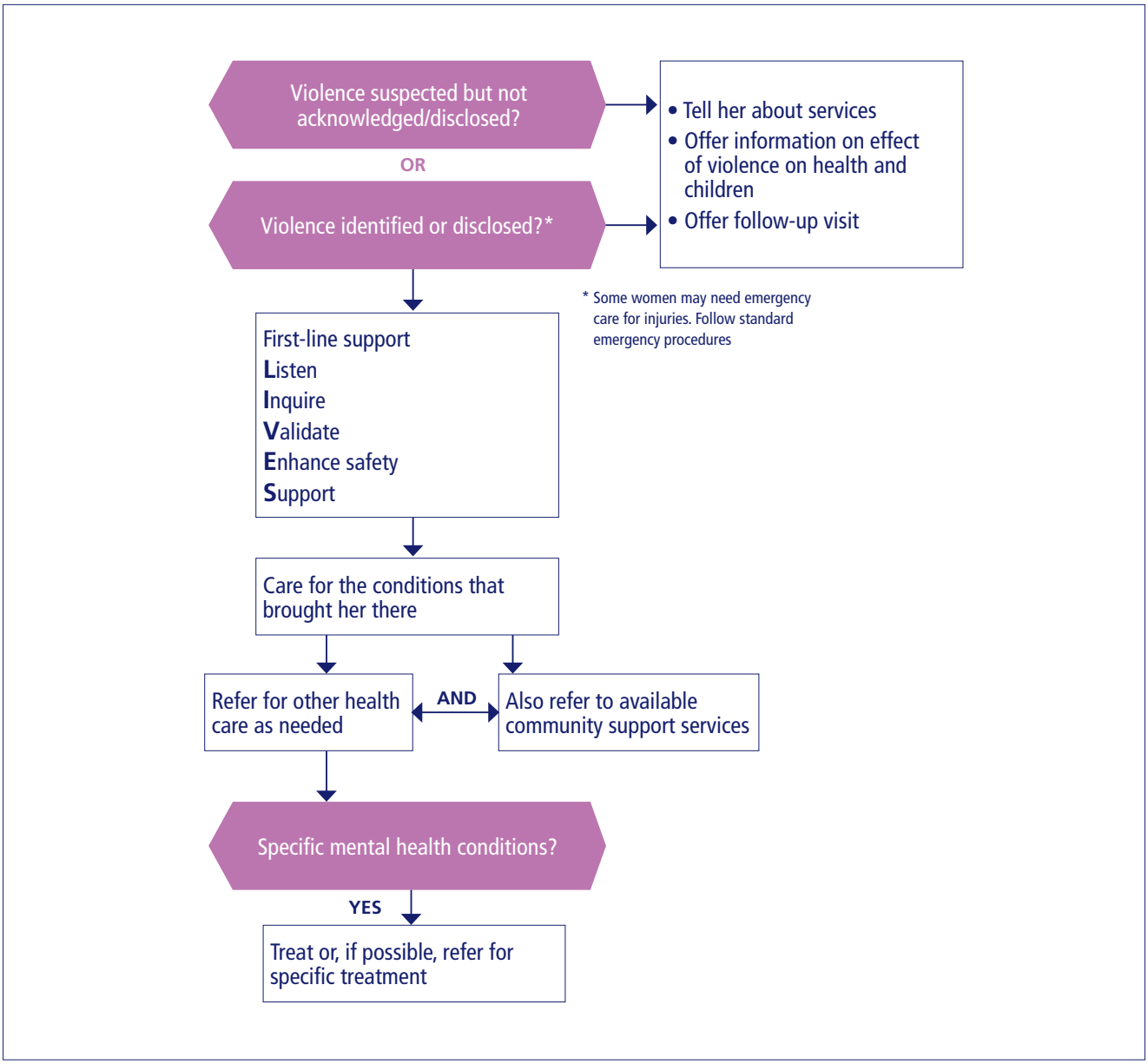
6. Appendices

Appendix 1: Example of a referral pathway for sexual and gender-based violence



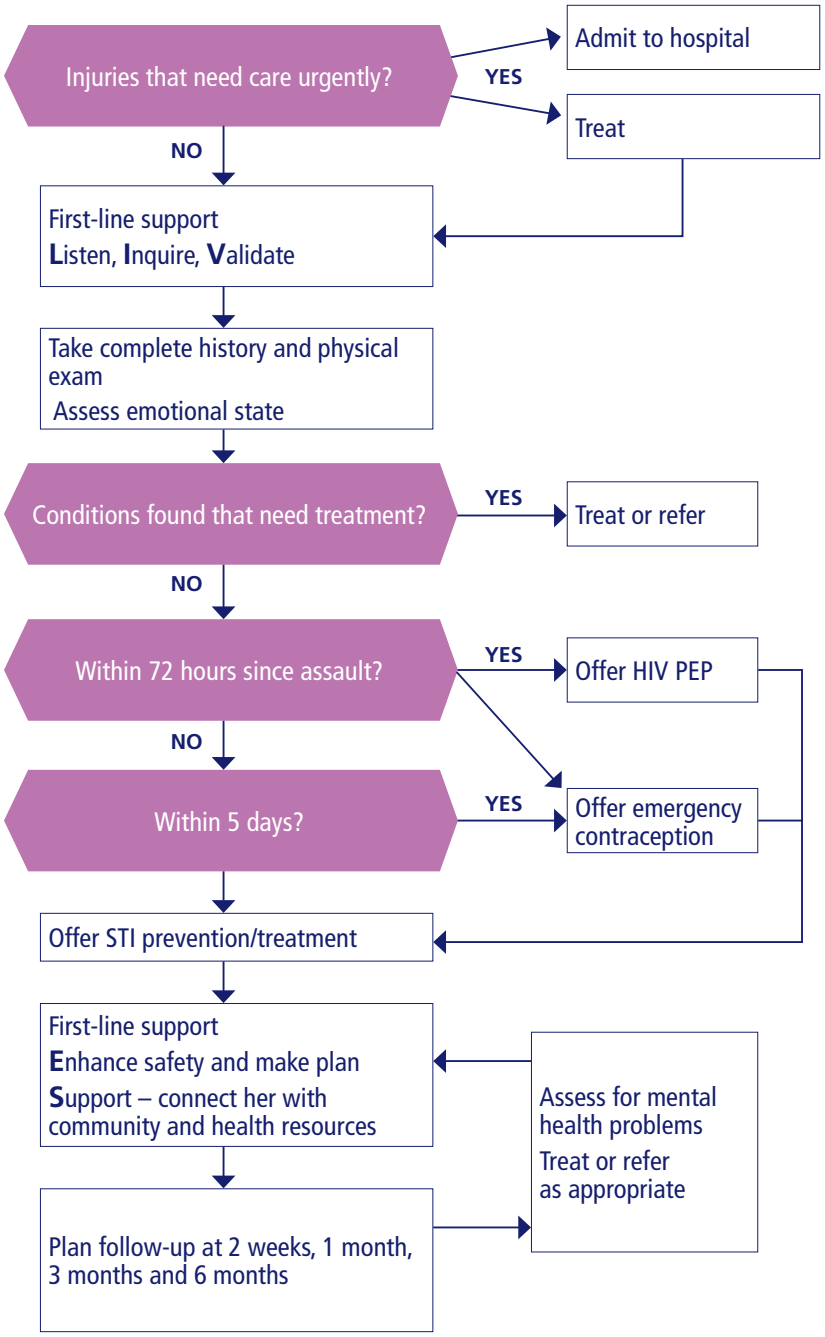
Source: Aadapted with permission from the Global Protection Cluster. Handbook for coordinating gender-based violence interventions in humanitarian settings. Geneva: Global Protection Cluster; 2010. Available at: https://gbvresponders.org/wp-content/uploads/2014/04/Handbook-for-Coordinating-Gender-based-Violence-in-Humanitarian-Settings-GBV-AoR-2010-ENGLISH.pdf. Accessed 28 April 2022. Note: Based on the referral pathway for GBV cases in Darfur

Appendix 2: Pathway for care for clients experiencing violence by an intimate partner



Source: Reproduced/translated with permission from World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: WHO; 2014. Available at: https://apps.who.int/iris/handle/10665/136101. Accessed 28 April 2022.

Appendix 3: Pathway for initial care after assault



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