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GENDER-BASED VIOLENCE PREVENTION AND RESPONSE

>> A METHODOLOGICAL GUIDE

MÉDECINS DU MONDE

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DR DENIS MUKWEGE

EDITORIAL

DR OLIVIER BERNARD,

PRESIDENT OF MÉDECINS DU MONDE (FRANCE)

Statistics on gender-based violence speak volumes and are… painful to hear. Worldwide, one out of five women will one day be the victim of rape or fondling. An estimated 10 to 69% of women (depending on the country) have been physically attacked by a male partner at some time in their lives. In Asia, 90 million women are “missing” in population statistics, consequences of selective abortions or infanticide, because of the widespread preference for male children. Between 100 and 140 million women and girls have undergone genital mutilation for cultural or religious reasons. Violence against women occurs everywhere in the world, in each region, each society and each culture. It can be perpetrated within the family or within the social group or community to which they belong, or committed during an armed conflict (where rape has become an actual weapon of war). Whether sexual, physical, moral or institutional, such violence leads to serious psychic damage, in addition to serious physical health disorders. It can also lead to death, through homicide, serious injury or suicide. Amidst the HIV/AIDS epidemic, it has become even more urgent to address the issue of gender-based violence.
Gender-based violence is a major public-health problem that must be addressed immediately, and for many years now and

in many countries (Guatemala, Pakistan, Nicaragua, Moldavia, Haiti, Egypt, Niger, Peru, Liberia, the DRC, Pakistan), Médecins du Monde has taken action to prevent and respond to violence against women. Beyond providing care, MdM takes an inclusive approach that aims, whenever possible, to achieve a social transformation. MdM intervenes in quite varied contexts, involving almost all forms of gender-based violence. In their daily work, Médecins du Monde teams face these various forms of violence. In the Democratic Republic of Congo, where sexual violence is very frequent and its perpetrators most often go unpunished; in Algeria, where domestic violence is quite common; or in Pakistan, where women fleeing violence and the threat of "honour crimes" find refuge in government homes, the so-called *Dar-Ul-Aman.*

In most of these countries, Médecins du Monde works with the backing of, and in tandem with, local associations, institutions or civil-society organisations. It is only by working together with all actors and through access to various skills that women who have suffered from violence can be offered the opportunity to put their lives fully back on a solid footing.

The fight against gender-based violence is now a policy emergency and a true public health challenge on a worldwide scale. With the assistance of its partners in the field and based on a quality, multi-disciplinary approach, and while respecting the communities involved, Médecins du Monde intends to continue aiding this fight, in both France and internationally, both here and there.

FOREWORD

DR DENIS MUKWEGE,

DIRECTOR-GENERAL OF PANZI HOSPITAL (DRC)

The stories and testimonies of women victims of rape are striking and shake us. Everyday, I meet these women, as a doctor, at the Panzi Hospital in Eastern DR Congo; women, who are survivors of sexual violence, or whose bodies have been destroyed because they do not have access to basic reproductive health care. They are paying the price for conflicts fuelled by financial interests that undermine the structures that shall uphold the basic human right to protection such as health care. Some people feel the pain in their body everyday, whether they are harmed physically, psychologically, or morally.

However, what we see here is just an expression of something that is universal; the mechanisms are the same in America, Europe, Asia, and Africa. Everywhere, there are people who bear the burden of having been subjected to gender-based violence. Nevertheless, no society, no country is giving this phenomenon enough attention.
There are those who believe that the issue is being raised, that it actually is on the agenda, and that appropriate legislation is being put in place. There are also those who claim that the descriptions of gender-based violence are exaggerated.

But if the world really understood what gender-based violence is, and what the consequences are, things would look different. This is not the time to minimize the problem; it is time to prioritize.

My experience after meeting thousands of survivors of gender-based violence has left me convinced that rape does not simply damage physically and mentally. It tears down the social fabric and creates disempowerment. It takes away a person's dignity and identity, not only in the eyes of the survivor herself, but also in the eyes of those around her.

The use of sexual violence has in some parts of the world become a strategy for breaking down communities. It is a weapon that moves slowly but its effects are devastating. We are very aware of the danger of a firearm or a chemical weapon, but we should be equally concerned about the consequences of sexual violence.

Different societies and countries view all survivors of sexual violence similarly. To some, the stigma is strong; so strong that returning home means going back to a family rejecting or blaming the woman for the assault. In the same way, a woman in another part of the world can be accused of having caused the abuse because she was dressed inappropriately. It is the victim, the survivor, who has to pay with her body and her dignity.
I think that if men were subjected to gender-based violence in the same way that women are today, the world would react differently. I think the laws would be applied, that the perpetrators would be tried and convicted for their deeds. The problem of gender-based violence is complex, but not complex enough to be pushed aside because of lack of solutions.

One of the most important fights we must take is the fight against impunity. For as long as we do not seriously apply the legislation, making it clear that gender-based violence is not accepted, women, families and communities will continue to lose their dignity and their ability to prosper.

It is our responsibility to take this fight; we have seen the consequences of gender-based violence with our own eyes and heard the stories. If we continue to accept this, we also accept the destruction of our world.

1 INTRODUCTION

1A PRESENTATION OF THE GUIDE

This methodological guide is the fruit of a cross-disciplinary project to consolidate the experiences and tools developed by MdM and of discussions on the issue of gender-based violence. It was put together through an international programme to fight gender-based violence that has been funded since 2007 by the French Development Agency (AFD), and under whose aegis this tool has been developed.

1 / WHAT IT IS

This guide's purpose is to:

→ **provide some channels for thought and action to develop programmes, programme components or special activities to prevent and/or respond to gender-based violence:**

→ **to raise awareness of the importance of this phenomenon.**

Beyond a general presentation of the issue of gender-based violence and the various real-world contexts behind that term, this guide deals with the various aspects of caring for victims of violence, as well as awareness-raising activities and the argumentation that can accompany those activities.
As a true **methodological tool, it aims to facilitate the development and implementation of actions to combat gender-based violence and to enhance the quality of interventions in the field.**

It also helps to **disseminate and highlight MdM's best practices and know-how** in this area by capitalising on its experiences and the methodologies and tools developed by MdM's teams and its partners. It is based on internal documents drawn up in the field and at the head office (including technical datasheets, training and awareness kits, care-providing protocols, workshop proceedings, exchanges of best practices, testimonies, etc.) and external documents (reference documents on the issue).

2 / WHAT IT IS NOT

This guide is not a tool detailing in an exhaustive manner all aspects of caring for and supporting victims of gender-based violence.
It provides no ready-made solutions for setting up gender-based violence prevention and response activities, as those must be adapted to each intervention context.

3 / WHOM IT IS FOR

This guide is meant for all persons wishing to better understand gender-based violence and to develop gender-based violence prevention and response initiatives.

More precisely, the guide is for personnel of MdM and its partners:

- → **In the field:** persons (coordination and technical positions) involved in combating gender-based violence or any other project, internationally or in France, whose users may include victims of gender-based violence.
- → **At the head office:** employees and volunteers involved in designing and monitoring projects fighting gender-based violence or any other project, internationally or in France, whose users may include victims of violence.

This guide is therefore meant not only for staff involved in specific programmes fighting gender-based violence. Nor is it solely for medical personnel, but rather for **all persons who may be involved in caring for victims of violence.**

1B

MEDECINS DU MONDE'S STRATEGIC APPROACH

While paying special attention to the diversity of contexts, Médecins du Monde is now seeking to develop a consistent cross-disciplinary approach to certain interdependent principles of intervention.

1 / AN **OVERALL AND INTEGRATED APPROACH** TO COMBATING GENDER-BASED VIOLENCE

The programmes deal with health as an overall state of well-being, i.e., that takes into account not just medical care, but also the political, social, economic, cultural, and family context. The idea is to go beyond caring for individuals and to think more in terms of the collective.

Médecins du Monde's commitment is thus based on an overall intervention strategy that aims not only to care for and rehabilitate victims of violence, but also to raise awareness among care-providers and communities, and to inform and train them.

2 / A **MULTIDISCIPLINARY APPROACH** IS A KEY PRINCIPLE IN CARING FOR VICTIMS OF VIOLENCE

As violence has many consequences, Médecins du Monde is seeking to develop a true multidisciplinary approach. While providing care and bearing witness remain our main missions, we want to broaden our activities. In addition to providing medical care, victims of violence must be identified, taken in and referred for appropriate further care, in order to provide access to psychological follow-up, legal assistance and socio-economic rehabilitation services. It is by combining these different aspects that the lives of victims of violence can be fully restored.

More than "multidisciplinary", the term "cross-disciplinary" expresses the mechanisms for coordinating care-providers. Care must indeed be cross-disciplinary, involving not just the individual intervention of various actors but also the strong operational referral links.

This multidisciplinary or cross-disciplinary approach is often possible only through the development and support of networks of local players.

3 / AN APPROACH BACKED BY **DEVELOPING NETWORKS** AND BY **STRENGTHENING THE SKILLS OF LOCAL PARTNERS**

The difficulties in gaining access to victims of violence and the importance of understanding the context and local perceptions of violence require working closely with local actors in societies in which the organisation operates. Moreover, MdM is not able to ensure all aspects of multidisciplinary care and is not meant to do so.

In most of its countries, Médecins du Monde thus works with the backing of, and in tandem with, local institutional or civil society partners. By developing networks and reinforcing capacities, it provides a concerted, complementary and long-lasting response to the phenomenon of gender-based violence.

4 / A COMMUNITY APPROACH TO COMBATING GENDER-BASED VIOLENCE

MdM promotes a community-based approach as part of its operations and when the programme context and objectives lend themselves to that. This intervention strategy is based on recognising the potential value of individuals, social networks and communities in responding to their social and health problems and seeking to enhance that value. It restores

to individuals and collective groups the means to be fully involved in their individual and social rehabilitation and to take part themselves in the fight against gender-based violence.

5 / TAKING SOCIO-CULTURAL DETERMINANTS INTO CONSIDERATION

Socio-cultural determinants[1] have an impact on actions and behaviours, and, above all, on individual and community perceptions. How local populations, care-providers, and the victims themselves depict violence is of prime importance and is included in most programmes. Socio-cultural determinants can form an obstacle to indentifying and recognising victims of violence, to providing quality care and to effectively enforcing changes in laws. Analysing theses determinants must therefore be included beginning with the project's diagnosis phase, to determine what activities to undertake and how to undertake them.

6 / AN APPROACH FAVOURING **THE INCLUSION OF MEN:** INTERVENING THROUGH THE PRISM OF GENDER

MdM stresses the importance of involving men in fighting gender-based violence. While it acts first and foremost to provide care and support for the victims, it must also take into consideration the perpetrators of violence, the family and society in general. As men fall under the influence of socio-cultural norms and are subject to numerous social pressures, they must also be part of the solution. The quality and sustainability of our projects depend on our ability to involve the population as a whole. Groups of men can thus be mobilised and encouraged to act not just individually, within their own homes and in their daily lives, but also collectively, in association with women's organisations.
MdM also intends to act in the area of depictions of masculinity, which are often at the root of violence and have an impact on the quality of the care that it provides.

7 / GOING BEYOND VICTIMHOOD

Our operations must be able to get past victimhood, so that users of our services are not caught in a passive role of victim. This means considering victims of violence as "subjects" and not as "objects" to be cared for.
This means that violent acts must be neither denied nor underplayed, but recognised by everyone, in particular by the care-providers and those who know the victim as a violation of the victim's rights. Once the victim is aware of this social recognition, she/he can then get past the "status of victimhood" and take on an active role in seeking care and rejoining society.

1. Socio-cultural determinants include all aspects of an individual's environment in a given context.

8 / PROTECTING VICTIMS OF VIOLENCE IS AT THE HEART OF OUR APPROACH

Caring for vulnerable people requires guaranteeing their protection, and ensuing that their immediate needs and physical security are provided for.
Protection is of particular importance in anti-gender-based violence projects, given that victims of violence who do seek care run the risk of suffering new acts of violence (reprisals / threats from the aggressor against the victim or the victim's circle, economic insecurity when the victim has left her home or been expelled from it, etc.).
Protection must therefore be at the heart of our approach to all acts of prevention and response to gender-based violence.

9 / BEARING WITNESS TO HUMAN RIGHTS VIOLATIONS AND DENOUNCING GENDER-BASED VIOLENCE

In addition to providing healthcare, the organisation's mission is to bear witness to the violence that its programmes combat and to denounce such violence in raising awareness of the phenomenon of gender-based violence. The iconographic collection and testimonies are precious in reporting on the contextual realities of each field and in increasing our credibility with authorities and local populations. However, this must be done in a way that does not exacerbate the insecurity and the stigmatisation of the victims of violence.

10 INCLUDING CARE OF VICTIMS OF GENDER-BASED VIOLENCE IN ALL OF MÉDECINS DU MONDE'S PROJECTS

Gender-based violence is an international phenomenon that knows no geographical or social boundaries: all intervention contexts are concerned; all service-providers involved in an MdM programme may therefore come face-to-face with it in the course of carrying out their activities.

→ The medical sector (particularly primary care, sexual and reproductive health and HIV/AIDS) is a **privileged entry point** in identifying and caring for (and/or referring) victims of gender-based violence.

→ The **quality** of care provided to our programmes' beneficiaries depends, among other things, on the capacity of care-providers to recognise situations of violence and to respond to them appropriately.

Pelvic pain can just as likely be due to gynaecological disorders (ectopic pregnancy, painful menstrual cycles, etc.) or urinary disorders (cystitis, pyelonephritis, etc.) as the consequences of acts of physical or sexual violence.

In the event of repeated consultations for cephalgia or abdominal pain, healthcare professionals must consider violence as one of their possible diagnoses.

→ Complying with the **principles of medical ethics** that MdM upholds in all its programmes, and particularly "the obligation to protect" requires making care-providers aware of the issue of gender-based violence and ensuring that they are able to respond to it.

THE OBLIGATION TO PROTECT

"MdM personnel cannot stand idly by, once they have found signs of violence."

"MdM personnel must reflect in a concerted manner (field-head office) on what must be done in the interest of the patient/injured person."

"Doing nothing might be considered as an acquiescing in abuse."

Dromer Carole, Desmarest Anne, Delorme Adrien, *For ethics in the field: sensitive personal data management (Health-Life stories),* MdM France, 2010.

1 / LINKS BETWEEN GENDER-BASED VIOLENCE AND **PRIMARY HEALTH**

The World Health Organization (WHO) defines primary healthcare as "essential health care […] made universally accessible to individuals and families in the community […] at a cost that the community and country can afford."

Primary healthcare is located at the point of entry of a healthcare system, offering generalist, all-encompassing, continuous, integrated healthcare that is accessible to the entire population, and coordinating and integrating the necessary services at other levels of healthcare[2].

Gender-based violence, in all its forms, has various consequences on health[3]. That is why healthcare facilities, regardless of where they are positioned in the healthcare system, is often a preferred entry point for responding to the various forms of gender-based violence.

2. From **Macinko J, Starfield B, Shi L.,** "The contribution of primary care systems to health outcomes within Organisation for Economic Cooperation and Development (OECD) countries", 1970 – 1998, *Health Services research,* 2003.

3. For more information, see the section relating to causes and consequences of gender-based violence page 100.

2 / LINKS BETWEEN GENDER-BASED VIOLENCE AND **REPRODUCTIVE HEALTH**

Gender-based violence, and especially sexual violence, has disastrous consequences on sexual and reproductive health, among which we would cite: sexually transmitted diseases (including HIV/AIDS), early or undesired pregnancies, termination of pregnancies in dangerous conditions, fistulas, genital mutilations, etc.

Pregnancy is also a factor in vulnerability to violence, intra-family violence in particular. As many as one out of four women suffers physical or sexual violence during pregnancy[4]. Such violence has consequences on the health of both mother and child, including miscarriages, hypotrophy at birth, premature births, etc.
Violence can also be an obstacle to women's freedom in choosing their sexuality and deciding whether and when to get pregnant.

Lastly, reproductive healthcare professionals are often the first, and even the only, persons to provide medical care to a large number of women and are thus well placed to identify and treat the violence that they may be the victims of.

4. Heise, L, M. Ellsberg and M. Gottemoeller, "Ending Violence against Women". Population Reports, Series L. N° 11: 17, 1999.

3 / LINKS BETWEEN GENDER-BASED VIOLENCE AND **HIV / AIDS**

The available facts on links between gender-based violence and HIV/AIDS show that such links are underlain by several direct and indirect mechanisms.

→ **Forced and violent sexual relations increase the risks of HIV transmission,** given that, during a forced sexual act, lesions, lacerations and abrasions are frequent, and they facilitate the entry of the virus through mouth, vaginal or anal mucosa.
"Studies carried out in Rwanda, in the United Republic of Tanzania and South Africa show that women who have been victims of violence are almost three times more at risk than others of contracting HIV[5]."

→ **Violence or the fear of violence can have the following consequences[6]:**
– Inability to persuade one's partner to use a condom;
– Reluctance to undergo an HIV/AIDS screening test;
– Reluctance to divulge one's HIV-positive status, delay in access to HIV/AIDS treatment, giving up medical care.

→ More indirectly, **victims of violence** (sexual abuse during childhood, forced sexual initiation and violence committed

5. 6. 7. WHO, "Violence against women and HIV/AIDS: Critical intersections; Intimate partner violence and HIV/AIDS", Information Bulletin series n°1; 2005.

by partners) **have a greater tendency, after the trauma, to adopt risky behaviour,** including multiple sex partners, paid sexual relations, sexual services in exchange for protection[7].

→ **Being HIV positive is a risk factor in suffering violence** from one's partner and the community.
Depictions and perceptions of the virus can lead to violent reactions in various forms against HIV/AIDS carriers.
A US study has found that overall "20.5% of the women, 11.5% of the men who reported having sex with men as their mode of HIV transmission (regardless of injection drug use), and 7.5% of the remaining men reported physical harm since their HIV diagnosis, of whom nearly half reported HIV-positive status as a cause of violent episodes[8]."

→ **Being a woman is also a risk factor in HIV transmission.**
From a purely physiological and biological viewpoint, women are more at risk than men of contracting AIDS during unprotected sexual intercourse.
Women are also more vulnerable to the AIDS virus for socio-cultural, economic and political reasons. These include trans-generational sexuality (when older men have sex with young women or girls) or certain traditional practices (female genital mutilations, early marriages, etc.).
"Women and girls' risk of and vulnerability to HIV infection is shaped by deep-rooted and pervasive gender inequalities - violence against them in particular[9]."

→ Lastly, in numerous conflicts, combatants **sometimes use their HIV-positive status to raise violence against their enemies to a new level.** They deliberately transmit the AIDS virus to their victims, promising them "a slow, painful death".

8. **Agency for Health Care Policy and Research,** "HIV Cost and Services Utilization Study - Fact sheet", Rockville, MD, 1998.
9. **WHO,** "Violence against women and HIV/AIDS: Critical intersections; Intimate partner violence and HIV/AIDS", Information Bulletin series n°1; 2005.

In light of all of these interconnections, it is essential to further develop links between the two issues.

4 / LINKS WITH EMERGENCY SITUATIONS

Gender-based violence often proliferates in conflict situations. Social upheaval, population displacement, breakdown of systems of protection are all situational characteristics that favour the occurrence of numerous cases of violence (gang-rapes, forced marriages to an enemy soldier, sexual slavery, mutilations, being made to watch the rape of a loved one, etc.). Care-providers involved in humanitarian emergencies must therefore be capable of helping to prevent and respond to the phenomenon of gender-based violence.

THE EXTENT OF SEXUAL VIOLENCE IN CONFLICT SITUATIONS

→ During the 1992-1995 conflict in Bosnia-Herzegovina, between **20,000 and 50,000 Muslim women were raped** (about 1.2% of the total pre-war female population)[10].

→ A report by the U.N. (1996) Special Rapporteur on Rwanda estimated that at least **250,000 women were raped** during the genocide[11].

→ In Liberia, towards the end of the five-year civil war, **49% of women** (15 to 70 years) who were surveyed reported experiencing **at least one act of physical or sexual violence** by a soldier or fighter[12].

5 / RECOMMENDATIONS

Given the close links that we have just pointed out, treating gender-based violence must be systematically integrated into all MdM programmes.

Gender-based violence can be included in MdM programmes to a greater or lesser extent by implementing a number of recommendations, including:

→ Include gender-based violence in service-provider (healthcare and non-healthcare personnel, both care-givers and support staff) **training and/or awareness raising sessions.** Topics to be discussed include: the definition of gender-based violence and its various forms; identification, processing, providing care (including clinical care in the case of rape) and referring victims of violence.

→ **Identify potential partners** in the intervention region, to which victims of gender-based violence can be referred for suitable and multidisciplinary care.

10. **UNICEF,** *Women in transition,* The Monee project regional monitoring report summary n°6, Florence, 1999.
11. **Human Rights Watch,** *Struggling to survive: Barriers to Justice for Rape victims in Rwanda,* New York, 2004.
12. **M.D. Swiss Shana et al.,** "Violence Against Women During the Liberian Civil Conflict", Letter from Monrovia, *JAMA*, 1998.

→ Organize, with MdM teams and partners, **sessions to share thoughts on perceptions and depictions of gender-based violence** ("normal" violence or "abnormal" violence, masculinity/femininity, etc.) in the intervention context.

→ Ensure the **availability of treatments necessary for providing medical care in cases of rape** (this must come with training of medical personnel in their use).

→ Integrate **indicators pertaining to gender-based violence** in programme monitoring and evaluation tools.

→ Include gender-based violence in the topics discussed during **awareness-raising sessions for local populations.**

The feasibility and relevance of these recommendations must be evaluated with regard to the intervention context.

Considering the complexity of the phenomenon of gender-based violence and its challenges on the socio-cultural level (perceptions/depictions of violence among care-providers, victims of violence and communities), including the issue in the programmes may not produce visible results until the medium term. It is therefore necessary for these activities to be maintained and repeated over time.

2 UNDERSTANDING GENDER-BASED VIOLENCE

INTRODUCTION
TO GENDER-RELATED ISSUES

WHAT DO WE MEAN BY GENDER-BASED VIOLENCE?

Definition of violence against women

"The term 'violence against women' refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

"Declaration on the Elimination of Violence against Women", New York, 1993, p. 6, Resolution 48/104 of the **General Assembly of the United Nations** on December 20, 1993.

Focusing solely on women, this definition seems too restrictive for our way of looking at the issue. We therefore prefer to use a different expression that identifies the act of violence as being based on 'the gender – male or female – to which an individual belongs'.

Definition of gender-based violence

Gender-based violence can therefore be defined as any act that leads to or intends to lead to physical, sexual or psychological harm or suffering **to a woman because she is a woman or to a man because he is a man,** including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

The expression 'gender-based violence' or 'gender-related violence' is often employed to emphasise specific socio-cultural characteristics attributed to individuals, according to their role or status as sexual beings. "Gender-based violence occurs as a result of harmful beliefs, traditions, behaviours or attitudes towards individuals on the basis of their gender[13]."

Links between 'gender-based violence' and 'violence against women'

There is evidence that, although women, men, boys and girls can all be victims of gender-related violence, it is women and girls who are the principal victims. This is symptomatic of the inequalities that exist between men and women in the way most societies are structured.

The terms 'violence against women', 'gender violence', 'gender-related violence', 'gender-based violence' and 'gender-specific violence', or indeed 'sexist violence', are often used interchangeably. In the context of this methodological guide, we favour the expression 'gender-related violence' or 'gender-based violence".

13. Josse Evelyne, "Les violences sexospécifiques à l'égard des enfants", 2007.

2A

DEFINITION OF KEY CONCEPTS

Some concepts associated with the issue of gender-related violence are worth defining.

1 / VIOLENCE

According to the World Health Organisation (WHO), violence can be defined as "the intentional use of physical force or power against oneself, another person or against a group or community, which results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation[14]."

Adopted by numerous national and international instruments, this definition gives **wide-ranging scope to the application of the concept of violence, stressing the diverse nature of violent situations, as well as of their consequences.**

14. **WHO,** *World Report on Violence and Health,* 2002.

"Violence is a complex problem related to patterns of thought and behaviour that are shaped by a multitude of forces within our families and communities, forces that can also transcend national borders."

Dr Gro Harlem Brundtland, WHO Director General.

2 / SOCIO-CULTURAL DETERMINANTS

Socio-cultural determinants include environmental factors relating to an individual in a given context. These factors are geographical, social, cultural, religious, familial, economic or, indeed, gender-related. Socio-cultural determinants have an impact on the actions, behaviours and perceptions of each individual. A violent act by a human being is not therefore an isolated phenomenon but is closely bound up with socio-cultural norms. **While gender-related violence exists in every society around the world, it is how that violence is perceived and the actions taken to deal with it that differ. To gain a better understanding of the phenomenon of violence thus requires the variables determining a person's place in society to be taken into account.**

"[Lori] Heise has developed an ecological model of factors associated with partner abuse in which she identifies four interacting levels – individual, relational (parents and friends), community and cultural/societal. This model, which examines the relationship between individual and contextual factors, sees **violence as the product of influences on behaviour at many levels."**

Bouchon Magali, *Practical approach – Violence against women: gender, culture and societies,* Analysis, Analysis, Technical Support and Advocacy Unit, MdM, 2009.

3 / GENDER AND ASSOCIATED CONCEPTS

Gender, as a socio-cultural determinant, provides a more specific standpoint from which to understand the issue of violence. It is perhaps helpful here to define certain concepts that are involved when taking account of gender in programmes to combat violence.

1. Differences between sex and gender

Gender refers to the characteristics of men and women that are socially determined, as opposed to those that are biologically determined. Each society sets out specific rules for its members, both children and adults, depending on whether they are male or female. "These implicit and explicit rules determine roles, status, responsibilities, obligations, activities, practices, relations between men and women, acceptable and appropriate behaviour for every individual in every situation in accordance with his/her gender. Although deeply rooted in every community, these rules acquired evolve - generally slowly - over time. Conversely, sex refers to biological and physical differences between men and women that are determined by biology, something that cannot change[15]."

15. **Josse Evelyne,** "Les violences sexuelles entre détenus de sexe masculin: un révélateur de la subordination de la femme dans la société", 2007.

Human beings are born male or female but learn within their community to be boys or girls and to become men or women.

Examples of sexual characteristics:

- → Women can menstruate whereas men cannot;
- → Men have testicles and women do not;
- → Women develop breasts and normally can breastfeed;
- → Women are on average not as tall as men.

Examples of gender characteristics:

- → Women earn markedly less than men for similar work;
- → Little girls should be 'gentle and submissive' and little boys should not cry;
- → Many more men than women smoke, as smoking was traditionally not considered appropriate for women.

Understanding violence from the perspective of gender makes it easier to see and appreciate the extent of the phenomenon and to adapt methods of intervening and dealing with victims to gender-based socio-cultural factors.

"Sexual violence is aimed particularly but not solely at women. Tackling this type of violence from the point of view of gender provides a **way of explaining why it can be a manifestation of men dominating women. But it also provides an opportunity to think about ways of intervening that go to the root of these problems by working on systems of values, representations and practices."**

MdM Haiti, livret de sensibilisation sur les agressions sexuelles, 2008.

"Society is organised on the basis of individuals' specific social characteristics within their community and culture according to their gender. Violence is therefore an illustration of how societal relationships are formed where power and authority are historically determined on the basis of inequality between men and women[16]. "Violence against women […] is deeply rooted in cultures the world over, so much so that millions of women see it as a way of life[17]."

2. Gender equality

Gender equality means equal rights, responsibilities and opportunities for women and men, girls and boys. Equality signifies that the rights, responsibilities and opportunities of men and women do not depend on whether an individual is male or female[18]. Analysing the barriers to gender equality reveals the situation of men and women in a given context. It also makes it possible to respond to the specific needs of each gender when caring for and treating victims of violence.

> Gender equality "refers to the equal enjoyment by females and males of all ages, and regardless of sexual orientation, of rights, socially valued goods, opportunities, resources and rewards. Equality does not mean that women and men are the same but that their enjoyment of rights, opportunities and life chances are not governed or limited by whether they were born female or male. Protecting human rights and promoting gender equality must be seen as central to the humanitarian community's responsibility to protect and provide assistance to those affected by emergencies."
>
> **Inter-Agency Standing Committee (IASC),**
> *Women, Girls, Boys and Men – Different Needs, Equal Opportunities,*
> Gender Handbook in Humanitarian Action, 2008.

3. An integrated approach to gender equality

An integrated approach to equality between men and women, known as gender mainstreaming, involves taking account of gender at each stage of the policy-making process – devising, implementing, monitoring and evaluating – with a view to promoting equality between women and men. This approach evaluates the impact of policies on the everyday life and on the situation of women and men, and takes responsibility for reorienting them where necessary[19].

> "The objective was to recognize the contributions and responsibilities of women in agriculture in Peru and involve them more actively as participants and beneficiaries in the main alternative development activities, rather than developing separate activities for them.
> The existing alternative development approach was adapted at two levels. Firstly, by improving the access of women to training as rural promoters in areas where women have traditional roles in agriculture. Secondly, approaches were developed to allow increased participation of women in the farmers' associations, both at grassroots and at managerial levels."
>
> **Office of the Special Adviser on Gender Issues and Advancement of Women,**
> *United Nations International Drug Control Programme: Alternative Development Work in Peru,* Good Practice in Gender Mainstreaming Example, 1999.

16. **WHO,** *World Report on Violence and Health,* 2002.
17. **Johnson Cate,** *Violence Against Women: An Issue of Human Rights,* 1997.
18. http://www.un.org/womenwatch/osagi/conceptsandefinitions.html
19. **Zeid Gihan Abou,** "Integration of gender approach in programs related to violence against women", regional workshop on providing care and support to women victims of violence, Cairo (Egypt), MdM, 2009.

"A gender-mainstreaming approach in programmes, and particularly in emergency situations, ought to:
→ Allow for a more accurate understanding of the situation;
→ Enable us to meet the needs and priorities of the population in a more targeted manner, based on how women, girls, boys and men have been affected by the crisis;
→ Ensure that all people affected by a crisis are acknowledged and that all their needs and vulnerabilities are taken into account;
→ Facilitate the design of more appropriate and effective responses."

Inter-Agency Standing Committee (IASC),
Women, Girls, Boys and Men – Different Needs, Equal Opportunities,
Gender Handbook in Humanitarian Action, 2008.

4 / THE CONCEPT OF VICTIM OF VIOLENCE

1. Victim-'Survivor'

The term victim[20] has been defined by the General Assembly of the United Nations. "'Victims' means persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that are in violation of criminal laws operative within Member States […or] of internationally recognized norms relating to human rights[21]."

20. This definition of the term 'victim' is used in a law enforcement or criminal sense. It does not therefore refer to victims of natural disasters or accidents.
21. Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, **UN General Assembly,** 1985.

Some English and Spanish-speaking experts prefer the term 'survivor'[22] to that of 'victim' in cases of gender-related violence. This preference is based on the perception that a victim of violence becomes a 'survivor' once the harm inflicted ceases and particularly when the victim decides not to put up with the violence any longer. Those who favour this terminology consider that a person has survived the violence he/she has experienced. The term 'survivor' is thus used to emphasise the individual's strength and refusal to subscribe to a process of victimisation. Conversely, some defend the use of the word 'victim' of gender-related violence because they believe that the use of the term 'survivor' links the act of violence to a 'death' for the person, who just survives rather than lives afterwards; they consider that persons who have lived through violence should be acknowledged as victims, as they have suffered a violation of their rights.

2. Victim-Patient

As a result of the wide-ranging effects of violence on the physical and mental health of the victims, these individuals often turn to healthcare services for treatment. These patients therefore present specific characteristics that healthcare staff must be able to identify and deal with:

→ Despite efforts at raising awareness, victims of violence rarely turn up at health centres voluntarily declaring that they have been assaulted. On the contrary, as they are often confronted with numerous obstacles[23], these individuals consult medical staff without revealing the cause of their symptoms.

22. *Survivante* in French and *Sobreviviente* in Spanish.
23. For more information, see the section relating to obstacles to providing care and support on page 271.

Healthcare staff must therefore **be vigilant and sufficiently well trained to recognise the physical and psychological signs that could point to acts of violence** (vague, confused and changing explanations, repeated consultations with several different staff for the same reasons, etc.)[24]. Ignorance of the causes of symptoms can undermine a good diagnosis and the quality of care dispensed.

→ Victims of violence often need multidisciplinary care. Healthcare staff must therefore **be capable of orienting patients and referring them to one or more colleague(s) in one or more area(s) of care.**

→ The treatment of victims of violence requires special care, as a result of the trauma associated with the violence suffered. Healthcare staff must therefore **take the time to listen, comfort and support these individuals.** Consideration shown in this way to all patients will also make it possible to recognise victims of violence more readily.

3. Direct or indirect victim

The degree of involvement of victims of violence in the traumatic event makes it possible to distinguish between **direct and indirect victims.**

The direct victim may have been the object of (have suffered) or witness to (have seen) the event.
The indirect victim, on the other hand, "has not witnessed the event but is concerned by it and/or its consequences as a result of his/her emotional proximity to the direct victims.

24. For more information, see the section relating to identifying victims of gender-based violence on page 134.

Indirect victims are all those close to a primary victim who are upset by the experience of the latter. Indirect victims are also called 'ricochet victims'[25]."

Any response within the context of combating gender-related violence must take account of direct and indirect victims of violence.

> "A child seeing or hearing a parent being attacked may be viewed as a form of psychological violence perpetrated in an indirect manner. Growing up in such an environment seriously damages the psychological and social development of the child: he/she may take the attacker as a behavioural role model or end up believing that victimisation is normal in any relationship."
>
> **Harang Emmanuelle,** "Les violences faites aux femmes – état des lieux", MdM, September 2006.

> "Sexual violence has psychological repercussions on family members, as well as on friends who have witnessed the attack without having the opportunity to react or intervene. This is particularly true for a man who has been unable to protect his partner, children, brothers, sisters or parents."
>
> **Josse E.,** "Les violences sexospécifiques et sexuelles à l'égard des hommes", 2007.

25. Josse E., "Victimes, une épopée conceptuelle – première partie: définitions", 2006.

2B

CONTEXTUALISING THE ISSUE

Gender-based violence is a universal problem that encompasses a range of different realities. Particular attention is currently being paid to it both at a national and international level, although such violence is still regularly underestimated or trivialized. Gender-based violence is an undeniable violation of human rights and a major challenge to public health, and **is therefore a significant problem that concerns every country in the world and every social class.**

1 / AN UNDENIABLE VIOLATION OF HUMAN RIGHTS

All violence prevents those who are its victims from enjoying their fundamental rights and freedoms. Human rights, as set out in international law[26], apply to everyone, regardless of gender. Any gender-related violence is therefore a violation of human rights. International law punishes such violations by means of various legal instruments that make up international human rights law, international humanitarian law and international criminal law.

All gender-related violence depends on how the place accorded to each gender – male or female – is represented in a society and culture. Such violence also has a range of consequences for the victims, that depends in particular on their gender. Gender-based violence therefore relies on discriminatory perceptions and helps such discrimination persist. Such acts of violence are opposed to the principle of **non discrimination,** which is the cornerstone of any system designed to protect the individual.

> "Violence against women is perhaps the most shameful human rights violation […]. It knows no boundaries of culture, geography or wealth. As long as it continues, we cannot claim to be making real progress towards equality, development and peace."
>
> **Annan Kofi,** Former UN Secretary-General.

2 / A MAJOR PUBLIC HEALTH PROBLEM

Statistics on gender-based violence show it to be a widespread, global phenomenon.

> **One out of three women** worldwide has been beaten, forced to have sex or abused in other ways during her lifetime[27].

26. Universal Declaration of Human Rights, adopted by the **UN General Assembly,** 1948.
27. In-depth study of all forms of violence against women: Report by the Secretary-General, **UN General Assembly,** N° A/61/122/Add.1, 6th July 2006.

One out of five women worldwide will be the victim of rape or attempted rape during her lifetime[28].

Every year around the world, some 5 000 women are killed by a family member in the name of family or community 'honour'[29].

Between **10% and 69% of women** around the world state that they have been physically attacked by a male intimate partner at some point in their lives[30].

In France in 2008, **156 women** died at the hands of their partner or ex-partner, a total of one death every 2½ days[31].

Every minute, 38 women around the world undergo a non-medical abortion and every eight minutes one woman dies as a result of a botched abortion[32].

It is widely recognised that gender-related violence can have serious repercussions for victims' physical and mental health, causing many cases of disablement and a large number of deaths[33]. As well as being potentially lethal, such violence can result in numerous medical problems relating to reproductive health (sexually transmitted infections, unwanted pregnancies, impotence, sterility, etc.), general physical health (injuries, chronic pain, etc.), as well as mental health (depression, anorexia, suicide, etc.). It is therefore estimated that "at a global level, violence against women represents as common a cause of death or disability among women of child-bearing age as cancer and causes more health problems than road traffic accidents and malaria combined[34]."

The scale and consequences of gender-related violence mean that it results in significant health risks for a large part of the population and thus constitutes a major public health problem.

The World Health Assembly adopted a resolution in 1996 declaring that "violence is a leading worldwide public health problem." In 1999, UNFPA (United Nations Population Fund) declared that "violence against women is a public health priority." Lastly, the WHO published the first ever Global Report on Violence and Health in 2002. In particular, it dealt with raising awareness of the global problem posed by violence and was concerned with strengthening preventive action led by the public health community.

According to the WHO, "the public health approach to violence […] has four key stages:

→ Uncovering as much basic knowledge as possible about all the aspects of violence […];
→ Investigating […] the causes;
→ Exploring ways to prevent violence […];
→ Implementing […] interventions, widely disseminating information and determining the cost-effectiveness of programmes[35]."

28. **Alcalá María José,** *State of World Population 2005. The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals,* UNFPA, 2005.
29. **WHO,** "Violence against women", factsheet, 2003.
30. **WHO,** *Global Report on Violence and Health,* based on 48 population studies carried out worldwide, 2002.
31. 2008 national study of violent deaths in France involving couples, **Ministry of the Interior,** Commission on Victims, 2009.
32. **IPPF,** *Medical Bulletin,* Vol. 42, N° 2, June 2008.
33. For more information, see the section relating to the consequences of gender-based violence on page 104.
34. **World Bank,** World Development Report: Investing in health, New York, 1993.
35. **WHO,** *Global Report on Violence and Health,* 2002.

2C

CATEGORISING GENDER-BASED VIOLENCE

Classifying gender-related violence is useful for:
→ Grasping the extent and complexity of the issue;
→ Revealing and defining the various forms of violence.
Drawing up a typology of gender-based violence also makes for a better understanding of the different areas in which MdM is actively involved.

Several forms of typology are possible, depending on the viewpoint from which the different forms of classifiable violence are considered, notably in terms of the nature of the violence or the relationship between the victim and the aggressor. Ideally, **there should be a cross-referencing of the indicators in order to grasp the full complexity of the various forms of violence.**

It is, however, difficult to partition the types of gender-related violence that are often suffered simultaneously. Such is the case, in particular, for victims of domestic violence,

who very often suffer physical, psychological, economic and sexual abuse. The violence suffered will thus be categorised in terms of the type of violence that most characterises the assault among the injuries sustained by an individual. A typology based on the link between the victim and the aggressor is often preferred in order not to reduce the facts to one single form of violence.

To illustrate the complexity of the phenomenon of violence, the WHO has produced a table highlighting the different ways of approaching (following page) the issue[36].

The classification of violence drawn up by the WHO highlights the diverse forms of violence. Each one of them may be considered as a gender-related act of violence in terms of the persons involved and the context in which it is perpetrated.

Drawing on this classification, two forms of typology of gender-based violence of violence will be retained here and categorised as follows:

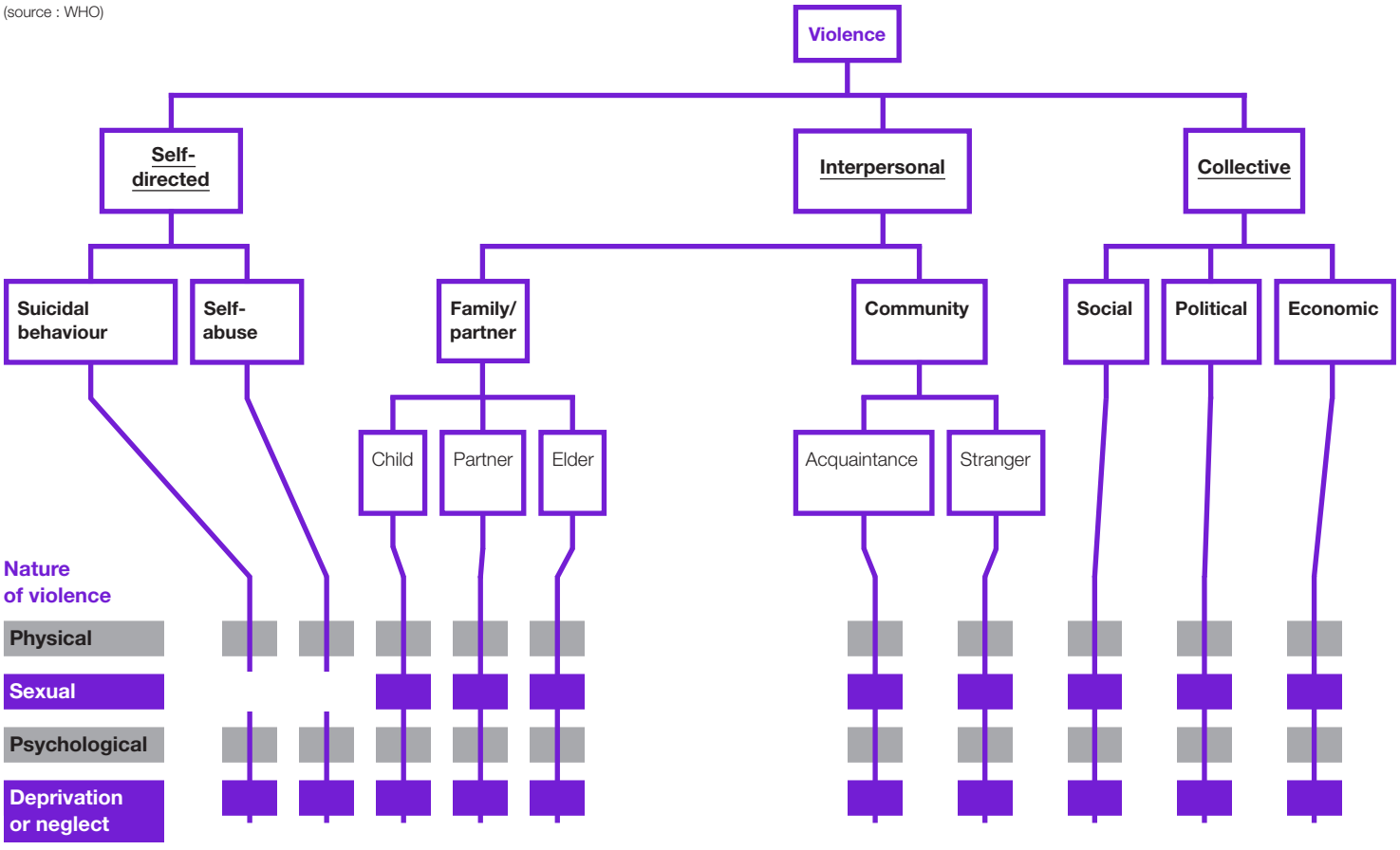
→ **The nature of the assault.** This refers to physical and sexual violence, emotional and psychological abuse, harmful traditional practices, economic and social violence and human trafficking;

→ **The link between the victim and the aggressor.** This refers to violence within families or domestic violence (including intimate partner violence), civil or community violence and violence perpetrated by the state.

36. **WHO,** *Global Report on Violence and Health,* 2002.

A TYPOLOGY OF VIOLENCE

(source : WHO)



1 / TYPOLOGY ACCORDING TO THE NATURE OF THE ASSAULT

1. Physical violence

Physical violence is defined as "the intentional use of physical force […] that […] results in […] injury, death or harm[37]." More specifically, the UN High Commission for Refugees (UNHCR) describes physical assault as "beating, punching, kicking, maiming or killing, with or without weapons; often used in combination with other forms of sexual and gender-based violence[38]." Other forms of physical violence include shoving, manhandling, shaking, dragging along the ground and throttling.

While **pregnancy** is often viewed as a time when women should be better protected, a number of women are nonetheless victims of violence during this period, posing a risk to both mother and baby.
Violence during pregnancy quadruples the risk of low birth weight and doubles that of miscarriage.
According to a multi-country study by the WHO[39], between **4% and 12% of women who had been pregnant reported that they had been abused** during pregnancy, and between **25% and 50% of the women involved** (depending on the countries studied) **confirmed that they had been kicked or punched in the abdomen.** In 90% of cases, the perpetrator of these violent acts was the father of the child they were carrying.

37. **WHO,** *Global Report on Violence and Health,* 2002.
38. **UNHCR,** *Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response,* 2003.
39. **WHO,** *Multi-country Study on Women's Health and Domestic Violence against Women,* Summary Report, 2005. http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf

2. Sexual violence

Generally speaking, sexual violence can be defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work[40]." Among such acts of sexual violence can be singled out rape, sexual abuse, harassment and sexual exploitation (defined in part as human trafficking).

Rape

According to the WHO, one in every five women is victim of rape or attempted rape during her lifetime[41]. No universally recognised definition of rape exists in international law, however, and its definition varies from country to country in the way it is described and constituted in legislation:

→ **In Pakistan** until 2006, the law required a victim of rape to present testimony in support of her complaint from four men seen as 'good Muslims';
→ **In Kenya,** marital rape is not recognised as a crime in law;
→ **In Liberia,** the new law on rape that came into force in 2005 amended the penal code that had applied since 1976.

40. 41. **WHO,** *Global Report on Violence and Health,* 2002.

Before this amendment, any sexual relations with 'a woman who was not one's wife' was viewed as rape. Since the introduction of the new law, rape no longer excludes marital sex even in the case of common law marriage.

→ **In Finland,** there are three categories of rape defined in terms of the degree of physical violence used by the attacker: rape, aggravated rape and coerced sexual relations. Thus, according to the law, a rape can be viewed as simply sexual relations with coercion (or 'rape with mitigating circumstances') if the perpetrator has made only limited use of violence or threats.

Socio-cultural perceptions and representations block progress towards a consensual and consistent definition of rape. Moreover, as a result of the family being viewed as a 'private domain', marital rape is not widely criminalised by national legislations, although it is particularly prevalent.

International criminal justice has contributed to a definition of the constituent elements of the crime of rape, while recognising in its jurisprudence that rape could, depending on the circumstances, represent a war crime, a crime against humanity or genocide.

Rape may therefore be defined as:
Any "act of non-consensual sexual intercourse [such as] the invasion of any part of the body of the victim or of the perpetrator with a sexual organ, or of the genital or anal opening of the victim with any object or any other part of the body by force, threat of force or coercion.
Any penetration is considered rape; efforts to rape someone which do not result in penetration are considered attempted rape.

Rape/attempted rape may include:
– Rape of a female adult;
– Rape of a female minor […], including incest;
– Gang rape, if there is more than one assailant;
– Marital rape between husband and wife […][42]".

Sexual abuse

Sexual abuse refers to "other non-consensual sexual acts, not including rape or attempted rape. […]
Examples of sexual abuse are:
– Forced removal of clothing;
– Forcing someone to engage in sexual acts, such as forced kissing or touching;
– Forcing someone to watch sexual acts[43]."

"Sexual abuse includes acts performed on a minor. […] Even if the child has given consent, sexual activity with a minor may indicate sexual abuse because she/he is considered unable to give informed consent[44]."

According to the definition adopted by child protection organisations in France, sexual abuse of minors refers to "any use of the body of a child for a person older than him/her, whatever the relationship between them and whether or not involving coercion or violence."

French criminal law can be helpful in defining different forms of sexual abuse and for distinguishing between:

42. 43. 44. **Reproductive Health Response in Conflict Consortium,** *Gender-based Violence Tools Manual: For Assessment, Program Design, Monitoring and Evaluation in Conflict-affected Settings,* 2004.

→ **Sexual assault,** that assumes the use of violence, coercion, threat or surprise (Article 222-22 of the Code pénal);
→ **Sexual interference** with a minor and involving no violence, coercion, threat or surprise. Included in acts of sexual interference are instances where minors are subjected to viewing acts (Article 227-25 of the Code pénal).

Sexual exploitation is often associated with human trafficking. This form of sexual violence will therefore be defined in the paragraph relating to trafficking.

Sexual violence in times of armed conflict

Times of conflict see a considerable rise in the number of cases of violence involving sexual violence, as well as other forms that may be gender related such as abduction, false imprisonment and forced recruitment. Such violence multiplies and is exacerbated as a result of sexual stereotypes and the chaos and social disintegration inherent in the situation. **Most acts of violence are therefore opportunistic and result indirectly from the conflict.**

Gender-based violence, and particularly sexual violence, is also regularly and systematically used as a weapon of war to destabilise, humiliate and terrorise members of the opposing community, often in an attempt to force them to flee. The enemy may, for example, attack women and young girls, as their humiliation also affects their families and often the community as a whole. The women and girls are targeted as the source and the bearer of future generations. Their rape therefore becomes a weapon of war and torture. International jurisprudence has recognised rape in this instance as a war crime, a crime against humanity and genocide[45].

45. Desmarest Anne, «Le cadre légal du crime de viol», MdM, November 2008.

"Women are seen as the embodiment of the opposing cultural identity and their bodies as territory to be conquered, or as a means of humiliating the men in their community. In this case, rape is a deliberate strategy aimed at corrupting community relationships. It represents a form of assault on the enemy and characterises the conquest and degradation of women or captured combatants."

Josse E., "Violences sexuelles et conflits armés en Afrique", 2007.

In certain regions of the world, conflicts have led to a wave of sexual violence used as a weapon of war, such as in Ex-Yugoslavia, Darfur, the Democratic Republic of Congo, etc. Even after a conflict is over, violence (and particularly sexual violence) tends to persist.

"It is important to point out that such rapes and sexual violence are committed in a methodical manner and that each armed group has its own operational method of terror, but in general:
→ Victims are raped by several men at a time, each in turn;
→ These rapes are public in front of parents, husbands, children or neighbours;
→ They are often followed by mutilation or other physical torture;
→ Sexual slavery lasting for up to several months is often reported;
→ Psychological torture of every sort is regularly reported.

These acts are perpetrated with the aim of humiliating, punishing, controlling or displacing the population.

> This is why we believe that these extremely brutal rapes committed to terrorise the victim and the community, as a form of sexual terrorism, should be included in the typology of rapes and violence against women."
>
> **Dr Muckwege,** Director of PANZI Hospital (DRC), "Gender-based violence: a public health issue and a human rights violation", regional workshop on providing care and support to women victims of violence, Kinshasa (DRC), MdM, April 2010.

Sexual violence, including in situations of conflict, does not affect only women and girls; boys and men are also victims but few data exist on this subject. **While sexual violence against women remains taboo in a large number of societies, such violence against men is even more so.**

> "[There are] specific forms of Gender Based Violence faced by men and boys in conflict situations: sex-selective massacre, forced recruitment and **sexual violence.** […] These forms of violence must be addressed, not only in the interests of securing human rights for civilian males but also in order for the anti-GBV agenda to succeed within protection initiatives."
>
> **Carpenter R. Charli,** *Recognising gender based violence against civilian men and boys in conflicts situations,* Department of Politics and International Relations, Drake University, 2004.

Sexual harassment

Sexual harassment is "any unwelcome, usually repeated and unreciprocated sexual advance, unsolicited sexual attention, demand for sexual access or favours, sexual innuendo or other verbal or physical conduct of a sexual nature, display of pornographic material, when it interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment[46]."

This definition uses the example of the work-related environment, but sexual harassment must be seen in a wider context, including any relationship of power, authority or control (such as within formal or informal education). Sexual harassment has profound repercussions on the psychological well-being of victims, resulting in feelings of shame and blame from not knowing how to defend themselves. An extremely humiliating and offensive experience, sexual harassment is not generally punished except where it occurs in the workplace. Promises, threats, advances and blackmail, aimed at obtaining sexual favours, are the usual means employed. When a job or crucial advantage is at stake, it is difficult to fight such harassment and the victim feels even more powerless.

3. Mental and psychological abuse

All forms of violence can have serious psychological consequences. It is essential, however, to view acts of psychological abuse as a discrete phenomenon. There is no formal definition for this type of violence. It can be inflicted by a partner or other person close to the victim, or by any person occupying a position of trust.

This type of violence is characterised by actions aimed at[47]:

→ Rejecting

Refusing to recognise the value of a person, despising him/her, ignoring his/her presence, making the individual believe

46. **UNHCR,** *Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response,* 2003.

he/she is inferior or useless and undermining his/her feelings or ideas.

→ Degrading
Behaving in a way that attacks the identity, dignity or confidence of the other person: insulting, ridiculing, humiliating, parodying, bullying, preventing from expressing him/herself, refusing to let him/her speak, criticising the company he/she keeps and treating him/her like a child.

→ Terrorising
Inspiring feelings of terror or extreme fear; coercing through intimidation; placing the victim in an inappropriate or dangerous environment or threatening to do so and making increasingly excessive demands of him/her.

→ Isolating
Restricting victim's living space, reducing his/her contacts, restricting movements within his/her own environment, excluding from significant events such as family or community celebrations.

→ Corrupting or exploiting
Leading someone to accept legally banned ideas or behaviour; materially or financially exploiting him/her and making him/her dependent.

→ Depriving of affection
Demonstrating insensitivity towards or paying a person scant attention; showing indifference towards him/her; only speaking to him/her when necessary and ignoring his/her psychological needs.

→ Blackmailing
Threatening suicide, poverty or dishonour.

Psychological abuse tends to be repeated and reinforced over time. It is, however, difficult to detect, evaluate and prove, as it leaves no visible traces, particularly at the outset.
Some aspects, such as excessive passivity or docility, social isolation, postponing or refusing essential medical treatment and unease or nervousness in relationships with close relatives can nevertheless help to reveal mental abuse.

47. Drawn from an article published by the **Public Health Agency of Canada:** http://www.phac-aspc.gc.ca/ncfv-cnivf/famvio-eng.php

> "For some women, the incessant insults and tyrannies which constitute emotional abuse may be more painful than the physical attacks because they effectively undermine women's security and self-confidence. A single occurrence of physical violence may greatly intensify the meaning and impact of emotional abuse".
>
> **WHO,** *Violence Against Women: A Priority Health Issue,* Department of Women's Health and Development (precursor to Department of Gender, Women and Health), 1997.

> The French Parliament adopted unanimously a new legislation related to responses to violence against women, which plans in particular the creation of an offence of "psychological violence".
>
> **Reuters,** 29 June 2010.

4. Harmful traditional practices

'Harmful traditional practices' should in themselves be viewed as acts of violence, as they damage the health and the physical and emotional integrity of those subjected to them. These practices pose a real challenge to public health and at the same time constitute a violation of individuals' rights to freedom and privacy.

As a general rule, diversity and cultural difference should be respected. This has, however, to be reconciled with a universal respect for fundamental human rights. The International Convention on the Rights of the Child invites Member States to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children[48]."

The practices are gender related because they are based on social, cultural and customary considerations that vary depending on the communities involved and on the place and role assigned to individuals in terms of their gender.

These practices may assume different forms of violence – physical (honour crimes, selective abortions and feminicide for example), sexual (genital mutilation and coerced sexual initiation), etc.

The Office of the High Commissioner for Human Rights provides a non-exhaustive list of the following harmful traditional practices: female genital mutilation, forced feeding of young women, early marriage, practices and taboos to control women's fertility, nutritional taboos, traditional birth practices, flattening of the breasts of young girls, son preference, female infanticide, early pregnancy and dowry[49]. This handbook deals only with those forms of traditional practices that are most commonly carried out against women.

Female genital mutilation

"Female genital mutilation/cutting (FGM/C) is the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons[50]."

48. **UN International Convention on the Rights of the Child,** Article 24/3, November 1989.
49. Factsheet 23 on harmful traditional practices affecting the health of women and children by the Office of the **UN High Commissioner for Human Rights**, 2009.
50. Factsheet on female genital mutilation, joint **WHO/UNICEF/UNFPA** statement, 1997.

These various practices include:
→ **Excision and infibulations** that are intended to destroy a woman's individuality by suppressing pleasure and reducing sexual intercourse to a purely reproductive function;
→ **Introducing corrosive substances** or plants into the vagina to cause bleeding or to tighten or narrow the vagina[51].

Young girls or women who have undergone whatever form of genital mutilation are exposed to irreversible risks to their physical and mental health, and to serious consequences for their future sex life.

> "We now estimate that 3 million girls on the African continent (Egypt, Sudan and sub-Saharan Africa) are subjected to the practice each year […] In addition, FGM/C has recently been found to be more prevalent than formerly believed in some countries in Asia and the Middle East. Growing migration has also increased the number of girls and women living outside their country of origin who have undergone the practice or who may be at risk. This includes some girls and women living in Australia, Europe and North America."
>
> Platform for Action – Towards the Abandonment of Female Genital Mutilation/ Cutting (FGM/C), 2009.

Forced and early marriages

→ **Forced marriages**

The Universal Declaration of Human Rights states that marriage

51. For classification of female genital mutilation, see *Eliminating Female Genital Mutilation, An interagency statement* (**OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO**), 2008.

should be the voluntary union between two persons who have reached their majority[52]. Forced marriages can therefore be defined as any "arranged marriage against a person's wishes"[53] and without their prior free and informed consent. Such marriages are often imposed on women and men for economic, tribal or ethnic reasons. For example, in some cultures, marriage may be used as a form of reparation: where a person has caused a death, a daughter is given as 'compensation' to the family of the deceased. The daughter is then obliged to have sexual intercourse with the father or brother of the deceased in order to give birth to a replacement son.

→ Early marriages

Early marriages are those that involve a person who has not yet reached sexual maturity. The minimum age for marrying differs from country to country. The non-binding UN Recommendation on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages (Principle II), dated 1965, declares: "Member States shall take legislative action to specify a minimum age for marriage, **which shall not in any case be less than fifteen years of age;** no marriage shall be legally entered into by any person under this age, except where a competent authority has granted a dispensation as to age, for serious reasons, in the interest of the intending spouses." Until 2006, the legal age for marriage in France was 15 years for females and 18 years for males. It is now 18 years for both young men and women.

Early marriages may be forced, as they do not allow children to exercise their right to choose: for some adolescents, marriage is imposed by their families, while other children are just too young to make a fully informed decision about marriage. While custom and law consider that such young people have given their consent, in reality this is not the case: either it is not free and full or it has been given by others on their behalf. Early marriages are not the exception but are a reality for many children worldwide.

> "Among women aged 15-24, 48 per cent were married before the age of 18 in South Asia (9.7 million girls), 42 per cent in Africa, and 29 per cent in Latin America and the Caribbean."
>
> **UNICEF,** *Early Marriage: A Harmful Traditional Practice,* 2005.

Forced or early marriages can have disastrous consequences. Firstly, refusing such a marriage can lead to acts of violence. When a marriage is concluded, a young couple also runs the risk of experiencing violence in the future marital home.

Within early marriages there are negative repercussions on the well-being of the children involved, in particular:
- → Psychological distress associated with violent situations and with isolation;
- → Schooling that is disrupted or irregular;
- → Risks to reproductive health: increased risk of maternal and neonatal morbidity/mortality and greater risk of contracting a sexually transmitted infection.

> **"Girls between the ages of 10 and 14 are five times more likely to die in pregnancy or childbirth** than women aged

52. Universal Declaration of Human Rights, adopted by the **UN General Assembly** on December 10, 1948.
53. UNHCR and International Protection: A Protection Induction Programme, Glossary of Terms and Credits, **UNHCR,** 2006.

20 to 24. Girls aged 15 to 19 are twice as likely to die. The vast majority of these deaths take place within marriage."

Factsheet prepared by **UNFPA,** 2009.

"In France, we are also developing methods of preventing the practice of forced marriages, as understanding and helping young girls faced with the threat of being married against their will has become essential in regions that welcome large numbers of families of Maghreb, Turkish or African origin. Training initiatives aimed at professionals have therefore been launched in several departements of Île-de-France."

Le développement de la pédagogie de l'égalité entre les femmes et les hommes, report on government regional services in Île-de-France, 2002.

Honour crimes

The concept of masculine honour is often bound up with the way women behave. A woman's sexuality in particular is viewed as a potential threat to family honour and a justification for certain crimes. Honour crimes are "acts of violence, usually murder, committed by male family members against female family members who are perceived to have brought dishonour upon the family[54]." A woman may be targeted by individuals within her own family for a range of reasons, including the refusal to take part in an arranged marriage, the refusal to grant sexual favours or attempting to divorce – whether because of domestic abuse by her husband or because of proven adultery. The simple interpretation of her behaviour as having 'dishonoured' the family is enough to trigger reprisals.

The concept of honour is sufficiently large to include the settling of purely financial differences between families: questions over a dowry or an inheritance are sometimes resolved through crimes. Many murders are covered up as domestic accidents or suicides.

In 2002, **315 acid attacks on women and girls** were recorded in Bangladesh that resulted in blindness and disfigurement or death[55].

A study of the deaths of women attributable to murder in the city of Alexandria in Egypt concluded that **47% of the women were killed by a relative** after having been a victim of rape[56].

In 2008, **475 women were the victims of so-called 'honour killings'** in Pakistan[57].

In May 1999, a court in England condemned a Pakistani woman and her adult son to life imprisonment for the murder of the daughter and sister who had two children and was pregnant. **The young woman was considered to have sullied the honour of her family** by having had an extra-marital affair[58].

"In Brazil […] one of the best-known cases dealing with the concept of the honour defence is the case of João Lopes.

54. **HRW,** "Integration of the human rights of women and the gender perspective: Violence against Women and 'Honour' Crimes", Oral Intervention at the 57th Session of the UN Commission on Human Rights, 2001.

55. "Bangladesh: Death for Man who Maimed Girl", *New York Times,* 30th July 2003.
56. **WHO,** *Global Report on Violence and Health,* 2002.
57. 2008 Annual report, Strategic Planning, Monitoring, and Evaluation Section, Aurat Foundation (Pakistan), June 2009.
58. *Pakistan: Honour killings of girls and women,* **Amnesty International,** September 1999.

Lopes stabbed his wife and her lover to death after catching them together in a hotel room. The highest court of appeal in Brazil overturned the lower and appellate court decisions acquitting Lopes of the double homicide, stating that homicide on the grounds of defending one's honour was legitimate[59]."

5. Economic and social violence

Gender-related economic and social violence is widespread but largely misunderstood. It comprises all acts of violence that breach individuals' economic and social rights, such as the right to health (access to healthcare), the right to education or the right to work (access to income). These violations of social and economic rights, although suffered by a large part of the population, are particularly dependent on gender. Such violence is linked to socio-cultural determinants and to the roles assumed by women and men in society. These practices also result in unequal opportunities and rights between men and women.

This form of violence may be legally prohibited or it may be tolerated.

In France, certain common conventions contribute to social and economic inequality between genders. This is the case as regards paid leave to care for a sick child, which only working mothers are entitled to receive. Following various objections raised by fathers, the Haute autorité de lutte contre les discriminations et pour l'égalité (Halde – Equal Opportunities and Anti-discrimination Commission) decided that these provisions were discriminatory and constituted a form of social and economic violence that was contrary to French employment law and the European Convention on Human Rights.

59. **Ms. Coomaraswamy Radhika,** Special rapporteur on violence against women, its causes and consequences, "integration of the human rights of women and the gender perspective violence against women", report submitted in accordance with resolution 2001/49 of the UN Commission on Human Rights, Cultural practices in the family that are violent towards women, 2002.

Acts of economic and social abuse can also be perpetrated by individuals, particularly within the context of domestic violence.

"The [economic and social] discrimination women face is linked to violence against women. It shapes the forms of violence that a woman experiences. It also makes some women more likely to be targeted for certain forms of violence because they have less social status than other women and because perpetrators know such women are less likely to report abuse or seek assistance."

Amnesty International, "Women, Violence and Poverty – Breaking out of the Gender Trap", 2009.

Access to healthcare

Depriving or denying an individual healthcare is a form of abuse that particularly affects women in a large number of countries. Health is too often dependent on the good will of men – of fathers or husbands – who decide the appropriateness of accessing healthcare, in particular in the area of sexual and reproductive health. This form of gender-related violence goes against the different international instruments that recognise universal access to healthcare.

"In Niger, the right to health is still largely constrained by geographical and economic access to health services. As a result of their economic and social dependency, women and children are often the primary victims of this exclusion from healthcare. Niger's health statistics are those of a country at war with one in every five children not reaching age 5 and one women in 17 dying in childbirth or following childbirth and while still of child-bearing age. A twofold initiative aimed at quality of care and accessibility to health services provides a concrete response to the economic violence that limits recourse to healthcare."

MdM, Interim operational report, International Program to fight gender-based violence, MAAIONG/AFD, September 2009.

Focus on reproductive health

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant[60]."

60. Programme of action of the International Conference on Population and Development (ICPD), 1994.

Conversely, the following constitute forms of abuse:

- → **Not having the choice of when to have a baby;**
- → **Not having the choice of whether to go ahead with a pregnancy;**
- → **Not having the choice of a method of protecting one's health where a decision is taken to terminate a pregnancy.**

The right to sexual and reproductive health forms part of the right to health. The option of freely disposing of one's own body is also associated with the right to dignity and to physical and mental integrity.

"The Human Rights Committee has found that criminalization of abortion, including in cases of rape, violates the prohibition against cruel, inhuman, and degrading treatment in article 7 of the ICCPR. Some human rights groups have argued that Nicaragua's enactment of the ban despite forewarning of the law's detrimental effect on women's health constitutes intent by the government to inflict harm for discriminatory purpose – meeting the Article 1 definition of torture."

Amon J., "Abusing Patients – Health Providers' Complicity in Torture and Cruel, Inhuman or Degrading Treatment", Human Rights Watch, 2010.

→ Contraception

"Regional levels of contraceptive use varied greatly: while 71% of married women in Latin American and the Caribbean were using contraceptives in 2003, only 28% of married African women were doing so. Nearly 1 in 4 married women in Africa had an unmet need for contraception in 2002–2007, compared with 10–13% of their counterparts in Asia and in Latin America and the Caribbean[61]."

"The evidence is strong and growing that empowering women with the means to decide for themselves when to become pregnant and how many children to have significantly lowers unintended pregnancy rates and thereby reduces the need for abortion,"

Camp S., President of the Guttmacher Institute.

→ Pregnancy termination

Although often a source of controversy, pregnancy termination, whether legal or not, is still common worldwide. Every year, out of an estimated total of 205 million pregnancies, 80 million are recorded as unwanted, that is 38% of the total. **Among these unwanted pregnancies, 42 million end in abortion, carried out in 20 million cases in insanitary conditions.** Around 34 million of unwanted pregnancies go full term[62].

These figures shed light on the considerable obstacles facing women to accessing a high quality services offering pregnancy terminations that pose no risk to their health.

These obstacles can be legal ones. The right to abortion is not recognised by the law in every country and may be completely forbidden or limited to certain situations, notably rape or incest, sexual intercourse with a minor, severe foetal abnormality or where the pregnancy poses significant risks to the physical and mental health of the mother. **The greatest obstacle therefore to accessing an abortion under good medical conditions is the fact that it is against a country's laws.**

In Algeria, it is illegal to terminate a pregnancy. Nevertheless, there are certain exceptions to the law for medical reasons, namely to save the life of the woman or where there is the risk of serious malformation in the unborn child. In cases of pregnancy following rape, abortion is not allowed unless the attack was committed as an act of terrorism.

In Pakistan, criminal law prohibits abortion whether or not the pregnancy is the result of rape. The only conditions for the legal recourse to abortion are those where the life of the mother is in danger or where it forms part of 'essential treatment' carried out before the foetal organs have developed. Abortion is only rarely performed.

In Nicaragua, abortion is strictly prohibited. Since 2006, a new law has forbidden any abortion, including for women who have been raped or who are at risk of dying in childbirth, or to save the life of the mother-to-be. Any woman caught attempting to abort a pregnancy or practising abortion risks four to eight years in prison.

In the Democratic Republic of Congo, criminal law severely punishes any termination performed on oneself or another (five to ten years imprisonment for a self-induced abortion and five to fifteen years when carried out on another). Only therapeutic abortions are permitted under Congolese law and only where the medical need is proved by three professionally recognised doctors.

In Colombia, the legal framework in theory provides a legislative model for Latin America. A decree issued

61. **Guttmacher Institute,** *Abortion Worldwide: A Decade of Uneven Progress,* 2009.
62. **WHO,** *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003,* Fifth edition, 2007 and *World population prospects: the 2006 revision,* Population Division of the **Department of Economic and Social Affairs of the United Nations Secretariat.**

in December 2006 authorised pregnancy termination throughout the country in instances of rape, foetal deformity and threat to the mother's life; and this applied to all women "independent of ability to pay and membership of the healthcare system". Health services and centres must ensure that they have the necessary staff and equipment available. Where a termination is authorised, no charge is made. Conscientious objection is a matter for individuals, not institutions, and cannot "be used to discriminate against a pregnant woman".

Even where the pregnancy termination is legal, effective access to it depends on other factors, such as availability of competent services, the complexity of certain procedures and the cost of the operation.

Over and above the legal context, **socio-cultural representations also impose considerable constraints.** Even where pregnancy termination is authorised by law, the way it is represented and perceived (notably by healthcare staff) serves to restrict the practice.

In Colombia, despite abortion being legal, there are numerous religious and moral obstacles imposed by society, both for women and for healthcare staff. It is difficult to find a doctor who performs abortions, as many professionals 'object on grounds of conscience' and thus refuse to apply the law. One of the main difficulties in this regard is how abortion is perceived by professionals, who often view it as a crime.

Faced with these various obstacles, women are often obliged to resort to abortions that carry a risk to their health. Such operations are generally carried out by one person who has not had the necessary training and/or is working outside the appropriate medical environment.

"Abortion occurs at roughly equal rates in regions where it is broadly legal and in regions where it is highly restricted. The key difference is safety. Illegal/clandestine abortions cause significant harm to women, especially in developing countries."

Guttmacher Institute,
Abortion Worldwide: A Decade of Uneven Progress, 2009.

Pregnancy terminations carried out in unsafe conditions can have disastrous consequences on women's health and therefore constitute a public health priority. The following are among the main complications that can arise: blood poisoning, haemorrhage, infection, fistula, perforation of the uterus, sterility and death.

Thirty-eight women undergo a non-medical abortion every minute and one woman dies every eight minutes as a result of a botched abortion. In addition to the 65 000 to 70 000 deaths recorded each year as a result of non-medical abortions, it is believed that 5 million women undergoing the procedure subsequently suffer from temporary or permanent disability. Among those, almost 1.7 million can no longer have children and more than 3 million face the consequences of a genital tract infection[63].

63. IPPF, *Medical Bulletin,* Vol. 42, n° 2, June 2008.

"**In Haiti,** many women are not aware of the dangers posed by pills for pap gadé timoun ('not keeping the child') following a positive pregnancy test result. According to Maryse Alvarez, a gynaecologist at the family planning centre that caters for adolescents from the poorest families: 'They take strong doses of Cytotec®, a substance used where a baby dies in utero, that triggers labour and can cause haemorrhaging and a ruptured uterus.' Repeated interventions and the conditions in which they are carried out have an impact on fertility and mortality."

Malengrez Maude, "Haïti: légaliser l'avortement pour plus de justice sociale", Syfia Press Agency, 2004.

Pregnancies and births resulting from rape are often an issue. Aside from the social stigma that attaches to victims of rape, the impossibility of securing an abortion after rape and thus the birth of an unwanted child can severely traumatise mother, child and close family members.

MdM's programme in the Meta region of Colombia shows that most rapes (occurring in high numbers due to the armed conflict and the perception of women as 'war booty') result in the birth of a child with all the social and psychological implications that this entails.

In Guatemala, sexual violence is very evident, often within families and involving girls of 12 and even younger. These victims of rape find that they are pregnant and have to go through a full-term pregnancy and bring up a child, even though they are scarcely adolescents themselves.

Testimony from MdM field staff.

MdM publicly supports reducing the health risks associated with pregnancy terminations carried out in dangerous conditions. It is currently developing programmes to achieve this.

→ Forced abortion and sterilisations

The right to sexual and reproductive health implies that any termination of pregnancy and sterilisation should be carried out with the consent of the individual concerned.
Some discriminatory laws and practices limit the number of children per couple. This is the case, for example, in China, where abortion in some instances therefore becomes obligatory. If a woman refuses to have an abortion, a medical intervention is performed without her consent.

"Mao Hengfeng was dismissed from her job in a soap factory in 1988 in Shanghai when she became pregnant for the second time. For an urban woman to have more than one child is against the country's family planning laws. Mao refused to have an abortion, and she was detained in a psychiatric hospital and injected with medication[64]."

Sterilisation of women may also be made compulsory, particularly where a country has a policy of demographic control or a government keen to control the birth rate among minority communities or women with learning difficulties. It is believed that a total of 300 000 women in Peru were sterilised either against their will or without their knowledge between 1990 and

64. Amnesty International, "China: Protestor against forced abortion sent to prison camp", October 8, 2004, http://www.amnesty.org/en/library/asset/ASA17/052/2004/en/bdd76c7a-d573-11dd-bb24-1fb85fe8fa05/asa170522004en.pdf.

2000. Several cases of Roma women being sterilised have also been documented in the Czech Republic and in Slovakia over the past few years[65].

Forced abortions and sterilisations can also result from constraints and pressures imposed by the family. In August 2005, the criminal court at Bobigny, in France, condemned a singer to five years' imprisonment for arranging for his ex-partner to be forced to have an abortion[66].

Access to education

In the area of education, considerations of gender form the basis for numerous disparities. Two-thirds of the billion illiterate people in the world are women[67]. Illiteracy increases poverty and individuals' dependency, limiting women's role to running the home and restricting their ability to access a job and financial autonomy. Limited access to knowledge thus constitutes economic and social abuse that contravenes the right to education and thereby has consequences for the enjoyment of other fundamental rights.

> "Children's discrimination is done [sic] in the country, mainly at the level of parents who prefer boys than girls. **As a result, when there is not enough money to send all the children to school, parents prefer to send boys to school rather than girls.** The annual statistics of the primary, secondary and professional teaching of the school year 2006-2007 shows [sic] the same situation by stating that in generally [sic], boys are more schooled than girls in all the provinces of the DRC."
>
> Alternative Report Summary presented by the **Child Rights Information Network** to the UN Committee on the Rights of the Child, September 2008.

65. **Romani Rose,** "Remembrance and Beyond: The Roma and Sinti during the Holocaust and Today", *UN Chronicle,* online publications.
66. See Bobigny Criminal Court (Seine-Saint-Denis) ruling for July 3, 2009.
67. **Fayner Elsa,** *Violences, féminin pluriel – Les violences envers les femmes dans le monde contemporain,* Librio, Document Collection, 2006.

Access to income

Many women worldwide are financially dependent on men: in their private life, men decide whether or not to give women the means to buy food, to meet other needs (particularly health related) and, on occasion, even whether they can enjoy spending their own earnings. This discrimination also exists in working life where women almost always earn less than men in the same job and where they are treated differently, notably as regards promotion opportunities and participation in decision-making. Men therefore directly influence women's well-being and economic rights.

Moreover, discrimination linked to property and inheritance is enshrined in the legislation of numerous countries. Some do not recognise women's legal capacity to own or inherit land and goods: once widowed, many women find themselves totally destitute and the resulting socioeconomic difficulties further increase their vulnerability to sexual exploitation and violence.

EXAMPLES OF GENDER-BASED DISCRIMINATION IN PROPERTY AND INHERITANCE LAW IN PAKISTAN:

> A survey conducted in 1995 involving 1 000 rural households in the Punjab revealed that only 36 women in the 1 000 households owned their land in their own name, while only 9 of those women had control over it[68].

Customary practices associated with depriving individuals of ownership rights represent a major problem from women in Pakistan.
"Sharia law regularly governs rights of inheritance, often depriving women of the right to property. Certain practices illustrate this:

→ *Haq bakhshawana:* Renouncing by women of their right to property in favour of the men in their family;
→ *Benami transfers:* Anonymous transaction whereby a woman buys a property with her own financial resources, although the property is registered in the name of an individual – any individual – who is male;
→ Denial of inheritance: Confiscation of a woman's property or its transfer in exchange for marriage.

In practice, commercial banks often ignore female customers because they are insolvent as a result of their dependence on men."

Testimony of **Imran Ali,** legal adviser, MdM Pakistan, January 2010.

6. Exploitation and human trafficking

The development of global commerce has generally encouraged the sex trade on an international scale: not only is sex tourism constantly growing, but trafficking in human beings is seeing a dramatic rise. Such trafficking represents an annual turnover of around 32 billion dollars[69], making it the most lucrative activity for organised crime within the European Union[70].

68. **Asian Development Bank,** Country Briefing Paper, Women in Pakistan, July 2000.
69. **ILO,** *A global alliance against forced labour: Global Report Under the Follow-up to the ILO Declaration on Fundamental Principles and Rights at Work,* report of the Director-General, 2005. http://www.ilo.org/public/english/standards/relm/ilc/ilc93/pdf/rep-i-b.pdf
70. **Europol,** 2006 Annual Report.

"The definition of trafficking, used in the most recent legal texts, covers facilitating the exploitation of another by, for example, recruiting, transporting or accommodating an individual. Trafficking is therefore not exploitation. For ease of language, the shorthand phrase 'human trafficking' is widely employed to mean the act of trafficking in the strict sense of the term, as well as acts that are described as exploitation. This can lead to confusion. The adoption of a clear definition of trafficking and of exploitation is a necessary prerequisite for implementing a coherent policy in this area and, if generally accepted, would provide a means of strengthening international cooperation.
In order to define the scope of application of binding international laws relating to human trafficking, the CNCDH [Commission nationale consultative des droits de l'homme – National Consultative Commission on Human Rights] recommends that France invite its European partners to define jointly the concept of exploitation."

"Avis sur la traite et l'exploitation des êtres humains en France",
National Consultative Commission of Human Rights,
Plenary Assembly of December 18, 2009.

Trafficking of human beings

According to the International Organisation for Migration (IOM), trafficking in human beings occurs where:

→ "A migrant is illegally engaged (recruited, kidnapped, sold, etc.) and/or moved either within or across borders;
→ Intermediaries (traffickers) during any part of this process obtain economic or other profit by means of deception, coercion and/or other forms of exploitation under conditions that violate fundamental human rights of migrants[71]."

71. **Reproductive Health Response in Conflict Consortium,** *Gender-based Violence Tools Manual: For Assessment, Program Design, Monitoring and Evaluation in Conflict-affected Settings,* 2004,

THE EXAMPLE OF MOLDAVIA

"Out of a population of around 4 million inhabitants, the IOM estimates that around 35% are now economic migrants (according to a study carried out in 2006). Trafficking in human beings in Moldavia is therefore encouraged by a massive exodus of the working population escaping poverty, the vast majority of whom are women (81%). They are usually duped into giving their consent. The women most at risk are those from poor, rural and violent backgrounds."

Extract from issue 92 of MdM's Journal des donateurs, project in Moldova, September 2008.

Exploitation "shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs[72]."

THE EXAMPLE OF THE STREET CHILDREN OF KINSHASA

"Many people profit from the prostitution of street children. These profiteers are directly or indirectly involved in the sexual exploitation of these children.
[…] The network is set up in such a way that the children do not always receive the profits from what they do, and these are redistributed directly to various individuals involved at various stages in the process. Besides performing sex, the children are also used to lure in clients who are then robbed by others."

Enquête sur l'exploitation sexuelle des filles de Kinshasa en RDC, **MdM,** with the collaboration of the DRC Ministry for Gender, Family and Children and funded by Unicef, December 2008.

Sexual exploitation is exacerbated in times of armed conflict. Individuals may be 'recruited' to cook, clean or fight, and are often forced to act as sexual partners or 'wives' of those fighting. These women are sometimes referred to as 'bush wives' (as in Sierra Leone during the civil war), or as 'comfort women' (as in those forced into prostitution for the Japanese Imperial army and navy during World War II).

2 / TYPOLOGY ACCORDING TO THE LINK BETWEEN VICTIM AND PERPETRATOR

Gender-based violence may be perpetrated by different people, groups or institutions in private or public life. This violence may thus be classified according to a typology based on the links that exist between victim and perpetrator.

1. Intrafamily or domestic violence

Intrafamily or domestic violence refers to all acts of violence perpetrated against an individual by a member of the same family. "The term 'domestic violence' includes violence […] by an intimate partner, including a cohabiting partner, and by other family members, whether this violence occurs within or beyond the confines of the home[73]."
Domestic violence is generally suffered within an individual's

72. Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime, Annex II, Article 3, December 2000.
73. Unicef, "Domestic Violence Against Women and Girls", Innocenti Digest, n° 6, June 2000.

private life, often making it invisible, either because the many acts of violence occur behind closed doors or because legislative and cultural norms treat such violence not as a crime but as a family matter or 'normal' occurrence.

"Domestic violence, in particular, continues to be frighteningly common and to be accepted as 'normal' within too many societies."

Yakın Ertürk, UN Special Rapporteur on violence against women, its causes and consequences, Foreword in the *Multi-country Study on Women's Health and Domestic Violence against Women, Summary Report,* WHO, 2005.

"Today, many States recognise the importance of protecting women from violence and punishing the perpetrators of the crimes. One of the major questions facing law reformers is whether to 'criminalize' wife battery. There is a sense that domestic violence is a crime between those who are linked by bonds of intimacy. The question of intimacy, i.e. whether wife-battery should be treated as an ordinary crime or whether there should be an emphasis on counselling and mediation, poses a major dilemma for policy makers."

Coomaraswamy Radhika, UN Special rapporteur on violence against women, *Combating Domestic Violence: Obligations of the State,* 2000.

Focus on intimate partner violence

Intimate partner violence is seen as the most common type of intrafamily gender-based violence suffered by women. This form of violence refers to "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship[74]." The intimate partner should be viewed as the current or former co-habiting partner, whether married or not to the victim of the violence. The violence or its consequences may therefore arise after the couple has separated.

"Intimate partner violence occurs in all countries, irrespective of social, economic, religious or cultural group. Although women can be violent in relationships with men, and violence is also sometimes found in same-sex partnerships, the overwhelming burden of partner violence is borne by women at the hands of men."

WHO, *Global Report on Violence and Health,* 2002.

Intimate partner violence can take many different forms: physical violence (blows and injuries), psychological violence (threats and harassment), sexual violence (intimate partner rape, being 'lent out to friends'), economic and social violence (financial resources confiscated by partner, breaking of ties with friends and/or family).

"One of the most common forms of violence against women is that performed by a husband or an intimate male partner. This is in stark contrast to the situation for men, who in general are much more likely to be attacked by a stranger or acquaintance than by someone within their close circle of relationships. […]

In 48 population-based surveys from around the world, between **10% and 69% of women reported being**

physically assaulted by an intimate male partner at some point in their lives […].

Studies from Australia, Canada, Israel, South Africa and the United States of America show that **40-70% of female murder victims were killed by their husbands or boyfriends,** frequently in the context of an ongoing abusive relationship. This contrasts starkly with the situation of male murder victims. In the United States, for example, only 4% of men murdered between 1976 and 1996 were killed by their wives, ex-wives or girlfriends."[75]

According to a national study of violent deaths in France involving couples (Étude nationale sur les morts violentes au sein du couple), carried out in 2008 by the Ministry of the Interior Commission on Victims, on average, one woman in France dies every two and a half days as a result of violence perpetrated by a partner. One man dies every thirteen days, killed by a partner who, in half the cases, had suffered violence at his hand.

There is a tendency to minimise violence within couples, or to see it as simply arguing. The dynamics and the implications of intimate partner violence provide indicators for recognising a relationship based on violence. Conjugal violence is a specific form of violence in that it often forms part of a cycle that increasingly encloses the victim within a relationship of dominance/dependency. "What differentiates conjugal violence from a conflict or dispute within a couple (that can also be violent) is its cyclical nature, while conflict occurs periodically. Indeed, the term 'cycle of violence' is used when referring to intimate partner violence[76]."

74. 75. WHO, *Global Report on Violence and Health,* 2002.

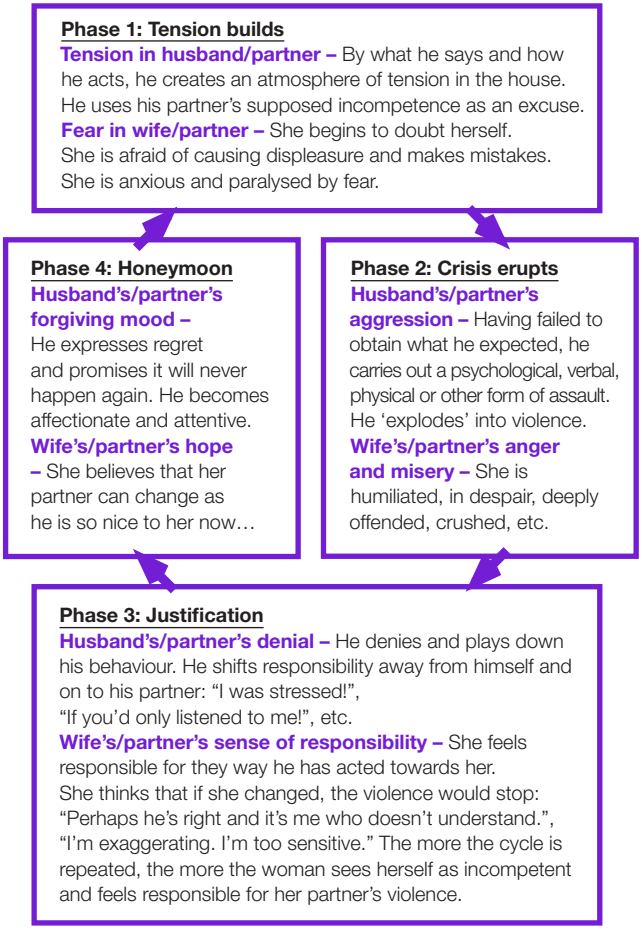
→ The cycle of violence

The fact that women are emotionally attached to those perpetrating the violence and are financially dependent on them has a significant impact on the dynamics of the violence. Some research[77] has tried to describe **the process of violence within a couple,** by highlighting evidence of the existence of a four-phase cycle: **climate of tension builds,** intensifies and leads to **a crisis situation.** There then follows a period **after the release of tension** when the man seeks forgiveness and tries to justify his actions. For a while the couple feels happy again, a time that is often referred to as **the 'honeymoon phase',** when the violent incident can be forgotten. This phase allows the couple to think that the violence will not reoccur but, as the days go, the tension mounts and the cycle restarts with greater intensity and frequency as each fresh incident arises.

The following diagram can be used to illustrate the cycle of violence:

In some cases of conjugal violence, particularly when the violence is characterised by increasingly frequent and serious incidents, the perpetrator **is in a position of power and control** over the victim. She is "no longer in control of her own thoughts, is literally taken over by her partner's psyche and has no mental space to herself. She is paralysed with no spontaneous changes occurring internally and it requires external help to put an end to the domination[78]."

76. http://www.violencesconjugales5962.fr/violences-conjugales/cycle-violences.html
77. Walker Lenore E. , *The Battered Woman,* New York, Harper and Row, 1979 and "Battered Women and Learned Helplessness", Victimology: An International Journal, Vol.2, N°3-4, I977-1978.
78. Hirigoyen Marie-France, *Femmes sous emprise – Les ressorts de la violence dans le couple,* 2005.



The dynamics of conjugal violence and the power and control phenomenon that develops in this kind of relationship justify emphasising its similarity to certain acts of torture.

> "When it is not a direct threat or violence that is being enacted, it is a type of ceremony heralding it. This can range from a simple change of look to words spoken, postures and scene setting. The victim knows these messages: the aggressor uses them ritualistically each time as preliminaries. They serve to strengthen the aggressor as he seizes control and to weaken the victim's capacity to resist."
>
> **Perrone Reynaldo R. and Nannini Martine,**
> *Violences et abus sexuels dans la famille,* 2006.

→ The links between conjugal violence and torture[79]

A fundamental difference between conjugal violence and torture lies in the link between the victim and the perpetrator of the violence (the intimate partner in the case of conjugal violence and the State in the case of torture).

This observation aside, certain similarities have been identified, notably as regards the consequences: conjugal violence, like any act of torture, usually results in the **destruction of the victim's identity and the establishing of a situation of power and control** between the perpetrator and the victim of violence. This twofold effect of identity destruction and domination is linked to the fact that the victim remains 'captive'

79. For more details, see **Josse Evelyne**, "Torture and domestic violence: a common outcome - the destruction of the victim's identity", regional workshop on providing care and support to women victims of violence, Cairo (Egypt), MdM, September.

for a long period and under the control of the aggressor. The victim is unable to escape, while the perpetrator of the violence is supposed to be the protector.

The similarities between conjugal violence and torture should make it easier to appreciate the complexity of these phenomena and to identify more readily the psychological and psychosocial signs that point to a victim suffering violence.

2. Civil or community violence

Civil violence refers to acts of violence committed by members of the community (individually or in groups) "with no family or conjugal ties and perpetrated outside the exercising of any public role (the aggressor may or may not be known to the victim and may be a neighbour or friend, or equally someone unknown to him/her)[80]." In this instance too, these acts of violence may be gender related where they are specifically targeted at a person on the basis of their sex.

In the village of Makanpur, 132km north of Kathmandu in Nepal, a group of a dozen inhabitants beat a woman to death for belonging to the Dalit community and after accusing her of witchcraft.

"(We) are often denied proper housing, access to healthcare and other public services, like use of water taps and temples," says Durga Sob, founder of FEDO – the Feminist Dalit Organization (Nepal) that fights against caste and gender discrimination in all regions of Nepal.

"Dalit women suffer a triple oppression, and are at the bottom of the pile," continued Durga. "As women they're second-class citizens anyway, but as Dalits they're subjected to social exclusion, and as the poorest group in Nepal, they experience chronic poverty."

"Nepal locals lynch Dalit woman accused of witchcraft", Women News Network, May 2010.

Homosexual men are also the target of violence in various forms, not because they are men but conversely because they do not meet the criteria expected of males in a society. Men who supposedly betray their masculinity (homosexuals as well as bisexuals, transvestites and transsexuals) are seen as defying convention and hence are a particular target for a variety of different forms of violence perpetrated by individuals and communities. "Throughout the world, homosexuals risk being attacked by homophobic individuals or groups of individuals acting as one[81]."

3. State or institutional violence

State violence is understood as all acts of violence perpetrated or tolerated by the State. This form of violence can also be gender related. Various actions by public authorities, such as implementing or applying regulatory measures that disadvantage one or other sex, constitute gender-based acts of violence. These measures usually discriminate against

80. MdM, "Training manual on a multidisciplinary and integrated approach to dealing with victims of violence", Haiti, 2008.

81. Josse Evelyne, "Les violences sexospécifiques et sexuelles à l'égard des hommes", 2007.

women and can include forced sterilisation, pregnancy and abortion. Equally, States can tolerate gender-based violence through ineffective law enforcement, with the result that the perpetrators in effect act with impunity. In addition to caring for victims, advocacy initiatives aimed at public authorities can also be undertaken to prevent these forms of State violence.

"Homosexuality is forbidden and is severely punished by many States. In sixty countries, those convicted are liable to imprisonment (ranging from several months to life), corporal punishment, deportation or forced labour."

Josse Evelyne, "Les violences sexospécifiques et sexuelles à l'égard des hommes", 2007.

State violence can also be perpetrated through intermediaries of the State – teachers, educators, police officers, judges, care or prison staff, etc. Acts of violence observed in the prison setting include prisoners forced to have sex by staff in return for privileges, goods or essential items, inappropriate surveillance of prisoners when showering or undressing and body searches carried out by a member of the opposite sex or in his/her presence.

"Generally speaking, institutional violence includes anything that contradicts or contravenes personal development in all its different psycho-emotional, cognitive, physical or social dimensions and anything that places the interests of the institution above the interests of the individual cared for[82]."

82. "Maltraitance, bientraitance: prévenir les violences institutionnelles", Interprofessional studies module in public health, **École nationale de santé publique,** Rennes, 2005.

The government in Pakistan set up a special institution called *Dar-ul-Aman* (DUA) for women in distress and their children. Until very recently the majority of these temporary shelters offered makeshift accommodation and ad hoc healthcare (and to a lesser extent they still do), failing to meet the fundamental rights of the residents, notably to adequate food and access to medical care.

In addition to the stigma attached to staying at the DUA faced by the women, instances of violence against them committed by centre staff were reported – beatings, made to accept visitors, or to return to their families, made to hand over money, etc. While the way these institutions are run reflects and reproduces Pakistani society's socio-cultural perceptions of women, the government is working hard today to improve the quality of the facilities and care offered at the DUAs.

Whether perpetrated by community or State, gender-based violence is more common in situations of armed conflict which tend to reinforce and exacerbate discriminatory and violent behaviour that already existed in society in times of peace.

"In situations of inter-communal strife or conflicts drawn along ethnic or religious lines, women of a particular community or social group may be assaulted because they are seen as embodying the 'honour' and integrity of the community. […]

In the former Yugoslavia, for example, men were forced to sexually abuse other men while being mocked by their captors. […] In the DRC, young boys and men are raped as a means of reprisal against individuals, families or communities, and to undermine the fundamental values and social fabric of the community."

Amnesty International, "Lives blown apart – Crimes against women in times of conflict", Public report, December 8, 2004.

2D

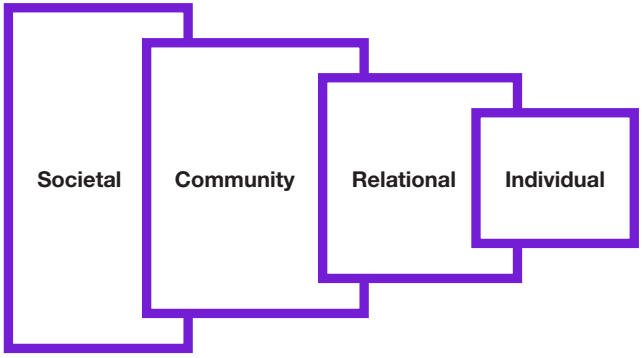
CAUSES AND CONSEQUENCES

No single factor explains why some people are violent towards others or why violence occurs more frequently in some communities than in others. Nevertheless, it is possible to pick out a range of causes that are common to the various forms of violence. These causes are risk factors that can help predict when acts of violence might arise. They result from the complex interaction of individual, relational, social, cultural and environmental factors.

At the same time, it would seem simplistic to highlight the physical, psychological and social consequences that apply to every victim of violence. On the other hand, there are signs those intervening can look for that indicate it is likely an act of violence has been committed against an individual.

1 / CAUSES OF GENDER-BASED VIOLENCE

The system referred to as the 'ecological model' makes it possible to analyse the influences that environment can have at different levels on the development and behaviour of individuals. These different levels are:



Some authors have used this model to understand the factors associated with different forms of gender-based violence[83]. Thus it has been shown that certain individual characteristics – biological factors, personal history, etc. – and collective characteristics – relational, community or societal – increase the risk of a person being either a perpetrator or a victim of gender-based violence.

83. **Heise L.L.,** "Violence against women: An integrated ecological framework", Violence against Women, 1998.

These characteristics influence the type and scale of the violence in each context. They are heightened by the different levels of authority and power that are assigned to each sex and that maintain privilege and subordination among members of a society.

The table below[84] illustrates certain factors that favour intimate partner violence. Such violence can also be the product of influences exerted on behaviour at multiple levels.

Individual

- → Poor level of education
- → Isolation and lack of a circle of family and friends
- → Low income
- → Witness as a child to acts of domestic violence
- → Absent father in the case of the man
- → Denial of paternity
- → Abused as a child
- → Alcohol and/or drug addiction
- → Age[85]
- → Belonging to a minority, marginalised or excluded community
- → Etc.

Relational

- → Marriage of convenience (financial, ethnic, political, etc.)
- → The man manages the money and takes the decisions in the family
- → Marital conflict
- → Wide disparity between partners (educational or financial)
- → Wife lives with her husband's family
- → Etc.

Community

- → Poverty, lack of financial security or unemployment
- → High population density
- → Isolation of women and families
- → Community attitudes tolerate and legitimise male violence
- → Poor institutional support and lack of social welfare for women
- → Inappropriate legislation
- → Inadequate awareness and understanding on the part of legislators, courts, etc.
- → Etc.

Cultural/Societal

- → Norms accord greater control over women's behaviour
- → Violence accepted as a means of resolving conflicts
- → Notion of masculinity linked to dominance, honour or aggression
- → Stereotyped roles attributed to both sexes
- → Etc.

It is important to understand and take account of these risk factors when designing effective, long-term strategies for preventing and responding to gender-based violence.

84. **Bouchon Magali,** *Practical approach – Violence against women: gender, culture and societies,* Analysis, Support and Advocacy Department, MdM, 2009.

85. For example, "immaturity associated with youth is one of the determinants of gender-specific and sexual violence perpetrated by adults against children", from **Josse E.,** "Causes et facteurs de risque des violences sexospécifiques et sexuelles exercées contre les enfants", 2007.

2 / CONSEQUENCES OF GENDER-BASED VIOLENCE

An understanding of the consequences of gender-based violence within a socio-cultural context makes it possible to formulate appropriate strategies for dealing with these effects and preventing further harm. Moreover, knowledge of the major repercussions of gender-based violence can make it easier to uncover those signs that point to the possibility of such acts and therefore easier to recognise those individuals who are victims.

While the consequences of violence can be classified by type, they are often interdependent and depend on the individual concerned, the nature of the consequences and circumstances of the violence.

Generally, the classifications distinguish between the fatal and non-fatal consequences of gender-based violence. Murder – honour killings, feminicide, etc. – is a direct consequence of an act of violence. Other fatal consequences may be indirect, such as suicide, maternal or infant death or death linked to HIV/Aids.

The diagrams shown on page 106 provide a clear and non-exhaustive list of the main non-fatal consequences of gender-based violence:

→ The consequences for physical and mental health (traumatic lesions, infections, chronic pathologies, psychosomatic consequences, behavioural problems, etc.);
→ The consequences for the economic and social relationships of the person affected by the violence.

1. Consequences specific to sexual violence

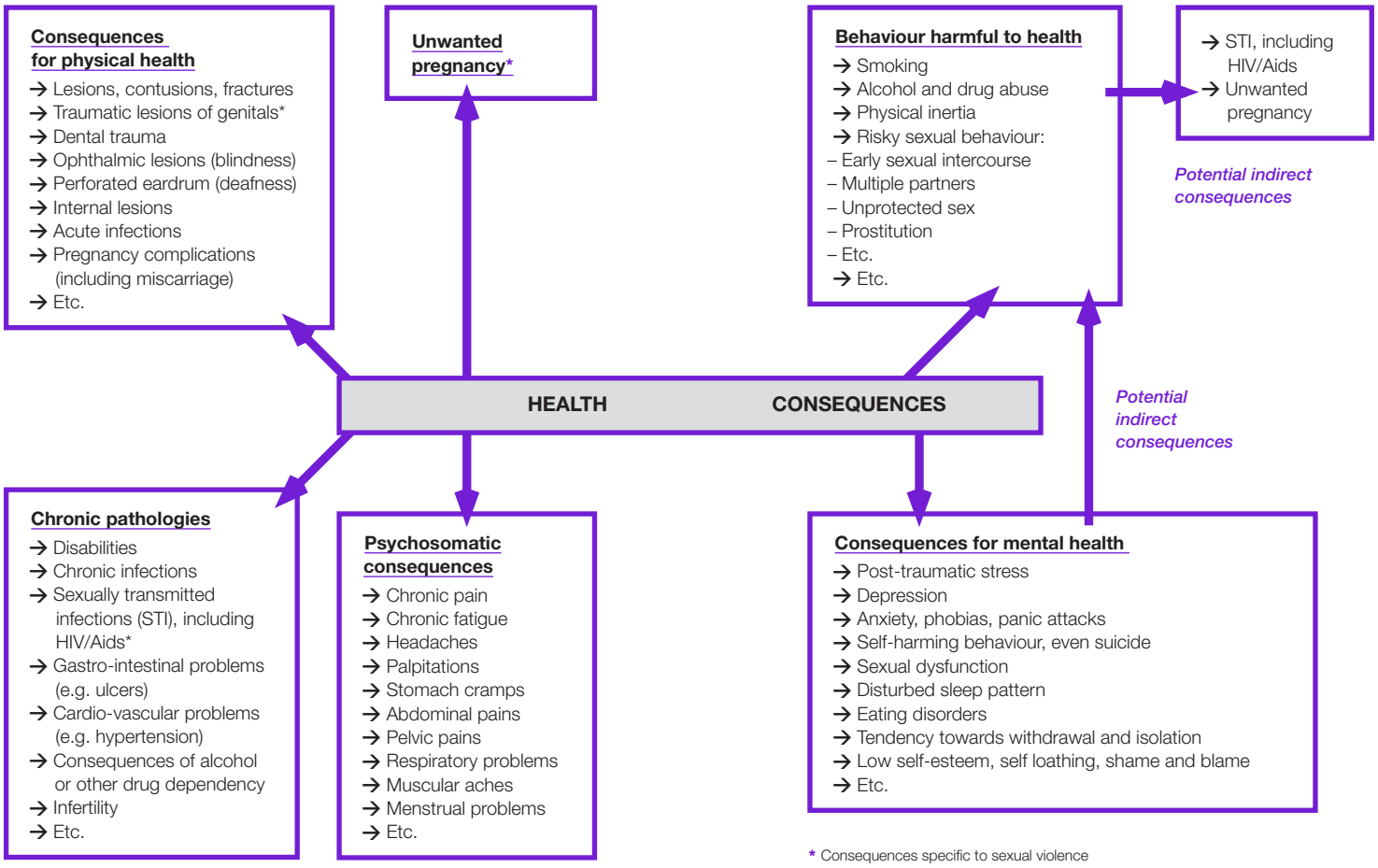
As a result of its link to reproductive health, **sexual violence has direct and indirect consequences that are particular to it.** The **direct consequences** include physical injury that has an impact in reproductive health, particularly resulting from damage to reproductive and genital tissue.

Sexually transmitted infections (STI), including HIV/Aids, and unwanted pregnancies may also be a **direct consequence** of rape. They may, however, also arise as a result of emotional distress following rape that prompts risky sexual behaviour. This is an example of the **indirect consequences** of sexual violence (cf. diagram on page 106).

2. Consequences associated with non-medical pregnancy terminations

Where pregnancy results from rape, and more generally where pregnancy is unwanted, a termination is often the considered option, even where it is illegal in the country concerned. Women in this situation are therefore prepared to opt for a **clandestine, non-medical termination that poses a major risk of death or illness.** The consequences of such non-medical abortions include: haemorrhaging, infections, poisoning due to the use of substances to trigger the abortion and internal traumatic lesions. They may also result in major complications requiring surgery (notably fistulas), cause irreversible sterility or even be fatal.

It has been shown that 38 women undergo a non-medical abortion every minute and that one woman dies every eight minutes as a



* Consequences specific to sexual violence

result of a botched abortion. In addition to the 65 000 to 70 000 deaths recorded each year as a result of non-medical abortions, it is believed that 5 million women undergoing the procedure subsequently suffer from temporary or permanent disability. Among those, almost 1.7 million can no longer have children and more than 3 million face the consequences of a genital tract infection[86].

Social and economic consequences

- → Distancing and even separation from a partner
- → Stigmatisation, individual rejected by the family and community; isolation
- → Loss of role/function in society
- → Less able to fulfil parenting role: neglecting, abandoning, rejecting and abusing, particularly children born as a result of rape
- → Disruption of professional activities or education
- → Violent behaviour, particularly towards own children
- → Etc.

3. The impact of gender-based violence on the community

As a result of its scope and its consequences, gender-based violence can upset the balance of a community/society, destroying its spirit and core values. It can thus lead to the disintegration of communities and to desocialisation. Existing traditional social cohesion may be undermined. The loss of moral points of reference can also render violence commonplace and give rise to general feelings of insecurity, sometimes reinforced by a culture of impunity.

86. IPPF *Medical Bulletin,* Vol. 42, n°2, June 2008.

3 KEY ELEMENTS TO PROVIDING CARE AND SUPPORT FOR VICTIMS OF GBV

KEY ELEMENTS FOR PROVIDING CARE AND SUPPORT
FOR VICTIMS OF GENDER-BASED VIOLENCE

KEY ELEMENTS FOR PROVIDING CARE AND SUPPORT
FOR VICTIMS OF GENDER-BASED VIOLENCE

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ACCESSING JUSTICE AND COMBATING IMPUNITY

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SOCIAL AND ECONOMIC REINTEGRATION

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H

OBSTACLES TO PROVIDING CARE AND SUPPORT

KEY ELEMENTS FOR PROVIDING CARE AND SUPPORT FOR VICTIMS OF GENDER-BASED VIOLENCE

Anyone involved in working on MdM programmes is likely to encounter individuals who are or have been victims of gender-based violence. As a result, whatever the context or the project, each service provider should be trained to identify and receive such individuals.

Preliminary identification and reception are crucial for ensuring good quality multidisciplinary care and support (medical, psychological, legal and social). They enable victims to be dealt with directly or to be referred to another service provider. Those responsible must therefore be well informed about the different existing and accessible services for the care and support of victims of gender-based violence.

3A RECEPTION

1 / RECEPTION – A KEY MOMENT

How a person is initially received is essential to the carer/patient relationship and continues to have an impact throughout the whole care of the patient. The first interview is crucial, particularly where violence is involved: **a bond of trust must be established to ensure that the individual concerned will attend the full care and support.**

A patient's readiness to reveal the violence suffered and a service provider's ability to identify such individuals in part depend on the quality of patient reception.

The first contact must also enable other acts of violence to be prevented by **implementing appropriate, emergency protection measures in keeping with the gravity of the situation.**

Lastly, the individual must, at the first interview, **be directed towards other services** that may be required, provided that they are available, accessible and of a good quality.

These principles of patient reception concern all those involved with caring and supporting victims at every stage, both within the context of general medicine that includes care for victims of gender-based violence and within specialist structures. Each care provider must therefore receive training in the principles of patient reception **applying to initial patient contact and to all subsequent interviews equally.**

2 / THE PRINCIPLES OF PATIENT RECEPTION

There are basic rules governing patient reception that must be applied by anyone working in a centre providing care and support (whether directly intervening or not) at every stage (from initial to final interview). The principles of patient reception are based on ethics, but also relate to other precepts associated with certain communication techniques.

1. The care provider as communication tool

Initially, and if the situation allows, it is important for the care provider to **make it clear that he/she is ready and willing to care for victims of violence.** Individuals consulting a care provider for a reason other than as a victim of violence may be encouraged to confide more readily if aware of the presence/competence of professionals ready to help them.
Wearing badges or displaying messages in waiting rooms or specific areas can be an effective way of encouraging victims of violence to talk to someone.
At the start of the interview, it is important that the care provider introduces him/herself, choosing his/her words carefully.

> The introduction and how the care provider introduces him/herself are crucial stages in patient reception. "Thus, it is important within the context of human relationships and in accordance with rules of politeness to greet the person and to introduce oneself and one's role: give one's name and one's position within the organisation."
>
> **MdM,** Manuel sur la prise en charge pluridisciplinaire et intégrée des victimes de violences, Haïti 2008.

The language used throughout the interview must be clear, comprehensible (avoiding technical terms) and reassuring so that **verbal communication** wins the trust of the patient. It is also essential to think of **non-verbal** communication as a way for the care provider to build a relationship with the victim. Non-verbal communication means assigning significance to various gestures and behaviours such as physical appearance, dress, movements, posture, look, etc.

The care provider's verbal and non-verbal attitudes and behaviours must convey **acceptance and availability.** They show the person that someone is trying to understand and accept him/her as a whole. This attitude is an essential precondition for instilling confidence in the person who has suffered violence, enabling him/her to confide in the care provider.

2. Basic principles

It takes a lot of courage for victims of violence to overcome their feelings of fear, guilt, and isolation and to dare to seek care and support. The way victims are received must not discourage them from taking the initiative.

Listening

Firstly, the care provider must **listen to** the individual. **Active and attentive** listening involves respecting the victim's moments of silence and not interrupting. He/she must finish his/her account before more detailed information is sought, preferably by posing open-ended questions. Although actively engaged in listening, the care provider must **show respect** and not cast doubt on or correct what is said, as showing doubt is a further form of aggression. The individual must understand that the care provider is not judging him/her or questioning what he/she has to say, and respects his/her decisions.

Empathy

Empathy is the key to listening attentively and respectfully. "It is a form of understanding defined as the capacity to perceive and comprehend the feelings of another person. Differing from sympathy and antipathy, empathy is a process whereby the practitioner tries to draw on his/her own world of references […] to focus on the way in which the person perceives reality[87]." Empathy develops closeness to the other person without however identifying with him/her. The care provider maintains his/her position and never confuses him/herself with the person cared for. This approach makes it possible to understand the ideas of the patient without subscribing to them, and to appreciate what an individual's behaviour and practices mean without justifying them.

Confidentiality

An environment must be created in which the individual can feel at ease and have the confidence to talk. To ensure that this happens, every interview must ideally begin with a one-to-one session to determine if the person really does want to be counselled and supported, and by whom. If this approach is adopted by the organisation, notice of the protocol should preferably be posted, so that everyone understands that it is standard procedure and that no one coming with the victim is personally targeted by a refusal to be received during this first stage of caring for an individual.

In some situations, it can be impossible for a person (often a woman) to come to a consultation unless accompanied by a member of the family, which undermines the confidentiality of the exchanges. These social and cultural constraints must be taken into account.

Generally, any coming or going is to be avoided throughout the interview. Some patients prefer to have the door to the interview room closed for greater privacy. Others, in contrast, like to have the door left open, particularly where the care provider is of the opposite sex. It is essential to understand the expectations of the individual and to respect these.

Lastly, the principle of confidentiality is constrained by the use of interpreters in instances where the care provider and the patient do not speak the same language. A document signed by the interpreter at the same time as the work contract must include a confidentiality clause.

87. **Tourette-Turgis C.,** "Les bases du counseling", http://www.counselingvih.org/fr/definition/empathie.php)

LISTENING

Helpful behaviour

- → Standing up to greet the person
- → Introducing oneself and one's professional role
- → Making eye contact (kindly expression, looking frequently at the person, etc.)
- → Using a kind, patient and tolerant attitude
- → Showing interest and listening attentively
- → Giving encouragement with nods, smiles and gestures
- → Prompting the person to continue ("And then?", "And so?", "Hmm… hmm", etc.)
- → Not interrupting the person
- → Putting questions to clarify a subject and asking for details
- → Repeating the person's own words
- → Giving useful advice (concrete and specific)
- → Not judging or criticising
- → Demonstrating that you are trustworthy
- → Maintaining an appropriate physical distance between you and the person

Unhelpful behaviour

- → Staring 'harshly' or in an investigative or insistent manner
- → An unpleasant attitude
- → Listening only distractedly or not asking any questions
- → Showing indifference
- → Interrupting the person
- → Criticising and judging
- → Making the victim feel guilty
- → Casting doubts on what they are telling you
- → Being too familiar with the person (in terms of your vocabulary)
- → Using technical language
- → Displaying an air of superiority
- → Arguing and trying to convince
- → Bringing up your own problems
- → Following the look or gestures of the person rather than paying attention to what she/he says
- → Joking or laughing inappropriately
- → Keeping too great or little distance
- → Forgetting what the person has said previously
- → Appearing too affected by what the person is saying (be it enthusiastic or moved

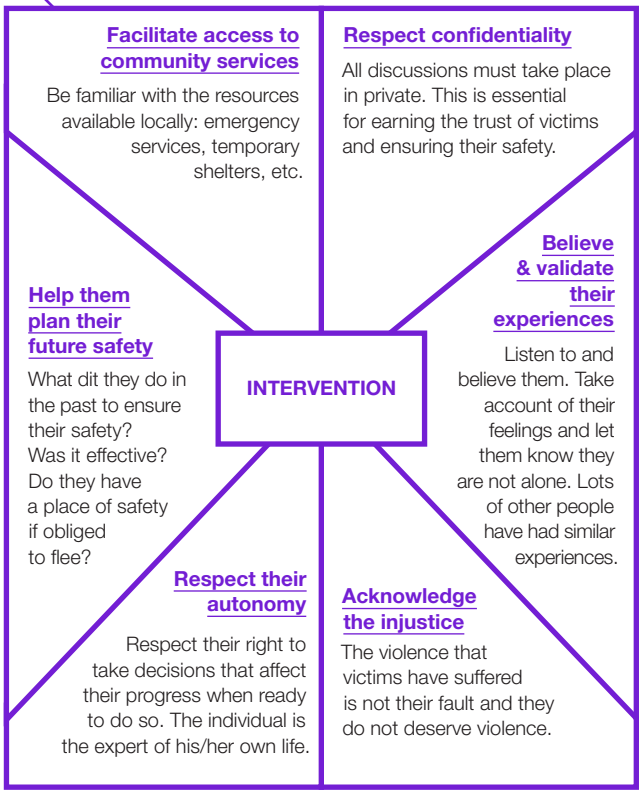
INITIAL CONTACT: ADVICE FOR THE SUPPORT WORKER

- → Sit somewhere quiet, where privacy will be guaranteed
- → Avoid potential distractions
- → Be one-to-one with the victim
- → Preferably, the worker should be of the same sex
- → Introduce yourself (role and organisation) and explain the aim of the interview
- → Ask the victim to introduce him/herself
- → Sit opposite the person, look at him/her and pay complete attention (listening skills)
- → Give assurances of discretion (confidentiality)
- → Ask the person if there is anything you can do to make him/her feel more at ease (leaving the door to the room open or closed, or contacting someone from his/her immediate circle)
- → Recognise that violence is common (do not cast doubt on what victims say)
- → Help the person express him/herself and respect silences
- → Show patience. It is perhaps the first time that the person has recounted the facts. Take into account the distress and confusion that can result
- → Reassure the person of his/her good reasons for coming

(asking for help when needed/in danger is a crucial step)
- → Listen with consideration and respect
- → Accept what the person is saying to you (not always easy)
- → Take account of his/her evaluation of the facts and not your own (e.g. do not view some forms of sexual assault as minor)
- → Let the person express his/her emotions while helping him/her to control them
- → Help him/her identify and formulate priorities
- → Refer to the law (defence, protection and conviction) and explicitly name those types of violence that have been used
- → Assign responsibility for the violent acts clearly to the aggressor: the victim is not responsible for any violence committed against him/her
- → Provide information on possible help and recourse (services that provide counselling, drop-ins, shelter providers, emergency hospital services, medical, social and legal services, police, etc.), on the next steps to take and on the role of each professional involved (psychologist, social worker, doctor, police officer, judge, etc.)
- → Just sharing information is not in itself enough (consider the person's interests, the possibilities, the most appropriate moment)
- → Help the victim to take the steps and ensure follow-up with other professionals involved. Where necessary, make sure the person is accompanied to places where he/she risks being stigmatised (e.g. when lodging a complaint)
- → In cases of intimate partner violence, help the victim identify the stages of the cycle of violence
- → Respect any measures the victim takes to protect people
- → Finish the interview looking ahead to the future
- → Encourage the victim to get back in touch with you further down the line

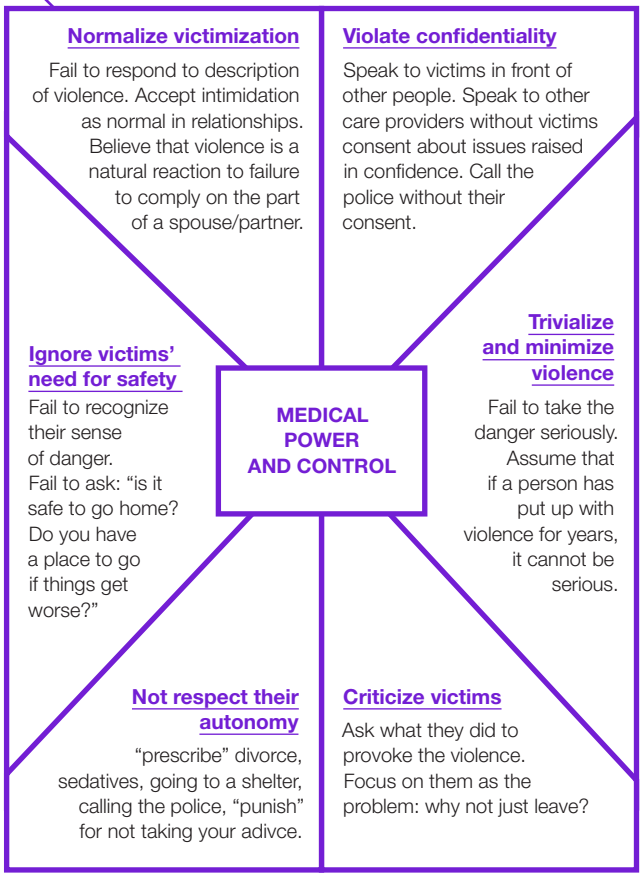
MdM – Regional workshop on providing care and support to women victims of violence, Latin America/Caribbean, 18th-21st November 2008.
Paper produced by Josse Evelyne, clinical psychologist.

WHAT TO DO



Adapted from "Ending Violence Against Women", **Population Report, Special Guide**, and The "Medical Power & Control Wheel", developed by the Wisconsin **Domestic Violence Project.**

WHAT NOT TO DO



3. Temporary protection measures

During the initial interview, the issue of protection must be tackled. The effectiveness of the overall care and the quality of the relationship between the caregiver and the victim of violence depend on the latter being and feeling safe. The protection afforded during initial and ongoing care must be effective, notably as regards respecting confidentiality. The worker also has a more general duty of care as regards the seriousness of the violence suffered and its potential reoccurrence.

Respecting confidentiality throughout the care pathway protect victims from renewed violence that might arise when individuals outside (perpetrator, family members, etc.) are informed of the steps taken. Information can leak out as a result of members of staff being indiscreet. Respect for the professional code of confidentiality is paramount and only essential and relevant information may be shared with other staff directly involved in providing care[88].

There is a greater or lesser risk of violence reoccurring depending on the circumstances. **In cases of intrafamily violence, some serious factors[89], often typical of a crisis situation, must be considered by care providers as pointing to a potential renewal of violence:**

→ Acts of violence happening more regularly and with increased frequency and/or ferocity;
→ Law enforcement agencies/justice departments/welfare agencies aware of situation;

88. For more information, see the section relating to the principles of medical ethics on page 147.
89. **Josse E.,** "Violences conjugales, quelques repères", training document designed for Algerian staff caring for women who are victims of intimate partner violence, October 2007.

- → Weapon kept at home;
- → Alcohol/drug abuse;
- → Death threats, threats made with a weapon (firearm or knife) or object;
- → Significant material damage (to furniture, walls, set fire to, etc.);
- → Indifference to other's suffering;
- → Violence against other family members (for example children);
- → Violence outside the conjugal home (on the road, towards neighbours, at work, etc.);
- → Scene setting or ritual behaviour leading up to the violence;
- → Psychiatric precedents;
- → Risk of victim committing suicide;
- → Victim self harming (auto-aggression);
- → Victims showing aggression towards, or even assaulting, partner or children.

The level of seriousness of the violent situation must be assessed to determine whether emergency protection measures need to be put in place, or whether the public authorities need to be notified of the situation.
In situations of heightened risk, different strategies may be drawn up in **partnership with the victim.**

Drawing up a safety plan

It is not easy to talk about the violence one has suffered and it is even more difficult to quit a violent environment.
Where there is repeated and often increasingly severe violence, such as in cases of intra-family violence[90], some protection measures can be implemented in advance as part of a safety plan:

90. For more information, see the section on the cycle of violence on page 94.

- → Prepare an 'emergency bag' (small amount of cash, identity papers, clothes, etc.);
- → Make a list of close contacts or people who can be trusted;
- → Make a list of the contact details of organisations that support victims of violence;
- → Make a list of available temporary shelters.

Children, who are old enough to understand, must be told of these measures so that they know what to do should the need arise.

Some countries have strategies in place to combat gender-based violence, which facilitate implementation of personal safety plans for victims of violence.

In France, **the law related to violence against women, domestic violence and their consequences on children** has been voted unanimously by the National Assembly and the Senate on 9th July 2010.

It marks in particular a new stage concerning the protection of the persons undergoing domestic violence.
It gives to the judge the means to prevent violence and their recurrence with **the device of the prescription of protection of the victims.** Concretely, the judge will rule as a matter of emergency and he/she can decide to eliminate from the family home the author of violence.
If the victim wishes to leave, the judge can decide to organize his rehousing to put him/her out of reach of his/her partner while ruling temporarily on the guarding of the children.

The electronic monitoring system will be also set up.
This system anti-link can be ordered when a violent partner is indicted for violence or threats, punished of at least 5 years

of detention. He will allow ensuring surveillance 24 hours a day, 7 days a week, 365 days a year."

French Government official website,
Law related to violence against women, July 20, 2010.

Temporary shelter for victims of violence

Among the temporary protection measures that are available, the provision of temporary accommodation is often considered in extreme cases where it is essential to remove the victim from the author of violence. Proposals are currently being developed to introduce temporary shelters for perpetrators rather than victims of violence. This measure would place responsibility for the situation firmly on the aggressor and on the aggressor alone. The victim would not have to leave home for an unknown destination nor have to see everyday life – including that of the children in the case of intimate partner violence – turned upside down.

Since the adoption in December 2001 of the federal law designed to increase the protection offered by the civil courts to victims of violence, law enforcement agencies in Germany can, where there is a clear and imminent threat, oblige anyone carrying out acts of domestic violence to leave the family home and forbid them from returning for several days.

FACTORS TO CONSIDER WHEN SETTING UP OR USING THE SERVICES OF TEMPORARY SHELTERS FOR WOMEN WHO ARE VICTIMS OF VIOLENCE

1. How victims of violence and society in general perceive temporary shelters

Temporary shelters may be perceived as places of protection. They may also, however, be viewed by the general population and by victims of violence as places of imprisonment, places that stigmatise or places of violence. Some women are, therefore, afraid that staying in a shelter will mean being excluded from the community. They often dread the moment when they have to leave. In addition, many women fear staying too long, disrupting their activities (job/income loss).

2. Criteria for selecting women who are victims of violence for referral to temporary shelters – Some examples

- → Existence of an immediate threat to the life of the woman or her children. The threat might come from the aggressor, the family, social circle or the woman herself (suicide attempt);
- → No possibility of the individual being taken in by her family (or someone in social circle);
- → Lack of own financial resources;
- → Geographical distance of victim of violence from centres providing care and support (isolated communities).

3. Preparing to leave the temporary shelter

- → Put measures in place that ensure the individual's safety;
- → Put professional training in place at the shelter to help women who have suffered violence get/return to work and become financially independent on leaving;

→ Support reintegration of the victim into the home/ family life;
→ Coordinate with other organisations for transport (back home);
→ Ensure that the shelter is part of/in touch with a network of multidisciplinary carers able to take over support of the individual after she leaves the shelter.

Preparations must be made to mitigate the dislocation an individual experiences between life inside the shelter (access to care, psychological support, balanced meals, etc.) and life after returning to her community. A commonly raised issue is the risk of experiencing the same violence again on leaving the shelter.

4. Caring for children in temporary shelters designed for women who have suffered violence

Women who are received at shelters are often accompanied by their children.

What this entails:

→ Taking account of this fact when first designing a project;
→ Setting aside space specifically for children;
→ Providing appropriate food and equipment;
→ Training refuge staff in caring for children;
→ Providing specialist psychological support;
→ Working in collaboration with the Ministry for Education to ensure children's schooling.

The issues this raises:

→ Defining what constitutes 'young children' (7/12 years max?);
→ Legal responsibility for unaccompanied minors;
→ Access to education: How can disruption to schooling be avoided?

5. Violence within temporary shelters

Ill treatment by supervisory staff:

→ Neglect:
– Insufficient food,
– Overcrowding/lack of personal space,
→ Psychological and verbal violence:
– Intimidation, insults, treating like a child, dehumanising,
– Lack of respect for privacy,
→ No preparation and support prior to leaving the shelter.

Violence among residents:

→ Physical violence,
→ Psychological and verbal violence,
→ Inter-ethnic violence.

Thoughts on this issue and suggested solutions:

Many problems are related to the structure's facilities (physical space and abilities and skills of staff).
It is therefore a matter of putting in place:
→ Sessions to raise centre staff awareness,
→ Staff training sessions regularly accompanied by staff support sessions,
→ Suitable premises,
→ Adequate funding,
→ Internal staff regulations,
→ Monitoring by public bodies (inspection),
→ Internal residents' regulations (rules for communal living),
→ Psychological care and/or psychosocial support for residents,
→ Social and recreational activities for mental well-being,
→ Designated areas for children.

MdM regional workshop on providing care and support for women victims of violence, Cairo (Egypt), September 2009.

3B

IDENTIFICATION

1 / IDENTIFICATION – A KEY MOMENT

In France as elsewhere, the vast majority of health professionals fails to spot that their patients are living in violent situations and rarely includes violence as a possible diagnosis[91].

Identifying victims is often problematic, as violence remains a taboo subject, particularly where it occurs within the family or where it is sexual in nature. The needs of victims of gender-based violence are not always expressed verbally: suffering is manifested indirectly in many cases via physical, psychological and/or behavioural signs. **Care providers must therefore know how to detect these signs that point to violence and must maintain a proactive approach in dealing with it.**

The terms 'identifying' and 'recognising' can sometimes be used interchangeably. In the context of gender-based violence, identification means **recognising** the individual not just as a patient or service user but also as a **victim of an act that violates his/her fundamental rights.**

Setting up mechanisms for improving identification of victims of violence must be accompanied by provisions for their care and support (either direct or indirect via partner organisations).

2 / IDENTIFYING THE PHYSICAL, PSYCHOLOGICAL AND BEHAVIOURAL SIGNS

Whether physical, psychological or behavioural, signs of violence in victims and, equally, in perpetrators, must sound a clear warning for informed professionals.

1. In victims of violence

Care providers must know how to recognize these various signs, interpret some in relation to others and take account of their cumulative significance; the more of them there are, the more likely a diagnosis of violence is correct, and the more likely the violence is serious and chronic. Awareness-raising and training for professionals involved is crucial to ensure they have the necessary skills to spot these signs and thereby identify victims of violence.

91. This comment is directed at all those likely to be involved along the care and support pathway of a victim of violence.

RECOGNISING SIGNS OF VIOLENCE

1. Physical/health related signs

Highly suspicious signs

- → Where the injuries are situated: cuts (contusions, burns, bruises, scratch marks, bites, lacerations, alopecia), fractures, dislocations, internal lesions (visceral and thoracic), deafness (torture);
- → Injuries from varying points in time;
- → The injury doesn't fit the explanation given for it;
- → The woman refuses to disclose the cause of the injury or of the sexually transmitted infection;
- → The woman hasn't mentioned traumatic injuries (unexpected discovery);
- → The woman offers vague, confused and changeable explanations as to the aetiology of the symptoms;
- → The woman sees the doctor repeatedly for the same reasons;
- → The woman claims that she has had an accident or that she caused herself the injuries (self harming);
- → The woman leaves visiting the doctor until late despite how serious her injuries are or if she is suddenly taken into hospital (complications following infection or surgery, or haemorrhaging for injuries that could have been dealt with sooner);
- → Sexually transmitted infections in young people.

Signs that are not specific

- → Recurring genital or urinary disorders, complaints or injuries: pelvic pain, dysuria, infections, dyspareunia, issues surrounding sex drive, etc.;
- → Request for HIV test (low occurrence in married women);
- → Somatic disorders without any physical manifestations: headaches, chronic pain (anal, abdominal or back pain), difficulty breathing, fever, tiredness, etc.;
- → Repeated visits with several members of the team for physical or gynaecological problems;
- → Difficulties coming to terms with a pregnancy, either in denial or delaying announcement, absent father (or identity concealed), requests for a termination (especially in the presence of family members), complications following a termination (haemorrhaging, infections), haemorrhaging prior to giving birth, rupture of the uterus, placental abruption, miscarriage;
- → Long term complaints: hypertension, diabetes, gastric or intestinal complaints, asthma.

2. Signs of a psychosocial nature

Mood and behaviour

state of shock, disorientation, confusion, demonstrates a slowness in their behaviour, anxiety (phobias, panic attacks, avoidant responses), depression (sadness, self-harming, suicidal tendencies), is on edge, insomnia, loss of appetite, memory and concentration issues, mutism, abusing psychoactive drugs, excessive concerns about hygiene, isolation, etc.;

Language

puts herself down or blames herself (indicating lowered self esteem) and / or isolation, expresses issues of atonement, carries out rituals, feels like giving up;

Attitude towards healthcare workers

embarrassment, worry, seeks to protect. A spouse who is too overbearing / considerate and speaks for his wife.

MdM, Regional workshop on providing care and support to women victims of violence, Latin America/ Caribbean, 18 - 21 November 2008." paper produced by Josse Evelyne, clinical psychologist.

The lack of staff training in identifying victims has led to serious situations arising. In one such instance, a woman was seen seven times at an MdM Caso [Centre d'accueil, de soins et d'orientation – Healthcare and advice centre] by five different doctors for a range of problems – hypertension incidentally revealing Hepatitis C, palpitations, back pain and amenorrhea, then dizziness, nausea, headaches and urinary problems, all on repeated occasions. A year and a half after the initial consultation, the patient was admitted to intensive care for a ruptured spleen caused by blows from her partner. Focusing on treatment for her hepatitis and hypertension, none of the doctors seen raised the issue of violence as a possible cause of her psychosomatic complaints.

Testimony from one actor intervening in the frame of missions in France **MdM France.**

When faced with a sign of potential violence, certain questions may be asked as a way of introducing the topic of possible violence suffered by the individual being cared:
"'Women who present with an injury like yours often tell me that they've been beaten. Is this what happened to you as well?' 'From what I can see, I think that someone has badly mistreated you and caused you pain.'"

Josse E., "Déceler les violences sexuelles faites aux femmes", April 2007.

2. In perpetrators of violence

Some behaviour may suggest that an individual has committed, or may commit, acts of violence. Professionals must therefore pay close attention to the behaviour of a person accompanying a patient. When viewed in conjunction with suspicious signs already observed in a patient, this behaviour can help identify a violent situation.

Signs pointing to potential acts of intimate partner violence include[92]:

- → He/she replies on behalf of his/her partner,
- → He/she insists on always being present,
- → If he/she cannot be present, he/she telephones several times during the interview,
- → He/she criticises the actions of his/her partner and makes comments to undermine the partner's credibility,
- → He/she displays contempt,
- → He/she dictates the partner's conduct or suggests what the doctor should do,
- → He/she controls the exchanges by facial expressions or by adopting an intimidatory attitude,
- → He/she displays an irrational jealousy towards his/her partner,
- → He/she minimises or denies the existence of his/her partner's health problems, as well as the seriousness of any injuries,
- → He/she voices firm ideas on the role of men and women,
- → He/she may be ultra considerate and excessively attentive in public, as well as extremely friendly towards the care provider.

92. D'Hauwe Dr P., "Le médecin généraliste face à la violence conjugale", *La Revue de la médecine générale,* N° 237, November 2006.

Identifying victims of violence remains a difficult stage, as much for the care provider[93] as for the victim/perpetrator, in the provision of care, as it touches on personal matters. Given too that victims of violence (and particularly sexual violence) are very often stigmatised by their community, they are reluctant to reveal the violence they have suffered. It is nevertheless possible to explore certain avenues as a way of identifying violent situations.

3 / AVENUES TO EXPLORE TO IMPROVE IDENTIFICATION OF VICTIMS OF VIOLENCE

Certain steps can be taken to identify victims of violence more readily:

→ **Showing oneself ready to welcome and care for victims of violence** can be an effective way to encourage them to talk to a care provider. Wearing badges or posting notices in waiting rooms or specific areas are examples of tired and tested methods.
→ **Systematic screening** can also be implemented to help care providers spot violent situations.
→ Lastly, **links with community teams** help to identify victims of violence more readily and facilitate their access to services providing care and support.

How professionals intervene must be looked at carefully to gauge the feasibility and appropriateness of such initiatives and to adapt the way they are implemented.

1. Systematic screening

Screening is a method often used in medical settings for identifying victims of violence. It involves putting a series of questions about violence **systematically to every patient,** whatever the reason for the consultation, in order to find out if he/she has ever had to cope with such violence.

The care provider must take time to set out the reasons for asking these delicate questions and the way in which this will be done: “I am going to ask you some questions that we ask all our patients.” Screening differs from questioning a patient because the care provider has previously detected signs that may point to violence: the questions posed will not be the same[94].

This method can prove beneficial both for victims of violence and the professional involved. The latter may be reassured by the use of predefined questions as part of a ‘protocol’ and feel less awkward about tackling this delicate subject. Likewise, a few simple questions may be enough to help the victim confide.

It is recommended that a screening protocol be implemented that takes account of linguistic nuances and socio-cultural determinants that apply to the given context. Before applying the screening process involving all service users, the professional staff can test it with a selection to see for themselves if the initiative proves effective. This technique for identifying victims of violence entails staff training and awareness-raising for the whole organisation providing the care.

93. For more information, see the section on obstacles to providing care and support on page 271.
94. For examples of questions to ask in cases of possible signs of violence, see insert on page 138.

A study has shown that it takes just twenty seconds to ask the three questions that effectively identify victims of intimate partner violence:

→ "Have you been hit, kicked or punched or received any other sort of injury over the past year?"
→ "Do you feel safe in your present relationship?"
→ "Do you have a partner from a previous relationship who makes you feel threatened today?"

Feldhaus, K. and al., "Accuracy of three brief screening questions for detecting partner violence in the emergency department", *Journal of the American Association,* 1997.

Other questions/approaches that can also be used:

→ "Before talking about a choice of contraception, it would be a good idea if you told me a bit more about your relationship with your partner."
→ "Given that sexual violence is very common, I now ask all the women I see: 'Have you, too, suffered this type of abuse?'"
→ "Given that women frequently experience violence, we have now started to ask all our service users questions relating to abuse."
→ "Many of my patients experience tension in the home. Some are too afraid or are too embarrassed to talk voluntarily about the problem and that is why I'm now going to put the question to you as a matter of routine. Is this a problem that you have?"

Josse E., "Les Violences conjugales, quelques repères", Training document designed for Algerian staff caring for women who are victims of intimate partner violence, October 2007.

Screening can contribute to **early and more effective identification** of violence and can encourage victims to acknowledge their situation more readily. The use of such a method could prevent incidents from escalating or reoccurring and thus reduce morbidity and mortality associated with gender-based violence.

2. Using community links

A community approach is "an intervention strategy that relies on the potential of individuals, social networks, community groups and their resources for dealing with their social and health problems; it is an intervention strategy that seeks the empowerment, means and support for that potential to be realised[95]."

Developing a community approach to preventing and responding to gender-based violence favours:

→ Programmes that are embedded in the local population,
→ Proximity to key figures in the community,
→ Community participation (training and informing the population),
→ Involvement of natural support workers (within the community who have been appointed following programmes – experienced workers, health advocates, peer support workers and counsellors),
→ Communication in the language(s) of the community[96].

More particularly, this approach facilitates identification of victims of violence and their access to care and support services

95. Bourque D., *L'approche communautaire – recueil de textes, Valleyfield,* 1987.
96. Laval C., sociologist, "The community-based approach to fight against gender-based violence: definitions, advantages and risks", regional workshop on providing care and support to women victims of violence, Kinshasa (DRC), MdM, April 2010.

via **community-based links.** As a result of their privileged position, those providing community-based support can offer **more accessible resources and have a better knowledge of the community.** They must be made aware of the issues surrounding gender-based violence and be informed of existing provision of care and support in order to be able to refer victims and perpetrators identified.

Questions must always be asked as to the appropriateness of using community links and the choice of community-based provider. Some may themselves be victims or aggressors, while others may no longer hold a privileged position in the community.

In every instance, it is important to ensure that the programme and the community links share the same definitions and perceptions of gender-based violence (given that some forms of violence are viewed as 'normal' and/or 'trivial').

The MdM programme **in Liberia** relied on some women with a traditionally privileged role within the community. Today, some of the women admit that their social standing is diminishing and that their role as advisers to the younger generation is no longer so effective. Moreover, some of these 'traditional women' are often linked to acts of gender-based violence perpetrated within the community. They close their eyes to intimate partner violence as a result of the way they perceive the role of women in the home. Many are also involved in harmful traditional practices carried out on girls and young women (genital mutilation).

MdM - S2AP, Programme Evaluation Report – Liberia Project, March 2010.

3C

PROVIDING MEDICAL CARE

Dispensing medical care provides one of the opportunities for identifying and caring for victims of gender-based violence. It is founded on ethical principles and on a sequence of essential steps – interview, clinical examinations and paraclinical tests, treatment, etc. – that guide professional practitioners and guarantee the standard of care.

1 / PROVIDING MEDICAL CARE – A SPECIAL GATEWAY

Physical and sexual violence are the most common forms of gender-related violence and the medical sector provides a special opportunity for victims of such violence to seek care and support.

80% of victims present more often for the first time at a medical facility[97] than at any other service providing care. Healthcare staff is thus often the first provider that victims encounter.

An ability to identify victims of violence and the quality of their reception and care are therefore crucial for ensuring that they will continue to attend the full care and support.

"The healthcare facility should be the gateway to a diverse network of support, each element of which works in a concerted manner to rehabilitate the victim […] it is therefore important that healthcare staff [is aware] of the role it plays in implementing a multidisciplinary approach, not only in the provision of care but also as a means of linking up with other sectors involved."

«Prise en charge et accompagnement des victimes de violences sexuelles», training booklet, Concertation nationale contre les violences faites aux femmes, Haïti, March 2005.

Medical care is nevertheless just one opportunity among others. The importance of the medical sector in a multidisciplinary care and support pathway will vary depending on the nature of the violence and the individual's background and situation.

When a victim of violence presents at a healthcare facility, it may be as a result of one of the following three scenarios[98]:

→ Individual requests care for a range of complaints, without any exact cause being given. Healthcare workers must then be able to determine whether acts of violence are the source of these symptoms and thereby identify individuals requiring specific care and support;

→ Individual presents voluntarily, with no prior approach being made to the police, to report acts of violence and to receive medical care;

→ Individual presents following a complaint being lodged. In this instance, the medical staff is requisitioned to dispense appropriate medical care.

97. Human Rights Watch, quoted in "Sexual and gender-based violence", Médecins sans frontières workshop, 2005.

98. Beausséjour Dr P., (Haiti), "Prise en charge médicale des victimes de violences", Regional workshop on providing care and support to women victims of violence, MdM, Managua (Nicaragua), November 2008.

2 / PRINCIPLES OF **MEDICAL ETHICS**[99]

"Ethics are not value judgements (like morals which proscribe), nor codes of good practice, but an approach. Ethics proceed from active, collective and interactive reflection on and discussion of the human values that should be safeguarded and the tensions that exist between the individual (and his/her protection) and other logics. Ethics examine the hierarchy of values and the criteria governing choice, particularly in the field of healthcare[100]."

The key principles of medical ethics are international ones that apply at any time (in conflict/peace) and anywhere. **They serve as points of reference for health professionals** and a failure to observe them constitutes professional malpractice. Such malpractice may be a matter of civil and/or criminal legal

99. Dromer C., Desmarest A. and Delorme A., *For ethics in the field, Sensitive personal data management, health – Life stories,* MdM France, 2010.

100. Bernard, Professor J., first president of the Comité consultatif national français d'Éthique (French National Consultative Committee on Ethics), 1985.

responsibility on the part of the professional, but only where the ethical principle that has been breached is enshrined in law. **An individual's legal obligations are set out in national legislation. Ethical principles on the other hand are a general undertaking to respect human rights.**

ESSENTIAL POINT

Principles of medical ethics apply firstly to doctors but are, nevertheless, transferable to all care and support providers acting for the well-being and/or rehabilitation of individuals, including those who are victims of violence.

Seven fundamental medical ethical principles may be set out:

1. Respect for dignity

Respect for the individual and his/her physical and moral integrity and dignity represents an essential human right and one of the fundamental duties of healthcare professionals.

"A physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity[101]."

2. Duty to treat people without discrimination

This entails providing treatment and care irrespective of race, ethnicity, nationality, gender, religion or beliefs, social group, political affiliation, mores, family situation, reputation, disability, wealth and state of health. Delivery of emergency treatment is the only criterion for prioritising care.

101. International code of medical ethics, **World Medical Association,** October 2006.

3. Duty not to cause harm

This entails inflicting no unnecessary suffering by act or omission. "I will use my power to help the sick to the best of my ability and judgement; I will abstain from harming or wronging any person by it." (Hippocratic Oath)

4. Free and informed consent

Service users must understand the stages of care – interview, examination, treatment, photographing, etc. – and must give their full and free consent.
Consent[102] is considered **free** when it is obtained without threat, constraint or illegal incentive.
It must be **informed,** that is to say preceded by accurate, comprehensible and full information presented on what the proposed treatment involves. It is not enough to provide the information: it is imperative that the doctor ensures the patient has correctly understood it.

Free and informed consent does not imply that it must always be explicitly formulated: for medical procedures and brief examinations that pose no significant risk to the patient, **tacit** or implicit consent is enough in instances where there is no doubt that it is being given.
Example: A patient who rolls up his/her sleeve and stretches out his/her arm to give a blood sample is demonstrating tacit consent that cannot be interpreted in any way other than acceptance of the procedure.

In the case of certain medical procedures, however, national legislation requires **written** consent.
Example: Under French law, any patient having to undergo a coloscopy must give written consent in advance (consent form).

The patient must also be aware that he/she can **withdraw consent** at any time.

Special cases

In situations where a **patient's free choice is constrained** by a relationship in which he/she is dominated by another, or by a lack of education, it can be tricky to obtain free and informed consent. In cases where the family or immediate circle considers that the patient should accept or refuse treatment, it is up to the health worker to ensure that the decision expressed by the patient reflects his/her true consent.

Minors also have the right to receive clear and accurate information. Their opinion must always be sought and taken into account in relation to their degree of maturity and understanding[103]. Their consent alone is, however, not sufficient and their parents or other legal representative (guardian) exercising parental responsibility must be consulted.

In certain circumstances (intrafamily violence, prostitution, sexual violence, etc.) and where violence has been perpetrated against a minor, informing the parents/legal representatives may put the young person at risk.
An alternative solution to informing the parents should therefore be found and a trusted adult designated by the minor should be sought for support. **The interests of the child must always take precedence and guide the healthcare worker.**

102. "'Consent' is a person's voluntarily given permission for an action, based on a sound understanding of what the action involves and its likely consequences.", **Declaration on Ethical Considerations regarding Health Databases, World Medical Association,** 2002.

103. Declaration of Ottawa on the Right of the Child to Health Care, adopted by the General Assembly of the World Medical Association, Ottawa (Canada), October 1988, and amended, New Delhi (India), October 2009.

5. Confidentiality

Patients are guaranteed medical confidentiality which covers not only the individual's state of health but also all personal data or data that might be cross-checked to identify a person. The confidential nature of this information must be safeguarded to maintain the bond of trust between the health professional and the patient, and to protect the latter's rights. This is even more crucial in violence cases.

Medical confidentiality applies to the collection, circulation and archiving of data. No personal details should be disseminated, except between members of the same network of care providers. This sharing of information cannot take place without the consent of the patient who thereby 'frees' the health professional from exclusive patient/doctor confidentiality.

RECOMMENDATION

Multidisciplinary care and support involves different members of a network working together. In such cases, the sharing of information is acceptable if it is done in the interests of the patient (shared professional confidentiality). In terms of medical ethics relating to confidentiality, each care provider must share only necessary and relevant information.

Medical confidentiality must also be guaranteed in the suitable layout of premises, ensuring a minimum of privacy for consultations.

The issue of confidentiality similarly arises where an interpreter is required. A document signed by the interpreter at the same time as the work contract must guarantee his/her adherence to the principle of confidentiality[104].

6. Duty to protect

Before an individual leaves a healthcare facility, it is important to ensure that, given the circumstances surrounding the violence he/she has suffered, he/she will not be in immediate danger.

For care providers, protecting does not mean systematically reporting acts of violence of which they are aware. On the other hand, **solutions that correspond to the victim's situation must be devised to avoid a repetition of the violence** (temporary measures for their physical protection). Such measures are only appropriate where the individual concerned has fully consented.

The obligation to obtain consent may be waived for the purposes of protecting the patient: thus, the systematic reporting of **children suffering abuse** is often recommended. The same applies to cases of torture or other inhuman or degrading treatment involving individuals in prison.

For **particularly vulnerable individuals** (person with a disability, dependent elderly person, person in a controlling relationship, etc.), obtaining free and informed consent can sometimes appear problematic: the care provider must therefore assess, according to his/her own conscience, what would be most beneficial for the individual being treated. The particular circumstances of each case must take precedence over the systematic reporting of abuse.

104. A sample confidentiality agreement is available in the 'toolkit' forming part of the handbook by **Dromer C., Desmarest A. and Delorme A.,** *For ethics in the field, Sensitive personal data management, health – Life stories,* MdM France, 2010.

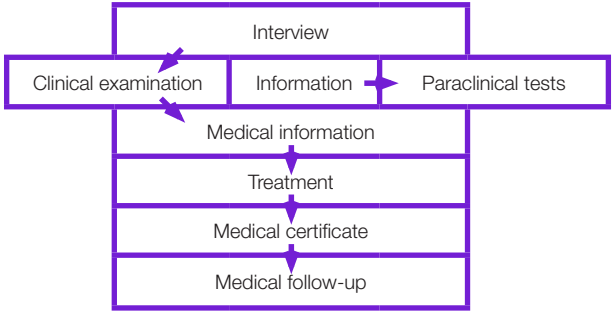
7. Duty to attest to a patient's claim[105]

If an individual wants a doctor to attest to his/her injuries or state of health, a medical certificate must be produced. This document must be based on the doctor's objective observations and not solely on the patient's account. Access to a medical certificate is a patient's right and a doctor's obligation. If the individual does not request a certificate, the doctor has a duty to offer one, stressing the usefulness and significance of a medical certificate.

3 / COMPONENTS OF MEDICAL CARE AND TREATMENT

Dispensing medical care and treatment comprises different stages. Certain prerequisites exist that ensure the quality of care dispensed. Over and above training for medical interventions, healthcare staff must also be trained to identify, receive and refer patients[106].

An ideal medical care and treatment pathway may be summarised in the following diagram:



1. Interview/Medical history

The interview must be conducted according to the principles of listening to and showing empathy towards patients[107]. It must not resemble an interrogation, so that the victim does not feel as if he/she is under attack again.

Here is a reminder of some of those principles:

- → Introduce yourself (state your role) and introduce anyone else who may be present in the room (nurse, interpreter, etc.);
- → Avoid being interrupted during the interview;
- → Be calm and promote an atmosphere of trust;
- → If the interview takes place in the examination room, cover medical instruments before required to be used.

In the case of the care and treatment of a child, it may be beneficial to use a doll to demonstrate the examinations that the health worker will carry out, but also to allow the child to describe more easily what he/she experienced and felt.

Case history comprises:

- → General information: Personal and medical history.
- → Description of incident.

General information[108]

Personal details

Surname(s) and forename(s): **Sex:** **Age:** **Date of birth:** **Place of birth:**	**Level of education:** **Current occupation:** **Previous occupation:**
Full address: **If displaced person, current address:**	**Parents' name if a minor:**
Married or single: **Name of spouse/partner:**	**Number of children:**

Medical details

- → Previous medical, psychiatric, gynaecological/obstetric and surgical history;
- → Current medication (including contraceptives), chronic illnesses (particularly HIV status and Hepatitis B and C);
- → Symptoms displayed (what the patient complains of);
- → Immunisation record (whether up to date);
- → Allergies;
- → Consumption of drugs, alcohol, tobacco (this is sensitive information that sometimes it is preferable to obtain during a follow-up rather than at the first consultation);
- → In cases of rape – date of last period and whether late.

Description of incident

The description of the incident, relayed by the doctor, is a transcript of what the patient says. Under no circumstances does it reveal any bias on the part of the doctor.

105. For more information, see the section relating to medical certificates on page 235.
106. 107. For more information, see the two sections relating to receiving and identifying on pages 117 and 134.
108. Medical history and examination form (used in health centres supported by MdM), created by **UNFPA**, Goma (RDC).

WHAT INFORMATION SHOULD BE GATHERED?

- → Date and time of the attack;
- → Place and circumstances of the attack[109];
- → Nature and description of the violence[110];
- → Any weapon(s) used; any drugs used[111];
- → Information on the attacker(s): number, known or unknown to the victim;
- → Previous violence, previous report(s) to police.

Where the situation allows for forensic examination to be carried out, some further information may be gathered in cases of rape (washing after the assault, sexual intercourse since the assault and how often, etc.)[112].

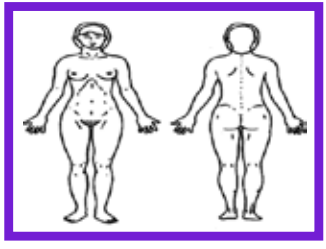
2. Clinical examination[113]

There are certain recommendations that relate to clinical examinations to ensure that they are in line with medical ethics:

- → Each individual has the right to decide whether he/she wishes to be accompanied during an examination and by whom. Some people prefer also to be examined by a person of the same sex. Where possible, these choices should be respected by the care provider;
- → Always begin by observing the patient before proceeding to a physical examination; note his/her general appearance and behaviour;
- → Explain each action;
- → Never ask the patient to undress or uncover him/herself completely: begin by examining the upper part of the body followed by the lower part and provide a gown so that he/she may cover him/herself;
- → Proceed with a close and systematic examination from 'head to toe', finishing with the genito-anal region in cases of sexual violence and proceeding system by system;
- → Look for signs that correspond to the individual's account (bites, punches, signs of restraint, etc.).

The clinical examination of victims of violence comprises three stages. Certain specific aspects should be taken into account in cases of sexual violence:

- → **Record vital signs:** Temperature, pulse, blood pressure and breathing rate.
- → **Record mental and emotional state:** Calm, irritable, crying, body language, withdrawn, afraid, worried, anxious, etc.



The use of a body diagram on which to record all details relating to each physical injury is recommended.

109. Examples: Sexual assault in the unlit toilets of a camp for refugees/displaced persons or during collecting of wood outside the camp; abuse inside a temporary shelter.
110. In cases of rape, specify whether there was penetration, fellatio, use of object(s), use of condom, etc.
111. Did the person consume or was he/she forced to consume alcohol or other intoxicating substances?
112. For more information, refer to the *Guidelines for medico-legal care for victims of sexual violence,* **WHO,** 2003.
113. **Dr Miloudi F.** (Algeria), "Main components of the medical care of women victims of violence", regional workshop on providing care and support to women victims of violence, Cairo (Egypt), MdM, September 2009.

→ **Record injuries:** The examination must pay particular attention to a description of the physical injuries (type, size, colour, shape and other characteristics). This involves systematically describing the exact location of all wounds and injuries.

ESSENTIAL POINT

Haematomas take a minimum of forty-eight hours to appear, particularly on black skin. The absence of physical signs does not imply the absence of violence. In 50% of cases, sexual violence does not cause genital lesions[114].

In some cultures, women's (and particularly girls') virginity is a guarantee of their chastity and dignity, as well as a matter of family honour. Protecting women's and girls' virginity can sometimes mean that they cannot undergo a gynaecological examination or use a tampon in order to avoid damaging the hymen. In such cases, some precautions must be followed: the doctor must avoid certain procedures – e.g. limit a genital examination to external organs and avoid using a speculum. In any case involving a young girl, the use of instruments for genital examination is not recommended.

3. Paraclinical tests

Complementary tests must be carried out **depending on the results of the clinical examination and resources available.** These may involve biological tests[115] in cases of sexual violence (blood tests, HIV rapid serological test, STI screening, urine sample testing, etc.), or other examinations such as x-ray and ultrasound scan. These different tests can have a **forensic purpose** concerning the perpetrator or the circumstances of the violence when used as part of judicial procedures[116].

RECOMMENDATIONS

Do not gather evidence that cannot be processed or used. In the case of paraclinical tests, abide by the protocols (methods for sampling, labelling, storing, etc.) that apply to the context in which the examination is being carried out to avoid damaging the forensic integrity of the sampling and analysis.

Do not hand over samples to the authorities if the individual does not wish to press charges.

4. Medical details

As is the case with every patient, healthcare staff receiving victims of violence must supply clear information on the methods for taking medication and on any possible side effects. Moreover, staff must advise patients of other existing care and support services that they might need.

5. Therapeutic treatment[117]

Therapeutic treatment entails caring physical injuries, the specific consequences of sexual violence and/or psychological problems.

Treating physical injuries

Where there is an open, weeping wound to the skin or mucous

114. **WHO, UNHCR,** *Clinical Management of Rape Survivors,* 2005.
115. For a list of standard paraclinical biological tests, see the part "Medical care following rape" on page 173.
116. Where the situation allows for forensic samples to be taken and analysed, refer to the *Guidelines for medico-legal care for victims of sexual violence,* **WHO,** 2003.
117. 118. For more information, see annex "Medical follow-up after rape" on page 173.

membranes, a prophylactic treatment must be administered to prevent tetanus, if the victim is not properly immunised.
A treatment is referred to as curative when it involves topical procedures such as cleaning, suturing wounds (only when they are clean and within forty-eight hours of an attack) or prescribing antibiotics (when the wounds are dirty and cannot therefore be sutured).

In some victims of sexual violence, physical lesions may include fistulas. As fistulas cause serious medical complications, the physical examination requires working alongside a doctor with the appropriate expertise. Where a fistula is confirmed or suspected in a woman surviving a sexual assault, she must be referred to a centre that offers surgical treatment to repair fistulas. Fistulas can only be repaired by surgical procedure, unless the lesion is very recent.

Module de formation des prestataires: volet médico-sanitaire,
Initiative conjointe de prévention des violences sexuelles et de réponse aux droits des victimes, Goma (DRC), June 2005.

Treating the specific consequences of sexual violence[118]

Acts of sexual violence can result in unwanted pregnancies and sexually transmitted infections, including HIV/Aids. Medical treatment must take into account these different potential consequences.

Treating sexually transmitted infections

If the assault is recent (< 3 days):
→ **Systematic prophylactic** treatment.

If the attack happened some time ago:
→ **Systematic prophylactic** treatment where the situation does not allow for a patient follow-up or biological tests[119];
→ **Treatment** if the biological tests have revealed an STI and/or the victim is presenting symptoms that correspond.

"We have treated more than 300 cases of sexual violence since the beginning of the year and I can assure you that all victims who suffered rape with penetration have an STI."

Testimony of Elise Mbusa, nurse with the Fepsi association, MdM partner in North Kivu (DRC).

RECOMMENDATIONS

Refer to national guidelines where they exist. Where such documents do not exist, medical teams may then refer to the MdM guidelines (which may also be collated with those of other NGOs operating in the area). Always opt in favour of the shortest and most readily implemented treatment.

Concerning Hepatitis B

The vaccine must be given within fourteen days following the attack at the latest, with two boosters needed on D+7 and D+28. The vaccine presents no contra-indications for pregnant women or anyone suffering from a chronic illness such as HIV. It can be administered at the same time as the anti-tetanus vaccine.

119. Emergency situations (armed conflict, population displacement or periods of extensive internal violence) leading to significant population mobility; situations where the healthcare system has collapsed, etc.

Concerning treatment for HIV/Aids

HIV cannot be accurately screened until three months after sexual intercourse carrying the risk of infection has taken place. Screening must nevertheless be offered to any victim of rape, regardless of the time that has lapsed. This will provide confirmation of his/her serostatus prior to the attack. If the test is negative or is refused by the individual, post-exposure prophylaxis (PEP) must be offered if, and only if, the rape occurred recently.

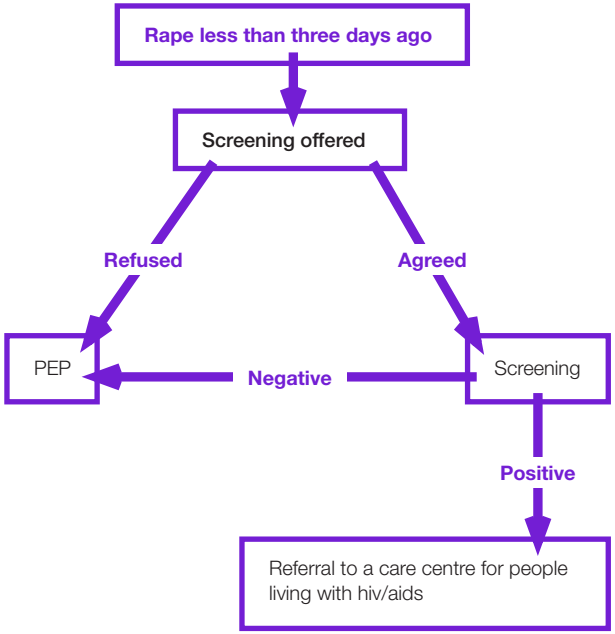
ESSENTIAL POINT

Post-exposure prophylaxis (PEP) is only effective and appropriate if administered within 3 days of the sexual violence.

Various scenarios are therefore possible:

- → The individual agrees to the screening test and the result is positive: a post-exposure prophylaxis is therefore useless as the result shows that HIV transmission occurred before the rape. The individual must be referred to appropriate healthcare providers;
- → The individual agrees to the test and the result is negative: a post-exposure prophylaxis must be offered;
- → The individual refuses the test: a post-exposure prophylaxis must be offered.

Post-exposure prophylaxis comprises two or three antiretroviral drugs (ARVs) to be taken over a period of twenty-eight days. Tritherapy is the preferred treatment but where it is unavailable bitherapy should be used.



RECOMMENDATIONS

As prophylactic treatment is only effective in the three days following a rape, it is absolutely essential to run awareness-raising and information campaigns for the local population on the time limits prescribed for the care of sexual violence.

The population must also be informed that, even if a period of seventy-two hours has elapsed, medical treatment for sexual violence remains crucial.

Awareness-raising leaflet produced in Haiti, **MdM,** 2008.

Treating the risk of pregnancy and pregnancy resulting from rape

Emergency contraception

Medical care for victims of rape involves preventing unwanted pregnancies that may result. An emergency contraceptive pill should therefore be offered. Again, this is a matter of personal choice that can only be made by the woman concerned. The doctor has a duty to inform victims of the issues surrounding emergency contraception, while taking account of how contraception and abortion are perceived in the context. It must also be explained that the emergency pill has to be prescribed **within a maximum of three days following the rape,** as its effectiveness diminishes over time.

ESSENTIAL POINT

The emergency contraceptive pill acts by disrupting the reproductive cycle. It does not terminate nor damage an existing pregnancy. The World Health Organisation does not consider it to be a method of abortion[120].

120. WHO, *Emergency contraception: A guide for service delivery,* 1998.

The doctor must also explain the issues surrounding sexual intercourse before and after the incident.
A positive pregnancy test reveals the presence of a hormone that is not secreted until ten days after sexual intercourse. Thus, **a pregnancy detected within ten days of a rape must be the result of sexual intercourse that took place before the incident.**
The victim was already pregnant at the time of the incident. Moreover, the emergency contraceptive pill cannot prevent pregnancy resulting from sexual intercourse that takes place after treatment. The doctor must therefore recommend contraceptive use as soon as possible, if the woman does not wish to have a baby.

The question of pregnancy termination

If a patient is pregnant as a result of being raped, the question arises of whether the unwanted pregnancy should be terminated. Here again, knowledge of the context is crucial as regards the legal framework (abortion in cases of rape not permitted, abortion for minors without the consent of legal representatives not permitted, etc.) on the one hand, and the perceptions of the local population on the other (socio-cultural and/or religious views that condemn pregnancy termination even where it is legalised).

If legal or socio-cultural constraints do exist, solutions may be envisaged that respond to victims' demands and are in the patients' interests:

→ Where the right to abortion is not recognised or is restricted in law, advocacy action may be envisaged to achieve a change in the legislation concerned.
The healthcare staff may also examine the legislation for any loophole that might make a legal termination possible.

> **"In Algeria,** abortion is forbidden by law. Legal exceptions nevertheless do exist for therapeutic reasons: to save the life of a woman where she is in danger, or where there is the risk of serious deformity in the unborn child. In the case of a pregnancy resulting from rape, abortion is not allowed unless the rape was an act of terrorism. Despite these prescriptions, and given that pregnancy resulting from rape can have serious repercussions on the mental health of the woman, a certain number of doctors use the loophole offered by the legal right to perform therapeutic abortions."
>
> Regional workshop on providing care and support for women victims of violence in Cairo (Egypt), **MdM,** September 2009.

→ Where there is a reluctance surrounding the practice of abortion associated with sociocultural perceptions or religious beliefs, whether on the part of the medical practitioner or in the general population, awareness-raising and information campaigns may be organised to reduce these constraints to accessing abortion for victims of violence.

> "There are numerous obstacles [to the practice of abortion] on a religious and moral level imposed by Columbian society on both women and professionals. It is difficult to find a doctor who carries out abortions as many professionals put forward the argument of 'conscientious objection' and thus refuse to apply the law."
>
> Testimony of a member of the **MdM** programme in Columbia, December 2009.

If the patient requests it and if the legislative context allows, the doctor must arrange for a termination and then ensure that the patient is referred for appropriate support. In so far as is possible, this should include putting the woman in touch with reproductive health services (emergency treatment in the event of complications, family planning advice, etc.), as well as with mental health and counselling services. If practising abortion goes against the doctor's own personal beliefs, then he/she has the right to refuse, but must refer the patient to an appropriate healthcare service.

In cases where termination is strictly forbidden, some women may wish to turn to illegal means to obtain an abortion. **They then run the risk of procedures carried out in dangerous conditions that do not guarantee their medical safety (untrained staff, unsatisfactory hygiene, etc.).**

> "Every year, out of an estimated 205 million pregnancies, 42 million end in a termination, carried out in 20 million cases in **insanitary conditions.** […] Over and above the 65 000 to 70 000 deaths recorded each year resulting from a non-medical abortion, almost 5 million women who have undergone one are estimated to have suffered temporary or permanent disability."
>
> **IPPF** *Medical Bulletin,* Vol. 42, N° 2, June 2008.

Advocacy initiatives aimed at changing the law, as well as awareness-raising and information campaigns on the risks associated with clandestine/non-medical terminations, may provide a way of reducing the risks associated with such practices carried out in dangerous conditions.

Treating the psychological symptoms

As has already been emphasised, violence of any sort has a range of consequences for an individual's physical and mental health. Healthcare staff, like the population in general, should be aware that psychological consequences **following an act of violence are common and can be severe**[121]**.** These symptoms must be taken into account. In many cases, victims of violence succeed in overcoming their emotional difficulties. Where the opposite occurs and they develop psychological problems, more complex support must be available and the doctor must be able to refer the patient to a competent professional – psychologist, psychiatrist, psychiatric nurse, etc. All victims of violence should not automatically be referred. Mild tranquilisers or anti-depressants may be prescribed as an option alongside psychological care, if the latter proves insufficient. Such medication must, however, be used with caution and always prescribed by competent medical staff. It should not be used to make up for inadequate counselling and psychological care.

6. Drawing up a medical certificate

Issuing a medical certificate is first and foremost a **medical procedure** and is thus one of the prerogatives of all doctors. It is based on the ethical principle governing the provision of certification at the request of a patient. It is a **confidential medical document,** as it is part of a patient's medical record[122]. The format of the medical certificate is crucial and must comply with specific regulations in order to be used for legal purposes[123].

121. For more information, see the section relating to the psychological care of victims of violence on page 185.

122. **Dromer C., Desmarest A. and Delorme A.,** *For ethics in the field, Sensitive personal data management, health – Life stories,* MdM France, 2010.

123. For more information, see the section relating to medical certificates on page 235.

7. Medical follow-up

Healthcare staff must make patients aware of the importance of medical follow-up care, i.e. the need to come back for a further consultation. Medical follow-up comprises:

- → Assessing patient's general health;
- → Verifying that primary lesions are healing;
- → Verifying prescribed treatment is being followed;
- → Offering STI and HIV screening once required period has elapsed since the sexual assault;
- → Monitoring pregnancy;
- → Suggesting psychological / psychosocial support.

In all instances, follow-up consultations must be an opportunity for the care provider to repeat advice and information given during the initial visit; indeed it is quite likely that patients seen just after an assault will not retain all the information provided, as a result of having suffered a traumatic experience.

MEDICAL CARE PROVIDED TO VICTIMS OF SEXUAL VIOLENCE

***Emergency "buffets"* in Haiti - 2009**

In May 2007, an audit carried out in the five hospitals MdM works with in Haiti revealed that the complexity of the medical care process was one of the reasons why many patients were put off continuing to seek help and why the three-day deadline was often missed.

Emergency "buffets" were set up in the hospitals to provide **care that was rapid, free and as complete as possible.**

The *"buffets"* ensured that the necessary **equipment and funding** were available for the provision of effective and free

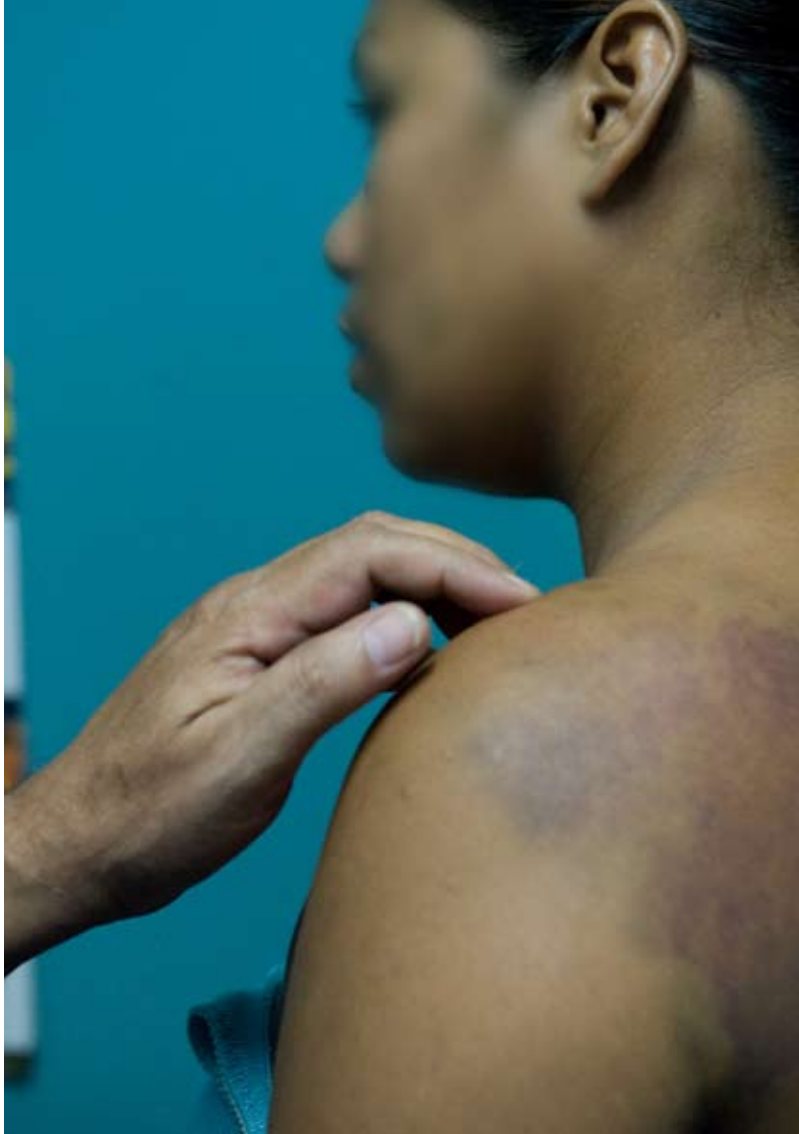
medical care, such as:
→ Sampling equipment;
→ Examination equipment;
→ Drugs;
→ Administrative resources, etc.

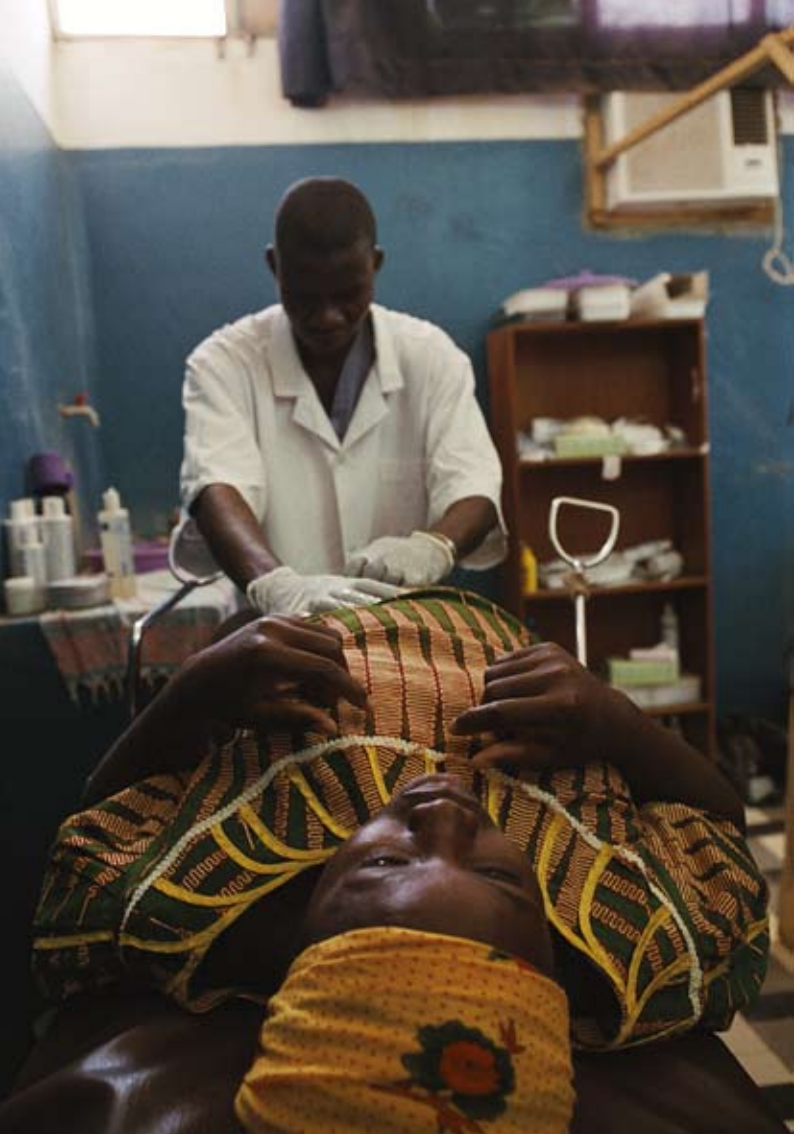
This investment has led to these facilities forming part of **medical protocols** implemented at a national level.

Each *"buffet"* is equipped with a cupboard in a key location, thereby ensuring the **security and availability of its contents 24/7.**

Complementary materials have also been created by MdM to facilitate the running of the "buffets":
→ Instructions for use;
→ Stock-taking forms;
→ Order forms, etc.

Lastly, hospital staff receives ongoing **training** on providing care and support for victims of sexual violence throughout the year.





MEDICAL CARE FOLLOWING RAPE

This protocol has been produced to complete the information and recommendations set out in the handbook, in particular in the section on 'Medical care' on page 145 which should be referred to for any further information.

Initial consultation and follow-up

HIV post-exposure prophylaxis (PEP) is only effective when started within (ideally) 4 hours and at least 3 days (72 hours) of exposure, and where the person is seronegative. Whatever the circumstances, the various tests carried out must not in any way hinder the dispensing of care and treatment.

The table below sets out all the tests that must ideally be carried out on a patient – male or female – who has been raped. It examines cases where PEP is and is not available. It should, of course, be adapted to suit what is realistically possible in the field.

Note: In cases showing symptoms of primary HIV infection, HIV serology and HIV viral charge are recommended, whatever the date.

	Treated sexual exposure	Untreated sexual exposure
D0	CBC, ALT, amylase and/or lipase and creatinine[124] as prescribed HIV, HCV*, HVB serology: Hbs Ag, Ac anti-HBs and Ac anti-HBc, TPHA/VDRL** Pregnancy test***	HIV, HCV*, HVB serology: Hbs Ag, Ac anti-HBs and Ac anti-HBc, TPHA/VDRL** Pregnancy test***
D15	CBC, ALT, creatinine and/or lipase, amylase as prescribed Pregnancy test***	No screening tests
D30	CBC, ALT, TPHA/VDRL**, chlamydia screening HCV* serology	HIV, TPHA/VDRL** serology, Chlamydia screening, HCV* serology
M2	HIV serology	No screening tests
M3	No screening tests	HIV and HCV* serology ALT
M4	HIV and HCV* serology	No screening tests
M6	Ac anti-HBs or ALT and Ac anti-HBc if no result (<10 mIU/ml) or not vaccinated, HCV* ALT serology	Ac anti-HBs or ALT and Ac anti-HBc if no result (<10 mIU/ml) or not vaccinated, HCV* ALT serology

* HCV monitoring recommended in cases of trauma or blood contact.
** TPHA/VDRL or other available syphilis test depending on circumstances.
*** For women of child-bearing age.
124. Checking creatinine ensures patient is not suffering renal failure, contraindicated for some treatments > refer to page 179.

HIV post-exposure prophylaxis (PEP)

HIV post-exposure prophylaxis is not automatically prescribed: the risk of HIV/Aids transmission must be assessed first. The HIV/Aids virus is present in all bodily fluids of the person affected: sperm and semen (ejected at start of an erection) in men, vaginal secretions and maternal milk in women, and blood. There is a risk of the virus being transmitted when a contaminating fluid comes into contact with a mucous membrane or an open wound.

A risk of transmission of HIV/Aids therefore exists in cases of rape where there is:
→ Vaginal penetration
→ Anal penetration
→ Oral penetration (if there is ejaculation in the mouth)

Where a victim bites an aggressor, there is a risk of transmission if the bite is deep and the victim gets the aggressor's blood in his/her mouth (blood/mucous membrane contact). Penetration with a finger or an object does not pose a risk of HIV/Aids transmission; PEP therefore serves no purpose.

For any MdM programme likely to be responsible for caring for a victim of rape, it must be confirmed upstream whether an authoritative national PEP protocol exists and, if not, one must be put in place in the service. In the absence of a national protocol, the one below may be used as it stands, or adapted to the field resources available.

Treatment

Recommended tritherapy:

2 NRTI = Nucleoside reverse transcriptase inhibitors
+ 1 PI = Boosted protease inhibitor

Truvada® (tenofovir TDF + emtricitabine FTC)
+ Kaletra® (lopinavir/ritonavir LPVr)

Or

Combivir® (zidovudine AZT + lamivudine 3TC)
+ Kaletra® (lopinavir/ritonavir LPVr)

Posology (see table on the following page)
NB: If the first dose is taken in the middle of the night, it should be followed by a dose in the morning (the night dose, even if close to that of the morning, serves as a loading dose).

Ideally, post-exposure prophylaxis is prescribed for only a few days initially, after which the patient is seen again by the HIV doctor responsible to assess treatment. If the doctor decides to continue the treatment, a prescription is reissued for a period of 28 days in total.

The doctor may equally decide to issue prescriptions for shorter periods – once a week or every two weeks – to provide better follow-up care, to check tolerability and to reiterate prevention advice.

Where there are questions over the prospect of follow-up care, the treatment may be prescribed immediately for a period of 28 days, to maximise the likelihood of the course being completed.

	Truvada®	Combivir®		Kaletra®	
Adults	1 tablet per day at mealtime	1 tablet 2 times per day		2 tablets of 200/50mg 2 times per day	
Children	Contraindicated (<30kg)	21-30kg	½ tablet morning and 1 tablet evening	>15kg	10mg/kg 2 times per day; 200mg or 100mg tablet
		14-21kg	½ tablet 2 times per day	<15kg and >2 years	12mg/kg 2 times per day; available as 80mg/ml syrup
		<14 kg	Contraindicated		

Combivir® is contraindicated for children weighing less than 14kg. Lamivudine 3TC and zidovudine AZT must be administered separately:

Children <14kg	3TC	AZT
1 month-12 years	4 mg/kg 2 times per day, available as 10mg/ml syrup	8 mg/kg 2 times per day, available as 10mg/ml syrup
>12 years	150mg 2 times per day, available in 150mg tablets	300mg 2 times per day, available in 300mg tablets or 250mg capsules

Contraindications

→ **Truvada®:** Treatment contraindicated -
– In children (<30kg),
– In cases of renal failure clearance of <30ml/min .
→ **Combivir®:** Treatment contraindicated where Hb<7.4 g/dl.

Common undesirable side effects (table next page)

Drug interaction

Before prescribing HIV post-exposure prophylaxis, remember to check possible drug interaction if the patient is taking other medication.

Preventing unwanted pregnancy in women of child-bearing age

Within 3 days of rape

Pregnancy test to check for pre-existing pregnancy:

→ If the test is positive, explain clearly to the person that the pregnancy cannot be as a result of the rape.

→ If the test is negative, prescribe emergency contraceptive to prevent pregnancy in the absence of any other form of contraception; depending on the context, the following may be available:

125. Hence the reason for doing a creatinine test wherever possible (see the first tab of this part)
Clearance = 1.23 x weight x (140 - age/creatm) for men
= 1.04 x weight x (140 - age/creatm) for women
Weight is in kg, creatinine is in µmol/l and result is in ml/min.

With Truvada®		With Combivir®		With Kaletra®
TDF	FTC	AZT	3TC	
Renal failure (see blood monitoring)	Headaches and migraine, tiredness and weakness, and dizziness	Nausea, vomiting, abdominal pains and diarrhoea	Digestive problems: Nausea, vomiting, abdominal pains and diarrhoea	Skin rash
Hypophos-phatemia	Insomnia	Anaemia and leukopenia	Headaches and migraine, insomnia, tiredness and weakness, and feeling sick/faint	Digestive problems: Nausea, vomiting and diarrhoea
Nausea and diarrhoea	Digestive problems: Nausea, diarrhoea and vomiting	Headaches and migraine, dizziness, tiredness and weakness, and muscle pains	Cough	High temperature, viral infections, hepatomegaly and pancreatitis in children
Muscle pains, dizziness and fatigue	Skin rashes and muscle pains		Muscle and joint pains and skin rashes	Headaches and migraine, tiredness and weakness, and feeling sick/faint
	Anaemia in children and neutropenia		High temperature	

– Levonorgestrel: The same formulation can be administered in two different ways:

Postinor 2® 0.75mg: 1 tablet followed by a second 12 hours later (where this is a problem, one single dose of 2 tablets is accepted as effective)

Or

NorLevo® 1.5 mg: 1 tablet

– Ethinyl Estradiol + Levonorgestrel:
Two different administering methods:

Ethinyl Estradiol® 0.5mg + Levonorgestrel® 0.25mg: 2 tablets followed by 2 more 12 hours later.

Or

Ethinyl Estradiol® 0.3mg + Levonorgestrel® 0.15 mg: 4 tablets followed by 4 more 12 hours later.

Where vomiting occurs within 3 hours, repeat the previous dose.

Note: Emergency contraception will not protect against future pregnancies: if a woman is sexually active but does not want a baby, remember to recommend a contraceptive.

STI prophylactic antibiotic treatment:

Protocols must be adapted to existing national protocols.

Cefixime (Oroken®):
→ Teenagers and adults: 2 tablets of 200mg administered in a single dose

→ Children <12 years: 8mg/kg administered as 2 doses 12 hours apart; available in powder form for oral solution:
– 40mg/5 ml for children aged 6 to 30 months
– 100mg/5 ml for children aged 30 months to 12 years

Azithromycin (Single dose Zithromax®):
→ Teenagers and adults: 1 tablet of 1g
→ Children <25kg: 10mg/kg administered in a single dose

Note: If the person is consulting more than 20 days after the event, benzathine penicillin (Extencilline®) 2.4M in a single IM dose is recommended for treating suspected syphilis. It is administered in two injections of 1.2M, one in each buttock. The treatment is very painful and so warn the patient to take a painkiller. Otherwise, azithromycin is adequate treatment for a case of syphilis during incubation.

In suspected cases of trichomoniasis, administer a preventative course of metronidazole:
→ Teenagers and adults: 2g administered in a single dose
→ Children: 5mg/kg 3 times per day for 7 days

Hepatitis B and C prevention

Hepatitis B

For those exposed to Hepatitis B who are not fully vaccinated, serovaccination using anti-HBs immunoglobulins + 1 dose of vaccine are administered via different locations.

Two vaccines are available: Engerix® and Genhevac®.

	Genhevac®	Engerix®
Adults	20 µg by injection	20 µg by injection
Children		10 µg by injection

The programme of vaccination should be completed according to one of the two following timescales:

D0, D30 and D180

Or

D0, D7 and D21, although this protocol should be followed only where the Engerix® vaccine is used.

Hepatitis C

Post-exposure treatment is not recommended.
Where anti-HCV treatment is available, it is important to rapidly screen for possible seroconversion in order to administer the appropriate treatment.

Preventing the risk of partner-to-partner STI transmission

The patient(s) must be informed of the need to use condoms during sexual intercourse for the 3 months following a sexual assault, and 4 months if he/she/they have been prescribed HIV post-exposure prophylaxis. Only after 3 months (4 months in the case of PEP) can a negative HIV/Aids test result confirm with absolute certainty that an individual has not been infected with HIV during a sexual assault and the risk of infecting any partner(s) eliminated.

Treating injuries

→ Clean all tears, cuts and abrasions.
→ Clean wounds may be sutured within the first 24 hours.
→ Do not suture dirty wounds.
→ Administer anti-tetanus vaccine if required.
If the person has never been vaccinated against tetanus, the following programme of vaccinations should be followed: D0, D30 and M6.

Sources

– French interministerial circular dated 13th March 2008.
– Rapport Yeni 2006 (most recent French consensus conference on HIV infection).
– HAS (Haute autorité de santé): Drug transparency directive dated 15th February 2006: http://www.has-sante.fr/portail/upload/docs/application/pdf/ct032519.pdf
– WHO, *Clinical Management of Rape Survivors – Developing protocols for use with refugees and internally displaced persons,* 2005 Revised edition.

Request for termination of pregnancy resulting from rape

For a better understanding of the issues surrounding terminating a pregnancy resulting from rape, as well as the risks posed by such a procedure (where non medical), see:

→ page 76, the section relating to pregnancy termination in ‘Sexual and reproductive health’;
→ page 159, the section relating to pregnancy risks and pregnancy resulting from rape in ‘Therapeutic treatment’.

The following directives and protocols for pregnancy terminations are also available:

– WHO, *Safe abortion: technical and policy guidance for health systems,* Geneva, 2004.
– Médecins sans frontières Belgium, Protocole d'interruption de grossesse, Fiche 23, Mémento VSX, January 2006.
– Médecins sans frontières, *Essential Drugs – Practical guide intended for physicians, pharmacists, nurses and medical auxiliaries,* 2010 Edition.

3D

PROVIDING PSYCHOLOGICAL CARE

Psychological care of victims of gender-based violence consists of any act that guides victims in their psychic and emotional reconstruction after an event that has taxed their psychological well-being.

The impact of gender-based violence on mental health and its possible repercussions in the form of mental disorders show how important psychological aspects are in providing multidisciplinary care for victims of violence. While the psychological consequences of violence are especially visible in persons who have suffered from such acts directly, they can also be considered from the point of view of the community and society at large. There are many possible therapeutic responses to gender-based violence. Choosing the right ones will depend on the psychological suffering of the victim, as well as on the resources available in the context. Ideally, two complementary approaches (a psychosocial approach and a medical approach) must be accessible for the psychological rehabilitation of all victims of gender-based violence.

1 / CONCEPTS LINKED TO THE PSYCHOLOGICAL CONSEQUENCES OF VIOLENCE

1. Mental health

According to the WHO, health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity[126]."

Mental health, meanwhile, is defined "as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community[127]." It "is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities [...], the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality[128]."

The link between mental health and violence has been emphasised in recent years by the concepts of psychic suffering and empowerment.

Regarding psychic suffering, it is important to point out that this is not the same as mental illness. Jean Furtos speaks of "sufficiently strong mental health" in France, defining that

126. Constitution of the World Health Organization, which entered into force on April 7, 1948.
127. **WHO,** "Mental health: a state of well-being," October 2009.
128. **WHO,** *Psychosocial and Mental Health Aspects of women's Health,* Division of Family Health and Division of Mental Health, WHO/FHE/MNH/93.1,1993.

as "the capacity to live and suffer in a given and transformable environment, i.e., as the capacity to live with others while remaining connected with oneself, without destructiveness but not without revolt[129]."
However, it is crucial to point out that psychic suffering can be either a driver of change or, on the contrary become paralysing and lead to, or exacerbate, a pathology that is either psychiatric or psychosomatic in nature.

The concept of empowerment[130] must be also taken into account in cases of gender-based violence, given the fact that in this type of violence, power relationships are at the core of the link between the victim of aggression and the aggressor. Perpetrators of violence seek to demonstrate their strength and superiority by humiliating and humbling the victim and by anchoring this power in intimacy and in the victim's very identity.

At this level, the concept of "psychological empowerment" is fundamental. This is defined as a feeling of control over one's life […]. The community dimension of empowerment involves individuals that act collectively in order to have greater influence and greater control over factors of health and the quality of life in their surroundings[131]."

Victims of gender-based violence experience a process of disempowerment, in which they do not control what happens

129. **Furtos Jean,** *Les cliniques de la précarité, contexte social, psychopathologies et dispositifs,* ONSMP-ORSPERE, Lyon, 2004.
130. For more information, see the section on the social and economic reintegration of victims of gender-based violence page 256.
131. **Longpré C., Forté D., O'Doherty C., Vissandjée B.,** *Projet d'empowerment des femmes. Conception, application et évaluation de l'empowerment (phase 1),* Centre d'excellence pour la santé des femmes (Cesaf), Consortium Université de Montréal, Montréal, 1998.

to them. They go along, they lose confidence in themselves, and they feel shame and searing guilt, often believing that they deserved what happened to them. Such guilt, along with an interiorisation of violence that can affect their very identities, is one possible reason so few victims come forward to seek the assistance of healthcare professionals. In this type of situation, an additional risk is that the professionals will interpret this submission to violence as a choice – thus reinforcing the notion that the victim is indeed at fault for what has happened to him/her – and even as the symptom of a pathology. Considering these people's problems as pathologies exacerbates the feelings of shame, powerlessness and despair that they are already feeling.

Mental health consequences of gender-based violence[132]

Consequences for the victim of violence

All acts of violence suffered by a person have repercussions on that person's psychic well-being and thus on her mental health. This results in a disruption of her psychological condition. Most cases of violence involve a state of shock, which corresponds to a normal period of crisis following an event that has endangered one's life or that one believes has endangered one's life. Psychic suffering in victims of violence can show up in several forms.

SOME EXAMPLES OF PSYCHOLOGICAL REACTIONS TO ACTS OF VIOLENCE:

Fear: "I'm afraid of going out alone. I'm afraid of the dark."
Anxiety: I feel so tense. My nerves are shot. I feel out of breath."
Anger/hostility: "I feel like killing him. I hate him. I hate everything and everybody."

Isolation/detachment: "I can't talk about this to anyone. My husband is going to ask for a divorce if he finds out, and my family will take away my children."
Guilt: "I feel like I must have done something to bring on what happened. I wish I hadn't…"
Shame: "I feel so dirty, as if I had been soiled, as if something was wrong with me. Can you tell that I've been raped? What do people think when they look at me?"
Loss of confidence: "I feel as though I can't do anything… even the simplest things."
Mood swings: "I feel as though I'm losing my head!"
Loss of self-esteem: "I'm disgusted with myself when I think about what happened. I'm worthless now."

Service-provider training kit: medical-healthcare component, Joint Initiative to prevent sexual violence and dealing with responses to the rights/needs of the victims/survivors, Goma (DRC), M**dM,** June 2005.

Each person reacts in his or her own way to a potentially traumatic event. On the other hand, the lack of visible reactions after the event is not necessarily an indicator of the future traumatic impact. "This means that not all violent situations lead to trauma and, conversely, not all traumas are necessarily produced by violent situations[133]." If the symptoms of psychic suffering linger beyond the first three months after the potentially traumatic event and begin to handicap the person, this is likely to be a case of trauma or post-traumatic stress syndrome (see below).

132. For more information, see the section on the consequences of gender-based violence, page 104.
133. **Lovell Anne,** *Work preliminary to the preparation of the Plan Violence and Health, in accordance with law of August 9, 2004 relative to Public Health policy,* Violence and Mental health Commission, March 2005.

Psychotraumatic reactions depend on the nature and context of the event (degree of violence, suddenness, duration of the act, whether it is repeated, threats made by the attacker, whether known or not to the victim, etc.), as well as the resiliency of each individual (which varies with age, maturity, personality and the vulnerability of the victim at the moment of the attack).

Resiliency is thus a primordial aspect in the psychological rehabilitation of victims of gender-based violence.
In psychology, resiliency is the "ability of the individual to cope with a serious difficulty or stress, not only effectively but so as to engender a better capacity to react later to a difficulty. Resiliency consists of a balance between, on the one hand, stress and difficulties and, on the other, the ability to cope with the situation and the availability of a source of support[134].

> "The reactions and after-effects will vary qualitatively and quantitatively from one individual to another, even though some things appear to be true of all victims. It is not about under-playing or overplaying those reactions and after-effects but, rather, individualising them, if we want to properly evaluate and help the victims."
>
> *Mental health as it relates to sexual violence, and psychosocial responses,* psychosocial counsellor training, Goma (DRC), **MdM,** August 2008.

The impact of violence on the family and community

Gender-based violence has psychological consequences on the persons who have suffered from it directly. It can also have repercussions on the victim's family and community.

Consequences of violence spread first of all within the family sphere. For example, negative emotions can spread from victims of violence to members of their families. **Emotional instability and psychological suffering felt individually can affect couples and families.**

Some **family members or persons around the victims may have been witnesses to acts of violence and may therefore suffer psychologically.** These persons can then be considered direct victims of the traumatic event[135]. Similarly, some **family members may themselves be the aggressors (in the case of conjugal violence, abuse, incest, etc.).** In such cases, consideration must be given to the family dynamic that contributed to such violence, in order to better grasp the behaviour and reactions of each family member to the act of violence.

The act of violence can also lead to **negative reactions in the persons surrounding the victim.** Instead of sympathising with the victim's suffering, the family may, through its behaviour and reactions, increase the victims' ill-being by ostracising them, casting them out, abusing them, etc. This is especially true in cases of sexual violence. Victims are often blamed, which exacerbates their feelings of shame. While such reactions are not justifiable, they can be considered as a way for the family to express its own suffering, as it has been indirectly affected by the violence. Such suffering must not be neglected. It must be taken into account in re-establishing family links.

134. **Mangham Colin, Ph.D., McGrath Patrick, Ph.D., Reid Graham, Ph.D., Stewart Miriam, Ph.D.,** *Résilience, Pertinence dans le contexte de la promotion de la santé,* Working document – Detailed analysis presented at Santé Canada, Atlantic Health Promotion Research Centre, Dalhousie University, 1995.

135. For more information, see the section relating on the "concept of the victim of violence", page 44.

While victims of violence are often cast out, this is also the case of children born of rape. Whether by the victim or other family members (husband, the couple's other children), **children born of rape are often discriminated against or even cast out** because of their origins (both the circumstances of conception and the identity of the biological father).

> Her mother [...] became pregnant after being raped by soldiers who held her captive in the bush for 14 days. She still struggles to accept her daughter and often uses her as a scapegoat when things go wrong.
> "I am unhappy because of this child," [the mother] said. "I would like to give [up for adoption] so I could forget the misfortune that came upon me."
> And [the child's] life is no better outside the home, as she is often singled out by her classmates. "What sin have I committed and for how long will I be an innocent victim?" she said.
>
> Interviews by Nsimire Sara, *Children Born of Rape Face Dismal Future,* **IWPR** (Institute for War and Peace Reporting) in Goma (DRC), ACR issue n° 240, January 5, 2010.

Collective relationships can be affected in some contexts of generalised violence. In such cases violence contributes to the breakdown of social ties (i.e. values and principles, including compassion for, and trust in others), and harms the collective well-being[136]. In other words, an act of violence can lead to psychological suffering in its victims. Society at large can also be affected in its community dynamic. This dimension must be taken into account for an act of overall reconstruction to be possible.

136. MdM, Les retombées psychologiques des violences aux niveaux individuel et collectif. Quelles solutions à apporter?, Goma (DRC), July 2008.

> "War is not a private experience. It is, first of all, a collective experience. In situations of social violence, suffering is not experienced internally but, above all as a breach of social and moral order."
>
> **Gilles Bibeau,** Introduction to the "Mental Health and Social Health" colloquium of the Association of Psychiatric and Mental Health Departments of the Catholic University of Louvain (Apsy-UCL), 2000.
>
> "Trauma does not occur in a void, and we must not expect those who have survived such shocks to be able to recover without the assistance of their community, which itself must also recover from the trauma."
>
> *Service-provider training kit: medical-healthcare component,* Joint Initiative to prevent sexual violence and dealing with responses to the rights/needs of the victims/survivors, Goma (DRC), **MdM,** June 2005.

2. Psychic trauma

Background

Throughout the 20th century, interest in traumatic disorders has risen steadily, particularly in the wake of the two world wars and the Vietnam War. In the 1970s, on the initiative of pacifist, feminist and child-protection movements, non-governmental and governmental organisations began to call for more attention to be paid to psychic suffering and the impact of violence on its victims.
In addition to "war neurosis", some authors[137] took an interest in "rape trauma syndrome", identifying the psychological and somatic after-effects of a trauma that until then had been mostly overlooked – sexual aggression.

137. Burgess Ann W. and Holmstrom Lynda L., "Rape trauma syndrome", American Journal of Psychiatry, 131:981-986, 1974.

Psychotraumatic reactions have thus been observed and studied in the world of psychiatry, which has investigated the role of trauma in the origins of mental disorders. Research in this area has arrived at a precise description of what is known in English as "post-traumatic stress disorder" (PTSD). A PTSD diagnosis was first introduced in the DSM-III[138] (The American Psychiatric Association's classification of mental disorders) and in 1992 in the World Health Organization's ICD (the International Classification of Diseases).

The American Psychiatric Association defines PTSD as a morbid state that begins in the course of an exceptionally violent event that is capable of causing distress for any person. For example, having one's life or the lives of one's loved ones threatened, being attacked, being the victim of an accident or a disaster.

French-speaking authors believe that PTSD cannot encompass all psychiatric and psychological reactions from a potentially traumatic event. They therefore prefer the broader notion of "psychological trauma[139]." This "recognition" of PTSD allows victims to be acknowledged as persons who have experienced a potentially traumatic event, without this being classified under severe psychiatric categories such as psychoses and hysteria.

> "Psychiatrists and psychologists all over the world have gradually developed suitable new techniques to both mitigate acute reactions and prevent long-term repercussions from traumatic events. They are refining procedures and adapting them to the various subject groups affected, such as soldiers, fire-fighters, victims of terrorism, sexual violence, torture, the broader population, etc."
>
> **Josse Evelyne,** *Le traumatisme dans les catastrophes humanitaires,* 2006.

The traumatic event

All psychotraumatic reactions are, as their name suggests, due to a traumatic event. "Trauma constitutes […] a process that is determined by interactions between the social environment and the individual's psychic feelings[140]." This is why the trauma of victims of violence does not depend solely on what they have experienced, but also on the manner in which they have been integrated or isolated socially or politically after the event.

There are several distinctions that can be drawn between potentially traumatic events:

- → those experienced collectively (earthquakes, wars, etc.) or individually (attacks, rapes, etc.);
- → those of natural origin (natural disasters, epidemics) or human origin (industrial disasters, violence, accidents, etc.).

Some events of human origin are triggered intentionally (abuse, rapes, wars) or accidentally (involuntary homicide, collateral damage of wars), and some may be caused by a member of the family (for example, conjugal rape, and, in some cases, female circumcision), an acquaintance (genocide committed by neighbours, as was the case in Rwanda) or a stranger (hold-ups, muggings)[141].

138. Diagnostic and Statistical Manual of Mental Disorder, 3rd edition, American Psychiatric Association.
139. De Clercq Michel, Lebigot François, *Le Psychic trauma,* Masson, Paris, 2001.
140. Direction du développement et de la coopération, *Genre, transformation des conflits et approche psychosociale,* 2006.
141. Josse Evelyne, "Le traumatisme psychique: quelques repères notionnels", Journal international de victimologie, Volume 5, No. 3, July 2007.

> "As the traumatic process always unfolds in a very precise social, cultural and political context, any symptoms that arise must be interpreted on the basis of this context. What is perceived as a symptom of trauma in a given context may be seen as healthy behaviour in other situations. Any misguided psycho-pathologisation or medicalisation of the trauma must be avoided. Project partners should draw up their own definitions of trauma and develop care-giving procedures that are specific to the context. A diagnosis of post-traumatic stress disorder, for example is not enough, as it is limited to the individual sphere and ignores cultural and social factors. Such a diagnosis reduces the trauma to just another disorder, thus omitting – or misinterpreting – the link between individual suffering and the political context. Such a reductionist approach would have the effect of marginalising the traumatised persons even more and to exacerbate their suffering."
>
> **Development Cooperation Directorate,** Gender, conflict transformation and the psychosocial approach, 2006.

Most forms of gender-based violence can thus be characterised as potentially traumatic events.

2 / PSYCHOLOGICAL SUPPORT MECHANISMS

Just like psychological reactions, there are many possible therapeutic responses to violence and choosing the right one will depend on the person's needs, as well as the context of treatment. Ideally, two complementary approaches should be used for the psychological rehabilitation of all victims of gender-based violence.

1. How psychological care and psychosocial support can complement each other

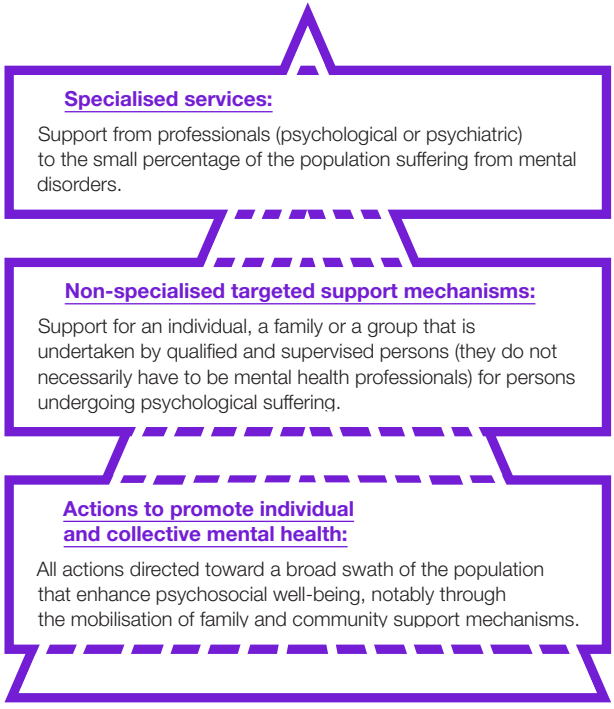
To combat the consequences of violence on the psychological level, a set of activities combining the clinical approach and the psychosocial approach must ideally be used. The clinical approach "focuses on the most fragile persons, who risk developing severe psychological disorders. The psychosocial approach is for a broader population and aims to restore and maintain the functioning of the community[142]." The psychosocial approach thus focuses on the individual's subjective experience in relation with her living environment. This approach also makes it possible to prevent the development of psychological disorders. "Psychosocial support is any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder[143]."

Ideally, in addition to its therapeutic objective, the psychosocial approach must ensure that persons needing specialised care are referred to it, when it is available.

While a dual (clinical and psychosocial) approach helps develop preventive actions and responses to the psychological consequences of gender-based violence, it often runs into various constraints, which vary with the intervention context.

Pyramid of psychological and psychosocial care in rehabilitating victims of gender-based violence[144]:

142. WHO definition, cited in **Josse E. et Dubois V.,** *Interventions humanitaires en santé mentale dans les violences de masse,* De Boeck Université, collection Crisis, September 2009.
143. 144. IASC (Inter-Agency Standing Committee) on Mental health and Psychosocial Support in Emergency Settings, 2007.



The main constraints include:

→ Shortages of specialised (psychological and psychiatric) human resources;
→ Material constraints, such as the lack of specialised facilities, psychotropic drugs, the refusal of public authorities to get involved in psychiatric care, etc.;
→ The difficulty of providing care over the long term, whereas quality psychological or psychiatric care requires an minimum number of consultations (this is due to population displacements, the cost of consultations and other factors);
→ Depictions of psychological care, which is still often thought as being for "crazies". This component of care can thus reinforce the stigmatisation of victims by those around them, who may judge their mental state unstable and therefore blame the victims for their distress and consider that the act of violence was justified.

In light of these constraints, the psychosocial approach to providing care and support for victims of violence is often the only way to treat the psychological consequences of violence. When they have been trained in psychological assistance, social workers can serve as valuable relays with victims of violence. They can help them to restore their individual and social well-being and thus help forestall the development of severe mental disorders.
When psychological care is necessary for a person (notably in cases of persistent post-traumatic symptoms), psychosocial care-providers must also refer this person to specialists (psychologists and/or psychiatrists) for clinical care (including psychotherapy).

2. Procedures/techniques for providing psychosocial care for victims of gender-based violence

Receiving the victim on her initial visit and carefully listening to her constitutes the initial phase of psychosocial assistance. This must also include therapeutic actions involving special techniques. These techniques can be developed by either psychosocial care-givers (with previous training) or psychologists (when they are available). Only psychosocial techniques will be discussed

here. We will not go into psychological care techniques, strictly speaking, as that requires special training and experience.

Psychosocial actions must allow persons who have experienced potentially traumatic events to speak up, but also to identify and refer persons needing specialised care (including psychotherapies dispensed by psychologists or psychiatrists).

ILLUSTRATION

How should a counsellor act? I begin with her ears, her look and her sealed lips. She has to have big eyes to actually see what the patient before her is suffering. So she must keep her eyes open. She has to have big ears to listen. She has to keep her mouth closed. A counsellor shouldn't talk. She must have a heart, a uterus, and a womb that feels what women suffer... You see, when a woman gives birth, there is horrible suffering. A counsellor must be able to carry in her womb the suffering of others. She must have a handbag full of the secrets of each person that the person cannot open or tell anyone about. She must have big feet planted firmly on the ground. That means that she has to spend experience lots of tough situations. A counsellor must not take things lightly. So we took this training course and those who are at my home have taken this training course.

Christian Laval, *Leçons d'humanité des conseillères de Goma,* Lessons in Humanity from Goma counsellors; Study of the backgrounds of "counsellors" to women victims of sexual violence, Goma (DRC), MdM, March 2007.

Psychological and psychosocial care-providers can undertake various types of activities to assist victims of gender-based violence, including individual interviews, family mediation, support groups and other therapeutic activities.

Individual interviews

Ideally, the interview is the first step in psychological care. It helps understand the person's psychological state and better respond to his/her needs. This is often the first opportunity for victims to put into words what they have experienced and the psychic emotions that they feel. Victims of violence, rape in particular, seldom speak spontaneously about the incident; in doing so, they are therefore placing their trust in the person they are talking to. However, the victim must not be pushed into sharing his/her personal experience more than he/she naturally wishes to. Active listening and certain communication techniques help the persons feel freer to express themselves[145].

Generally speaking, psychological assistance, particularly as part of individual interviews, consists in[146]:

- → Carefully listening to the person with empathy, with no wariness or incredulity, or value judgments;
- → Helping her to manage the psychological effects of violence (emotional disorders, distress, etc.);
- → Helping her to manage irrational fears and expectations;
- → Helping the person to make decisions, not imposing one's point of view on the person but rather assisting her in making a decision that is truly hers and that she can live with.

145. For more information, see the section on the reception of victims of gender-based violence, page 117.

146. Asif Muhammad, MdM Pakistan, *"Psychologist's position in a closed institution such as Dar-Ul-Amans",* regional workshop on providing care and support for women victims of violence, Cairo (Egypt), MdM, September 2009.

A group session can supplement individual psychological assistance to victims of gender-based violence.

Family mediation

The impact of violence on the mental health of the victims' families has already been noted. That's why it is often important to provide support to the people around the person suffering psychologically. This will benefit both the family members and the victims themselves.

Family mediation consists in revealing the manner in which the act of violence was experienced (perceptions and emotional experience) by the victim as well as by family members. This raises awareness and helps share latent (unconscious) thoughts or emotions linked to the trauma that act on intra-family relations. For example, understanding why a husband has repudiated his raped wife or why he no longer wants to go home will make it possible to discuss with him whether his behaviour is justified and thus incite him little by little to renew dialogue with his wife.

> "We began with mediation with the mother who no longer wanted to see her daughter. Today, T. can go see her mother, but her mother still won't let her live with her. T. has gone back to school. She would like to register for university studies. She would like to study law, in order to defend others."
>
> Testimony of a counsellor of the Sofepadi association in Béni (DRC), MdM press dossier "République Démocratique du Congo: le viol se generalise dans le Nord-Kivu", November 25, 2009.

In other words, "family mediation is a process of building or rebuilding family ties based on the autonomy and responsibility of the persons involved in situations of breach or separation in which an impartial, independent, qualified third party with no decision-making power – i.e., the family mediator – uses confidential interviews to promote communication and the managing of conflicts within the extended family in its diversity and evolution[147]."

However, family mediation is not the right response to cases of conjugal violence. This form of violence is different from mere disputes between husband and wife. And undertaking family mediation in such situations is tantamount to considering that violence is a mere conflict within the couple, i.e., a difference that can be resolved through dialogue.

Support groups

Support groups are sessions involving persons who have gone through similar experiences. These settings offer them an especially safe, cohesive and empathetic environment for discussion. Support group members can encourage the victim to express herself more freely about the violent act and the consequences that it has had on the individual, familial and social levels. They also promote contacts and discussion between the participants and the group leader.

The therapeutic framework also creates a mirror effect between the participants. They can see themselves in what another person is relating (identification), and have the feeling of being less alone in experiencing/having experienced this situation of violence. This helps **stimulate mutual support and reinforces their self-confidence,** as they become aware of their own resources. A participant that is further along in her recovery can become a model for the others. The contacts generated can create constructive solidarity and promote community links.

147. Definition adopted by the **French National Consultative Council on Family Mediation,** 2002, 2002, www.mediation-familiale.org/media/index.asp.

Here are some elements in providing psychological assistance within the framework of collective therapy:

- → **several persons** meet with a therapist simultaneously;
- → in a **social setting** that is also a physical place;
- → for **simultaneous changes of participants;**
- → with the **contribution of all participants** through many and varied group exchanges;
- → which changes the therapist's role from a doctor-healer to a **group leader and facilitator of change;**
- → as well as the patient's role from a "passive" role to an "active" one, as he/she is considered **the main agent of his/her change**/healing through his/her degree of involvement.

Gasibirege Simon, "Approche systémique et cadres thérapeutiques collectifs/communautaires" (Systematic approach and collective/community therapeutic frameworks), MdM Goma (DRC), February 2009.

Support groups can also bring together perpetrators of violence, with a goal of helping them become aware of their acts and to modify their behaviour.

Support groups are meant for any man who has admitted perpetrating conjugal and family violence and has been sent by the prosecutor or social workers. They are also meant for any man who, on his own initiative, wishes to understand and modify his violent behaviour within the family circle. Support groups are a way to welcome, assist and support each participant, to help them recognise abusive and violent behaviour, realise that violence is a legal infraction, to cease all physical and/or emotional violence, to identify each form of violence, in order to diminish and gradually eliminate it, to modify certain beliefs justifying the use of violence, to discover various alternatives to conjugal and family violence, to see the family and the social and professional environment in a new light, and to acknowledge others as subjects, not just objects."

GAPS (*Groupement d'Aide Psychologique et de Soutien,* or Psychological Aid and Support Group), www.aide-psy-gaps.com/

Therapeutic activities

Therapeutic activities are "any activity having an impact on an individual and improving his/her self-confidence and self-esteem[148]." Some activities can therefore be ways of contributing to the psychological or emotional well-being or better-being of persons (like relaxation and therapeutic theatre).

Psychological care activities in Pakistan's Dar-Ul-Amans (DUA), temporary government shelters for women in situation of great distress and their children:

- → Various entertaining and therapeutic activities: dancing, singing, cooking, sewing and embroidery, therapeutic theatre, etc.;
- → Relaxation exercises: body/muscular relaxation, deep breathing, etc.;
- → Psycho-educative sessions for DUA personnel and residents;
- → Preventing and managing conflicts within DUAs;

Asif Muhammad, MdM Pakistan, "Psychologist's position in a closed institution such as Dar-ul-Aman", regional workshop on providing care and support for women victims of violence, Cairo (Egypt), MdM, September 2009.

148. Maqbool Roohi, MdM Pakistan, "Theatre as a therapeutic activity", regional workshop on providing care and support for victims of violence, in Cairo (Egypt), MdM, September 2009.

Example: relaxation techniques

Among psychological care techniques, relaxation exercises[149] can have a therapeutic impact. They help the persons to keep themselves from drowning in their emotions and to manage their stress. Once they have been initiated in these exercises by a care-giver, in either an individual or group session, persons can do them on their own. Relaxation exercises can thus play a role in the process of the psychological well-being of victims of violence.
For example, they can be subject to crises of anxiety preventing respiration (palpitations, shivering, heat flashes, muscular tremors, an impression of suffocation, pain or thoracic discomfort, nausea, dizziness, etc.). Through relaxation, the person can learn to control his/her respiration, restore his/her calm and thus prevent other crises.

Example: theatre

THEATRE AS A THERAPEUTIC ACTIVITY

Pakistan's *dar-ul-amans*

In Pakistan, Médecins du Monde, in tandem with its partners, provides multidisciplinary care (medical, psychological, legal, economic and social) for women who are victims of violence and/or in situations of great distress who have found refuge in the Dar-Ul-Amans (DUA). These temporary shelters guarantee the protection of residents and are one step further in their social rehabilitation.

Therapeutic theatre is one of the activities used in multidisciplinary care for DUA residents.

Therapeutic theatre includes:

→ Expressing one's inner self;
→ A curative aspect;
→ Social and cognitive integration;
→ Enhancing consciousness and foresight;
→ An solution-based approach, i.e., that identifies the problem, determines possible solutions, raising the awareness of the spectators (through interaction between actors and spectators).

These elements thus make it possible to:

→ Highlight the problems and situations that women endure;
→ Let them know that they are not alone in facing these problems;
→ Restore their confidence in themselves and their image of themselves;
→ Let them speak up before the community so that they can find solutions;
→ Re-establish the broken links in the cycle of life.

The methodology of therapeutic theatre includes the following phases:

→ Choose a theme or a realistic story (based on reality);
→ Explain to participants the importance of their role, both individually and collectively;
→ Set up an attractive environment (setting and stage, sitting arrangement for the audience);
→ Secure the support of a professional team (a professor of theatre and a psychologist).

This activity helps residents to continue their **process of personal and social reconstruction.** It can be a way to combat depression and isolation, and to express oneself to the community. Theatre helps residents analyse their difficulties and plan their future. In addition to its therapeutic effect for victims of violence, therapeutic theatre helps **raise awareness** of the issue of violence against women **among the media, NGO representatives or ministry officials invited to performances.**

Maqbool Roohi, MdM Pakistan, *Theatre as a therapeutic activity,* regional workshop on providing care and support for women victims of violence, Cairo (Egypt), MdM, September 2009.

149. Zimmerman Eva, "Techniques for individual care of victims of violence", Training kit for psychosocial counsellors, Goma (DRC), October 2009.


MÉDECINS

3E

ACCESSING JUSTICE AND COMBATING IMPUNITY

Ensuring that victims of gender-based violence have access to justice is essential for such violence to be recognised by everyone for what it is, namely a genuine violation of human rights[150]. Access to justice is equally crucial in fighting impunity for those who perpetrate such acts of violence.

The prevalence of gender-based violence is generally in direct relation to the existence and enforcement of the law. Gender-related violence is particularly favoured where:

- → No legislation exists criminalising all forms of gender-based violence, which for some forms translates as an absence of any criminal sanction and legal redress;
- → Laws and policies are formulated or interpreted in such a way as to potentially discriminate against either gender, and to contribute in this way to violence based on gender;
- → A deficient and corrupt legal system undermines the confidence of those subject to the law, resulting in low rates of reporting to the public authorities.

150. For more information, see section on "contextualising the issue" on page 48.

Some customary practices, such as amicable settlements (compensation in payment or in kind, marriage with the perpetrator of the violence, etc.) may also reinforce gender-specific types of discrimination, prejudice suffered by victims and impunity on the part of perpetrators of acts of violence.

Likewise, many communities operate their own systems of traditional justice. These customary tribunals or committees must be taken into account, as they are seen as part of the overall judicial system and are sometimes more accessible to those within the communities.

> "I could cite the case of parents whose little 3-year old girl died after being raped by three men, who were brigands the whole community had known about for a long time. We helped her family press charges. At the end of a trial lasting several years, three of them were condemned to ten years in prison. They have all since escaped. And this is far from an isolated case."
>
> Testimony of **Julienne Lusenge,** President of the Sofepadi Association, "Democratic Republic of Congo: Rape becomes widespread in North Kivu", MdM press dossier, November 2009.

While a legal framework that punishes gender-based violence is a necessary prerequisite for recognising victims' rights, it is not enough. **Each individual must have sufficient**

knowledge of his/her rights as to be able to assert them. Certain actions may be taken, therefore, to improve knowledge of the legal framework applying to gender-based violence on the one hand, and to facilitate the pursuit of justice by victims on the other.

> "Women in Uganda have been left with no faith in the justice system. The failure of the government to protect and support victims of sexual violence undermines the quest for justice. Lack of government resources and political will mean that perpetrators rarely face justice."
>
> Statement by **Widney Brown,**
> Senior Director of Amnesty International,
> in "Uganda: Discrimination and financial barriers stop victims of sexual violence accessing justice", Amnesty International, April 2010.

1 / THE LEGAL FRAMEWORK APPLYING TO GENDER-BASED VIOLENCE

Gender-based violence is an indisputable violation of fundamental human rights relating to the dignity and integrity of the individual and the principle of non discrimination.

A legal framework exists at international, regional and national levels that can be used as a basis for promoting and defending respect for these rights and protection of individuals. Knowledge of the legal framework associated with forms of gender-based violence is therefore crucial to make use of the legal processes open to victims for securing rehabilitation. This knowledge must be accompanied by a sound understanding of strategic policies and the way they are implemented, as well as a good grasp of judicial mechanisms, so as to bring about a change in the law in general and in aspects of legislation in particular.

1. The international legal framework

This guide does not claim to set out all legal texts relating to international human rights' law, nor even those dealing with women's rights in particular[151]. It is, however, useful to be aware of the legal corpus, as well as States Parties' obligations resulting from it.

PRINCIPAL INTERNATIONAL LEGAL INSTRUMENTS FOR PROTECTING HUMAN RIGHTS

United Nations Charter, 1945

The United Nations Charter states that one of the fundamental aims of the international community is "promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language or religion[152]." The Charter thus constitutes the basis on which all modern-day human rights are developed, using as a starting point the **principles of equality and non discrimination** among human beings.

International Human Rights Charter, that comprises:

→ **The Universal Declaration of Human Rights,** adopted by the UN General Assembly on 10th December 1948, is generally recognised as the foundation for international

151. For more information, see the website at www.ohchr.org.
152. Article 1, para. 3 of the **United Nations Charter,** adopted at the San Francisco Conference, 26th June 1945.

law relating to human rights. Although it is not a legally binding instrument, it may be regarded as a statement of universal norms relating to human rights. Articles 1 and 7 reiterate the principle of equality; article 2 sets out the principle of non discrimination.

→ **The International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights** of 16th December 1966 reaffirm the principle of non discrimination as a cornerstone of human rights.

The Universal Declaration of Human Rights and the two covenants are the only general UN instruments relating to human rights.

The Convention on the elimination of All forms of Discrimination Against Women (CEDAW)

The Convention resulted from the observation that widespread discrimination against women exists everywhere and that it is the main source of violence committed against them. Adopted on 18th December 1979, the Convention came into force in September 1981 and was signed by 186 States. Viewed as a **genuine international declaration of women's rights,** it provides the basis for implementing equality among men and women by ensuring equality of access to political and public life, as well as equality of opportunity in all areas, including the right to vote and to stand for election, and equality in education and employment. The signatories undertake to implement its provisions and, in particular, must adopt legislation that prevents, forbids and punishes discriminatory attitudes, customs and regulations. **This assumes the inclusion in their national constitutions of the principle of equality between men and women and the adoption of laws and measures to enforce it.**

The Declaration on the Elimination of Violence against Women, 1993

Although unanimously adopted by the UN General Assembly, this is a declaration by the States Parties and is not a legally binding text. **However, with this declaration, the UN for the first time defines what constitutes violence against women.**

All these instruments are freely available to consult online at: www.ohchr.org

International human rights' law entails both rights and obligations. It thus establishes certain prerogatives directed at States[153]:

→ **To respect human rights,** which means that States must not hinder the exercising of human rights;

→ **To protect human rights,** which means that States must safeguard individuals and groups against a violation of their rights;

→ **To implement human rights,** which means that States must take positive steps – in particular regarding national measures and laws – to facilitate the exercising of fundamental human rights;

→ **To offer internal means of remedy,** which means that any individual who believes that his/her rights have been violated must have an effective means of remedy before a competent national body with the power to grant redress and to enforce its decisions.

Where an individual cannot rely on national legislation in exercising his/her rights, he/she may then have recourse

153. **Desmarest Anne,** "International and regional legal framework on women victims of gender-based violence, regional workshop on providing care and support for women victims of violence, Kinshasa (DRC), MdM, April 2010.

to complaints procedures at an international level to ensure those rights are recognised, respected and protected.

Where a State does not recognise that a law included in an international text, to which it is already a signatory, takes precedence over national legislation, mechanisms exist for individuals to pursue their case at an international level. These mechanisms are open to individuals, groups and NGO.

INTERNATIONAL MONITORING MECHANISMS

By ratifying international human rights treaties, governments undertake to implement national measures and to adopt laws in keeping with the obligations arising from these texts. Thus, where human rights violations cannot be remedied by judicial processes at national level, mechanisms exist at an international level, guaranteeing that international norms governing human rights will be respected, protected and instigated at a national level.

The UN system comprises two types of monitoring mechanisms: UN Charter bodies, including the Human Rights Council; and bodies created by international human rights treaties.

UN Charter bodies

1 – The Human Rights Council

Created in 2006 by the General Assembly, the Human Rights Council is an intergovernmental body whose main purpose is to address instances of human rights violations and to make recommendations on them. A Universal Periodic Review (UPR) enables the Council to assess whether each State is abiding by its obligations and undertakings on human rights.

In addition, a revised Complaints Procedure enables individuals and organisations to bring complaints of human rights violations to the Council's attention.

2 – Human Rights Council 1503 Complaints Procedure

The '1503 procedure' is a confidential, universal mechanism for examining complaints submitted by individuals or NGO that point to wholesale cases of flagrant and systematic violations of human rights. This procedure does not deal with individual cases.

3 – Special procedures

Special procedures have been created to deal with the particular situation in any one country or with particular issues worldwide. An individual – a rapporteur, special representative or independent expert – or working group represents these procedures.

→ The special rapporteur responsible for the issue of violence against women, its causes and consequences is Mrs Rashida Manjoo, who was appointed in June 2009 for an initial period of three years. She has the task of analysing a vast collection of data and of recommending measures to eliminate violence against women at an international, regional and national level. Consultations with civil society are integral to her work. Women's groups, NGO and other civil society stakeholders can inform the special rapporteur of cases of violence for inclusion in her annual report.

→ The special rapporteur on racism and xenophobia in today's world examines issues such as systematic rape and sexual slavery occurring, in particular, during armed conflicts.

Treaty monitoring bodies

Several **committees monitor implementation of the principal international human rights treaties** and ensure that States Parties fulfil their obligations. Worthy of mention here are

the Human Rights Committee, the Committee of Economic, Social and Cultural Rights and, lastly, the Committee for the Elimination of Discrimination against Women.
States must submit various reports to the committees, which are generally drawn up by the governments in question. To ensure that these documents are as comprehensive and objective as possible, it is recommended that NGO and civil society stakeholders be involved. The reports are examined by the monitoring bodies that then issue recommendations. It should be noted that failure to abide by these recommendations does not result in any sanctions being imposed other than being awarded a black mark against one's national human rights record.

The Convention on the Elimination of Discrimination against Women focuses on discrimination against women in all its forms, without referring explicitly to violence. The **CEDAW Committee,** on the other hand, has clarified this point: "Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of article 1 of the Convention."

Violence towards women (as a result of their sex) therefore comes under the terms of the Convention and the States Parties are obliged to take measures to prevent and punish gender-based violence, as well as to guarantee redress.

National and international NGO closely monitor the States' reports and provide experts with relevant information and, on occasions, even contrary reports.

In addition to this process for monitoring implementation of the treaties, complaints may be brought before the Committee for the Elimination of Discrimination against Women. This procedure recognises the right of individuals to appeal at an international level.

CEDAW's Additional Protocol (open for signing since 1999) enables individuals or groups of individuals to submit complaints to the Committee, either as a victim / victims or on behalf of a victim / victims of gender-based violence. The Protocol also makes provision for the Committee itself to launch an enquiry on its own initiative and on the basis of credible information into serious or systematic violation of the rights set out in the Convention.

For more information on the mechanisms for lodging a complaint with the Committee for the Elimination of Discrimination against Women, see the website at: http://www.un.org/womenwatch/daw/cedaw/committee.html

Advocacy action may also be taken to bring about changes to the law applying in a given situation[154].

While international human rights law applies anywhere and at any time, **international humanitarian law** is a set of rules that aims to limit the effects of armed conflicts. It seeks to protect people who are not involved (civilians, humanitarian staff, members of religious orders, etc.) or no longer fighting (sick or wounded soldiers, casualties and prisoners of war), and to limit the means and methods used in times of war.

The International Criminal Court (ICC) is the first international criminal court of law in permanent session that is competent to pursue and try individuals for the most serious crimes against the international community – war crimes, crimes against

154. For more information on advocacy methods, see the section on advocacy strategies and actions on page 310.

humanity and crimes of genocide. The Rome Statute that established the ICC was the first international treaty to designate crimes against women as crimes against humanity, war crimes and, in certain instances, genocide.

In particular, the Statute recognises rape, sexual slavery, forced prostitution, forced pregnancy, forced sterilisation, persecution founded on gender, human trafficking (especially of women and children) and sexual violence as crimes that come within its jurisdiction. The Rome Statute also provides a benchmark for best international practice for national judicial systems in the future.

> "The Rome Statute's gender provisions are an encouraging example of how the development of the international women's rights movement is positively impacting international human rights and humanitarian law despite the strong influence of conservative political forces. […] While much remains to be done, the progress made since 1994 is extraordinary."
>
> **Radhika Coomaraswamy,** Special Rapporteur on violence against women, see: www.unhchr.ch/Huridocda/Huridoca.nsf/0/a9c6321593428acfc1256cef0038513e/$FILE/G0311304.pdf

2. Regional legal frameworks

Legal and judicial systems have been set up at a regional level to promote and defend human rights, but it is only recently that gender-based violence has been of concern within these legal systems.

To date, the most successful system for promoting and protecting human rights at a regional level is that of the **European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR).** Signed in 1950, the Convention came into force in 1953 and covers 45 countries in the geographical area. The European Court of Human Rights ensures that the Convention is enforced by the States concerned.

> "Positive obligations on the State are inherent in the right to effective respect for private life under Article 8 [of the Convention]; these obligations may involve the adoption of measures even in the sphere of relations of individuals between themselves. While the choice of the means to secure compliance with Article 8 in the sphere of protection against acts of individuals is in principle within the State's margin of appreciation, effective deterrence against grave acts such as rape, where fundamental values and essential aspects of private life are at stake, requires efficient criminal-law provisions. Children and other vulnerable individuals, in particular, are entitled to effective protection […]."
>
> *M.C. v. Bulgaria,* Appl. No. 39272/98, **Council of Europe: European Court of Human Rights,** 3rd December 2003.
>
> **For more information on the European system of protecting human rights, consult the website at: www.echr.coe.int/echr/**

On the American continent, 35 countries have, since 1948, ratified the **Charter of the Organization of American States** (OAS), one of the aims of which is to protect and promote human rights. In 1994, these same countries adopted the **Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women, known as the 'Convention of Belem Do Para'.** The latter is the only international legal instrument that deals specifically with gender-based violence and that is binding. Thus, any individual, group of individuals or NGO may petition the Inter-American Commission

on Human Rights concerning a violation of the rights guaranteed by the OAS Charter or the Belem Convention. The Inter-American Court is then competent to judge the violations.

For more information on the inter-American system of protecting human rights, see the website at: www.cidh.org/Default.html

The African continent also has its own legal text and mechanism for applying and monitoring human rights compliance. Gathered under the umbrella of the Organisation of African Unity that subsequently became the African Union, in 1981, 53 African States adopted the **African Charter on Human and Peoples' Rights,** thereby establishing a full set of regional instruments for promoting and protecting human and peoples' rights.

For more information on the African system of protecting human rights, see the website at: http://www.achpr.org/english/_info/news_en.html

These regional judicial systems reinforce the responsibilities of the States Parties by creating an extra layer of legal mechanisms for promoting and protecting human rights.

3. National legal frameworks

National legal systems, particularly in developing countries, can be seriously lacking in their capacity to protect victims of gender-based violence – domestic violence tolerated, rape not viewed as a crime, etc. Gradually, however, human rights organisations have succeeded in altering mindsets and in bringing about significant changes to legislation.

Some examples include:

→ In 1999 **in Egypt,** the law recommending that a rapist be acquitted if he marries his victim was repealed.

→ **In Morocco,** the Code of Personal Status (Moudawana) was amended in October 2003 and henceforth "both partners are joint heads of the household, a responsibility previously accorded to a husband; the law no longer requires a wife to obey her husband; a wife no longer needs a guardian to sign her marriage contract; the minimum age for marrying is eighteen for both men and women – as opposed to fifteen for women; polygamy is still permissible, but only in limited circumstances; divorce by repudiation is only permissible where a judge decrees it; a woman may ask for divorce; a mother or father may have custody of any children following divorce; children born outside marriage are protected and both partners decide on a contract for the disposal of shared possessions[155]."

→ **"In Belgium,** domestic violence is not explicitly an offence. It is generally described as bodily harm. However, the law of 24th November 1997 strengthened the sentences applying to various 'deliberate bodily injuries', when inflicted by a spouse or a person with whom the victim 'has cohabited and maintains or has maintained a long-term emotional and sexual relationship.' The link between aggressor and victim is therefore seen as an aggravating circumstance[156]."

→ In December 2005, **the Liberian parliament** adopted a new law making rape a crime. This law fixes punishments

155. **Mohsen-Finan Khadija,** « L'évolution du statut de la femme dans les pays du Maghreb », Institut français des relations internationales, June 2008.
156. *La lutte contre les violences conjugales,* French Sénat working documents, February 2005.

of between seven years and life imprisonment for rapists, depending on the gravity of the crime, with no option of bail. Previously, no law relating to rape existed, even though gang rape was seen as a crime.

→ In July 2008, Liberia ratified the protocol to the **African Charter on Human and Peoples' Rights** that deals with women's rights.

"It is not only useful but is essential for us to take a close interest in the international and regional undertakings of those States where we intervene. By analysing and comparing the international and regional obligations of the States with their respective (national) legislations, we can identify gaps and/or inconsistencies that offer potential areas for discussion and even advocacy."

Desmarest Anne, "International and regional legal framework on women victims of gender-based violence", on providing care and support to women victims of violence, MdM, Kinshasa (DRC), April 2010.

2 / ACCESS TO JUSTICE

Very few victims of gender-based violence press charges and a good number who dare to do so do not pursue their case to its conclusion. There are various organisational, social, cultural and economic reasons for this lack of access to justice and poor rate of legal redress. All these factors must be taken into account to provide an adequate response to victims of gender-based violence and to combat perpetrators' impunity.

Improving access to justice for victims of gender-based violence involves:

→ Informing them of their fundamental rights;
→ Supporting them in the process of pressing charges;
→ Training and raising awareness of public authorities likely to be involved in the victims' judicial process (police officers, lawyers, magistrates, etc.).

Factors that may explain why individuals suffering violence fail to obtain legal redress:

→ Inability of the victim of violence to recognise the situation as an assault due to ignorance of/lack of information about his/her rights;
→ Fear of reprisals or of repeat of violence by the perpetrator;
→ Fear of being stigmatised, being singled out;
→ Lack of understanding of the judicial process;
→ Psychological suffering;
→ Impression of being the only one to experience such a situation;
→ Lack of financial resources to meet costs of process;
→ Poor reception from and prejudices encountered among care providers. Fear of not being taken seriously;
→ Trivialising of violence by the authorities;
→ Slowness of the judicial process;
→ Lack of proof;
→ Feeling of impunity enjoyed by those perpetrating violence.

Handbook on multidisciplinary and integrated care for victims of violence, **MdM,** Haiti, 2008.

In Pakistan, the MdM project's main aim is to improve the quality and variety of services offered in government temporary shelters for women in distress (Dar-Ul-Amans). By mobilising

a group of volunteer lawyers, legal accompaniment has been integrated into the shelter services. The lawyers are responsible for informing women of their rights and providing them with personalised legal advice and legal assistance, including representation in court if need be. A group of volunteer lawyers has been set up in each district and the network now totals around 85, of whom 42 have been trained by MdM.

In Haiti, the Haitian organisation Uramel has for a long time been a special partner of the programme developed by MdM. Uramel's mission is to promote forensics and medical law among those working in the judicial and medical professions in particular, and among the public in general.
In addition to training care providers in the use of medical certificates and advocacy initiatives aimed at securing free medical certificates in healthcare facilities, victims of gender-based violence are assisted in the legal process by networking and by referring to legal aid organisations.

As part of the project set up by MdM in **Guatemala** to support women working in the export industry (*maquilas* textiles and agri-business), victims of violence are referred to partner organisations, particularly the *Derechos Humanos* association and the local body responsible for conflict resolution in the *maquilas*, one of whose objectives is to discuss difficult situations and to put forward appropriate solutions.

In **Moldova**, victims of trafficking identified within the context of the MdM project are supported in the legal process by being referred to an assistance and protection centre (CPTF – Centre for the Prevention of Trafficking of Women), which has a regional office in the area where MdM is working. In addition to legal consultations, the CPTF can also represent victims in court who wish to pursue their complaint.

"The Sofepadi programme of action [Congolese organisation for the promotion and defence of women's rights] in **Goma** has had a very positive impact: more than 60% of detainees in the central Goma prison are violent sexual offenders, as the police and soldiers are committed to combating this form of violence in the wake of work done by campaigning organisations, and this despite them often being discouraged by the State."

Testimony of David Bodeli Dombi, head of special police forces for the protection of women and children in Goma. Regional workshop on providing care and support for victims of violence, **MdM,** Kinshasa (DRC) April 2010.

1. Informing victims of gender-based violence of their rights

The aim is to make victims of violence aware of their fundamental rights and to inform them of ways of ensuring these rights are respected. **To do so, those providing support must themselves be informed and aware of national legislation, notably as regards the following questions[157]:**

- → Which national laws and procedures apply? What are the different legal definitions of the various forms of gender-based violence?
- → If the country's constitution contains a declaration of rights, can the relevant provisions be called on for dealing with certain forms of gender-based violence?
- → What is the legal framework relating to abortion? If abortion is generally prohibited, are there any particular circumstances (exceptions) in which it may be permitted – for example when a woman is pregnant following rape, when a woman's life

157. UNHCR, *Sexual and Gender-based Violence against Refugees, Returnees and Displaced Persons,* 2003.

is in danger? What proof is required to confirm the existence of one of these particular circumstances?

"In Guatemala, awareness raising among communities, and notably among women workers [in the maquilas textile and agri-business industries], is carried out by means of an ongoing programme of training for health promoters run by the MdM team […]. Women trained in this way can then go on to promote the overall health of their colleagues in their communities and in their homes. **Among the themes tackled during training worth mentioning is law and health that involves examining official legal texts and case studies and gaining a knowledge of civil society institutions and organisations that may be able to offer support."**

MdM Guatemala, Interim Operational Report, AFD/MAAIONG, July 2009.

2. Accompaniment during the judicial process

Accompanying victims of violence during the judicial process involves supporting them in their dealings with the judicial authorities, notably as regards filing a complaint and representation in court.

As part of its activities, MdM facilitates this support by referring individuals to legal professionals. MdM also works to improve victims' access to medical certificates, a crucial piece of evidence in the judicial process. The principles of listening and empathy[158] must be adhered to when supporting an individual during the judicial process, just as when any form of care and support is offered to someone who has suffered violence.
A certain number of obstacles, whether linked to social and

legislative discrimination or to the complex nature of some judicial systems, may limit access to justice for victims of violence, reinforcing the need for support by professionals.

"The particular procedure of khula (no-fault divorce) is applied in Pakistan and Egypt (among other countries) in cases where a divorce is sought. In Egypt, it is used a lot by women as a means of fast-tracking divorce, but in so doing these women agree to renounce future financial rights, to repay the dowry they received when marrying their husband and to hand back any gift received during their married life. Conversely, in divorce cases where a fault is cited, the woman may claim financial rights but is then subject to strict rules of evidence (such as where accusations of violence often have to be substantiated by witnesses). Once again, as is the case with all divorces, husbands are not willing to agree to their wives taking the initiative. The women are therefore often discouraged before they even initiate proceedings."

Dr Magda Adly, "Facilitating access to justice for women victims of violence", Regional workshop on providing care and support for women victims of violence, Cairo (Egypt), MdM, September 2009.

In France, as part of the programme supporting sex workers in Nantes, MdM sometimes physically accompanies individuals to the police headquarters to file a complaint or when a complaint has not been acted on following an initial visit. MdM also refers sex workers to lawyers. **This support is given only where requested by the individuals concerned.**

158. For more information, see the section relating to receiving victims of gender-based violence on page 117.

In Pakistan, one of the major problems in the judicial system lies in its complexity and, more particularly, in the huge number of courts that are competent to deal with cases of violence. Thus family and personal matters, as well as certain criminal ones, are subject to the justice of each religious community and to tribal justice (tribal law may be seen as a system of reconciliation and mediation that has no legal legitimacy), while each Pakistani citizen is also obliged to submit to the country's constitutional law.

Parallel judicial and legal systems therefore exist that lead to confusion for those seeking justice in general and for victims of violence in particular. Not knowing which system to turn to, victims of violence approach several judicial bodies for the same case, each of them competent to deal with the matter. As a result, there is the risk that victims of violence will find themselves subject to potentially contradictory decisions issued by different courts.

Ali Irman, "The case of Pakistan: Actions to protect human rights – Marriage, divorce and property law", regional workshop on providing care and support to women victims of violence, Cairo (Egypt), MdM, September 2009.

As is the case for any form of care and support dispensed to victims of violence, **legal assistance and support must be considered from the point of view of the need to protect victims. Protection afforded must ensure the security of all individuals involved in the legal proceedings initiated against perpetrators of gender-based violence, including witnesses and support workers.**

Next page: Julienne Lusenge, "Access to law and justice for women victims of violence", Regional workshop on providing care and support for women victims of violence, Kinshasa (DRC), MdM, April 2010.

RISKS AND PROTECTIVE MEASURES

SUPPORT GIVEN TO VICTIMS OF SEXUAL VIOLENCE IN THE LEGAL PROCESS IN NORTH KIVU BY THE SOFEPADI ASSOCIATION

(Women's Solidarity for Integrated Peace and Development)

	Type of incident	Measures
Victims	Sexual violence	– Coding identifiers: From identifying to providing care – At itinerant hearings: Cover victims with a veil – Obligatory accompaniment at each stage of the process
	Physical threats, perpetrators temporary released/possibly life-threatening	– Request explicit guarantees of security from judicial authorities: Argument developed by lawyers during pleading – Direct summons to court – Constant contact with authorities – Relocation of victim
	Verbal threats and serious verbal insults	– Reinforce counselling and psychological support – Raise community awareness
Witnesses	Reprisals aimed at witnesses and their families by perpetrators	– Contact authorities locally to ensure witness protection

Support workers	Serious (possibly life-threatening) threats	– Contact authorities locally and inform them of the incident
	Night-time visits to home by armed men: theft of possessions and physical torture, loss of data and other important trial materials	– Reinforce security of offices and back up data
	Unexpected searches of offices and premises (information services or militias)	– Keep inventory of archives, back up data using 3 devices – flash, CD and Martus box; print documents only if necessary
	Arbitrary arrests followed by illegal detention	– Report to authorities and alert others promptly
	Verbal threats (gratuitous insults and accusations, etc.)	– Summons to and censuring before a hearing in consultation with partners

The Rome Statute pays particular attention to the interests and rights of victims who have suffered the violent event and/or witnesses who play a crucial role in bringing criminals to justice. A Victims and Witnesses Unit has been set up within the International Criminal Court. It draws up short and long-term strategies for the security of victims and witnesses, recommends protection measures for Court bodies to adopt, and advises victims and witnesses appearing before the Court. Thus, on the recommendations of the Unit, the ICC may protect the identity of victims and witnesses or of the accused by directing part of the proceedings to be held closed-door, or by allowing statements to be gathered by electronic or other special means[159].

PROTECTING VICTIMS OF VIOLENCE AGAINST ANY POTENTIAL DANGER ARISING FROM ACTIONS OF COMMUNICATION

Individuals' safety must be protected at every stage and in every aspect of our intervention, including our communications. Any communication (written, photographic or audiovisual documenting and testimonies) is likely to reveal information particular to an individual's situation. These personal data and clues may pose a serious threat to the physical safety of victims of violence by providing perpetrators with information and thus facilitating acts of reprisal.

Communications can also undermine the confidentiality sought by the individual, by divulging information that he/she had deliberately decided to withhold.
Communications about situations of violence must therefore respect certain ethical principles, notably: to cause no harm, to respect confidentiality and to ensure the free and informed consent of the patient.

These ethical principles require those involved to weigh up the potential risks incurred by the individuals from whom the evidence is being gathered against the benefits expected from the communication.
Where it is conceivable that a person may be put in danger, any element identifying him/her must be removed in accordance with the above principles. The Médecins du Monde Charter on the collection of testimonies by the press[160] thus emphasises:
→ **"Respect the person's anonymity** – by changing his/her name, blurring his/her face, avoiding geographical details, etc.;

159. **Desmarest Anne,** "International and regional legal framework on women victims of gender-based violence", 2008.
160. Médecins du Monde Charter on the collection of testimonies by the press, April 2010.

→ **Choose an isolated place of meeting**
(outside of the health centre or of his/her village);
→ **Carry out an in-depth study of the situation,**
on a case-by-case basis, by coordinating between the communication department and persons in the field."

When gathering photo-documentary evidence and testimonies, free and informed consent means giving the individual precise details of the use that will be made of his/her image and testimony. If the person has not consented, or is not in a position to grasp the implications, any clue as to his/her identity must be removed.
The interests of the individual are more important than any other consideration, including those of advocacy and promoting human rights.

161. Definition by **Dr Pouillard Jean,** a former attaché-consultant of Hôpitaux de Paris, Vice-President of the French Council of the Order of Physicians, and a member of the French Society of the History of Medicine. http://www.entremed.fr/doc/redaction_certificats.pdf
162. Unité de santé internationale, Montréal, 2009.

3F

MEDICAL CERTIFICATES FOR CASES OF VIOLENCE

MEDICAL CERTIFICATE OR MEDICO-LEGAL CERTIFICATE?

Generally speaking, the certificate is a document from a competent authority that certifies a condition.
Medical certificates for assault and body injury can therefore be defined as an "official attestation of a medical condition[161]."
It is the tool with which the care-giver (most often a doctor) certifies the physical and psychic condition of a patient or injured person and gives an opinion on whether this condition is consistent with the patient's account.
Certificates are "medico-legal" when they are issued by a doctor on the order of a court of law. Medico-legal certificates are thus "documents issued by a doctor (or a medical institution) to be presented to a judge or another legal authority in the event of a complaint or an accusation[162]."
When the document is issued by a doctor (or empowered medical personnel) on a patient's request (as opposed to a court-ordered certificate), it is called a "medical" certificate.

1 / THE IMPORTANCE OF THE MEDICAL CERTIFICATE

1. Link between medical certificates and medical ethics[163]

Issuing descriptive medical certificates is part of the "obligation to attest", a fundamental principle of medical ethics.
This is one of the mandatory certificates that doctors are required to draw up and provide to any patient who wishes to have documentary proof of his/her injuries or medical condition.
Victims of violence often do not spontaneously request medical certificates, mainly out of ignorance concerning their usefulness.
The doctor is responsible for informing patients and offering them a medical certificate.

All victims are entitled to receive a medical certificate and all doctors are required to provide one.

Legal medicine, and, more concretely, the issuance of medical certificates to victims of violence must be considered an integral part of medical practice and not a separate activity.

2. Link between healthcare and justice

Access to healthcare and justice are two essential components of rehabilitating victims of violence. **The medical certificate constitutes decisive proof for legal purposes and is thus at the crossroads between the medical and legal fields, and between care and protection.** It is therefore crucial that quality medical certificates be made available.
However, there currently exists no common international framework governing the drafting and issuance of medical certificates in cases of violence. The wide divergences from one country to another raise the issue of persons' rights as patients and as victims of violence. Such a framework is essential for setting the guidelines on the legal value of a medical certificate, for establishing channels for issuing them, for determining which healthcare professionals are entitled to issue them, and codifying their format and content.

3. The usefulness of medical certificates

Medical certificates for acts of violence are **mainly issued for legal reasons.** A person who wishes to go to court to defend his/her rights and obtain redress for wrongs done to him/her can produce a **medical certificate as proof of that he has been the victim of violence.**

For all civil and criminal procedures, it has a role in determining:
→ the classification of the infraction,
→ in some countries, the nature of the court having jurisdiction,
→ the extent of the sentencing.

In some situations, medical certificates can provide rights to a disability pension, compensation by a national or international court, or compensation from an indemnity fund.
They can also be used by persons arriving in a country **in support of an asylum application or a request for an alternative status of protection.** Medical certificates can therefore be useful even when it is not possible to use them in the country of origin (due to conflict situations, corruption, or dysfunctional legal systems).

163. For more information, see the section relating to providing medical care for victims of gender-based violence page 145.

> "To obtain refugee status, you simply must send me a medical certificate mentioning the marks that you have on your body, in particular to the eyes, due to the torture and abuse that were inflicted on you[164]."
> "Torture is part of our daily life at Ofpra (the French Office for protection of refugees and stateless persons) and has become mundane. One's word is therefore not enough. When people tell us about their scars, we tell them to go see a doctor. So medical certificates must be just as eloquent as a photo[165]."

Regarding each patient's right to information, the doctor must systematically mention these possible uses of the medical certificate in cases involving violence. It is up to the patient himself whether or not to use the certificate, but is up to medical personnel to attest to acts of violence. Not issuing certificates makes certain violent crimes seem mundane and helps cover up traces of such violence.

2 / SPECIFICATIONS OF MEDICAL CERTIFICATES FOR ACTS OF VIOLENCE

1. Legal value

Judicial authorities often do not attribute the same legal value to medical certificates issued upon the request of a victim of violence as to certificates that are court-ordered after the victim files charges at a police station (i.e., medico-legal certificates). **Certificates from non-sworn physicians will never have absolute value of proof, but they do constitute an important element of proof and after several years they are often the only material element that remains, apart from the victim's word.**

It is not necessary to be a medical-legal physician or a court expert to issue a medico-legal certificate; any doctor can do it. The quality of the document depends on the doctor's capacity to describe the lesions and to write out a medical certificate that will stand up to scrutiny.

Failure to comply with formal procedures does not detract from the value of a medical certificate. However, current local regulations must be investigated further, including matters such as who is empowered to issue medical certificates, whether there is an official format, and so on.

The certificate does not lose its validity, as such, with time. However, its use in a court of law may be rendered impossible in the event that the statute of limitations takes effect on the infraction concerned. In many countries, victims may, for serious acts, file a complaint for at least 20 years after the events, in order to seek justice and redress of wrongs done to them. In all cases, victims must keep their certificate(s) for an indefinite amount of time.

2. Medical certificates are potentially dangerous

For the victims:
Victims of violence may face reprisals for seeking medical care. Revealing acts of violence to a care-giver, and, above all, filing a complaint, can put the victim's health at risk and even endanger his/her life.

164. Fassin Didier, D'Halluin Estelle, "The Truth from the body: medical certificates as ultimate evidence for asylum seekers", *American Anthropologist,* 2008.
165. Dromer Carole, "Le certificat médical, pièce jointe à la demande d'asile en France", master's thesis DH/DIH, 2007.

However, the victim alone (in some cases assisted by other associations) is in a position to evaluate the advantages and drawbacks of using the medical certificate and to decide the most appropriate moment to do so.

The doctor, meanwhile, must be careful of the use that he makes of the medical certificate and the advice that he gives to patients. **The certificate must first of all be read out to the patient and assurance must be obtained that he has understood its content and scope.** The patient can then decide himself what use he will make of the certificate. He must then be informed of the possibility of using this certificate for medico-legal reasons in a judicial or non-judicial proceeding.

Medical certificates are generally given directly to the patient. MdM does not forward them to third parties. If the patient refuses to take a copy with him/her, the care-giver must keep it in a secured file while informing the patient that he may come get it later. **In all cases, medical certificates must be made out in duplicate, with one copy retained by the care-giver in a secured location[166].**

"**In Kinshasa,** in the Democratic Republic of Congo, it has become dangerous to deliver a medical certificate to a child living in the street. Such a document could be lost or stolen; the child victim could then face reprisals from his aggressor. Only MdM retains copies of medical certificates."

Testimony during the workshop on "Protecting girls living in the streets of Kinshasa", **MdM,** April 2010.

166. For more information on the filing and forwarding of medical certificates, see **Dromer Carole, Desmarest Anne, Delorme Adrien,** *For ethics in the field: sensitive personal data management (Health-Life stories),* MdM France, 2010.

For the doctor:
Issuing a certificate is an obligation but can also put the certificate issuer at risk. In addition to the legal liability incurred by this act, any person involved in a potentially coercive action involving a third party, especially one who is influential in his/her surroundings, may be subject to pressures.

It is important to manage this risk and the fears linked to it by deciding whether it is better to have the medical certificate signed by doctors or by national or expatriate medical personnel, and by keeping their court appearances to a minimum. If a patient uses the certificate in court, MdM may decide to merely authenticate the certificate, without testifying.

Moreover, belonging to an international organisation in countries governed by a repressive regime and/or police state could make doctors reluctant to issue medical certificates for acts of violence. Doctors who do so while working for a foreign entity could, in certain cases, displease the authorities and hinder the association's activity in the country.

In Egypt, any activity that could be interpreted as harming the image of the state or that does not comply with the "country's cultural context" could undermine MdM's presence in this country. Drawing up medical certificates in cases of violence (often a taboo subject) for legal reasons can be considered an example of this.

Report on access to medical certificates, **MdM,** Egypt, April 2009.

3 / MAKING MEDICAL CERTIFICATES **TRULY AVAILABLE**

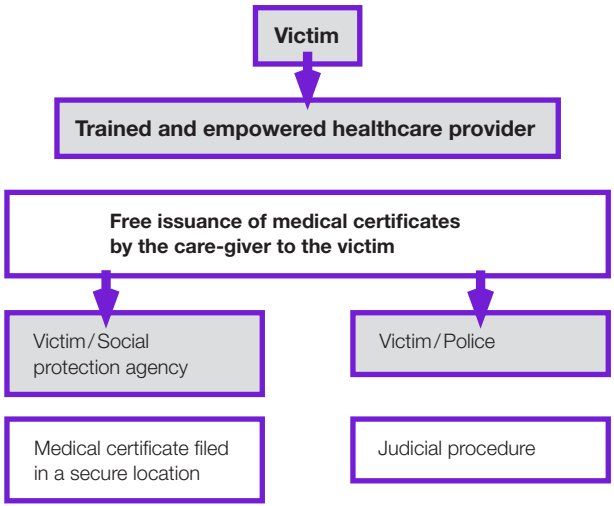
True access to medical certificates is often restricted by a number of factors, such as the **lack of empowered personnel** at healthcare facilities, the **fact that issuance is not free of charge,** the obligation for a woman to be accompanied during medical examinations, or the prior obligation to file a complaint with the authorities. **The long and complex process for obtaining medical certificates for acts of violence can be truly dissuasive to persons wishing to assert their rights.** Facing numerous obstacles, most victims of violence get discouraged and give up.

> In Egypt, victims of violence must go to a police station and submit a request for a medical certificate, but girls living in the street don't do so, as they are afraid "of being arrested or be subjected to further acts of violence."
>
> Report on access to medical certificates, **MdM,** Egypt, April 2009.

Ideally, any victim of violence should have direct and free[167] access to a trained care-giver who is empowered to make out and issue a descriptive medical certificate with no other intermediary, so that the victim can use the certificate in a court of law if he/she so desires.

167. Or at least included in the price of a consultation.

1. Ideal channel for obtaining a medical certificate for violence



Depending on the specific obstacles encountered in a given context, **there do exist ways to make it easier for victims of violence to obtain medical certificates.**

On the operating level the following initiatives can be taken:

→ training sessions for medical personnel to enhance their ability to draw up certificates that stand up to scrutiny;

→ sessions to raise awareness of the importance of medical certificates and the ethical principles applicable to healthcare personnel.

When the national laws require that medical certificates be issued free of charge, assurance must be obtained that facilities backed by MdM actually do so.

It is also possible to **engage in advocacy to bring about changes in the laws** (regarding free-of-charge medical certificates, medical personnel empowered to issue certificate, streamlining of the channels for obtaining one, etc.)[168].

2. Who can issue a medical certificate?

In most of MdM's intervention contexts, a doctor must examine the patient, then draw up the certificate and sign it. Local laws sometimes allow non-physicians to draw up certificates; in some cases, though, the law empowers only local and sworn physicians to do so.

In Liberia, the Ministry of Health and Social Affairs allows any doctor, doctor-assistant, nurse or midwife to draw up a medical certificate for acts of violence.

In France, the medical certificate [to back an asylum request] can be issued by any doctor. The Asylum Appeal Board never asks for a certificate from a medico-legal expert[169]. It is preferable for the family doctor to issue the certificate himself, as long as he is informed of the context of the demand and the rules of certification. […] Otherwise, a medico-legal physician can be used. In any case, an assessment that is impartial to both parties is essential[170]."

It is important to check national legislation for the validity of medical certificates issued by different categories of care-givers. But **in all cases and regardless of the context, it is essential that any victim of violence have the option of obtaining a medical certificate from any doctor.** In practice, doctors (whether local or expatriate) are often few in number and concentrated in large cities. There is therefore limited access to persons empowered to issue medical certificate. However, there are some possible ways around this. When only doctors are legally authorised to issue medical certificates and they are few in number in certain regions, care-givers and doctors can coordinate their work together.

In Goma, while only doctors are empowered to issue medical certificates for acts of violence, most healthcare centres [mainly in rural areas] are run by nurses. In this case, the procedure for issuing a medical certificate for acts of violence depends of the willingness of care-givers to call in doctors within a reasonable amount of time, and the doctors must themselves be available to come in.

Making medical certificates truly available also depends on training care-givers and raising awareness among all personnel who come in contact with victims.

In Haiti, all civil society has stressed the importance of medical certificates for acts of violence. Public authorities responded to this initiative by adding a legal medicine curriculum in two medical schools in 2001.

Report on access to medical certificates, **MdM** Haiti, April 2009.

168. For more information, see the section relating to advocacy strategies and initiatives and see the kit for advocating for an easier access to medical certificate for acts of violence, page 310.
169. **AAP** has become the national court for asylum law.
170. Guide Comede, 2008.

Ideally, persons empowered to draw up medical certificates must develop these skills during **initial training.**

Refresher courses and further training are just as important. It is essential to involve government authorities in training sessions organised on the initiative of civil society or international associations, as this encourages them to develop such initiatives.

Any service-provider who comes in contact with victims of violence, including care-givers, psychologists, social assistants, legal counsellors, magistrates, police officers, etc., must also be made sufficiently aware of the challenges involved in obtaining and using medical certificates.
Effective coordination among all actors can make the process of obtaining a medical certificate easier for the victim.

In 1999, a seminar was held on "medical assessments" in Haiti by MdM and the Unit for Legal Medical Research and Action (Uramel), in tandem with the French magistrate's school.

The purpose of this seminar was to train a group of legal and healthcare professionals in the delicate exercise of medical assessments, but also to raise awareness on the importance of legal and medical professionals' working in tandem in the judicial investigation process.

3. Direct access: to whom can a medical certificate be issued?

"The certificate is a confidential medical document, as it is excerpted from the medical file. As a matter of principle, the care-giver must **hand it to the patient and only the patient**[171]." This complies with the principle of patient protection and confidentiality. **MdM does not provide medical certificates to third parts, except in the following cases:**

- → When a minor or incapable major is involved, in which case the certificate is given to the legal guardian;
- → When it is ordered to do so by a court of law, in which case it is issued directly by the care-giver to the court authorities.

4. When can medical certificates be issued?

A medical certificate for acts of violence can be **drawn up at any time** (prior to the expiration of the statute of limitations on the infraction itself) **based on the patient's medical file,** as long as he/she has been examined by a care-giver at the time of the events. Ideally, certificates should be issued upon the initial examination and should report the observations made on that day. But it can also be drawn up during a later visit. The certificate is then dated on the day of its drafting and states that it refers to the medical file to describe previous observations.

5. Free-of-charge medical certificates

Providing **medical certificates free of charge** in cases of bodily injury is an important principle. Economic factors can limit actual access to medical certificates considerably, because they can legally be charged for, or because forms of corruption exist in the access channels. Issuance of medical certificates must be an integral part of the consultation and not be charged for separately.

171. **Dromer Carole, Desmarest Anne, Delorme Adrien,** *For ethics in the field: sensitive personal data management (Health-Life stories),* MdM France, 2010.

In Haiti, two circulars signed jointly by the Ministry of Public Health and Population and the Ministry of the Feminine Condition and Women's Rights have since 2007 clarified the legal framework of medico-legal certificates. […] with the second circular requiring that medical certificates be issued free of charge as a medical act practiced in public institutions.

Intermediary operations Report, MAAIONG/AFD, **MdM** Haiti, 2009.

In Peru, the findings of medico-legal examinations and court-ordered psychological assessments are not provided to victims of violence free of charge. If the victims wish to have a copy they must pay 3 soles (1 dollar) to the Bank of the Nation (which is government controlled) and, receipt in hand, go to the institute for legal medicine where the tests were made, to obtain a copy.

Report on access to medical certificates, **MdM,** Peru, April 2009.

Medical certificates must meet precise specifications to ensure that they will stand up to scrutiny in a court of law.

4 / WRITING OUT MEDICAL CERTIFICATES

To give a better idea of the requirements for drawing up medical certificates, a sample technical datasheet providing the document's essential items has been included[172].

172. S2AP, "Technical datasheet: Writing out a medical certificate", regional workshop on providing care and support for women victims of violence, Cairo (Egypt), **MdM,** September 2009.

TECHNICAL DATASHEET: WRITING OUT A MEDICAL CERTIFICATE

1. Identity

I, the undersigned, Dr X, of Médecins du Monde, hereby certify that I have examined (followed up on) Mr./Mrs. X… born on…
→ **Identity of the signatory doctor,** name of the NGO.
There is no need to include all the care-giver's diplomas, unless that might add credibility to the medical certificate.
→ **Last name, first name, birth date** of the patient examined.
For security reason, do not note the victim's address.

2. Statements by the patient

Mr./Mrs. X states (with or without the assistance of a translator): "……"
The use of quotation marks shows that you are quoting the patient/injured person directly.

You can also use the wording:
Facts stated or statement of the examined patient:
– Struck on the face
– Threatened
– Dragged by the hair
– (other)

→ Note the **date of the events.**
Quote **the patient's very words** for the circumstances, the date and place of the attack using the words *Mr./Mrs. X states: "……".*
Do not judge the clarity of the statement or its consistency (that is up to the judge).

→ Note **only those facts** that have a **direct consequence** on the state of health and your medical observations.

Don't write out the entire statement.
There's no point in recounting the patient's life story.
→ Use **the present or past tense.**
Do not use the conditional or wording such as "claims" or "alleges", as that might suggest that you doubt the patient's word.

3. Complaints/clinical examination

Mr./Mrs. X complains of: ……
Do not draw up a certificate without first examining the patient.
– Emotional state: ……
→ Note down at least the **emotional state** of the patient during the consultation (agitated, tense, passive, amorphous, etc.); if you are qualified to do so, make a note of the **psychic examination.**
– Psychic state: ……

→ Under clinical examination, mention only what is **significant** regarding functional signs and events.
Do not mention all "negative" signs or information that is not significant, such as blood pressure, weight (if normal), etc.
Do not mention chronic disorders that have nothing to do with the events (if you believe that they do have something to do with the events, say so and back it up).
→ Note the observations of the clinical examination with **the most details possible,** including types of lesions (abrasions, scratches, etc.), exact location, length and width, and, if possible, how long they have been there (using drawings if necessary). You may take photographs if the patient consents to them (in which case, attach them to the medical file and treat them as sensitive information).
→ In the case of sexual violence, note the findings of the genital, anal and mouth examinations.
→ If relevant, undertake a **pregnancy test or estimate the risk of pregnancy and sexually transmissible infections.**

4. Additional examinations (where applicable)

……
→ Note down what additional examinations have been made for diagnostic or therapeutic reasons and their findings (X-rays, for example).
→ Note whether an examination **corroborates the patient's statement or clinical examination.**

5. Samples (where applicable)

……
→ Mention the samples that have been taken for medico-legal purposes, including the nature of the samples and their purpose.

6. Post-operative report (where applicable)

……
→ A post-operative report, where applicable, can be attached to the certificate. **If so, ensure that the certificate is consistent with the information in the post-operative report.**

7. Conclusions

……
→ Indicate if your observations on the patient's condition and changes in his/her condition are **consistent with his/her account.**
Consistency **can be in degrees** *("Results of both physical and psychic examinations are highly consistent with the account presented by Mr. X", for example. You can also say that "there are indeed traces of psychic trauma"*
or "the examination corroborates the patient's account").
Do not draw a legal conclusion from the facts, such as "In conclusion Mr. X was tortured" or "Mrs. Z was raped". It is up to the judge to do that.

→ If the patient requests **a certificate for rape** and you have not observed any physical lesions, conclude that ***"the lack of physical lesions is not inconsistent with the account of Mrs./Mr. X."***

→ If you have described **psychological disorders without physical lesions,** write:

"The psychological disturbances of Mrs./Mr. X. are consistent with the statements made. The lack of lesions cannot rule that out."

Note: the lack of physical traces during the clinical examination is not sufficient to conclude that no aggression has been committed, for two possible reasons: 1) because various forms of constraint may have been used; or 2) because of the time elapsed between the aggression and the consultation.
You therefore must not conclude that there has been no aggression or that your observations are not consistent with the patient's account.

→ Where applicable, you may indicate the medical seriousness of what you have observed and the possibility that treatment can lead to recovery.

→ If required to do so by law, determine whether there is total temporary work disability[173].

No personal judgement should be included on the certificate, nor any assessment of the truthfulness of the patient's account (this is not the care-giver's role). You should therefore not say that you believe the patient's account: "I believe that Mr. … is telling the truth."

173. This is different from the duration of medical leave. For more information, see the website of the French Conseil national de l'Ordre des médecins, www.cnomedecins-dz.com/articles.php?lng=fr&pg=47

8. Issuance of the certificate

This document is handed personally to Mr./Mrs. "……"

→ Indicate to whom the certificate is being given. It is most often handed personally to the person concerned.

→ If the patient is a minor, give the certificate to his legal representatives (if this is possible).

Do not give the certificate to any third party.

9. Date, place, time

Done at ……. (city, village, district),…… (country), on …/…/……(DD/MM/YYYY), at 00:00.

→ Indicate the precise place, the complete date and the time of the clinical examination.

Do not pre-date or post-date the certificate.

10. Signature(s), printed out name(s), stamp

→ If the certificate has several pages, the date, hour, name of the patient and name of the examiner must be written on all pages.

A stamp is not enough. The more signs there are that identify the care-giver, the more credible the certificate will be. It is unnecessary to have the examined patient sign it.

Dr Buddy Whatsup

→ The signature must be by hand.

The stamp must not cover up the signature.

3G

SOCIAL AND ECONOMIC REINTEGRATION

Helping victims of gender-based violence reintegrate into society and employment is an essential aspect of multidisciplinary care that is a key part of their overall rehabilitation.

Although very much in keeping with MdM's approach to providing care and support for victims of gender-related violence, social and economic reintegration does not generally come within the organisation's remit. Médecins du Monde contributes to this aspect of rehabilitation by developing networks of providers and by referring programme users to partner organisations.

Social and economic reintegration is concerned with notions of **autonomy and empowerment** for women in general, and for victims of gender-related violence in particular. Empowerment concerns the individual and his/her control over his/her own life. But it also refers to the community and to the power of the individual within a group as part of a collective

vision of how society and politics should operate. Empowerment may thus be defined as "the process of acquiring power at an individual and collective level. In an individual or a community, it refers firstly to the capacity to act autonomously, as well as to the means and processes required to attain this capacity and to make choices in life and in society[174]."

> Women's empowerment has five components: women's sense of self-worth; their right to have and to determine choices; their right to have access to opportunities and resources; their right to have the power to control their own lives, both within and outside the home; and their ability to influence the direction of social change to create a more just social and economic order, nationally and internationally.
>
> **United Nations Population Information Network** (Popin), Guidelines on women's empowerment.

1 / REMINDER OF THE LINKS BETWEEN GENDER-BASED VIOLENCE AND **SOCIOECONOMIC ISSUES**

Victims of gender-related violence may have to face socioeconomic problems arising from the immediate or long-term consequences of a violent situation. These problems include:

174. Commission for women and development, L'approche de l'empowerment des femmes: un guide méthodologique, General Directorate of the Belgian Cooperative, June 2007.

- → Distancing – even separation – from a partner;
- → Loss of accommodation and the need to find somewhere to live – on an emergency, temporary or permanent basis;
- → Disruption of professional activities (with possible job loss) or of schooling;
- → Children's problems at school/disrupted education;
- → Lack/loss of financial means to pay for housing, food, care, etc.;
- → Family poverty;
- → Decline in parenting skills: neglect, abandonment, rejection, abuse – notably of children born as a result of rape;
- → Childcare problems;
- → Etc.

As has already been highlighted in this guide[175], aspects of an individual's social and economic background may encourage violent situations to develop, notably:

- → Poor level of education;
- → Isolation and lack of a circle of family and friends;
- → Low income/precarious financial situation;
- → Unemployment;
- → Wide disparity – educational and financial – between partners;
- → Etc.

> Poverty, unemployment and the lack of a future – felt all the more keenly when the country borders the European Union – are the factors which most explain trafficking in human beings.
>
> **MdM,** "Moldova – Trafficking in Human Beings", Journal des donateurs, September 2008.

175. For more information, see the section on the causes and consequences of violence on page 100.

The social and economic reintegration of victims of gender-related violence is severely constrained by the socioeconomic determinants that contribute both to the causes and the consequences of gender-related violence.

2 / ACTION TO HELP THE SOCIAL AND ECONOMIC REINTEGRATION OF VICTIMS OF GENDER-BASED VIOLENCE

1. Definitions

Social work consists of action taken to improve an individual's situation on a social, economic, psychological and cultural level. In more practical terms, it involves informing people of their benefits rights, as well as directing them towards support services.

> "Social work 'promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance general well-being […] social work intervenes at the points where people interact with their environments."
>
> Definition of social work adopted by the **General assembly of the International Federation of Social Workers,** Canada, July 2000.

Social and economic reintegration is a process that provides people with the necessary independence to reintegrate into society via social, economic or educational activities. It identifies and overcomes the weakness (of individuals) and the limitations (of the context) that

contribute to vulnerability, enabling people to enjoy their social and economic rights to the full[176].
The process thus involves working with the person who has experienced the violence to consider and identify possible solutions and available resources, whether within the social and family background of the victim (e.g. support of friends and family), or through civil society organisations and institutions.

2. Actions for social and economic reintegration

Any action must respond to the socioeconomic problems of the individual, help him/her regain a place and role in society, enable him/her to overcome exclusion and facilitate his/her independence.

As part of the process of socioeconomic reintegration, victims of gender-related violence may be supported in a number of different ways, such as:

→ Psychosocial support;
→ Education and professional training;
→ Help with developing income-generating activities;
→ Etc.

A distinction may be drawn between social work and economic reintegration. The former encompasses wider aspects of the life and environment of each individual, while the latter deals more specifically with options for professional/income-generating activities. They are often complementary, however, and form part of the same programme of support.

176. Social rehabilitation of victims of violence, Topic Sheet No.9, regional workshop on providing care and support to women victims of violence, Cairo (Egypt), MdM, September 2009.

> "It is important to start economic reintegration at the same time as psychosocial support, as it enables victims to offload their suffering. During workshops or training sessions, the girls can talk to each other and imagine their future. The worst thing for them is the stigma."
>
> Testimony of Neema, 26 years, psychosocial counsellor in Butembo, **MdM** press dossier "RDC: Rape becomes widespread in North Kivu", November 2009.

Psychosocial support

Social work can contribute to the psychological rehabilitation of individuals who have suffered violence. By encouraging and strengthening social and community ties, it has an impact on individuals' mental health. The family and the rest of the community play an important role in the ability of a victim to overcome his/her traumatic experience. Likewise, psychological counselling provides a way of ensuring that an individual's suffering no longer hinders social and economic reintegration.

> "Psychosocial support recognises the importance of the social context in addressing the psychological impact of stressful events experienced in emergencies. In practice, this means facilitating the reconstruction of local social structures (family, community groups, schools, etc.), which may have been destroyed or weakened by an emergency, so that they can give appropriate and effective support to those suffering severe stress related to their experiences."
>
> **S. Nicolai,** *Psychosocial needs of conflict-affected children and adolescents,* 2003.

"The term 'psychosocial' denotes the interconnection between psychological and social processes"[177]. **Psychosocial care** is used when those providing social support have been trained in the psychological counselling of victims of gender-related violence and fulfil a dual social/psychological role.

In Goma, (DRC), MdM works in close collaboration with local organisations involved in the psychosocial care of victims of sexual violence. MdM **reinforces the skills of psychosocial** counsellors, who are most often the first to encounter victims of sexual violence and who provide counselling and orientation.

On their return to their own country, victims of human trafficking, and especially of sexual exploitation, have to face the full impact of being stigmatised by their community. The MdM mobile team in Moldova, comprising a social worker and a psychologist, looks for ways to combat this ostracism, so that individuals may reintegrate into their communities.

"Sometimes their relatives think that their reputation has been damaged. […] We therefore work directly with families and neighbours to prepare for victims returning to their communities. We also support them in obtaining new papers, accommodation, medical follow-up, etc…as they get back to normal life one step at a time."

Testimony of Tatiana, social worker, **MdM,** Moldova, September 2008.

177. IASC Reference Group, *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Actors Know?,* Geneva, 2010.

Education and professional training

Literacy is a human right, a tool of personal empowerment and a factor in social and human development. Two thirds of people in the world who are illiterate are women.

"Literacy is crucial to the acquisition by every child, youth and adult of essential life skills that enable them to address the challenges they can face in life, and represents an essential step in basic education which is an indispensable means for effective participation in societies and economies of the twenty-first century."

UN General Assembly, Resolution A/RES/56/116 of 19th December, "United Nations Literacy Decade: education for all".

Access to literacy and education are important issues in the care of victims of gender-based violence, contributing to the rehabilitation of the individuals concerned. Indeed, a lack or poor level of education is a factor, often associated with the social precariousness of some victims, which increases vulnerability to gender-related violence. It may also act as an obstacle to care and support, limiting individuals' freedom of choice as regards the steps they can take.

"All residents shall be provided with opportunities to attend educational and vocational trainings. […] According to their age, each child residing with his/her mother in Dar-ul-Aman shall be awarded the opportunity to get educated and take part in collective socio-educative activities. Educated women from amongst the residents shall also be encouraged to teach other women and children."

Guidelines for the improvement of functioning of Dar-ul-Amans in the province established by Social Welfare, women development and Bait-Ul-Maal Department.

In addition to basic education, adults may benefit from **professional and vocational training,** enabling them to develop the means to earn a living. Such training also has a social element, as it offers the opportunity to construct a life plan and to gain a sense of one's own future. In other words, in addition to the financial aspect of these activities, they also help victims of violence reintegrate socially.

If finding work in Moldova is tricky for most people, the problem is all the more acute for those who have been exposed to trafficking. It takes time to overcome the psychological and physical trauma and to be ready to envisage restarting work. When the conditions are right, MdM directs service users towards the network of local job centres that can provide support and specific training programmes for the most vulnerable people.

MdM, Interim Operational Report on the international programme to combat violence against women, MAAIONG/AFD, September 2009.

"Since 2003, reintegration has involved 250 people out of the 1 016 cases that we've seen. The women have gone to one of the eight apprenticeship centres to be trained in the area of their choice – soap making, cooking, knitting, embroidery or agriculture. The youngest have been reintegrated into the school system and some have succeeded in obtaining their university diploma."

Testimony of Mambo Zawadi, from the **Sofepadi Association** in Beni (DRC), MdM press dossier "RDC: Rape becomes widespread in North Kivu", November 2009.

Income-generating activities

In many contexts, women have limited access to **income-generating activities.** They thus find themselves dependent on the earnings of their close families, particularly their husbands. When one of them is a victim of gender-based violence and dares to speak out, she often has to face being stigmatised by her family and community, making her already precarious situation even worse. Moreover, particularly in cases of conjugal violence, denouncing the perpetrator often means the woman is no longer able to access all or any of the family income, the family home, etc.

As part of a programme of multidisciplinary care, developing income-generating activities helps victims achieve **greater financial independence and increases their self-reliance and their participation in the household and the community.**

Between 2004 and 2008, the project entitled Working towards Safe Motherhood in South Asia: Combating gender-based violence during pregnancy in Nepal and Bangladesh was set up by the South Asia office of the International Planned Parenthood Federation (IPPF).

The income-generating element of the project has enabled a number of women to benefit from direct financial help in the form of loans and from skills acquisition and micro-business start-up support. Groups supporting victims of gender-related violence and community groups have also been established

to help prevent violence and to lead awareness-raising activities about the issue.

In 2008, several women benefited from a workshop during which they exchanged their experiences of and thoughts on the subject. Among them was a woman from Rupandehi in Nepal who recounted how she had received 5 000 rupees microcredit to set up her own business selling incense that has led to an average monthly income for her today of 5 000 rupees. She received this help via the Family Planning Association of Nepal (FPAN), which she approached following physical and mental abuse inflicted on her by her in-laws.

Another woman from Makawanpur in Nepal provided evidence of the link between financial independence and social empowerment. She received a loan of 6 000 rupees to pay for training as a car mechanic. Today she works in this trade alongside her husband, who was previously violent towards her. She assured the meeting that her partner no longer viewed her in the same way, notably as a result of her being able to contribute to the couple's earnings.

Lastly, a woman from Comilla in Bangladesh told how, following mental abuse and financial pressure from her in-laws, she turned to the Family Planning Association of Bangladesh (FPAB), which helped her get trained in fish farming. Now her husband works alongside her and they own their own ponds.

Microcredit initiatives involve allocating small loans to anyone who cannot obtain bank loans in the usual way. Microfinance often, and sometimes exclusively, targets women. "Of the poorest clients [benefiting from microfinance services], 83.4% are women[178]." According to Juan Somavia, Director-General of the International Labour Organisation, "microfinance services lead to women's empowerment by positively influencing women's decision-making power and enhancing their overall economic status".

In Nepal, women's life expectancy is lower than that of men. Maternal mortality rate is 7.4‰, while the neonatal mortality rate stands at 39‰, one of the highest in the world. The cost of transport and of giving birth in a health centre is too great for families to bear with the result that they often do without these services and thereby reduce women's access to healthcare.

Against this background, Médecins du Monde has set up an **innovative programme combining reproductive health and microcredit.** Women's groups have been established along the lines of cooperatives: the women manage the funds themselves, meaning they can release sums of money for getting to the health centre as and when required.

Médecins du Monde, press release – World Health Day, 7th April 2010.

It is important to remember that for income-generating activities, as for any humanitarian action, careful thought must be given to the general population concerned. Intervening to assist a specific group may discriminate against the rest of the population and make the problems of social reintegration of those using the service more acute.

It is also worth emphasising the particular effect microcredit activities aimed specifically at women may have. It is the

178. **Daley-Harris Sam,** *State of the Microcredit Summit Campaign Report,* 2009.

case that "although microcredit strengthens women's ability to stand up to family violence, in some cases it has increased violence against women and family break-ups[179]."

Studies have also shown that women sometimes have little or no control over their loans, with the husband or a male member of the family being the one who takes all the decisions[180]. Access to microcredit can also increase women's workload.

The issue of childcare has been approached as one of a range of initiatives aimed at women's financial independence. Some innovative solutions have been found to overcome the difficulties involved in being a mother at the same time as studying or earning a salary.

> "Three childcare centres have been set up by the project close to each of the literacy centres, so that those attending courses have no worries about collecting their children at the end of each learning session. There are 60 children looked after each day at the centres, each of which is staffed by two childcare workers."
>
> "Caritas et Banque Mondiale appuient la réinsertion socio-économique des ex-combattantes", **ReliefWeb,** RDC/Kalémie, 9th February 2010.

Temporary accommodation

While the issue of social and economic reintegration involves all victims of gender-related violence, it is of particular concern to those receiving support while resident in temporary accommodation.

179. **UNESCAP,** *Economic and Social Survey for Asia and the Pacific,* 2007.
180. **Goetz Anne-Marie and Sen Gupta Rina,** "Who takes credit? Gender, Power, and Control over Loan Use in Loan Programs in Rural Bangladesh", World Development, 1996.

ISSUES OF SOCIAL AND ECONOMIC REINTEGRATION RELATING TO TEMPORARY ACCOMMODATION

During a regional workshop organised by MdM in Nicaragua in November 2008, those taking part highlighted the importance of the following:

Risks/fears associated with temporary refuges:

→ Some victims of violence are afraid that their stay in such a centre will only lead to their exclusion from the community. They often dread the moment they have to leave the centre;
→ Many victims of violence are also worried about staying too long and having to give up their activities with the resulting loss of employment/income.

Criteria for selecting victims of violence for referral to temporary refuges include:

→ No possibility of being taken in by someone in their family or social circle;
→ Lack of financial resources of their own.

Preparation for/support on leaving the temporary refuge:

→ Put professional training in place at the refuge to help residents get/return to work and become financially independent on leaving;
→ Support residents' reintegration into home/family life;
→ Coordinate with other organisations for transport back home.

MdM's activities in Pakistan take place within government-run temporary refuges (*Dar-ul-Amans*) for women in distress and their children. Using a study carried out by students at the Department of Social Work at the University of the Punjab as

a starting point, consideration was given to the needs of residents and potential areas for social intervention. As a result of this study, a pathway to rehabilitation was drawn up for residents leaving the refuge.

PATHWAY TO SOCIAL REHABILITATION FOR VICTIMS OF VIOLENCE

- → Focus on protection and security of women
- → Bridge the gap between in/out or during/after DUA ("de-close" the institution while ensuring security, guarantee proper follow-up, involve family/community when possible)
- → Bridge the gap between DUA and "the rest of the world" i.e. insert DUA within a social protection system for women in distress: inter-coordination between government institutions/departments (police, court, etc.) and civil society (organizations, volunteers, etc.)
- → Open up women's range of possibilities / opportunities parting from their needs and abilities / skills and the feasibility of their personal project
- → Sensitize at family and grass-root levels, individually and collectively, to de-stigmatize DUA and women leaving those / advocate and raise public awareness at large

Maqbool Roohi, "Reintegration of victims of violence, particularly residents of the *Dar-ul-Amans,* based on their needs", regional workshop on providing care and support for women victims of violence, Cairo (Egypt), MdM, September 2009.

3H

OBSTACLES TO PROVIDING CARE AND SUPPORT

There are **numerous obstacles to providing care and support to victims of violence.**

Firstly, there are those linked with the victims themselves, who may hesitate to seek supportfor fear of being rebuffed or of possible reprisals, or simply because they are ashamed. Care and support facilities may also be difficult to access, particularly for financial or geographical reasons.

Other obstacles relate to care providers. According to a study into the negative experiences women have had with health professionals[181], many reported that they sensed the care provider was irritated, uninterested or sceptical, when they recounted their story. Health professionals were also criticised for only being interested in physical injuries and for referring patients to the police for any other complaint. These criticisms

181. IPPF, *Improving the Health Sector Response to Gender-Based Violence, a Resource Manual for Health Care Professionals in Developing Countries,* 2004.

expressed about consultations with health professionals could equally apply to those with any care provider.

1 / OBSTACLES RELATED TO VICTIMS

The **reluctance** of victims of violence to ask for support and to take steps to obtain care is **often linked to attitudes and behaviour of their immediate circle or their community** towards violence.

1. Fear of stigmatisation

Victims of gender-based violence frequently have to endure **being stigmatised** by their families and communities, **particularly when sexual violence is involved.** This may take the form of an engagement being broken off, a husband abandoning the marital home or being repudiated.

> "I was collecting firewood for my family when three armed men on camels came and surrounded me. They held me down, tied my hands and raped me one after the other. When I arrived home, I told my family what happened. They threw me out of our home and I had to build my own hut away from them. I was engaged to a man and I was so much looking forward to getting married. After I got raped, he did not want to marry me any more and broke off the engagement because he said that I was now disgraced and spoilt."
>
> Testimony of a young woman, 16 years old, West Darfur, in MSF report, *Shattered lives: Immediate medical care vital for victims of sexual violence,* March 2009.

Victims of violence may therefore be reluctant to present at a care centre or service because to do so may prompt those around them to ask questions. The risk of stigmatisation is all the greater where the service provider specialises in dealing with victims of violence and advertises the fact. Integrating such a service into a health centre can enable victims of violence to attend without fear of being stigmatised. In all cases, it is a matter of guaranteeing patients absolute confidentiality and ensuring that service providers do not stigmatise victims in their attitudes or speech.

2. Fear of reprisals

Victims who dare to break their silence often suffer **reprisals that are sometimes tolerated by national legislation.**

These reprisals can take different forms, such as:

→ **Renewed violence committed by the aggressor,** if the latter learns that the victim has talked to someone about the violence, including to a care provider. Fear of this type of reprisal is all the greater when the perpetrator of the violence is a close family member and someone known to the victim.

> "As most of rapes are committed by people known to the victims, proximity to the perpetrator generates fear of reprisal. According to 84% of victims interviewed in non-mobile health facilities, fear for their safety or that of their family prevented them from seeking health care."
>
> **MSF** report, *Shattered lives: Immediate medical care vital for sexual violence victims,* March 2009.

Pupils who are the victims of violence and sexual abuse at the hands of their teacher are often reluctant to report incidents as they fear the school will take no action and that they will be victims of reprisals carried out by their teacher.

Jones N., Moore K., Villar-Marquez E. with Broadbent E., Painful lessons: *The politics of preventing sexual violence and bullying at school,* ODI, London, October 2008.

→ Being charged and **punished** for a crime in countries where victims of gender-based violence may be seen as responsible for the violence they have suffered:

– In some countries, like Afghanistan and Pakistan, criminal law sometimes views rape as adultery on the part of married women and as sex outside marriage for those who are single. Women who have been raped therefore risk being condemned to be stoned to death, imprisoned or beaten if they speak out about the violence they have suffered.

– In other situations, such as in Somalia, traditional justice may impose marriage to the rapist.

In Somalia, a young woman reported to the militia that she had been raped by three men; she was then accused of adultery by an Islamic court, placed in detention and then stoned to death while not one of the three men who raped her was arrested.

Amnesty International, "Child of 13 stoned to death in Somalia", 31st October 2008.

3. Shame/blame

In many communities, **honour is not a personal concept:** each individual is responsible for the honour of his/her family and even community. For this reason, most people do not allow themselves to talk about the violence they have suffered, as, by doing so, they bring shame on themselves and on their families and communities. This situation is **exacerbated in cases of sexual violence,** as sexuality is a focus for numerous values and taboos that are both personal and social. Sexuality is part of a genuine social contract.

"Among those who had suffered sexual violence, 81% of women interviewed in mobile clinics and 95% in health centres and hospitals said that shame was the main reason they did not seek care."

MSF report, Shattered lives: Immediate medical care vital for sexual violence victims, March 2009.

"It is so shaming to be raped here that women just don't want to press charges. They are too scared. It's like a conspiracy that makes revealing a case of rape the worst possible thing."

Testimony of Anna Halford, MSF project coordinator in Masisi.
MSF report, Shattered lives: Immediate medical care vital for sexual violence victims, March 2009.

"I accepted things thinking that yes, I was to blame for it all. I was the idiot, the stupid person, the criminal: he, a highly intelligent, reasonable and cultivated person, was 'always right'. He was doing me an honour, giving me a gift, by being with me. I owed him everything."

Testimony gathered as part of the French government campaign to combat violence against women: "Lutte contre les violences faites aux femmes : grande cause nationale pour 2010."

4. Minimising the problem

Some people minimise situations of violence[182], seeing them as part of an ongoing pattern (childhood violence, domestic violence, harassment, etc.), or as part of a general background of violence (as is the case in so many conflicts for example): violence is thus trivialised and considered a fact of life by victims.

> "Ignorance about what sexual violence is and about its physical, psychological and social consequences contributes yet further to the trivialising of such crimes. When the victims are girls living in the streets, the indifference is even more marked and such violence continues to be perpetrated with impunity, increasing the girls' feeling of helplessness. The trivialising of this violence by the community, the authorities and the perpetrators means that the victims themselves come to view these acts as normal. Acts of violence are commonplace when one is a girl living in the streets."
>
> **MdM,** "La rue, c'est la chance?", Surveys of sexual exploitation and violence involving young girls in the streets of Kinshasa, 8th March 2009.

For others, **minimising the problem is a way of protecting themselves at psychological level:** they try to manage the impact of the violence and minimise the severity of the consequences. Therefore they may refuse to recall painful memories and may avoid anything that reminds them of the violence, as their main priority is to forget.

182. Josse E., "Déceler les violences sexuelles faites aux femmes", 2007.
183. For more information, see the section relating to the typology of gender-based violence on page 52.

5. Financial and geographical barriers to access

In addition to the obstacles associated with the ways violence is perceived and represented, **financial and geographical barriers severely hinder victims' access to care and support.** In many situations, there are few facilities able to meet the needs of individuals who have suffered gender-based violence. Those that do exist are centralised in large villages and cities and very often charge for their services.

Many victims of violence do not have sufficient means to attend these facilities and benefit from care and support, either because they are from poor socioeconomic backgrounds or because they are victims of economic violence[183] and cannot freely dispose of the household income.

Distance from care facilities is also an issue, as violence often results in physical and/or mental health problems that prevent victims from making long journeys. In situations of conflict, these difficulties are made worse by a state of insecurity that may restrict travel.

Where care and support options are limited or nonexistent, service providers may be reluctant to identify victims of violence, as they do not have the option of then referring them to other carers.

2 / OBSTACLES **RELATED TO CARE PROVIDERS'**

1. Prejudices

Care providers often share the prejudices of their communities towards violence and seek to justify such acts using arguments

that perpetuate stereotypes, such as men having uncontrollable sexual needs, young girls behaving in an ambivalent manner that is seen as provocative, or women acting inappropriately and thereby making their partners violent.

How care providers represent gender-based violence thus conditions their attitude towards the victims they support. Their own life experiences feed such prejudices and influence the care they dispense. This affects the quality of services offered to victims of violence and, in particular, has an impact on identifying victims in the first instance.

> In a study carried out in South Africa with male and female nurses working in public health, 11 of the 36 women interviewed said that they had suffered intimate partner sexual violence and 6 of the 8 men interviewed admitted that they had abused a partner. Both male and female nurses considered that violence against women was sometimes justified.
>
> **Kim J., Motsei M.,** "'Women enjoy punishment': attitudes and experiences of gender-based violence among PHC nurses in rural South Africa", Social Science & Medicine, 2002.

2. Excessive workloads

Workshops organised by MdM to exchange good practice brought together numerous professionals involved in responses to gender-based violence, who cited excessive workloads and lack of time as the most common obstacles to providing care and support for victims. This was a particular problem for those working in non-specialist facilities (such as hospitals and health centres dispensing primary care), who had difficulty in finding the time needed to listen to patients and to deal with a problem not often viewed as a priority or emergency (particularly in cases where the repercussions were 'only' psychological).

Excessive workloads are also a feature of emergency situations, when the number of patients increases considerably, limiting the time that can be spent with each. In such circumstances, injuries that are not immediately apparent or that are difficult to pinpoint are rarely seen as a priority.

3. Lack of training/awareness raising

Obstacles to responding to gender-based violence are also largely associated with a lack of awareness raising and training among service providers involved in providing care and support for victims. What is needed above all is for professionals to be made aware of and to take responsibility for these individuals.

In addition to being able to identify and care (or refer) victims of gender-based violence, improving the quality of intervention they are offered involves changing related attitudes and beliefs. Training and awareness raising on this subject is thus essential. **Such training must take account of the personal experiences and perceptions of the care providers** who may themselves have been confronted with violent situations, either as victims, witnesses or perpetrators.

4. Distress caused to those supporting victims of violence

Those providing care and support for victims of violence must listen and respond on a daily basis to human suffering. **This type of work calls on significant personal resources and increases the likelihood of emotional exhaustion and**

secondary trauma. Emotional exhaustion may be experienced as a loss of sensitivity, a tendency to minimise the problems recounted by patients, a refusal to listen to them attentively, etc. It may also manifest itself in psychosomatic troubles, recurring thoughts of work or testimonies heard, projection of this anxiety on to personal life, general irritability, loss of motivation as regards work (lateness, absences, etc.), frustration, etc.

Secondary trauma is "when meeting a traumatised person is in itself a traumatic event[184]." The care provider must therefore be able to maintain 'sufficient distance' from the individuals being cared and supported.

In addition, what a victim relates when confiding in a care provider may awaken emotionally charged memories in the latter, particularly where he/she has suffered or witnessed violence him/herself. The care provider must be able to listen to him/herself, be aware of what is happening inside, identify it and find the cause in order to deal with it appropriately[185].

What care providers suffer may thus hinder the dispensing of good quality care. This should be anticipated and mechanisms put in place to enable care providers to deal more effectively with their proximity to violent situations.

In the project developed by MdM in Goma (DRC), psychological support is offered to counsellors involved in a carer/victim relationship with individuals who have suffered sexual violence. Such relationships bring them face to face with difficult experiences undergone by others, but which may resonate with personal suffering that they themselves have experienced.

A psychologist is available for any counsellor wishing to discuss personal problems, whether associated or not with their dispensing of care and support for victims of sexual violence. In these sessions, counsellors may 'offload' and analyse the impact of the suffering heard and shared, as well as their own personal suffering, like any other mental health practitioner.

MdM, Interim operational report, International programme to fight gender-based violence, MAAIONG/AFD, September 2009.

Some recommendations can be put forward for ways of minimising the distress caused to care and support providers.

SOLUTIONS FOR PREVENTION AND RESPONSES TO DISTRESS OF CARE GIVERS

There are solutions for preventing and responding to distress amongst professionals, which can also help with post-traumatic resilience. The options are: **personal** or **organisational**. Generally speaking, these solutions can both prevent and cure.

Personal solutions

→ Personal reflection: stress management is based on our resilience. To overcome it, we can sometimes look to ourselves for help.
We must therefore learn to recognise the sources and signs of stress, to understand our own resources and coping

184. **Josse E.,** "Le traumatisme psychique : quelques repères notionnels", International journal of victimology, 2007.
185. Handbook "Santé mentale en lien avec les violences sexuelles et relation d'aide psychosociale", **MdM** Goma (DRC), 2008.

mechanisms and reflect on our relationship with death/violence, etc.

→ Social support: adopt a 'buddy system' (share your stress with one or more colleagues and ask them to tell you if they notice you behaving in an unusual 'stressed' way; make the most of support from family and friends.

→ Work-life balance: ensure you have a good balance in terms of physical activity (sport, nutrition, rest, etc.), on a psychological level (relaxation, hobbies and activities, making the most of weekends, etc.), family (making time to spend with family members), and on social (contact) and professional levels (working hours, networking). Know how to set boundaries between professional and private life.

→ Help: know how to ask for help, accept being helped, psychotherapy, etc.

→ Training: tools, reading, seminars, etc.

→ 'Political' engagement (particularly getting involved in other organisations or causes).

Organisational solutions

→ Manager's role: organising team building activities and stress management exercises (short breaks for staff), communication, management style, mutual support between colleagues, identifying stressed colleagues.

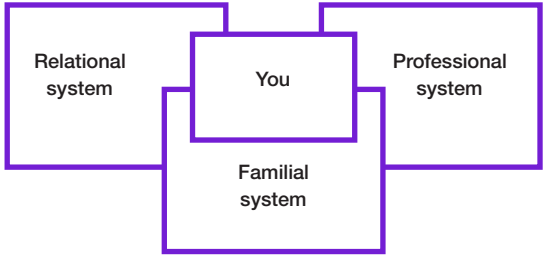
→ Work management: effective management of working hours/implementing a balanced timetable (breaks during the day), don't limit yourself to one problem (alternating care of victims with other tasks), work in a network and create a formal space for discussion. Recruit sufficient numbers of staff.

→ Detecting signs of stress (occupational health).

→ Follow up and support for care profesionnals:

– Peer to peer sessions;
– Supervision sessions;
– Implementing debriefing and relaxation sessions;
– Coaching and training;
– Recourse to specialists (lawyers, psychologists, etc.) who can help care givers.

If these measures do not appear sufficient, you may need to turn to a therapist or meet your managers or human resources service to find solutions and help reframe the situation.



MdM – Regional workshop on providing care and support for women victims of violence. Middle East, 27th September-1st October 2009.
Paper produced by Josse Evelyne, clinical psychologist.

Whether linked to victims of violence or to care providers, these different obstacles to providing good quality care and support must be taken into account upstream when devising initiatives to prevent and respond to gender-related violence.

4 PREVENTATIVE AWARENESS RAISING AND ADVOCACY ACTIVITIES

PREVENTATIVE, AWARENESS RAISING AND ADVOCACY ACTIVITIES

4A

PREVENTIVE ACTIONS: SOME ILLUSTRATIONS

Combating gender-based violence involves taking preventive actions alongside and upstream from caring for the victims. Those preventive actions should be intended to have an impact on the behaviour of individuals and communities as regards gender-related violence, caring for victims, respect for human rights and gender relationships within society.

Any such action must take account of the complexity and diversity of causes of violence, as well as the scope of their consequences, the objective being to bring about a change in the way populations think about and represent the issue. Talking and communicating about the subject may therefore be as tricky and as taboo as the issue itself.

"I didn't know that the way my dad treated me was violent, I just thought it was normal…"

Testimony gathered during an information day organised by MdM on the subject of sexual and reproductive health (also dealing with the issue of violence) at a centre for teenagers in Peru.

The strategies deployed must be adapted to how any given context is represented, to its practices and its environment (the latter in its widest sense, i.e. geographical, social, economic, political, etc.), so that the messages conveyed make sense within the culture of the target group. To reach a wider section of the population and to get round certain taboos, the issue of gender-based violence may be approached as part of a series of awareness-raising activities on wider themes. This 'gateway', often afforded by the medical context, allows for more open discussion and for what is said to be more readily accepted.

In Cairo, Médecins du Monde is organising activities to raise awareness of the health problems of street children, and young girls in particular. These activities deal in a general way with primary health, reproductive health and mental health. During interactive sessions, the subject of violence suffered by women is broached and discussed in a lateral manner. Violence (notably sexual violence, injuries, mental trauma and conjugal violence) is often to be found at the heart of discussions with women's groups.

MdM, Interim operational report, International programme to fight gender-based violence, MAAIONG/AFD, September 2009.

Preventative action is addressed at anyone who is a potential victim or perpetrator, as well as anyone likely to encounter a victim of violence, whether or not he/she is a care provider.

PREVENTION: RAISING AWARENESS AND INFORMING

Preventative action must:
→ **Raise awareness of the issue** of gender and the violence associated with it and enhance understanding and knowledge of the issue;
→ **Provide information on existing care providers** whom victims can approach.

1 / DIFFERENT LEVELS OF PREVENTION

There are three distinct levels of prevention[186]:

→ **Primary prevention:** a range of activities aimed at preventing violence before it arises, e.g. raising awareness of peaceful conflict resolution and of human rights in schools, communities, etc.

→ **Secondary prevention:** measures implemented to reduce the short-term consequences of an existing violent situation, e.g. raising awareness of the importance of receiving treatment within 72 hours after a rape and of hospital treatment, emergency accommodation, etc.

186. Manuel sur la prise en charge pluridisciplinaire et intégrée des victimes de violences, MdM, Haïti, 2008.

→ **Tertiary prevention:** initiatives taken to minimise the long-term consequences of violence, e.g. therapeutic follow-up, social follow-up, support groups, etc.

These are complementary levels of protection, even though they apply at different points in time: primary prevention takes place before a potential act of violence happens, secondary prevention a short time after such an act and tertiary prevention may be implemented over the long term. Prevention must therefore stop violence arising, but also minimise its consequences for the individual and his/her immediate circle, as the impact violence has often encourages its repetition.

Example: A victim of violence may have difficulty meeting the material needs of his/her family. This situation may force his/her children to fend for themselves. In some situations, children may even find themselves on the streets with the risk of becoming victims or perpetrators of violence themselves.

2 / DIFFERENT FORMS OF PREVENTATIVE ACTIONS

Preventative action, whatever form it takes, must be adapted to suit the environment where it is deployed, the public targeted and the message(s) it hopes to deliver. A message is only as effective as the tools it relies on, and the quality and relevance of the latter depend on whether or not the sociocultural determinants of the community targeted have been taken into account when the tools were devised.

1. Mass awareness-raising campaigns

Gender-related violence is a phenomenon that affects every society every social background and every sphere of life – both private and public. As a result, everyone is concerned with this issue and may one day have to confront it. For this reason, certain awareness-raising campaigns must address the population as a whole. It is equally important for information to be distributed as widely as possible, detailing the steps individuals need to take and the services they need to approach.

For information to be distributed effectively, **the places and times for organising campaigns must be carefully chosen to enable as high a proportion of the population** as possible to be reached, for example by using marches, public transport, community events, etc.

Demonstration in Peru during the International Day to Eliminate Violence against Women in which MdM took part on 25th November 2009.

Q&A session organised by a psychosocial counsellor during an awareness-raising day on sexual violence, Kituku market, Goma, July 2008.

In Liberia, mass awareness-raising campaigns are organised in schools, markets and clinics. The topics deal with cover the causes and risk factors of violence and the typology of violence (i.e. definition of rape, forced prostitution, sexual exploitation and excision). In 2009, 6 800 people attended these information sessions.

The media can also provide a particularly effective vehicle for transmitting information on a large scale.

Radio

In Haiti, Médecins du Monde organised an awareness-raising campaign on conjugal violence, sexual assault and child abuse. A joint campaign was set up involving more than 20 radio stations, 6 of them national, chosen on the basis of several criteria – listening figures, type of audience, type of station (i.e. public information, entertainment, etc.), in order to reach a wide cross-section of the population[187].

Television

In Goma, in the Democratic Republic of Congo, MdM has made particular use of television as a means of targeting a section of the public independently of its geographical location and its level of involvement in and knowledge of the fight against sexual violence. Three-minute spots were used to raise the population's awareness of the importance of multidisciplinary care and to develop their understanding of the consequences of sexual violence on the mental health and well-being of individuals and the community as a whole.

187. Final report of seminar organised by **Médecins du Monde** in partnership with the organisation **Sosyete d'Animasyon Kominikasyon Sosyal,** from 24th to 28th March 2008, aimed at radio journalists, Haiti.

Print media

In 2008, following a press tour of Moldova where MdM was developing a programme to combat human trafficking, *Le Parisien* devoted a special report to this issue in the country, and the daily newspaper, *L'Actu,* produced a special edition on it.

As part of MdM's project in Algeria, awareness-raising was carried out using monthly inserts in different Arab and French newspapers. The information given out was aimed mainly at advertising the existence of a 'listening and support service' run by the Wassila network[188]. This anonymous, free helpline is intended for women who may potentially suffer violence, a total of 3 664 400 women and girls in 1998 in the ten *wilayas*[189] around Algiers.

In Moldova, **a mass media campaign** was launched in January 2008. It involved organising a monthly television or radio broadcast alongside publication of an article in the regional press about trafficking and the risks associated with emigration. The campaign was called "Who will break the trafficking chain, if not you?".

It is recommended, however, that great care be taken when broadcasting information about the existence of places where victims of violence may be supported, to avoid adding to the stigma that some places, and the people who go there, may already suffer. Alongside their mission to inform, these campaigns must also seek to combat a community's prejudices towards care and support centres.

188. Network of professionals providing care and support for women victims of violence in Algeria.
189. Territorial division.

In Pakistan, temporary refuges for women in distress (*Dar-ul-Amans*) and their residents suffer a considerable stigma.

An awareness-raising campaign was organised aimed at women victims of violence and the population in general. This initiative was prompted by a request from the Ministry of Social Affairs to MdM in response to difficulties encountered in promoting the recently established *Dar-ul-Amans.* The campaign was publicised via the distribution of 17 000 leaflets and the displaying of 4 hoardings at strategic locations – courts, police stations, hospitals, etc.

MdM, Interim operational report, International programme to fight gender-based violence, MAAIONG/AFD, September 2009.

2. Involving specific groups

Action to raise awareness can be addressed **at specific individuals or groups who are at particular risk** of confronting violent situations.

Awareness-raising sessions on human trafficking are organised for teenagers aged between 13 and 17 years. The sessions are held in secondary schools and specialist institutions in the region where MdM is involved. According to a study by Unicef[190], almost a third of Moldovan children under the age of 15 have at least one parent who has emigrated, a situation that makes these children particularly vulnerable to trafficking.

MdM, Interim operational report, International programme to fight gender-based violence, MAAIONG/AFD, September 2009.

This type of action may also concern those seen as agents of social change, by involving them either as a target group or as facilitators. The message will be more readily conveyed as a result of their influential position within a community. Particular attention must, however, be paid to which individuals are chosen from within a community to be targets for and conveyers of awareness-raising messages. Some people may be more authoritative than others in terms of their credibility, legitimacy, etc.

In July 2008, as part of the project set up by MdM in Goma, a conference/debate was organised entitled "The psychological fallout of violence at individual and community level: What solutions can be applied?". Those who took part in this event were people involved in combating gender-related violence and who had the power to bring about change in civil and political provincial society. Among others, they included those working for organisations fighting sexual violence, military leaders, representatives of the political and administrative hierarchy, religious leaders and those in charge of education.
The conference provided an opportunity to discuss and consider the involvement of these stakeholders in psychosocial initiatives. Following discussion, recommendations were drawn up and subsequently submitted to the provincial authorities.

MdM, Interim operational report, International programme to fight gender-based violence, MAAIONG/AFD, September 2009.

Influential individuals should be encouraged to commit themselves to preventive action initiatives. A real advantage can be gained by developing their role as agents of awareness

190. Unicef, *The impact of migration on children in Moldova,* October 2008.

raising and thereby increasing the impact of the preventative action. Their involvement also makes it easier to adapt the message to the real life situations of the people targeted. It could therefore be seen as essential to train such stakeholders on the issues surrounding gender-based violence.
Such training must take account of how the stakeholders themselves perceive and conceive of violence, so that they are able to deliver a consistent message. In addition, training ought to be about increasing their skills relating to group management, facilitator techniques, tools and support materials and an interactive/educational approach.

Involving men

As it is mainly men who are responsible for acts of gender-related violence, it is crucial to involve them fully in any awareness-raising action. Despite this, men have for a long time played little part either as a target group or as vehicles for raising awareness.

Moreover, men can be victims of assault too and so it is important that they are made aware and informed of the issue as well, so that they know where to go and who to call on for help.

The Association of men against violence in Nicaragua has, since 2000, brought together a group of **men committed to combating gender-related violence.** Supported by MdM, the association leads awareness-raising activities aimed at men to promote and protect women's rights in Puerto Cabezas where the project is based. A particular feature of their activities is that they are based on the personal experience of the members: each is committed to making life changes that will improve relationships with women.

Juan Jiménez Vaquez, "Promoting non-violent behaviour as a new form of masculinity", regional workshop on providing care and support for women victims of violence, Nicaragua, MdM, November 2008.

Peer-to-peer approach

A peer-to-peer approach may be used as a way of making specific groups key players in awareness-raising. An individual with whom the target group can identify should thus relay the message. This enables a relationship of trust to be built up between the target group and the care provider, and helps remove taboos associated with the issue.

In Peru, MdM is training teenagers who, in turn, raise awareness among other teenagers:

Training peer promoters is intended to reinforce their facilitator skills and to tackle subjects such as sexual and reproductive health and also the issue of violence. These promoters in turn organise awareness-raising sessions in youth centres and schools, targeting other teenagers at the same time. The latter will then be trained themselves to raise awareness among their friends. The promoters also take part in local radio shows for teenagers.
This type of activity is a much more effective form of prevention, as the message is conveyed to teenagers by someone they know, who is culturally and sociologically close to them. This preventive action also enables members of the community to be fully involved, so that they will be able to continue the work without support in the future.

MdM, Interim operational report, International programme to fight gender-based violence, MAAIONG/AFD, September 2009.

3 / DIFFERENTS AWARENESS-RAISING MATERIALS

Certain tools and materials aimed at a wide public, such as films, posters and radio spots, can be used to ensure that awareness-raising activities are a success. Information can also be conveyed on an individual basis by distributing leaflets, booklets, etc.
As part of the programme set up in Port-au-Prince, Haiti, MdM has created an **awareness-raising toolkit** containing a wide range of materials aimed at community outreach workers.

CONTENTS OF THE AWARENESS-RAISING TOOLKIT

Project to combat violence in Haïti (2009)

1. The **films** 'Nou Bouke' on conjugal violence and 'Fok Nou Pale' on sexual violence provide a basis for discussion of these forms of violence and are accompanied by two facilitator handbooks.

2. **Laminated posters/drawings** on conjugal violence provide materials for discussion of this topic.

3. **Leaflets:**
"72 hours to respond to rape" and "A medical certificate is a legal requirement – Demand yours"

Leaflet produced by the Ministry for Women's Affairs and Women's Rights with the support of UNICEF, November 2004.

4. **T-shirts** for community outreach workers.

"*nou lite kont tout kalite vyolans*":
"We are fighting all forms of violence".

"*Kadejak Se pwason vyolan pou yon sosyete. Fok nou pale.*":
"Rape is a violent poison for society: we must talk about it."

5. **Awareness-raising booklets:**
On sexual assault, child abuse and domestic violence.

Booklets written by **Robert Congo Noel,** social worker, legal adviser, trainer and head of community awareness-raising for MdM, Haiti.
With the collaboration of **Marguie Moreau,** social worker and trainer with the MdM awareness-raising team.

Handing out awareness-raising booklets means that those taking part in training sessions can take away printed materials about what was discussed. They can then refer back to these if need be, or can pass them on to someone concerned with the issue. Simply distributing the booklets is not recommended, as it is not considered to be an effective way of raising awareness, given that only those directly affected as victims of violence are likely to be interested in the subject of their own accord, and may even raise questions that there will no one competent around to answer. Distributing booklets must therefore go hand in hand with an activity to raise awareness of gender-related violence.

4 / TAKING ACCOUNT OF **SOCIO-CULTURAL DETERMINANTS**

Tools for preventative action must be based on an accurate understanding of the socio-cultural representations and characteristics of the target population. This ensures that the message will suit the context, will make sense to the public, will be better understood and will be less likely to shock.

The two principal means of conveying a message are the image and the written or spoken word. Both are highly codified in relation to a culture and society. Words, photos, objects, places and gestures are all signs that convey information and draw on all aspects of the culture and life of a society. **In messages, the presence of an object, the characteristics of a place and the gesture of a figure transmit a meaning that sometimes goes beyond the usage of the object.** Depicting a syringe may signify therapeutic treatment, such as a vaccine, but may also indicate risk behaviour, for example injecting with heroin. Questions must therefore be asked about the significance given to the terms and signs used, based on consideration of the social and cultural background in which they appear.

"In Burkina Faso, as in a large number of French-speaking African countries, the most frequently used formula for conveying messages to combat AIDS is presented in the form of an alternative – 'faithfulness or condom'.
The second option causes no confusion as it refers to a material object (a contraceptive device), but what about the significance of the word 'faithfulness' [i.e. 'fidélité' for French speakers] for those whom such a message addresses? […] The message directs individuals to adopt specific sexual behaviour that is apparently self-explanatory, as no precise details are given. […] Observing how young adults live their lives […] raises the following questions: What significance do they attach to the term faithfulness? What place does this concept hold for them among all the standards and values governing relationships between men and women in the area of sexuality? What influence might this message be expected to have on young people?"

Taverne B., Moral values and prevention strategy: 'faithfulness' as a weapon against AIDS in Burkina Faso, 1996.

Creating strategies and mechanisms for raising awareness thus demands a precise grasp of the meanings and codes accorded by a culture, and some recommendations may be offered here.

TAKING ACCOUNT OF SOCIOCULTURAL DETERMINANTS WHEN DEVISING TOOLS FOR RAISING AWARENESS OF THE ISSUE OF GENDER-RELATED VIOLENCE

MdM – Regional workshop on providing care and support to women victims of violence, Middle East – 27th September, 1st October 2009.
Document produced by Bouchon Magali, anthropologist, S2AP, MdM.

Using the written word

→ The message must be as clear and informative as possible.
→ How people communicate verbally must be known – language, levels of education and understanding, ways of addressing people, etc.

Note: The written word remains a source of discrimination.

The left-hand example, in contrast to the one on the right, does not appear particularly appropriate for use with the general public. Not everyone might understand or agree with an argument based on the idea that violence against women is a 'public health problem'.

Source: WHO, Department of Gender, Women and Health, 2007.

Source: French Ministry of Work, Social Cohesion and the Civil service, 2007.

For further examples on awareness-raising posters and for more information, see www.MdM-scd.org

Representations of violence: Using "clichés"

→ The messages are more accessible and comprehensible but do not always reflect the complexity of violence – cycle of violence, psychological violence, etc.

→ Manipulating the image (use of Photoshop, models, colours, etc.) means there is a risk that the reality of the problem will be lost.

The example on the left, in contrast to the one on the right, does not seem to fit with the realities of violence; violence is depicted in a 'fictional' almost 'appealing' manner (the same representational codes may be used in adverts or films).

Source (left) : ACT Celebrity Campaign.
Reproduced with the kind permission of the UK national charity, Women's Aid, www.womensaid.org.uk.

Indirectly representing violence: metaphor and metonymy

→ These methods make it possible to convey ideas that are impossible to depict – a plastic bag over a woman's face can suggest the feelings of suffocation she gets in the family home; psychological abuse can be represented by a clenched fist, threatening a woman and coming out of the mouth of a man, etc.

→ These may, however, be less well understood, as they require a good grasp of cultural codes.

From the example on the left, it may be deduced that the message is about the relationship between a couple (the reference to an engagement ring), but it is difficult to grasp the meaning of the message with any certainty.
The example on the right is more appropriate, using the metaphors of a rose to represent the female sex and of sewing to represent infibulation, when often propriety prevents this form of violence from being depicted.

Note:
– The message may be ambiguous and must be adapted to cultural representations.
– The image alone is not enough: information must be conveyed (i.e. requires text).

Using codes and signals

→ It is important to know whether codes are already used/present in the cultural context and environment (road signs for example), and are thus noticed and understood by the population.

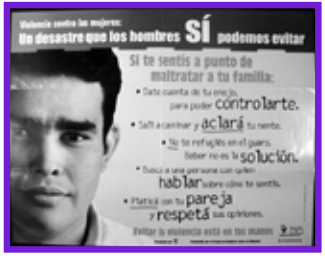
→ This requires an accurate understanding of the meaning given to signals and codes by the population – e.g. does a cross signify approval or prohibition? Is the symbol representing the female gender meaningful or incomprehensible?

Role of the messenger

→ Some basic questions must be asked to ensure the credibility of the message: Who is saying it? Who is best placed to speak about it? On the basis of what knowledge does the messenger claim to be speaking (experience, right, etc.)? From what position is he/she speaking? From that of common sense? Experience? How do people address one another in a particular society? What are the most appropriate forms of address?

→ Look for cultural and social proximity – gender, age, etc. – to adapt messages to the reality of the target group's lives.

Example: When addressing men



Copyright@2006**MenCanStopRape.**
Photography by Lotte Hansen.
Source: Puntos de Encuentro Association

→ Ask questions about the influence that individuals might have, whether or not they are seen as knowledgeable or intelligent, whether they have special status, etc., and whether they exert any influence socially (imitation, conformity, obliging behaviour, obedience, persuasion, etc.).

"But who is she to give advice?"

Participant at the regional workshop on responses to violence against women, Cairo (Egypt), MdM, September 2009.

"In Haiti, it's very rude to speak to people without looking them in the eye and even more so with your back turned!!!"

"Who is that young man to give advice?"

Participants at the regional workshop organised in Managua (Nicaragua), MdM, November 2008.
Source: Campaign to combat violence against women, 2004-2006, Seine Saint-Denis (France).

Role of coercive messages: The consequences of acts of violence

→ Avoid bald commands without offering solutions or explanations: give information on the consequences (health, mortality, prison, etc.) accompanied by alternatives.

Atmosphere of fear

→ Catches the attention: show the unacceptable, evoke fear and appeal to sense of solidarity.

→ But only acknowledge the climax of violence – cinematographic, unreal depiction of victims and abusers.

Depicting victims facing up to abuse

→ Encouraging victims to act can be reversed, however, depicting the victim's response as an 'act of heroism', something that not everyone can attempt.

Role of religion

→ Religion undoubtedly has an influence on the way men and women are represented in a society.

→ It can also be used as a means of dissuading individuals from committing acts of gender-related violence.

4B

ADVOCACY STRATEGIES AND ACTIONS

The fight against gender-based violence encounters numerous obstacles, often enshrined in law. Access to a medical certificate or pregnancy termination, or the socioeconomic situation of women are just some of the many issues on which the quality and impact of providing care and support for victims of violence may depend. In the majority of cases, these obstacles cannot be removed without a change in policy and the legal framework that advocacy alone can influence.

1 / DEFINITION OF ADVOCACY

To care for and bear mandate are Médecins du Monde's self-declared primary missions. Bearing witness, while essential, is not the same as advocacy.
Thus, bearing witness is part of a specific, fact-based initiative, aimed at describing a situation or draw attention to an issue, but is not primarily aimed at bringing about change (even if it makes an indirect contribution to such a goal). Most often, bearing witness serves to raise awareness among the general public of a situation or issue[191], but it could equally serve as part of an advocacy strategy or in the framework of legal decisions (during a trial prepared by the International Criminal Court, for example).

Advocacy, on the other hand, involves implementing pro-active strategies of influence brought to bear on decision-makers so as to force the roll out of concrete solutions to an identified problem.

As caring and bearing witness are not always enough, it may sometimes be necessary to strengthen MdM's capacity to influence policymakers in order to achieve long-term change: this is the purpose of advocacy.

Thus, Médecins du Monde defines advocacy as "The activity that consists of using a number of different channels to influence the decision-making bodies. It aims to bring about long-lasting change in policies and practices having a direct impact on the health of population groups targeted by Médecins du Monde's missions[192]."

Long-term change may mainly be directed at the following:

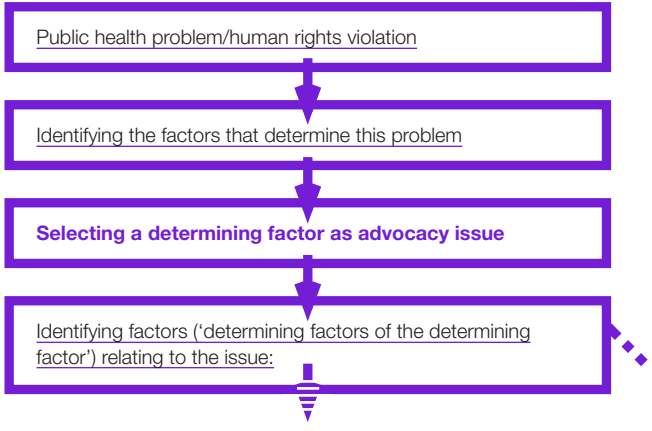
- → Adoption of new policies enabling the health of populations to be improved;
- → Respect for existing policies or statutory regulations not currently enforced; or, conversely,
- → Questioning of policies or practices judged by MdM as contrary to the interests of the populations concerned.

191. For more information see insert relating to protecting people at risk where involved in communication activities on page 233.
192. MdM Board of Directors, November 2007.

2 / SELECTING AN ADVOCACY ISSUE AND FORMULATING OBJECTIVES

The general aim of advocacy is to achieve change as part of a long-term strategy (10-20 years) that is thus not attainable during the lifetime of a project.
It must be framed as several specific objectives to make it easier to implement related activities. These are short-term objectives that are concerned with each particular element of the change that is sought and that set out clearly who can achieve the change, how it can be achieved and over what period of time.

General and specific objectives of the advocacy action must be determined **in relation to the public health problem/human rights violation targeted by the project.**



Starting with the public health problem/human rights violation targeted by the MdM project (e.g. morbidity linked to HIV/Aids, gender based violence, malaria, mother and child mortality, etc.), a list is drawn up of the factors determining/causing this problem from which one is selected for action.

The choice of factor determines the issue of the advocacy. This choice must be made on the basis of prioritising criteria, such as availability of funding and equipment, MdM added value or the presence/absence of potential partners, etc.

Once the advocacy issue is selected, the next step is an analysis of the background to the issue to **identify in greater detail the principal issues (determining factors of the determining factor) that arise in terms of change.** Once again, prioritising criteria must apply (issue(s) that allow the most significant advances to be made, advocacy activity/activities likely to have the greatest impact, windows of opportunity afforded by national and/or international policies and agendas, etc.).

The next stage involves **formulating the general aim to be argued for and the specific objectives to be achieved. Lastly, it is time to embark on a schedule of activities** and to implement the advocacy initiative.

ILLUSTRATION: GUARANTEE VICTIMS OF GBV DIRECT ACCESS TO A PROPER MEDICAL CERTIFICATE

Public health problem/human rights violation

Mortality and morbidity resulting from gender based violence

Determining factors (background analysis)

→ Lack of care and support services;
→ Limited access to proper medical certificate;
→ Perceptions surrounding gender based violence;
→ Stigmatising victims of gender based violence.

Selecting determining factor among those identified

→ Limited access to proper medical certificate.

Issues linked to determining factor selected

→ Insufficient numbers of staff qualified to issue a medical certificate;
→ Insufficient staff trained and aware of the issue;
→ Lack of information available to victims on their right to obtain a medical certificate;
→ Fees charged for medical certificates.

General aim:

→ To guarantee victims of GBV direct access to a proper medical certificate.

Specific objectives:

→ Within one year, the Ministry of Education will incorporate training sessions on how to draw up a medical certificate into doctors' formal education;
→ Within two years, midwives will be authorised by the Ministry of Justice to issue medical certificates in cases of GBV.

Activities:

→ Meetings with Ministries of Education and Health;
→ Sessions to formalise the content of the medical training curriculum with those involved ;
→ Sessions to draw up a standard medical certificate;
→ Regular meetings with civil society partners involved in the advocacy initiative;
→ Produce a report concerning the legal value of a medical certificate and give evidence of the obstacles encountered by victims of violence when pressing charges.

Advocacy is not therefore pursued independently but is an integral part of programme planning: **it is one of a range of different ways of intervening when confronted by an identified public health problem/human rights violation** in a given context, alongside healthcare interventions, developing community campaigns, improving living conditions, etc. During the project's analysis phase, it is therefore essential to incorporate advocacy as a possible option and to think of different strategies for its implementation.

3 / IMPLEMENTING AN ADVOCACY INITIATIVE

To achieve a set of fixed objectives requires the use of strategies to proactively influence decision-makers and to encourage real solutions to be applied to the problem identified.

Firstly, the background to decision-making must be analysed:

Who are the parties concerned?

List the stakeholders, level of involvement and position (pro, neutral or anti).

Who is the advocacy targeting?

Identify the individuals who need to be influenced: decision-makers who are directly responsible for approving the desired policy change, but also individuals or groups with power to influence decision-makers.

In Guatemala in 2007, MdM launched an advocacy initiative in favour of access to healthcare for women working in the *maquilas* textile and food processing aimed at various stakeholders:

→ **Local and national bodies responsible for preventing conflict in the *maquilas*:** Supporting and strengthening civil society representation on these bodies to facilitate a commitment in the medium term to concrete action in favour of the women.
Four workshops have already been organised within the local body for representatives of NGOs to improve care and support for women working in the maquilas.

→ **The Guatemala Institute of Social Security (IGSS).**
By collecting information on the social and medical situation of women workers and by holding consultations at maquilas, MdM is in a position to inform the IGSS and raise awareness of issues, as well as press it to become more involved in identifying those maquilas who make no employee contributions to the IGSS.

→ **Decision-makers within the *maquilas*** who accept the organising by MdM of medical consultations in their factories.

→ **Local Economic Development Centre (Ceadel),**
a local organisation supporting women workers.
This association is very active in monitoring and running the local body responsible for conflict prevention.
As part of its strategy, MdM supports this association in putting pressure as a group (all participants) and individually (by organisation and area of work) on the national body. The latter is able to bring about amendments at a government level relating to workers' rights (via the National Assembly of Guatemala) and the practices of the maquilas.

→ **The Redicam network** (Red Integral de Centros de Atención para las Mujeres Maltratadas) holds meetings once a month. A social worker and coordinator from the MdM team take part. The meetings provide an opportunity to inform members of the latest network events and activities. Workshops are also organised during the meetings on different topics, such as analysing the experiences of women, who have suffered intrafamily violence, of care facilities or public ministry and forensic authority involvement in dealing with violence against women.

→ **The victims of violence network:** Trained by different government and civil society institutions, the Catholic church and MdM since July 2008.

MdM, Interim operational report,
International programme to fight gender-based violence,
MAAIONG/AFD, September 2009.

The message must present the change sought in a concise and persuasive manner, highlighting:

- → The aim;
- → The why;
- → The how;
- → Suggested action(s) that need to be taken by the person receiving the message.

The message must be repeatedly conveyed but, no matter how many times it is communicated, it must retain the same content and essential meaning. How and by whom the message is conveyed will vary depending on the person addressed.

Different types of leverage/actions may be employed to get the message across:

- → Lobbying (directly influencing those targeted)
- → Media
- → Alliances/partnerships
- → Mobilising the population
- → Research/expertise

1. Lobbying

Lobbying is the classic advocacy activity. It involves entering into direct contact with the targeted decision-makers to establish a genuine platform for exchange and dialogue. This communication provides an opportunity to set out and convince decision-makers of the changes hoped for. Efforts should then be made to maintain regular contact.

Other lobbying activities involve:

- → Sending letters to identified targets;
- → Signing petitions addressed to identified targets;
- → Calling targets to account through speaking up in conferences, symposiums, seminars;
- → Participating in government/NGO consultation processes;
- → Maintaining an active presence on official platforms for dialogue between public authorities and civil society, where such exist;
- → Joining ministerial working groups.

2. Media

A 'media strategy', where it is part of an advocacy initiative, generally fulfils **two functions:**

- → To back up lobbying efforts, for example on the eve of major meetings (via opinion columns, press inserts destined for decision-makers, etc.);
- → To raise the profile of the cause being supported: by informing the public and raising public awareness and publicising the arguments in favour of change.

The type of media used and the way the message is conveyed will vary depending on the advocacy strategy adopted and who the message is directed at. When it involves pressing for a decision to be taken at a specific event, one option is to use the specialist press (opinion columns and inserts) as a vehicle for communicating with decision-makers. If the action taken is likely to involve confrontation with the authorities, the use of community radios may be appropriate for raising public awareness.

Consideration of these various aspects can ensure an action is relevant. Lastly, for 'media strategies' to work, it is essential to develop relationships with journalists that are as personalised as possible.

3. Forming alliances/partnerships

Forming partnerships is helpful for supporting advocacy, as a collective step which can lend more weight to the message and show that the defended cause garners wide support.

Moreover, as MdM projects do not last indefinitely, building alliances is crucial for ensuring that advocacy efforts continue after MdM's withdrawal (exit strategy).

Partnerships may involve different numbers of stakeholders, such as other local and international NGOs, universities and, more rarely, institutions.

4. Popular mobilisation

Despite the fairness of the cause and the efforts made in terms of lobbying and media campaigns, we often run up against rigid positions within political circles. One option in the face of political resistance is to mobilise public opinion through social awareness campaigns. It is important, however, to take account of the national context: such leverage should only be used where there is a stable democracy in place in which public opinion can bear some real weight on decision makers.

Mobilising the population can be done via:

- → Petitions and handing over petitions to the targeted decision-maker in the presence of the media;
- → Web-based actions (online petitions, interactive blogs, etc.);
- → Public rallies and demonstrations (e.g. 'shoe pyramids', marches, etc.);
- → Letters addressed to locally and nationally elected representatives;
- → Use of a distinctive campaign symbol prominently displayed (red ribbon, white bracelet, etc.).

These activities are often linked to media initiatives to achieve as high a profile and as wide an impact as possible.

5. Research/expertise

Advocacy action is legitimised by arguments based on information gathered in the field. This information must be regularly updated. It may come from research (data collection, country case studies or action-research) and/or field expertise. The information helps build the legitimacy of MdM as a reliable, objective and relevant negotiator in the eyes of the public authorities and decision-makers. The solutions put forward as part of the advocacy action must conform with findings in the field.

As part of the programme developed in Guatemala, one of the objectives has been to promote the right of women working in the maquilas to healthcare across the continent. Between 2006 and 2009, **MdM carried out a survey of these women to find out more about their working conditions, their health, and their difficulties in gaining their rightful access to healthcare.**

On 21st April 2010, MdM and its partners organised an international colloquium in the capital on the right to health of women working in the maquilas and agribusiness industries. Those who were invited to attend were stakeholders in civil society in Guatemala and in other Latin American countries. The event was organised **to publicise the results of the survey** and to raise companies' awareness of the rights of women workers and of where these were not being met. More than 500 people from various sectors also took part in round table discussions where concrete proposals in favour of women workers were formulated.

The decision as to which forms of leverage to apply is taken on the basis of the sociopolitical context in the country concerned, and on the opportunities and resources (notably human) available.

Where the field resources available for advocacy action are limited, it is preferable to concentrate on lobbying and field expertise.

4 / ADVOCACY ACTION IN THE FIELD: ILLUSTRATIONS

Since 2007, combating gender-based violence has been a priority adopted by MdM for advocacy action, alongside other issues such as removing financial barriers to healthcare, human resources in health, funding healthcare and the health of migrants.

Various examples illustrate the advocacy action taken in the field by MdM on the issue of gender-based violence. The forms of leverage and the advocacy objectives are obviously linked to the programmes' specificities and particular context, which explains the wide variety of issues to which MdM is devoting its energies.

1. Examples of issues chosen

As part of MdM programmes

As part of the project developed in Niger and ultimately in the sub-region of Niger/Mali/Burkina Faso, the objective is to establish comparative analysis of the healthcare systems and to promote fair funding of health that will remove barriers to accessing care, particularly for pregnant women and children under 5 years.

With fourteen years of experience to draw on, **the project in Haiti** is involved in advocacy action on four main themes:

→ Multidisciplinary and integrated care and support for victims of violence;
→ Recognition of medical certificates for victims of violence as a medical matter and implementation of a policy of certificates being issued free of charge in public institutions;
→ Implementation of a national strategy to combat violence against women within public health facilities;
→ Recognition by those involved in aid relations of the importance of the psychological rehabilitation of victims of violence.

In Peru, the project is involved in advocacy issues that are aimed at improving local development, focusing particularly on respect for human rights and gender equality, in order to eradicate institutional and intrafamily violence and to reduce the number of teenage pregnancies.

The project underway **in Pakistan** is also committed to an advocacy initiative the main objectives of which are to get key stakeholders in the Punjab Department of Social Affairs to take account of violence against women and to change the attitudes of public institutions towards women staying at the Dar-ul-Amans and towards the Dar-ul-Amans themselves.

As part of programmes developed by partner organisations

Project – To promote the rights of women through marriage contracts – Amusnaw Association, Algeria

The general aim of this project is to promote the rights of Maghreb women – in Morocco, Algeria and Tunisia – through the strategic use of marriage contracts in the framework of community mobilisation and citizenship education activities. The project comprises a series of community consultations with women in different regions of the three countries, production of a standard contract and development of advocacy action to get the contract adopted. The consultations provide an opportunity to:

→ Assess the women's knowledge of marriage and the different laws relating to it;

- → Find out, on the basis of the women's personal experiences, their opinions of the marriage contract and its impact on their lives;
- → Get the women to take part in drawing up a list of clauses that have to be included in the marriage contract;
- → Identify the challenges and obstacles that the women foresee in negotiating a marriage contract;
- → Develop with the women strategies for negotiating a standard marriage contract.[193]

As part of programmes developed by other stakeholders

Programme supporting the rights of lesbian, gay, bisexual and transgender communities – Human Rights Watch, Burundi
Human Rights Watch along with 62 other Burundi and international human rights organisations published a joint statement calling for a provision of the new criminal code that criminalised homosexual conduct to be withdrawn. They drew in particular on testimonies revealing that individuals felt "their very identities have been rendered criminal by Burundi's new law." The associations' joint report was published on 30th July 2009 and is entitled *Forbidden – Institutionalizing Discrimination against Gays and Lesbians in Burundi.*

2. Examples of leverage used

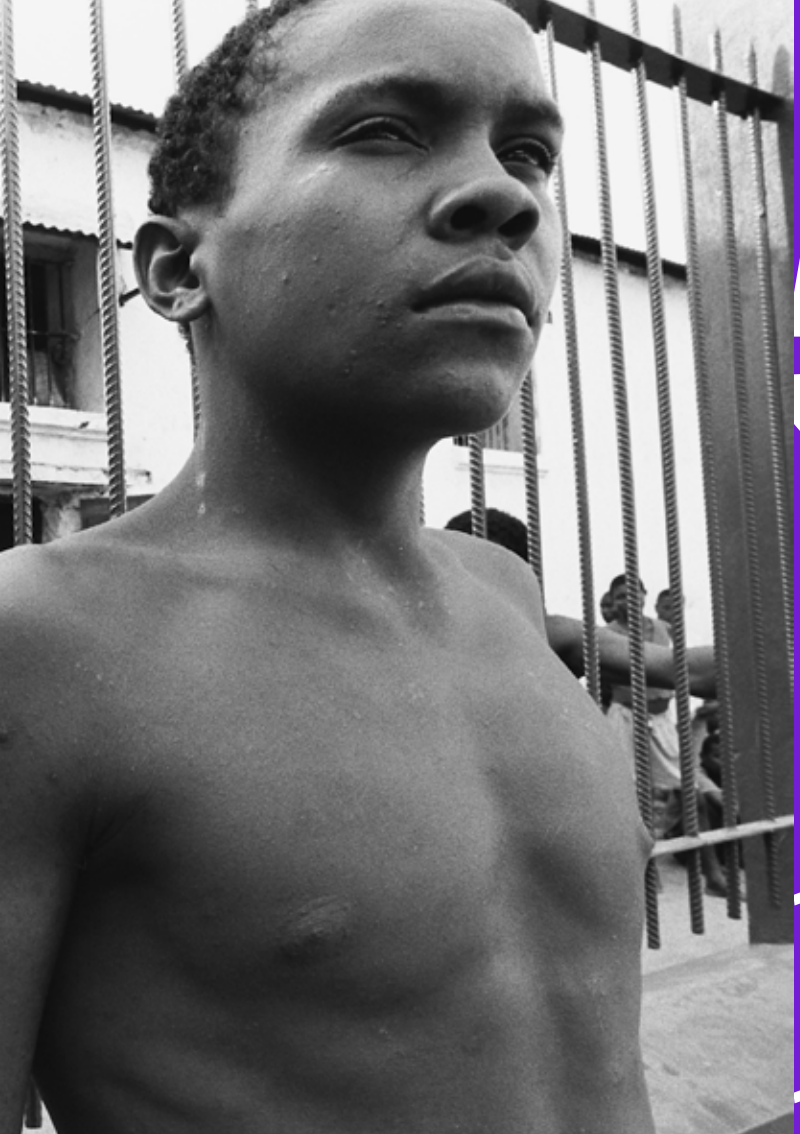
MdM programmes make use of different forms of advocacy leverage. In most cases, actions are developed within national or local **consultative arenas** and in **support networks** that already exist or are set up by the programmes. **Outreach work** is also regularly undertaken with identified decision-makers. In addition, some projects base their actions on writing and disseminating reports produced from analysis of **data collected.** Advocacy action is sometimes relayed **by the media and public awareness-raising campaigns.** Lastly, certain programmes also develop strategies at continental or interregional level.

In Haiti, a National Plan to Combat Violence against Women was launched in 2002, as a result of a desire to coordinate prevention and care activities addressing violence specifically against women. This umbrella body brings together three types of stakeholders – public institutions, civil society and international organisations. Médecins du Monde is responsible for coordinating a commission on psychosocial care and plays an active part in two other commissions: "prevention and communication" and "medical care". **The National Plan invites different stakeholders to sit down together and to come up with a multidisciplinary response to violence and the mechanisms needed to coordinate that response.**

In Pakistan, MdM is working with the Department for Social Affairs responsible for the *Dar-ul-Amans* (temporary shelter for women in great distress and their children) and, more specifically, with its provincial office in the Punjab. MdM has the use of premises within the department, enabling it to maintain **a regular presence and contacts.** MdM is invited to all department working meetings where joint actions are also discussed. By working in close partnership with Punjabi government bodies, MdM is placing itself as an agent of social change at the heart of public institutions.

MdM, Interim operational report, International programme to fight gender-based violence, MAAIONG/AFD, September 2009.

193. Moussaoui F., Amusnaw Association, "Anti-violence against women campaigns and the code of family law in the Kabylie region of Algeria" – Regional workshop on providing care and support for women victims of violence, Cairo (Egypt), September 2009.



5 ANNEXES

5A ACRONYMS

AAP: Asylum Appeal Board
AFD: Agence Française de Développement (French Development Agency)
ARV: antiretroviral drugs
Ceadel: Centro de Apoyo al Desarrollo Local (Local Economic Development Centre)
CEDAW: Convention for the Elimination of Discrimination against Women
CNCDH: Commission nationale consultative des droits de l'Homme (the French National Consultative Commission on Human Rights)
Comede: Comité médical pour les exilés (French medical committee for migrants)
CPTF: Centre for the Prevention of Trafficking of Women
DRC: Democratic Republic of Congo
DUA: Dar-Ul-Aman
ECHR: European Convention for the Protection of Human Rights and Fundamental Freedoms
FEDO: the Feminist Dalit Organization (Nepal)
FGM/C: Female genital mutilation/cutting
FPAB: Family Planning Association of Bangladesh
FPAN: Family Planning Association of Nepal
GBV: Gender-based violence

Halde: Haute autorité de lutte contre les discriminations et pour l'égalité (Equal Opportunities and Anti-discrimination Commission)
HIV/AIDS: Human immunodeficiency virus/Acquired immune deficiency syndrome
HR/HIL: Human Rights/Humanitarian international law
HRW: Human Rights Watch
IASC: Inter-Agency standing committee
ICC: International criminal court
ICCPR: International covenant on civil and political rights
ICD: International Classification of Diseases
ICPD: International Conference on Population and Development
IGSS: Instituto Guatemalteco de Seguridad Social (Guatemala Institute of Social Security)
ILO: International labour organisation
IOM: International Organization for Migration
IPPF: International planned parenthood federation
MAAIONG: Mission d'Appui à l'Action Internationale des ONG (Mission to support international actions of NGO)
MdM: Médecins du Monde (Doctors of the World France)
MONUSCO: United Nations Organization Stabilization Mission in the DRC
MSF: Doctors without Borders (Médecins sans frontières)
NGO: Non-governmental organisation
OAS: Organisation of American States
OECD: Organisation for Economic Co-operation and Development
Ofpra: Office français de protection des réfugiés et des apatrides (the French Office for protection of refugees and stateless persons)
OHCHR: Office of the High Commissioner for Human Rights

ONSMP: Observatoire national de pratique en santé mentale et précarité (the French monitoring centre of practices on mental health and precariousness)
ORSPERE: Observatoire régional Rhône Alpes sur la souffrance psychique en rapport avec l'exclusion (the French regional monitoring centre in Rhône Alpes on psychic trauma dealing with exclusion)
OSAGI: Office of the Special Adviser on Gender Issues and Advancement of Women
PEP: post-exposure prophylaxis
Popin: United Nations Population Information Network
PTSD: post-traumatic stress disorder
Redicam: Red integral de centros de atención para las mujeres maltratadas (Integrated network of centres providing care and support for women victims of violence)
STD: sexually transmitted diseases
STI: sexually transmitted infections
UN: United Nations
UNAIDS: United Nations commun fund for HIV/AIDS
UNDP: United Nations Development Programme
UNECA: United Nations Economic Commission for Africa
UNESCAP: United Nations Economic and Social Commission for Asia and the Pacific
UNFPA: United Nations Population Fund
UNHCR: United Nations High Commission for Refugees
UNICEF: United Nations Children's Fund
UNIFEM: United Nations Development Fund for Women
UPR: Universal periodic review
WHO: World Health Organization

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Throughout the world, **gender-based violence represents a major public health issue and an undeniable violation of human rights.**

This leads us to question the strategies of intervention and the prevention and response actions to gender-based violence, always taking into account the different socio-cultural contexts. This guide does not intend to provide responses but reflexion elements **for the development of programmes or activities to fight gender-related violence.**

Through the presentation of **key concepts, methodological tools** and **field examples** this guide aims to **improve the identification and the multidisciplinary care and support of the victims of violence, as well as to improve the quality of the awareness-rising and advocacy activities associated to it.**

This guide draws its practical use from MdM's know-how on the subject, which the organisation has developed thanks to its international programme on gender-based violence, executed with the financial support of the French Development Agency.

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