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The Health Sector and Gender-Based Violence in a Time of War

Summary

- Multisectoral approaches are essential to address sexual and gender-based violence (SGBV) in armed conflict. In countries where conflict-related SGBV is taking place, the health sector can contribute by providing essential medical interventions and support for survivors, documentation for legal cases, programs that assist in reducing social stigma, and data for effective programming.
- These functions, however, often remain largely unfulfilled because of inadequate integration of the health sector into programming to respond to SGBV. Staff is not sufficiently trained to address the needs of survivors, resources for sustainable programs are absent, guarantees of confidentiality and consent are not sufficiently robust, and security for staff and patients is lacking. These challenges can only be met with a strong commitment at the political level to service provision, protection and community engagement.

Introduction

Rape and other forms of sexual and gender-based violence are horrific forms of strategic weaponry in many contemporary conflicts. War-related sexual violence not only brutalizes its victims, many of whom are quite young, but often contributes to destabilization of families and communities by stigmatizing victims, breeding fear of disease and infertility, and increasing costs of health care.¹ The dynamics of sexual and gender-based violence in armed conflicts vary greatly; in some wars, it is an extension of violent patterns already existing in society, while in others it escalates dramatically as a weapon of war.

Responses to the needs of survivors of sexual and gender based violence (SGBV) in conflicts and post-conflict settings have often focused on the law enforcement and security sectors, frequently combined with community-based supports. The health sector, though having the potential to play a central role in providing support and interventions for women, has received far less attention. This is partly a result of inadequate financial and human resources, but also a product of other factors. These include a lack of consensus on the role of the health sector in service provision, coordination and support in response to sexual and gender based violence and the existence of free-standing humanitarian programs. Isolated, narrow, or uncoordinated responses, combined with lack of capacity, have resulted in programs that do not adequately address the holistic needs of survivors or enable them to access the needed range of services.

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On February 17th, 2010, USIP's Health and Peacebuilding Working Group and Gender and Peacebuilding Initiative met to discuss the role of the health sector in addressing sexual and gender-based violence and the ways in which health policymakers and health care providers can contribute to a multisectoral, effective response. Nancy Glass, associate director of the Johns Hopkins Center for Global Health, and Jocelyn Kelly, the gender-based violence coordinator at the Harvard Humanitarian Initiative (HHI), presented findings from their work. Kathleen Kuehnast, gender adviser at USIP, participated, and Leonard Rubenstein, coordinator of the Peacebuilding and Health Working Group, moderated the discussion.

Health as a Key Element in a Multisectoral Response

It is increasingly apparent that the need for services for and, in some cases, reintegration of, SGBV survivors requires collaboration and coordination among the health, security, economic, judicial and social service sectors.² An effective multisectoral response can ease the burden on a survivor reliving her* history of violence, and instill trust, reduce stigma, ensure confidentiality and address her medical and material needs for food, shelter and the education of her children. Protocols for working with survivors, along with linkages among services and assurances for their sustainability, are essential. To be effective, the programs need to be linked to structural interventions to reform laws and institutions that discourage or prevent women from seeking services and health leadership at the national level. If such an integrated approach is reinforced by international donors who support such interventions, the likelihood of long-term impact will be greatly enhanced.

Reintegration services should be defined by local needs but may include mediation between survivors and their families and communities along with interventions that aim to reduce trauma and enable women who have been abandoned to earn a livelihood. By building on community strengths, leadership and culture, mediation can address the stigma associated with rape. Reintegration programs can also address concerns about sexually transmitted infections, including HIV, and the costs of health care for the survivors, which can add to the social stigma associated with war-related rape. Where appropriate, programs can address the often neglected impact of such sexual violence on men in the community, especially victims' husbands, fathers or children.

It is in this multisectoral context that health services can make their greatest contribution. The health sector has the potential to be a source of first response and support. Aside from critically needed medical interventions, health centers can offer women a safe point of entry into health and non-health support services, provide documentation of their case history for legal purposes and play a role in reducing stigma.³ Exercising all of these functions, however, presents an enormous challenge to the health sector. Provision of appropriate health services for SGBV survivors is complex, time-consuming and requires skills beyond medical knowledge. All too often, in regions of conflict health clinics lack the staff, training, resources, and equipment. In addressing the needs of survivors, moreover, clinic staff must be aware of and respect the need for protection of confidentiality, privacy and consent; indeed, these concerns often lead survivors either to seek services outside their community or ignore their health needs altogether. Furthermore, meeting these requirements is often not a priority in health sector policy.

The health sector's ability to address the needs of survivors is further complicated by insecurity. In some settings where levels of violence are high, female health care workers may be in short supply and may have legitimate serious security concerns about travelling between towns. The

* In some conflicts, men are also subjected to sexual violence.

combination of insecurity and shortage of services sometimes means that women seeking health services for SGBV must travel long distances at high cost. As a result, many of these women do not seek health services in a timely manner, if at all.

What would it take for the health sector to play a role in an integrated response to SGBV? At a minimum, local clinic staff, including male providers, should be trained and equipped to address and respect the needs and human rights of survivors. Staff should also learn how to connect to community-based groups and other sectors, and be provided with greater security where needed. A political commitment is needed to ensure ongoing funding of and support for integration of SGBV services into the larger health system and community-based systems of support. One response has been to establish specialized health programs for survivors of SGBV, sometimes in the form of mobile services, but these programs can be further stigmatizing and are neither sufficient nor a long-term strategy for community-based service provision. In such difficult environments, local leadership can also be instrumental in expanding services and building confidence in the capacity of health clinics to address the needs of survivors. But here again, training in leadership capacity is often necessary in order to help local leaders plan for the future and not just for meeting immediate needs.

Documentation and Evidence

Health care centers can play a significant role in documenting episodes of SGBV and the medical history of the patient. Here, too, fragmentation of services poses an obstacle to a strong response. The use of one medical record, for example, would simplify the referral process within the health sector. Health care centers, with the individual's consent, can also provide evidence for the justice system that can be used to promote accountability. Yet implementing this role has proven difficult in some settings. In documenting their stories for judicial purposes, some women have reported a fear of reprisals and, indeed, health centers themselves can become vulnerable to attack in places where perpetrators fear being held accountable. As a result, an increased role for the health sector in furnishing medical evidence must be accompanied by greater attention to its security.

Data collection for systemic purposes is also essential to build a sustainable model of recovery. Such data collection can go beyond the prevalence studies that have been the principal source of information about SGBV in armed conflict. The work of Dr. Denis Mukwege, director of the Panzi Hospital in the Democratic Republic of Congo, and Dr. Susan Bartels of the Harvard Humanitarian Institute shows that health facilities can collect data from survivors that reveal the scope, nature and dynamics of sexual and gender based violence, which can be a powerful tool for improving service, programming and advocacy. The Panzi Hospital data, for example, revealed that 75 percent of the victims accessing services were gang raped, that more than half of the attacks occurred at night in women's own homes, and that the average time from attack to presentation at the Panzi Hospital was more than a year. Such data collection systems can be standardized to ensure consistency and completeness of data, and simple tools can be employed to mitigate the burden of documentation work on health care staff. Confidentiality of data is, of course, essential to ensure the safety of survivors and integrity of the system. Developing such a system poses challenges because of a lack of electricity and by the practice of patients taking their own medical charts with them when they leave the hospital.

Finally, strategies for prevention, response and reintegration need to be evaluated to determine whether they are successful in helping survivors. While interventions should be developed to address the local context and needs, knowledge about models of care are proving effective in different settings, and whether they meet the short and long term needs of survivors, is critical.

ABOUT THIS BRIEF

The challenges of effectively addressing sexual and gender-based violence in war torn communities are daunting. There is a growing consensus that a multisectoral approach is essential, one in which the health sector can play a central role. This Peace Brief describes the pivotal role the health sector can play, obstacles to its exercising these needed functions, and steps that can be taken to contribute to developing support for survivors as part of an integrated approach.

Conclusions and Recommendations

A coordinated and sustainable multisectoral response to SGBV is needed to address the needs of survivors, as well as an effective community approach to dealing with SGBV. The health sector can play a central role in this overall strategy. Health sector responses need to be integrated into the multisectoral response, as well into an overall plan for the health sector. The many challenges in meeting this role include setting coherent policies that includes linkages to community-based supports, offering training to the staff and resources to the centers, assuring security for patients and staff, and guaranteeing confidentiality and consent. Building an evidence base is also critical for programming and accountability. Engaging communities in setting priorities, contributing to program design, and addressing stigma will enhance the ability of the health sector to meet these needs.

Endnotes

1. Sexual Violence Research Initiative and WHO. "Rape: How Women, the Community and Health Sector Respond." World Health Organization, 2007.
2. Inter-Agency Standing Committee. "Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies." Inter-Agency Standing Committee, 2005.
3. Interagency Gender Working Group of USAID. "Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers," 2nd ed. USAID, 2008.



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