FEASIBILITY AND ACCEPTABILITY OF **GENDER-BASED VIOLENCE SCREENING:** PRIMARY HEALTH FACILITIES **IN HUMANITARIAN SETTINGS**

Findings from implementation among refugees in Dadaab, Kenya

BACKGROUND

Gender-based violence (GBV) includes acts of physical, emotional and sexual violence, forced and early marriage, and sexual exploitation and abuse. In conflict-affected areas, it is an epidemic. Recent research suggests that **at least 1 in 5 refugees or displaced women in humanitarian settings have experienced sexual violence** — this figure is even higher when considering women who experience violence or threats of violence by intimate partners or other family members.

Competent, confidential and compassionate care is critical for reducing the risk of ongoing injury, suffering and long-term consequences for survivors. International standards for humanitarian interventions recognize this need, noting the right of survivors to access care and to be treated with dignity and respect and free from blame. These responsibilities cannot be realized, however, without addressing two key realities: survivors are often reluctant to self-report, due to the stigmatizing and sensitive nature of GBV, and health care workers are not routinely trained to care for and identify women who have experienced GBV.

Enabling skilled providers to confidentially, efficiently and effectively identify individuals who have experienced GBV is a crucial part of ensuring that survivors receive care that meets their needs and promotes their safety.

Humanitarian practitioners are interested in the practice, based on studies suggesting that screening for GBV in health care settings is acceptable to clients and providers, and can increase the identification of survivors who might need care. Despite this, the World Health Organization's recommendations around GBV screening remain weak pending additional research proving that screening reduces violence and improves health outcomes in low-resource settings.

EVALUATION

To advance the evidence around GBV screening, the International Rescue Committee (IRC) has conducted a rigorous evaluation of its feasibility and acceptability in diverse humanitarian settings. In 2010, the IRC began collaborating with Johns Hopkins University (JHU) to pilot the **"Assessment Screen to Identify Survivors Toolkit " for GBV (ASIST-GBV)** — a screening tool developed by JHU that seeks to proactively and routinely identify survivors of different types of GBV, such as intimate partner violence, sexual violence, forced marriage, sexual exploitation, forced pregnancy and/or abortion. Based on these efforts and promising findings, and with generous support from the U.S. State Department's Bureau of Population, Refugees and Migration, the IRC and JHU conducted a multi-country evaluation of feasibility and acceptability of screening for GBV in health facilities among female refugees.

This 12-month project included IRC programs with refugees in Dadaab refugee camp in Kenya and Syrian urban refugees in northern Jordan. According to JHU guidelines, all women over the age of 15 seeking health care were asked seven questions concerning their experiences within the past 12 months with different types of GBV. Only women presenting alone were included, and all women were asked for consent prior to the intervention. The preparation phase included adaptation and translation of the screening tool, training of staff, community sensitization and pilot testing of the tool. The intervention phase lasted six months and was followed by three months of formal evaluation and data analysis.

Kenya and Jordan host two of the world's largest refugee populations as a result of the prolonged conflict and drought in Somalia and the ongoing civil war in Syria. Both locations are considered challenging for GBV programming in terms of cultural sensitivity and, in the case of Jordan, mandatory reporting to the authorities for certain types of

JOHNS HOPKINS UNIVERSITY

INTERNATIONAL RESCUE COMMITTEE

Photo by L. Ongoro /The IRC

GBV. Due to programmatic challenges that were not directly linked to the screening intervention, Jordan withdrew from the evaluation study at an early stage. The findings below are therefore based on research conducted in Dadaab, Kenya, and bolstered by implementation and program experiences from other humanitarian contexts including South Sudan and DRC. The recommendations have applicability for health programs operating in similar low-resource settings that serve refugee or crisis-affected populations.

Successes

The project produced several positive outcomes as evidenced by an increase in GBV cases identified and referred, as well as favorable feedback from clients and providers. Overall, the number of referred cases of GBV to the support center rose significantly during the intervention period. This increase was partly due to women who presented as a direct result of the GBV screening as well as a general increase in referrals from health facilities.

In addition to receiving improved access to care, women also demonstrated greater willingness to report GBV cases and began speaking openly about GBV with providers and referring cases involving acquaintances, such as family members and neighbors. This increased comfort was also shared by providers, who not only felt that they could speak more freely with patients about different forms of GBV, but expressed a desire to take on more responsibility for providing care for GBV. This change in attitude was supported — and facilitated — by greater collaboration and communication between different program sectors, improving the overall referral pathway.

Both providers and women provided key insight and opportunities that significantly improved the IRC's overall approach to screening. Though screening was initially time-consuming, it was decreased to two to three minutes by conducting group sessions on general GBV awareness — which women deemed acceptable — prior to obtaining individual consent. Furthermore, our initial assumptions about the individuals best placed to carry out the screening were proven wrong. We initially hypothesized that nurses, midwives and clinical officers should carry out the screening but found that, in spite of concerns raised by some providers, women trusted refugee staff members who also spoke the local language. All staff members received additional training on the importance of confidentiality and privacy before task-shifting was executed.

Challenges

While our screening resulted in the encouraging trends noted above, the full potential of our reach and impact were challenged by limitations concerning staff, structure and immediate availability of follow-up services. It was found that health facilities were often ill-equipped to provide private spaces where the screening could take place, which is one of the prerequisites for GBV screening. Options were often limited to shared consultation rooms or open-air consultations due to uncomfortably hot climates indoor, resulting in fewer women being screened.

Conducting the screening also resulted in an increased workload for staff operating in an already overworked environment, where the provider-to-patient ratio more than doubles the standards set by the Sphere guidelines. As a result, though the numbers of women screened increased every month, it still reflected a lower percentage of women screened than expected.

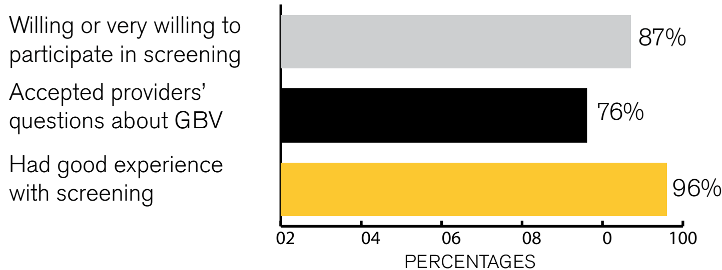
The high workload continued to negatively impact providers' ability to respond to the needs of women even after the initial screening. A considerable number of women who did not screen positive for GBV within the past 12 months still expressed a need for psychosocial support. For some women, the assault(s) may have happened prior to that period, or have included types of assault that are not based on gender. Case managers struggled to meet the needs and expectations of these clients due to their already overstretched capacity.

Even after the screening, operational barriers limited our ability to fully meet the needs of survivors. Psychosocial support and case management was not immediately available in the health facilities and women either had to walk to the support center or wait for ambulance referral. As a result, women often chose to postpone referrals due to other pressing responsibilities, such as household chores.

Providers need to be equipped to deal with the reactions from women during and after the screening. For a woman to be screened positive doesn't necessarily mean that she identifies herself as a survivor. She could have sufficient support and coping mechanisms in place to deal with the situation and in some cases, such as marital rape and forced pregnancy, the types of GBV that were screened for may not have been considered abusive according to cultural/religious perceptions. Providers need to address this in a respectful manner.

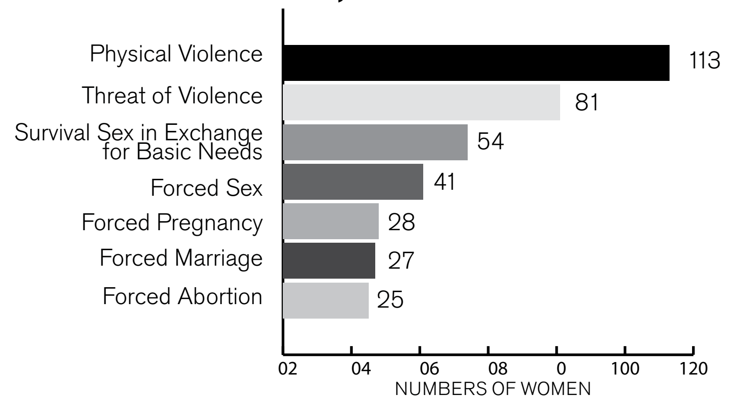
KEY FINDINGS

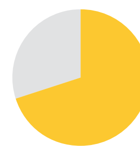
Women in general were positive towards the screening intervention:



- **89.3%** of women offered screening for GBV accepted the intervention.
- **2.5%** (213/8,369) of women screened were identified as a survivor of at least one type of GBV within the past 12 months during the intervention period.
- The health facilities increased GBV referrals by **241%** (58 vs. 17) compared to the same period the previous year.
- Women referred from the health facilities accounted for **25%** (58/243) of the women seen in the Support Center.
- **57%** (33/58) of those presented as a direct result of the screening intervention.

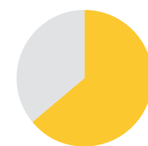
213 women reported 369 different incidents of GBV, as follows:





70 percent

reported that GBV happened in their home, school or place of work



64 percent

reported that GBV was perpetrated by a current or former intimate partner

Recommendations

- **Establish plans for addressing staff increase and workload.** As mentioned in ASIST-GBV guidelines, screening will lead to an increase of survivors reporting for GBV response services, which will impact not only the health sector carrying out the intervention, but all sectors involved.
- **Select locations according to predefined eligibility criteria.** The criteria that must be considered include availability of staff members trained in clinical care for sexual assault survivors (CCSAS), the availability of private consultation rooms, quality referral services and the ability to ensure confidentiality according the ASIST-GBV guidelines.
- **Conduct community sensitization prior to implementing screening for GBV.** These activities should provide information about the intervention, to raise awareness about the importance of timely reporting and confront taboos. These efforts are more effective by involving women's and men's groups and community and religious leaders.
- **Carefully adapt the screening tool to take into account local cultural and religious considerations.** It is essential to pilot the tool among providers and patients prior to implementation.
- **Properly assess clinic staff in order to identify who is best placed to screen prior to implementation.** Considerations may include language, sex, workload and role.
- **Allocate resources specifically to the screening intervention.** While it is important to integrate screening into the health facility visit, it is critical that providers take ownership. Responsibilities should be integrated into job descriptions and project outputs.
- **Provide technical support in the initial phase for training and evaluation.** A dedicated person needs to be appointed to continuously support screening activities, do follow-up trainings, ensure cross-sector communication and address challenges.
- **Position GBV officers and psychosocial counselors in the health posts or in the immediate vicinity.** Women shoulder many family and community responsibilities and often don't have the option of taking more time out of their day to follow up on referrals after being screened.

Conclusion

Based on evaluation findings and experiences from our GBV screening interventions, the IRC strongly believes that GBV screening is an effective way for health providers in humanitarian settings to assist survivors of GBV. We find that, with the appropriate measures taken and prerequisites met, GBV screening by health providers has the potential to 1) create a confidential environment where survivors can speak openly about their experiences with GBV, 2) ensure competent care and referrals based on individual needs and wishes of survivors, and 3) increase community awareness about GBV issues, thereby reducing stigma and improving attitudes.

Our experience also highlights that, like any other program that involves women's sexual and reproductive health and rights, screening for GBV needs to be addressed appropriately. The design and implementation should be based on proper assessments in terms of culture, religion, gender norms and attitudes of clients, as well as providers.

Documenting direct links between improved health outcomes, reduced violence against women and screening for GBV is challenging. We recommend that future research efforts and resources be focused on measuring whether screening for GBV leads to increased knowledge of available resources/services and that women who screen positive and receive comprehensive services feel supported and safe.

The International Rescue Committee

The IRC responds to the world's worst humanitarian crises and helps people to survive and rebuild their lives. Founded in 1933 at the request of Albert Einstein, the IRC offers lifesaving care and life-changing assistance to refugees forced to flee from war, persecution or natural disaster. At work today in over 40 countries and 22 U.S. cities, we restore safety, dignity and hope to millions who are uprooted and struggling to endure.

For more than 20 years, the IRC has been breaking down barriers that prevent survivors from disclosing violence and seeking services. We continue to work in areas characterized by insecurity, displacement and a collapse of health services. The IRC is providing clinical care for gender-based violence in 19 countries and psychosocial and women's empowerment support in 26 countries.

We work to ensure that:

- Services are provided free of charge in a compassionate, competent and confidential matter,
- Skilled providers are trained to effectively care for and identify survivors, and
- Services provided are based on a comprehensive, multi-sectoral approach that addresses both response and prevention.

Johns Hopkins University

The Johns Hopkins University is an internationally-renowned research institute and brings together expertise in emergency medicine, violence research and interventions, and epidemiologic assessments of human rights violations. Since 2010, JHU has worked to develop and test the "Assessment Screen to Identify Survivors Toolkit" for gender based violence (ASIST-GBV) to help health care workers proactively and routinely identify survivors of GBV among conflict affected populations and in humanitarian settings. JHU has partnered with IRC and other implementing partners to train local staff, test and implement the screening tool in six countries across sub-Saharan African, Middle East North African, and Latin American regions.

Photo Credits: M.Kovac (Front) and L.Ongoro (Back) / The IRC