

Gender Based Violence in Fragile, Conflict, and Violence (FCV) Situations

Five key questions to be answered

SUMMARY

The importance of addressing gender-based violence (GBV) in FCV situations is increasingly recognized by countries and international humanitarian and development agencies. This note highlights the best practices in designing, implementing and evaluating a project involving addressing GBV in conflict and fragile situations. The note also provides an overview of the World Bank's current engagement on GBV in fragile settings and internal resources available to TTLs.

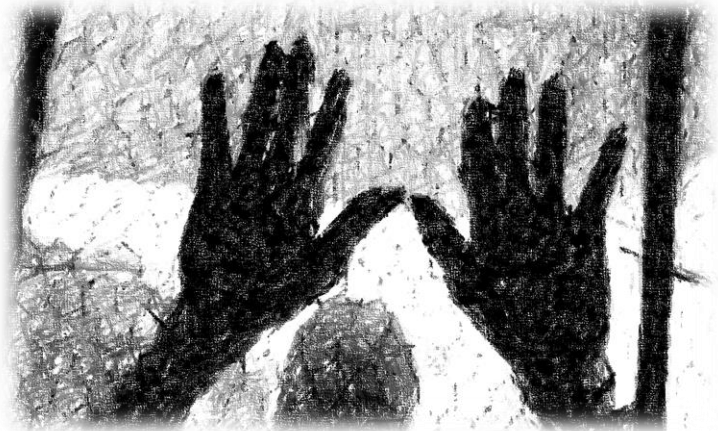


Photo credit: Dominic Chavez/World Bank

Gender-based violence has [long term effects on the health](#) of women, men and children who experience it. WHO estimates show that women who have experienced violence are 16 percent more likely to give birth to low weight babies; are twice as likely to have an abortion; and are at a higher risk of contracting HIV/AIDS where the disease is pervasive. Moreover, victims of most types of GBV often experience [stigmatization](#), and often the crime goes unreported.

Displaced people and refugees have a [high risk of GBV due to their vulnerability](#). This can take various [forms](#) including rape, forced and child marriages, or sex-selective genocide, with brutal long-lasting consequences for all genders and age groups. The risk of [human trafficking](#) also increases in fragile situations with the majority of victims being women and children.

[Investing in addressing GBV](#) as a public health issue supports the emotional health of displaced populations and their rehabilitation. On a humanitarian level, prevention and management of GBV helps to restore and maintain people's basic human rights. As a public health measure, it reduces the risk of unnecessary mortality and morbidity; and it helps to improve social conditions among displaced populations which can also contribute to economic opportunity.

Q1

WHY should we focus on GBV in FCV situations?

Gender-based violence (GBV), as [defined](#) by the World Health Organization (WHO), refers to physical, sexual, emotional and psychological abuse, or financial control by a person (or a group of people) that cause harm to another person rooted in gender norms.

Globally, [over one-third of women](#) report having experienced some form of physical or sexual violence. Another study estimates that [about 7.6 percent of young boys and 18 percent of girls](#) experienced sexual abuse over the course of their childhood. It is likely that the actual incidence of abuse is much higher. For example, a 2005 study of male students aged 13 to 15 years in [Lebanon](#) reports that 19.5 percent had experienced sexual abuse, defined as verbal harassment or inappropriate contact. Recent estimates show that 65 percent of [women in Lebanon](#) have experienced domestic violence, and about 18 percent suffered sexual violence. Fragility and conflict create conditions that are ripe for the exploitation of people.

Q2

WHO should be targeted for GBV interventions?

Women and girls are the most obvious victims of GBV in fragile situations. Beyond outright genocide, violence often takes the form of rape and sexual exploitation. This is used as a **weapon of war** to **create fear and terrorize** populations. This tactic has been used by conquering/occupying forces around the globe for centuries. Most recently, in Syria, young girls have been forcibly married, sold, and brutally raped, including gang rape, by ISIS. While estimates vary, studies suggest that sexual violence against female refugees is high. In a series of recent surveys of over 2000 South Sudanese refugees, **65 percent** of females had experienced some form of physical or sexual violence, for example. In another smaller survey of Syrian refugee women (n=385), **32 percent** reported gender-based violence.

Unaccompanied children are especially at risk for GBV. Since they are alone, their vulnerability to **sexual violence and coercion** increases. They are also prime targets for human trafficking. There were over **28 million child refugees**, including **200,000 unaccompanied children** across 80 countries who applied for asylum between 2015 and 2016. Violence against children does not only take place when they are on the move. In situations of fragility, it can take place anywhere. Young girls in Nigeria, for example, are repeatedly kidnapped by Boko Haram, in northern parts of Nigeria, to serve as child brides for their men (with the most famous case being of the **276 school girls** kidnapped from their hostel in Chibok).

People who identify as LGBTI are also especially vulnerable to sexual abuse and violence during times of conflict. In Syria and Iraq, for example, homosexual men are being **brutally executed**. In several countries, lesbian women have been subjected to '**corrective rape**' by men to 'cure them'.

Men and boys are a key target population for prevention of GBV. They can be both perpetrators and victims of violence. GBV against men and boys takes the form of sex-selective genocide, especially at the early stages of **conflict** (such as in Rwanda and Sudan), and sexual abuse. For example, in a survey of 520 Syrian refugees **10.8 percent** of men and boys admitted to having experienced sexual violence. Comparable proportions of non-partner sexual violence are reported by refugee men in Rumbek (9 percent) and Juba (6 percent) **in South Sudan**. Men and



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boys also have a role in creating safe spaces for all, such as in refugee camps and migration routes, to reduce the risk of GBV.

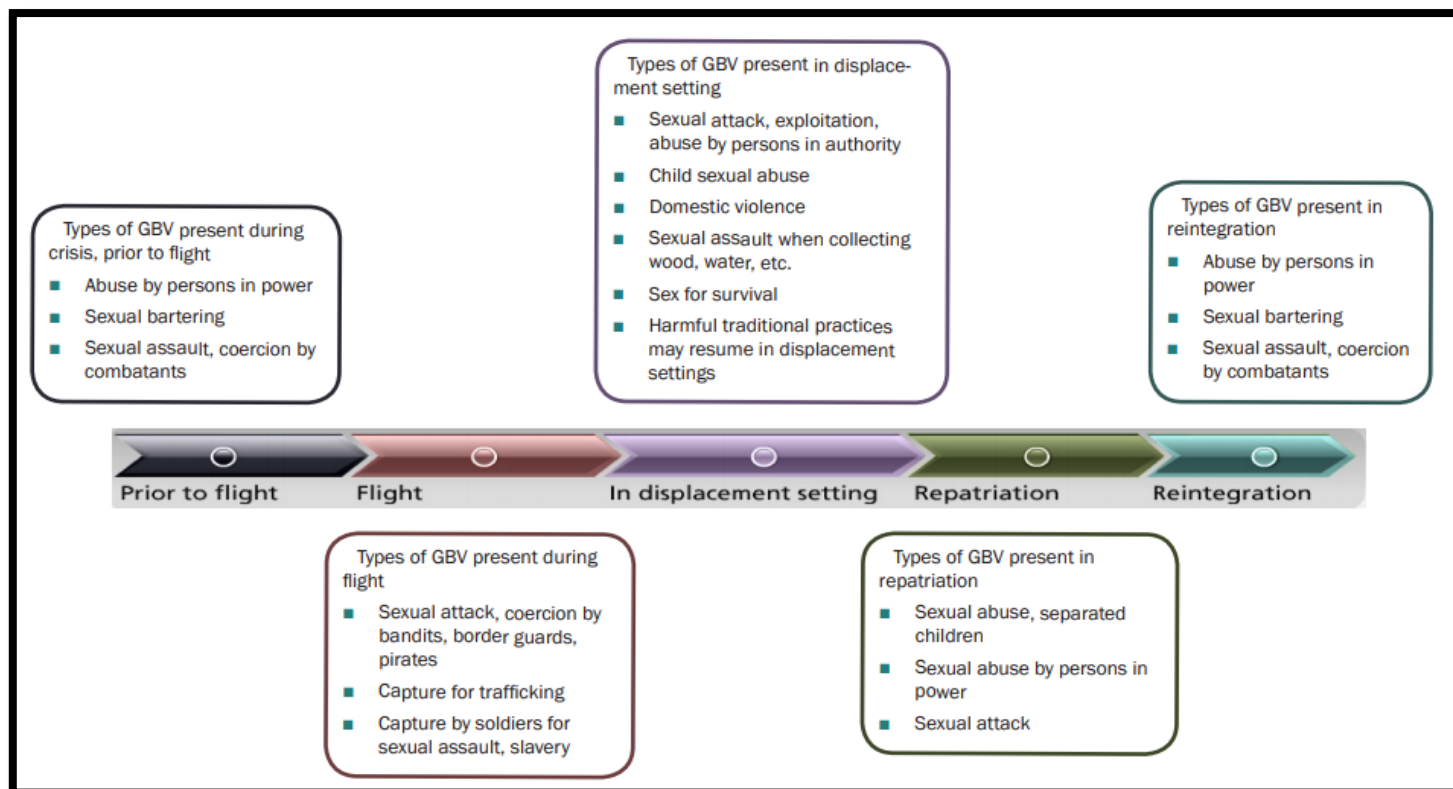
Service providers and security personnel including emergency responders, peace keeping forces, healthcare workers, and teachers have a very important role to play. Health services providers are among the first points of contact for refugees and displaced populations. Training them to recognize and respond to GBV is critical. Similarly, teachers in camps, and other service providers who come in contact with vulnerable groups, can help reduce the incidence through understanding how to recognize signs of GBV and take steps for its prevention. These groups also need to be properly trained and supported so that they themselves do not become perpetrators of violence.

Community leaders are a target population as well since they serve as gatekeepers and role models in their communities. This holds for refugee camps and temporary settlements of displaced populations. Engaging them as champions can help to create greater acceptance of health and social services and prevent negative behaviors.

Development agencies and civil society are also stakeholders in eliminating GBV. In fragile or conflict situations, staff have a responsibility not only provide much needed services, but to ensure that they conduct themselves with integrity and ensure that vulnerable populations are not exploited.

Note: The Inter-Agency Standing Committee's (IASC) latest guidelines on gender based violence interventions provide a **fuller profile of 'at-risk' groups** and why they may become victims of violence.

Figure 1.1 Types of Gender-Based Violence in Humanitarian Emergencies



Source: [UNFPA 2012](#)

Q3 WHAT interventions should be considered?

Gender-based violence has long term repercussions.

While the complexities of gender, social, and cultural norm that contribute to gender-based violence are too broad to discuss here, suffice it to say that in conditions with poor protections for certain groups of a population (such as women, young girls and boys, LGBTI), perpetrators are empowered. In fragile and conflict affected settings, there is a breakdown of most protections, putting these populations at greater risk. Figure 1.1 outlines the nuanced shape of gender-based violence in fragility and conflict settings. Understanding these differences is important for planning and implementing interventions that will have maximum effect.

Interventions to address GBV must also take a long-term approach with an immediate, emergency response, and a longer-term rehabilitation approach. Evidence shows that [effective responses](#) to GBV in conflict settings have been varied. The [IASC](#), [ICRC](#), [WHO](#), [UNHCR](#), [UNFPA](#), [UNICEF](#), and the [empirical literature](#) have outlined good practices in providing supports to victims of GBVs. Box 1.1 presents some of the key guidelines on how and where to integrate GBV interventions.

BOX 1.1 International Guidelines for Addressing GBV in FCV Situations

- Inter-Agency Standing Committee's (IASC) [Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#) (2015)
- Violence Against Women and Girls ([VAWG](#)) Resource Guide developed by the World Bank, IADB, the Global Women's Institute at GWU, and ICRW (2015)
- UNFPA's [Guidelines on Gender-Based Violence in Humanitarian Settings](#) (2005)
- UNHCR's [Guidelines for Gender-based Violence in Humanitarian Settings: Focusing on Prevention and Response to Sexual Violence in Emergencies](#) (2005)

Other Related Resources

- UNFPA's [Minimum Package of Essential Services \(MISP\)](#) for providing reproductive and maternal health services and gender-based violence prevention/management in humanitarian settings (2015).
- Inter-Agency [Gender-based Violence Case Management Guidelines](#) (2017)

The IASC guidelines are the most recent and updated set of guidelines for planning, designing, and monitoring interventions at the implementation level.

The guidelines include modules for different sectors including health. The main takeaways from the guidelines for the health sector are:

- Develop and/or standardize protocols and policies for GBV-related health programming.
- Engage all stakeholders, especially victims/survivors, in designing policies and programs.
- Enable inter- and intra-agency information-sharing on GBV incidents and take a multi-sector, cross-cutting approach.
- Ensure confidentiality, compassion, and quality of care for survivors of GBV, and referral pathways for multi-sectoral support.
- Implement monitoring and evaluation throughout the project cycle.

Taking a long-term approach: *Immediate and longer-term interventions*

The health sector has a pivotal role to play in managing and preventing gender-based violence in any setting. In fragile and conflict situations, first aid and emergency health workers are among the first points of contact for victims of violence. It is essential that these personnel are aware and equipped to provide support to these people.

Key immediate health interventions include:

- [Training](#) health personnel / emergency responders on recognizing signs of GBV, treatment, counselling, referral mechanisms, and rights issues.
- Provision of [reproductive and maternal health](#) services and ‘[dignity kits](#)’ as part of the package of basic/essential health services.
- Provision of health services to manage GBV. This may include provision of emergency contraception, post-exposure prophylaxis for HIV, administration of rape kits, emergency counselling, and referrals for more comprehensive mental and physical health services.

At the same time, especially when resources are limited, **community level interventions** may be adapted to reach large groups of populations that have been exposed to violence.

For example, in the [DRC](#), community-based health services have had success in reaching victims of violence in South Kivu, where access to services was otherwise limited.

Examples of community-based interventions include:

- Provision of community-based psychological and social support for survivors/victims.
- Community level behavior change interventions that actively engage community leaders, men and women for prevention of GBV.
- Provision of food and nutrition support for displaced populations.

In the **medium to longer term**, more comprehensive interventions that focus on mainstreaming GBV interventions may be implemented within the health sector. These include, but are not limited to:

- Establishment or strengthening of referral mechanisms for victims of violence for more comprehensive mental and physical care, as well as access to legal and other resources.
- Expansion and integration of GBV and reproductive health services within the health system as part of the essential package of services.
- Conduct ongoing training and supportive supervision of health staff.
- Ensure quality of care through regular evaluations and assessments.

Finally, in the longer-term, the health sector can also collaborate with other sectors through linking victims and their families with social and economic programs that empower victims of violence as part of larger efforts to reintegrate and rebuild. For example, education and income generation programs for girls and women.

In addition, multi-sectoral interventions may also target **perpetrators and victims** through and [economic empowerment and livelihood programs](#) that enhance people’s ability to reintegrate, improve their self-esteem, and provide economic independence – focusing on sustainability over a longer period of time. At the **community** level, good interventions include advocacy and [community programs](#) to reduce stigma, engage men and boys, and change behaviors.

Q4

WHAT is the World Bank doing to address GBV? What are the challenges and lessons learned?

200+ World Bank projects that include GBV since 2012

- 33 HNP operation projects that cover GBV; 10 in FCV situations (Table A.2)
- 5 non-lending HNP products; 1 in FCV countries

800+ World Bank reports and papers on GBV, including:

- [World Development Report 2017: Gender Based Violence and the Law](#) (2017)
- [Community Based Approaches to Intimate Partner Violence](#) (2016)
- [Gender-based Violence Prevention: Lessons from World Bank Impact Evaluations](#) (2014)
- [Violent Conflict and Gender Inequality](#) (2013)
- [Sexual and Gender-Based Violence: What is the World Bank Doing and What Have We Learned, A Strategic Review](#) (2013)

4 World Bank resource websites on GBV

- Expertise: [GBV Working Group](#)
- Brief: [Violence Against Women and Girls](#)
- Blog: [Working to Address Gender-based Violence in Fragile Situations](#)
- Webpage: [Fragility, Conflict, and Violence](#)

Note: Table A.1. presents list of FCV situations

BOX 1.2 Voices from the Field

Common Challenges Emerging from Task Team Leader Interviews

- Poor understanding of what gender-based violence encompasses, especially in terms of health sector interventions.
- Poor capacity, not only at the implementation level, but also at the planning level.
- Capacity challenges (skill, financial, other resources) in scaling up or mainstreaming GBV interventions within the health sector.
- The devastation is so vast that economic and social systems are disrupted, and GBV is not a high priority for reconstruction and rehabilitation.

Key Lessons Learned

- Ensure a common understanding of what encompasses a health response to GBV so that there is a clear understanding of GBV interventions.
- Build capacity at all levels. This includes health personnel as well as administrative staff, and the Ministry of Health.
- GBV requires a multi-sectoral response, one that engages at the individual and community level to promote safety and build social networks, along with key investments in rule of law and jobs.
- Mental health interventions with multiple points of entry/service are a good investment.
- Collaboration with partner organizations and other non-state stakeholders to leverage knowledge, skills, reach, and financial resources is important.

Q5

HOW should we evaluate GBV interventions?

Evaluation evidence on the effectiveness of GBV interventions is scarce. This is due to a number of [reasons](#), ranging from ethical considerations and measurement issues to timeframe of evaluations and the long term nature of GBV interventions. Moreover, rigorous quantitative impact evaluations of GBV interventions are limited, and in majority of these, small sample sizes often pose measurement [challenges](#). When planning an evaluation, a mixed method approach may be able to provide more insights.

Box 1.3 presents several toolkits and resources available to guide practitioners interested in evaluating GBV interventions. These include both quantitative and qualitative methods.

BOX 1.3 Guidelines on Evaluating GBV Interventions

- ✓ Inter-Agency Standing Committee's (IASC) [Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)
- ✓ [Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions Along the Relief To Development Continuum](#) by USAID
- ✓ Measure Evaluation's Training Module on [Monitoring and Evaluation of GBV Prevention and Mitigation Programs](#) goes over key issues in data collection and how to develop an M&E framework.
- ✓ The Reproductive Health Response Consortium's (RHRC) [Gender-based Violence Tools Manual for Assessment, Program Design, Monitoring and Evaluation in conflict-affected settings](#) includes qualitative and quantitative methods for data collection, sample questionnaires, and guidelines on codes of conduct.
- ✓ The [Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia Resource Package](#) developed by WAVE and UNFPA discusses several alternative approaches to RCTs for GBV evaluating GBV interventions including outcomes mapping, most significant change technique, and the quality of life battery method.

Indicators for Measuring GBV

The Sustainable Development Goals (SDG) Framework recommends the following **outcome indicators** for [measuring the prevalence of GBV](#). While these focus on women and girls, at the project level, these can be adapted for men and boys and multiple age groups.

- Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months
- Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18
- Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
- Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
- Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18
- Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting, by age

At the same time, it is important to **monitor inputs and outputs**, especially from the project perspective. While this is not an exhaustive list, several key [service delivery](#) indicators that can be adapted to FCV situations include:

- Availability of social services for GBV victims within acceptable distance

- Proportion of health service providers trained to recognize, refer, and/or clinical care for sexual assault survivors/GBV survivors
- Knowledge of health personnel on GBV related standards of operation
- Number of health personnel trained on GBV service provision that are female
- Attitudes of service providers towards survivors of GBV

In addition to outcome and output indicators, the [IASC guidelines](#) also recommend several types of monitoring indicators for inputs at the planning and administration level, such as:

- Inclusion of GBV-related questions in health assessments and/or surveys
- Proportion of female participation in health assessments and/or surveys
- Number of health facilities with trained personnel on GBV guidelines
- Inclusion of GBV prevention and management in health funding proposals and strategies
- Female participation in program design
- Existence of a standard pathway for GBV referrals
- Existence of national policies meeting international standards for GBV related health services/clinical care for sexual assault survivors

These examples of measurement indicators highlight how different dimensions of GBV related health policies, programs, and projects can be evaluated. The choice of indicators should be based on factors such resource availability, ease of collecting data, and the time frame, while aiming to ensure that GBV interventions are monitored and data is available by different demographics such as age, and gender.

Table A.1: Harmonized List of FCV Situations (FY19)

East & South Africa	West Africa	East Asia & Pacific	Middle East & North Africa	Latin America & Caribbean	East & Central Asia	South Asia
Burundi	Central African Rep.	Kiribati	Yemen, Rep.	Haiti	Kosovo	Afghanistan
Chad	Congo, Dem. Rep.	Marshall Islands	Djibouti			
Comoros	Congo, Rep.	Micronesia, Fed. Sts.	Iraq			
Eritrea	Cote d'Ivoire	Myanmar	Lebanon			
Mozambique	Guinea Bissau	Papua New Guinea	Libya			
Somalia	Gambia, The	Solomon Islands	Syria			
South Sudan	Liberia	Timor-Leste	West Bank/Gaza			
Sudan	Mali	Tuvalu				
Zimbabwe	Sierra Leone					
	Togo					

Live link available at: [Harmonized List of FCV Situations](#)

Table A.2: HNP GP Projects with a GBV focus

Project ID	Project Name	Country	Task Team Leader	Approval date
P147489	AFCC2/RI- Great Lakes Emergency Sexual and Gender Based Violence & Women's Health Project	Africa	Hadia Nazem Samaha, Patricia Maria Fernandes, Verena Phipps-Ebeler	2014
P157977	Additional Financing Nigeria State Health Investment Project	Nigeria	Ayodeji Oluwole Odutolu	2016
P160108	Ethiopia Health MDGs P4R Additional Financing	Ethiopia	Anne Margreth Bakilana	2017
P160207	Nepal Health Sector Management Reform Program	Nepal	Kari L. Hurt, Vikram Menon	2017
P160846	Health Sector Support Project	Bangladesh	Patrick M. Mullen, Kari L. Hurt	2018
P163387	Jordan Emergency Health Project	Jordan	Fernando Montenegro Torres	2017
P155658	AFCC2/RI-Southern Africa Tuberculosis and Health Systems Support Project	Africa	Ronald Upenyu Mutasa	2016
P158557	Additional Financing NG-Polio Eradication Support Project	Nigeria	Ayodeji Oluwole Odutolu, Ana Besarabic Bennett, Shunsuke Mabuchi	2016
P152394	Transforming Health Systems for Universal Care	Kenya	Yi-Kyoung Lee, Jane Chuma	2016
P123394	Punjab Health Sector Reform Project	Pakistan	Tayyeb Masud	2013
P148435	Strengthening Universal Health Insurance in Costa Rica	Costa Rica	Eleonora Del Valle Cavagnero	2016
P144688	Health System Improvement Project	Albania	Lorena Kostallari	2015
P163541	Mozambique Primary Health Care Strengthening Program	Mozambique	Humberto Albino Cossa, Furqan Ahmad Saleem	2018
P118806	Sri Lanka - Second Health Sector Development Project	Sri Lanka	Kari L. Hurt	2013
P152799	Health System Strengthening and Support Project	Turkey	Ahmet Levent Yener, Claudia Rokx	2016
P154807	Regional Disease Surveillance Systems Enhancement (REDISSE)	Western Africa	John Paul Clark, Francois G. Le Gall	2016

P120798	Nigeria States Health Investment Project	Nigeria	Ayodeji Oluwole Odutolu, Fatimah Abubakar Mustapha	2012
P150080	Sahel Women's Empowerment and Demographics Project	Western Africa	Christophe Lemiere, Margareta Norris Harrit	2015
P152136	Nicaragua Strengthening the Public Health Care System	Nicaragua	Amparo Elena Gordillo-Tobar	2015
P157864	DRC Health System Strengthening Additional Financing	Congo, Democratic Republic of	Hadia Nazem Samaha	2017
P156012	Health System Support Project ("KIRA")	Burundi	Alain-Desire Karibwami, Laurence Elisabeth Marie-Paule Lannes	2017
P153030	Health System Support Project Additional Financing	Central African Republic	Paul Jacob Robyn	2015
P163976	Zimbabwe Health Sector Development Support Project III - AF	Zimbabwe	Ronald Upenyu Mutasa	2018
P119815	CF-Health System Support Project	Central African Republic	Moulay Driss Zine Eddine El Idrissi, Paul Jacob Robyn	2012
P163476	Lebanon Health Resilience Project	Lebanon	Nadwa Rafeh	2017
P147555	Health System Strengthening for Better Maternal and Child Health Results Project (PDSS)	Congo, Democratic Republic of	Hadia Nazem Samaha	2015
P163313	Additional Financing for the Improving Maternal and Child Health Through Integrated Social Services Project	Haiti	Andrew Sunil Rajkumar	2017
P146591	Supporting Psychosocial Health and Resilience in Liberia	Liberia	Preeti Kudesia	2015
HNP Non-Lending Projects				
P151327	HIV Incentives Evaluations in Swaziland	Africa	Marelize Prestidge	2019
P164946	Investing in the Early Years	Ethiopia	Erika Marie Lutz, Alaa Mahmoud Hamed Abdel-Hamid	2018
P159620	Making mental health a global development priority	World	Patricio V. Marquez, Sheila Dutta	2018
P145230	SN - Health Result Based Financing (RBF) impact evaluation	Senegal	Maud Juquois, Christophe Lemiere	2019
P165595	PNG Nutrition Study	Papua New Guinea	Aneesa Arur	2019

Note:

- Projects in FCV countries/situations that are tagged for gender-based violence



The FCV Health Knowledge Notes Series highlight operational tips to resolve health issues in FCV situations. These Notes are supported by the Middle East and North Africa Multi Donor Trust Fund and The State and Peacebuilding Fund (SPF). The SPF is a global fund to finance critical development operations and analysis in situations of fragility, conflict, and violence. The SPF is kindly supported by: Australia, Denmark, Germany, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom, as well as IBRD.

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