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Sexual and gender-based violence services and programming

Introduction

Sexual and gender-based violence (SGBV) refers to any harmful act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. Such violence results in, or may result in, physical, sexual, and, or psychological harm.

SGBV is a major public health issue, a clinical health problem, and a violation of human rights. It is rooted in gender inequities, and further promotes them. Globally, approximately one in three women are affected by SGBV.

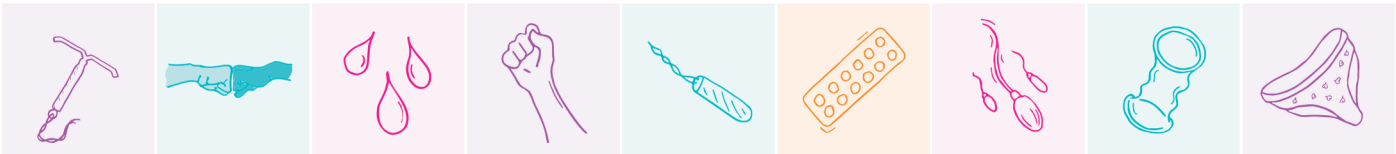
The International Planned Parenthood Federation (IPPF) acknowledges that SGBV is a key barrier to fully accessing sexual and reproductive healthcare and affects both the general health and sexual and reproductive health of survivors.

IPPF is dedicated to scaling up work at the community level, including in humanitarian contexts, to prevent and respond to SGBV. We are committed to feminist principles in humanitarian action and recognizes that conflict-related sexual violence is increasingly being used as a weapon of war. In centering human rights and challenging existing inequalities, IPPF strives to advance the rights of women, girls, men and boys and lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) people in emergency contexts and beyond.

Our Member Associations (MAs) aim to integrate quality SGBV care in every clinic as part of the Integrated Package of Essential Services Plus (IPES +).

Key Documents for MAs:

- IPPF (2022) Client-Centred Clinical Guidelines for Sexual and Reproductive Health Care. Chapter 10 Sexual and Gender-based Violence.
- IPPF Strategy 2028.
- IPPF Institutional Data Guidelines 2023-2028.
- IPPF (2020) International Medical Advisory Panel (IMAP) Statement on Sexual and Gender-Based Violence (SGBV).
- IPPF (2015) Quality of Care Framework.
- IPPF (2024) Feminist Principles in Humanitarian Contexts.
- IAWG (2018) Inter-Agency field manual on reproductive health in humanitarian settings and Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crisis situations.
- World Health Organization (2014) Health care for women subjected to intimate partner violence or sexual violence : A clinical handbook WHO/RHR/14.26.



IPPF results framework and SGBV

The IPPF Strategy 2028 has four pillars and focuses on providing quality Sexual and Reproductive Health and Rights (SRHR) for everyone, everywhere, breaking barriers with core IPPF areas such as gender, youth, humanitarian and rights running across the strategy.

These pillars are:

Pillar 1. Centre care on people to expand choice, widen access and advance digital and social self-care.

Pillar 2. Move the Sexuality Agenda through ground advocacy, shift norms and act with youth.

Pillar 3. Solidarity for change to build strategic partnerships, support social movements and innovate and share knowledge.

Pillar 4. Nurture the Federation by charting our identify, grow the Federation and 'walk the talk'.

Under Strategy 2028, SGBV is **integrated across the four pillars** and can be broken into SGBV clinical Service Delivery (Pillar 1) and SGBV Programming (Pillars 2,3,4), *Figure 1.*

Table 1. Examples of MA activities for SGBV clinical service delivery (SGBV service delivery) under Pillar 1 and SGBV programming under Pillars 2,3 and 4 of the IPPF Strategy 2028.

SGBV SERVICE DELIVERY (PILLAR 1)	SGBV PROGRAMMING (PILLAR 2, PILLAR 3, PILLAR 4)
• Have the capacity to provide services & are **'SGBV Service Ready'.** • Provide quality and accessible first-line clinical **support** to survivors of violence and referrals pathways for clinical, psychosocial and protection services (IPES+, DHIS2). • **Trained/registered SGBV counsellors** (optional). • Actively engage with formal **national SGBV referral mechanism** (where existing), & SGBV stakeholders. • Meet **quality standards** (Net Promoter Score, client feedback). • **Accessible & inclusive services** (e.g., youth friendly, diverse SOGEISC*/LGBTQI+ and disability inclusive). • During crises - transition from IPES + to MISP Objective 2 (response) for clinical care of survivors then back to IPES+ (recovery).	• **Ground advocacy** (P2) to connect SRHR advocacy at all levels, amplify marginalized/ excluded voices, Support global commitments (e.g. CEDAW). • **Shift norms** (P2) to prevent SGBV & promote Gender Equality, Disability and Social Inclusion (**GEDSI**) e.g. GEDSI analysis, community outreach, digital communication & community-based prevention. • **Act with youth** (P2) - youth-centered meaningful participation, comprehensive sexuality education. • **Support social movements** (P3) cross-sector campaigns (e.g., 16 days) and amplify messages. • **Build strategic partnerships** (P3) and expand collaboration with Government & SGBV stakeholders. • **Drive innovation** & share knowledge (P3) through SGBV Champions Community of Practice, knowledge products, research. • **Walk the talk** (P4) challenge discrimination, embrace gender & sexual diversity. • During crises - transition from IPES + to MISP Objective 2 (response) for **coordination, prevention & risk mitigation safe spaces** then back to regular SGBV programming (recovery).

*SOGEISC-Sexual Orientation, Gender Identity, and gender Expression and Sex Characteristics

SGBV Service Delivery

SGBV service delivery falls under Pillar I: Centre Care on People to provide open, accessible, and respectful SRH services. The three indicators to measure success under Pillar 1 are: (1) the proportion of service providing IPES+ and meeting quality standards, (2) the number of clients served by type of services and model of care and (3) the services provided by type of services and model of care with focus on adolescents and young people, people in humanitarian settings and other marginalized and excluded people.

To qualify as providing IPES+, MAs must report providing two SGBV services:

1. First-line clinical support to survivors of violence, and

2. Referral mechanisms for clinical, psychosocial and protection services.

Specialised SGBV counselling is an optional code for MAs with trained/registered SGBV counsellors.

Clinical management of Rape (CMR) is reported under first-line clinical support and includes several services provided under IPES-Plus (e.g. emergency contraception, HIV PEP, STI syndromic management, pregnancy tests etc.).

To provide high-quality and accessible first-line clinical support to survivors of violence and referrals for clinical, psychosocial and protection services, MAs need to have the capacity to provide the services by being 'SGBV Service Ready'.

For MAs this also means that they are following best practice Client-Centred Clinical Guidelines (CCCG) and meet Quality of Care (QoC) standards (e.g., safe and confidential environment, well-managed services, secured supply chain, confidential client data, protocols, communication resources, referral protocols, trained staff etc.).

Building MA capacity for SGBV service delivery includes having SGBV Standard Operating Procedures in place, ensuring all staff are regularly trained on SGBV and first-line support e.g. the SGBV Fundamentals training and that clinicians are CMR trained.

Other specialized trainings should also be available, such as GBV in emergencies (GBViE) Minimum Standards, Mental Health and Psychosocial Support (MHPSS), and SGBV Counselling.

IPPF recommends adopting **selective screening of clients using a clinical inquiry approach** if:

- Staff are appropriately trained (with survivor-supportive attitudes and skills).
- The clinic can ensure the privacy, safety and confidentiality of clients.
- A referral pathway is in place.

IPPF **does not recommend any type of screening for SGBV if specialized care or referral pathways are not available** as this can do more harm to survivors. This includes screening during humanitarian settings when instead it is recommended to implement the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crisis Objective 2.

SGBV Programming

IPPF is committed to **advancing gender equality** and understanding the importance of addressing the root causes of inequities and structural barriers faced by marginalized individuals and communities in accessing SRHR, particularly in times of crisis.

SGBV programming can be considered as all other activities different from SGBV service provision, that corresponds to the objectives under pillar 2 (move the sexuality agenda), pillar 3 (solidarity for change) and pillar 4 (nurture the Federation). Technical assistance is provided by various technical leads and can include building MA capacity to 'walk the talk' in line with IPPF values.

Interventions may include:

- Supporting social movements and implementing activities that support social change, advocacy and strategic partnerships on Sexual and Reproductive Health and Rights (SRHR), gender equality, disability and social inclusion etc.
- Expanding collaboration with government authorities and other local stakeholders to strengthen national SGBV referral frameworks and ensure that its included into national disaster risk management structures.
- Activities that help to shift gender and social norms by making sure to include SGBV information and awareness into other behaviour change initiatives during community outreach activities and/or information sessions conducted as part of mobile clinics alongside clinical services.
- Making sure that SGBV is included into comprehensive sexuality education (CSE) and youth peer education programmes using a youth-centered meaningful participation approach.
- Including SGBV into awareness raising initiatives and social movements such as the annual 16 days of activism campaigns.
- Strengthening capacity for targeted SGBV prevention work such as community-based prevention interventions and to link to the RESPECT framework for preventing and responding to violence against women.
- Building MA capacity to 'walk the talk' in line with IPPF values for gender equality, inclusion and sexual and reproductive health and human rights, IPPF localization policy and the feminist humanitarian principles.
- Support staff who are survivors of SGBV.
- Supporting global and national advocacy efforts to advance SRHR and gender equality committments e.g. the core international human rights treaties, the sustainable development goals, the International Conference on Population and Development Programme of Action (ICPD PoA), Family Planning 2030 (FP2030) as well as the Sendai Framework for Disaster Risk Reduction Gender Action Plan and other international commitments that support SRHR in times of crises.

Our Approach

Addressing SGBV in Stable TImes

IPPF is committed to ensuring **that by 2028, there will be an increase in societal support for the prevention of sexual and gender-based violence, access to abortion and promotion of gender equality.**

Addressing SGBV in stable times requires not just strengthening SGBV service delivery and SGBV Programming but supporting efforts to identify and address the root causes of inequities and structural barriers faced by marginalized individuals and communities in accessing SRHR.

The CCCG recommends a pathway for care of clients experiencing sexual violence and/or violence by an intimate partner. While this refers primarily to physical and/or sexual violence, it may also include psychological and/or emotional abuse or other forms of SGBV.

MAs should also include actions to address other forms of SGBV that are prevalent in their national context, such as:

Denial of resources, opportunities or services, including denial of access to health services and access to SRH and family planning.

Economic abuse is an aspect of abuse where abusers control victims' finances to prevent them from accessing resources, working or maintaining control of earnings, achieving self-sufficiency and gaining financial independence and may impact on a client's ability to purchase health commodities, such as menstrual hygiene products, contraceptives etc.

Technology Facilitated SGBV is an emerging issue where one or more people harm others based on their sexual or gender identify or by enforcing harmful gender norms using the internet and/or mobile technology. It includes different types of abuse such as stalking, bullying, sexual harassment, defamation, hate speech and exploitation (Hinson et. al).

Reproductive coercion where individual(s) exert power and control over another's reproductive health and choices, predominantly by men against women but also observed in women and girls with disabilities from caregivers and health providers. Reproductive coercion may include pregnancy coercion (pressure to become pregnant), contraceptive sabotage (direct interference with contraception), and control of pregnancy outcomes (forcing the pregnant person to have an abortion or to continue with a pregnancy that they do not want). Not all clients who live with reproductive coercion are affected by other forms of SGBV such as intimate partner violence.

Harmful traditional practices are accepted forms of violence in a specific culture by society that have taken place over time predominately against women and girls and been carried out in the name of tradition. Such acts include **child, early and forced marriage (CEFM)**, honour killing and female genital mutilation. **Female genital mutilation (FGM)** is a pervasive human rights and public health issue. It encompasses all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons.

IPPF's position on FGM is as follows:

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

Addressing SGBV in Crises

During emergencies, the risk of SGBV increases and all humanitarian responders are required to **assume GBV is occurring**, treat it as life-threatening problem and take action as per the centrality of protection and GBV guidelines. This includes addressing conflict-related sexual violence.

Humanitarian Action is outlined in Strategy 2028 through IPPF's continued commitment to offer lifesaving SRHR care in humanitarian crises. IPPF focuses on localization through partnership with our Member Associations and in line with IPPF's commitment to feminist principles in humanitarian contexts. Emergencies exacerbate new and existing risks of SGBV within communities, and MA programming must therefore focus on **survivor-centred treatment and prevention of sexual violence.**

MAs are supported by the IPPF Global Humanitarian Team to implement the **Minimum Initial Service Package (MISP)** for reproductive health in emergencies at the onset of a crisis to ensure access to lifesaving SRH services.

Table 2. IPPF Integrated Package of Essential Services Plus transition to the Minimum Initial Service Package (MISP) for reproductive health in emergencies during crises.

IPES +	TRANSITION	MISP
SGBV First-line clinical support to survivors of violence AND Referral mechanisms for clinical, psychosocial and protection services.	**Continue** • Survivor identification. • First-line clinical support using a Survivor centred approach with a focus on continuing Clinical Management of Rape (CMR) services. • Referrals (with updated referral pathways). **Start** • Coordination with clusters (especially the Protection and GBV sub-Clusters or working groups) to support GBV prevention measures. • Adapt IEC materials to include awareness of and any changes in available. services for survivors. • Integrated Risk mitigation for SGBV in all MA services.	**Objective 2: Prevent sexual violence and respond to the needs of survivors** • Work with other clusters especially the protection or gender-based violence sub-cluster to put in place preventative measures at community, local, and district levels including health facilities to protect affected populations, particularly women and girls, from sexual violence. • Make clinical care and referral to other supportive services available for survivors of sexual violence. • Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.

Note: In MISP Objective 3 (STI/HIV) Providing PEP to survivors of sexual violence and having syndromic diagnosis and treatment of STIs is recommended. Ensuring access to safe abortion care is available, to the full extent of the law is an 'other priority'.

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