

When a survivor does not want to access healthcare

“For a recent GBV incident, it is important to determine whether a medical referral is required. This is particularly important for incidents of rape, sexual assault or any form of non-sexual physical assault that may have resulted in acute injury, pain or bleeding. You can understand a survivor’s health needs primarily by listening to their story of what happened and determining the medical implications.

You may also have to ask clarifying questions—the goal of which is to understand:

- Nature of the incident (i.e. if it was a rape or sexual assault, medical treatment is highly recommended)
- Date/timing of the last incident (i.e., for sexual assaults that happened within 72 or 120 hours, lifesaving treatments can be provided as described below)
- Presence of and/or complaint of pain or injury.”¹

Health responses following incidents of GBV could include the clinical management of rape (prevention of HIV and sexually transmitted infections, prevention of pregnancy, treatment for acute injuries or the collection of forensic evidence (if deemed safe, and only with the survivors consent). It could also include health needs such as treatment for sexually transmitted infections, incontinence of urine or stool, or safe access to abortion to the full extent of the law (pregnancy may be safely terminated up to 22 weeks).²

GBV survivors should be able to access confidential, quality and age appropriate survivor-centered healthcare (including MHPSS) for sexual violence, intimate partner violence and other forms of GBV and referrals for follow up. Health services are often the first (and sometimes only) point of contact for survivors and they should be delivered in a confidential, non-judgmental and non-discriminatory manner. Health actors need to be able to provide:

1. Survivor-centered care and first-line support (i.e. psychological first aid) to address basic emotional needs.
2. Identification and care for survivors of IPV.
3. Clinical care for survivors of sexual violence.
4. Training of health workers.

5. Coordination and safe and ethical data collection for service delivery.
6. Provide or refer for additional mental health care.³

However, many survivors will not seek help from a health-care provider (or any other provider) due to shame, fear of blame, repercussions, stigma and rejection from partners/families.⁴ If health care providers are not well trained or if services are not perceived to be safe and confidential, then survivors are unlikely to seek help or accept a referral to these services. Additionally, a lack of confidential spaces, supplies, equipment, and trained female staff can also be barriers to help seeking. Mandatory reporting procedures may also limit survivors' access to life-saving health care.

Case Worker Responsibilities

Case workers play a supportive and facilitative role in the case management process, aiding survivors to receive the care they need, based on their agency and self-determination. This is part of the recovery process to enable/assist survivors in making decisions about their own care. In this, survivors should not be subjected to treatment(s) they decline, but case workers can play an important role in communication.

This communication should include providing survivors with all needed information about health services available, the importance of accessing services, any time constraints (e.g. 72 hours in the case of sexual violence to access HIV PEP). The information provided should be comprehensive, including the benefits and risks of each referral and any mandatory reporting requirement.

If the survivor refuses health service, the case worker should try to understand the reason for the refusal. The service might be refused for many different reasons. Logistical problems (distance of the facility, transportation, children to take care of that don't allow her to move), financial difficulties (no money to pay the health services or the transport), fear of stigma, mandatory reporting requirements, concern that going to the health facility would jeopardize the confidentiality, issues related to that specific health facility (presence of someone the survivor knows and mistrusts in that health facility, location of that health facility in a not safe area etc.). The case worker should try to ask the reason for the refusal without pushing the survivor to answer if she does not want to.

For some of the above mentioned reasons for refusals, the case worker and her organization could likely provide support (e.g. offering the transport, paying the costs of the health service, referring the survivor to a child-friendly spaces to take care of the kids while she goes to the health facility, suggesting a different health facility if the survivor does not feel comfortable with that one, offering to accompany her, etc.). All those possible supportive solutions should also be discussed and considered as possible scenarios during the set-up of the case management service and the

development of the project/budget. If the case worker is able to identify the reason behind the refusal of the referral, a possible solution should be looked at and discussed with the survivor, to overcome the obstacle.

Ultimately, the wish of survivors must be respected. If the survivor doesn't want to tell the case worker why she does not want to go to the health facility, that's her right. If, despite all the efforts of the case worker to address the obstacles that do not allow the survivor to get medical care, the survivor still refuse the service, that's her right. It can be frustrating for the case worker, especially if the case worker knows how important getting health care would be for the survivor, BUT the decision of the survivor should be respected.

If the survivor still refuses the health service, the case worker should respect the decision and explain to the survivor that, if she changes her mind, she can always go to the health facility by her own, or together with the case worker, if she prefers so. The case worker should make sure the survivor has all the contacts needed in case she decides later on to go to the health facility by herself. During the following case management sessions, the case worker can also check with the survivor how she is doing and eventually, if the survivor is still in need, reminding her that, if she wants, she can still receive health care.

In the case of child survivors, the child should be included in all decision-making processes and should be providing informed assent/consent (as determined by their age and stage of development). The child's care giver or trusted adult should also be engaged to provide consent. Confidentiality is also limited by the mandatory requirement to report all cases of child abuse in accordance with local protocols. Mandatory reporting for child sexual abuse refers to state laws and policies that mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).⁵ The best interests of the child and their immediate care and safety should be the primary consideration in all decisions including for health care referrals.

Supervisor Responsibilities

The supervisor should try to identify the trend of the referrals and identify the obstacles that are leading to refusal of services and develop a strategy to address those obstacles, from the very operations point of view (covering costs and transports, having more health facilities available for referral etc.), but also from the advocacy point of view (for mandatory reporting an inter-agency coordinated advocacy strategy would be needed) or staff training and capacity (i.e. if they are unfamiliar with the referral pathways or do not fully understand health protocols and responses)

In this role, the supervisor should also ensure that case workers are aware and familiar with the survivor-centered approach and trained to respect survivors' decisions, even when they don't agree with them. Supervisors can

support case workers in dealing with the sense of frustration that might arise when referrals and, more in general, management of cases becomes difficult. Some self-care for case workers is always a good practice.

How to increase referrals to health services and reduce barriers to access

- Map the health facilities available and evaluate the types and the quality of the service provided in the health facilities in order to be able to provide the survivor with the most comprehensive information. Train health staff on GBV including GBV guiding principles, basic psychosocial support and referrals in order to apply a survivor-centered approach in the health facilities, improve the attitude towards GBV survivors, and reduce stigma and risks of breach of confidentiality.
- Encourage health facilities to have female staff and train these as GBV focal points.
- Support the health facilities to have a more survivor-friendly environment through private space, lockable cabinets, and safe wash facilities for women, etc.
- Create a direct link between the case workers and the health facility (possibly identify a focal point within the health facility) to facilitate referrals.
- Understand the legal context and IF there is a mandatory reporting for the health staff. If there are legal obstacles for the access of survivor to health facilities, engage relevant local authorities in an inter-agency coordinated advocacy effort to address the legal obstacles.
- Budget for and create procedures for addressing some of the practical obstacles survivors might have in accessing the health facilities. This might include providing transport, child care for survivor's children s while going to health center, and/or having case workers accompanying survivor if she wants so.



¹ Inter-Agency Case Management Guidelines https://gbvresponders.org/wp-content/uploads/2017/04/Interagency-GBV-Case-Management-Guidelines_Final_2017_Low-Res.pdf

² Ibid.

³ World Health Organisation (2014) Clinical Handbook: Health care for women subjected to intimate partner violence or sexual violence.

⁴ IASC (2015) Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action

⁵ IRC (2012:17) Caring for child survivors of sexual abuse in humanitarian settings.