Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_______________________________ __04/21/2022_________
Michelle Nguyen Date

Needs Assessment of the Clinical Management of Sexual-Gender Based Violence across Medical Teams International Country Offices in Bangladesh, Tanzania, and Uganda

By

Michelle Nguyen
Masters of Public Health

Hubert Department of Global Health

____

Ameeta Kalokhe, MD, MSc
Thesis Committee Chair

Needs Assessment of the Clinical Management of Sexual-Gender Based Violence across Medical Teams International Country Offices in Bangladesh, Tanzania, and Uganda

By

Michelle Nguyen

BA International Affairs
University of Georgia
2019

Thesis Committee Chair: Ameeta Kalokhe, MD, MSc

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health

ABSTRACT

Needs Assessment of the Clinical Management of Sexual-Gender Based Violence across Medical Teams International Country Offices in Bangladesh, Tanzania, and Uganda

By Michelle Nguyen

Background: Women and girls are among the most vulnerable groups to experience sexual gender-based violence (SGBV) within complex humanitarian settings. Provisions of legal care, psychosocial care, and clinical management of rape (CMR) services are available to survivors, in respond to their SGBV needs. While there is a growing number of SGBV cases, many cases go unreported due to reporting hesitancies. Underreporting can result in lack of SGBV service utilization, including CMR services, putting the survivor at risk for serious short-term and long term physical, mental, and social health consequences.

Objective: To assess the current practices and gaps in existing protocol around SGBV reporting and clinical management of rape survivors in Uganda, Tanzania, and Bangladesh.

Methods: The study employed qualitative data collection through interviews with six SRH/HIV officers overseeing the nine settlements in Mtendeli and Nyarugusu, Tanzania, Adjumani, Palorinya, Kyangwali, Mbarbara, Kyaka II, and Rwamwanja, Uganda, and Cox's Bazar, Bangladesh. One-on-one interviews were conducted between June 2021 and August 2021. A deductive codebook was developed and used for thematic analysis of the key informant interviews.

Results: The interviews revealed location/setting, facilitator/reporting authority, communication methods, support systems, emergency shelter/protections, prioritization of justice, and referral as major themes of the reporting process. Participants discussed language barriers and lack of access and knowledge of SGBV services as challenges to the reporting process. Themes of initial treatment, loss to follow-up, tracking, staff training/guidelines, and overall capacity emerged during discussion of the treatment process. The treatment process was met with barriers of staff capacity, treatment documentation, and medication stock/supply. Both the reporting and treatment process were met with the challenges surrounding cultural norms/stigma and structural privacy and confidentiality.

Discussion: With knowledge of the existing practices and gaps to the reporting and treatment process, the development of potential projects, funding considerations, and updated protocols may help strengthen the overall quality of CMR services offered. There is a need across all settlements to strengthen the privacy and confidentiality of the reporting and treatment process, as well as to reduce the stigmatization of SGBV within the communities.

Needs Assessment of the Clinical Management of Sexual-Gender Based Violence across Medical Teams International Country Offices in Bangladesh, Tanzania, and Uganda

By

Michelle Nguyen

BA International Affairs
University of Georgia
2019

Thesis Committee Chair: Ameeta Kalokhe, MD, MSc

A thesis of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2022

Acknowledgements

I would like to thank Medical Teams International for being the spark of inspiration for my thesis. I am grateful for the team's expertise and trust in me to execute such an amazing project.

I am extremely grateful for my thesis chair, Ameeta Kalokhe, for her wisdom and guidance. Thank you for being a source of peace and calm for me during this thesis journey. Your kindness and patience fostered such a positive experience for me.

To my family and friends, there aren't enough words to express the blessings and gratitude I have for your unconditional love and support. I want to dedicate this thesis to my ông ngoại. Thank you for being my number one supporter in my academic pursuits and thank you for always being proud of me regardless of my direction.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION……………………………………………..………..…………1

CHAPTER 2: LITERATURE REVIEW………………………………………………..……6

CHAPTER 3: METHODS…………………………………………….……………………30

CHAPTER 4 : RESULTS……..……………………………………………………………36

CHAPTER 5: DISCUSSION…………………………………………….…………………45

CHAPTER 6: PUBLIC HEALTH IMPLICATIONS………………...……………………….52

REFERENCES…………….…………………………….………………………………54

APPENDICES

APPENDIX 1: PARTICIPANT INTERVIEW GUIDE…….………...………………59

APPENDIX 2: QUALITATIVE CODEBOOK…….………..…………………….....61

ACRONYMS AND ABBREVIATIONS

Acronyms	Meaning
AIDS	Acquired Immunodeficiency Syndrome
CMR	Clinical Management of Rape
HIV	Human Immunodeficiency Virus
HPV	Human Papillary Virus
IDP	Internally Displaced Persons
MCH	Maternal Child Health
MHPSS	Mental Health & Psychosocial Service
MISP	Minimum Initial Service Package
NGO	Non-governmental Organization
PEP	Post Exposure Prophylaxis
PID	Pelvic Inflammatory Disorder
PTSD	Post-Traumatic Stress Disorder
SGBV	Sexual Gender-Based Violence
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
UNHCR	United Nations High Commissioner for Refugees
UNFPA	United Nations Populations Fund
WASH	Water, Sanitation, & Hygiene
WHO	World Health Organization

INTRODUCTION

Context

Women and girls are among the most vulnerable groups to experience sexual gender-based violence (SGBV) within complex humanitarian settings. SGBV can be defined as any act that is perpetrated against a person's will based on their gender, rooted in gender inequalities, unequal power dynamics, and harmful norms (UNHCR, 2003). It's said that one in five displaced women in complex humanitarian settings have experienced sexual violence (Vu et al., 2014). With the increasing number of displaced individuals globally, the prevalence of SGBV within humanitarian settings, such as refugee camps and internally displaced persons (IDP) sites, is growing every day (Vu et al., 2014). Complex humanitarian crises create new vulnerabilities for women and girls, challenging their structural and physical protection within refugee camps and IDP sites (Simon-Butler & McSherry, 2019). The environment magnifies the unequal power dynamics and inequalities experienced by women and girls, observed from the starting point of the crisis within the origin country, the passage to the resettlement site, to the resettlement within the camp sites (Block et al., 2019; Wirtz et al., 2013).

Organizations within IDP sites and refugee camps have worked towards strengthening the prevention and response to SGBV, through provisions of legal, psychosocial, and clinical management of SGBV care. However, the true prevalence of SGBV within these settings is likely to be an underestimation due to underreporting. Reporting refers to the formal account of a survivor's SGBV incident to an associated facility within the camp's SGBV system. In order for survivors to receive treatment for their SGBV injuries, the incident needs to be reported to non-governmental organizations (NGOs), the police, hospitals/clinics, community centers, and/or

community leaders. However, survivors must overcome multiple barriers to report their rape incidents, making the process difficult, and discouraging reporting altogether.

The lack of reporting puts the physical, mental, and social health of the survivor at risk, as their SGBV injuries are left untreated and unmonitored, leading to serious short-term and long-term health consequences. The experience of rape is a traumatizing event, with negative effects on the survivor's mental health, including the development of post-traumatic symptoms (UNHCR, 2002). The post-traumatic symptoms can become debilitating for survivors, therefore, without the appropriate psychosocial care, the survivor may begin to withdraw from daily responsibilities and interactions with their community (Friedman, 1992). Without the proper screening and treatment for survivors of rape, STIs/HIV, unintended pregnancies, and reproductive complications may fail to be diagnosed, prevented, and treated (Undie et al., 2016). Depending on the incident, the severity of the physical wounds are prone to infection, with potential further complications if not immediately treated (UNHCR, 2002). Timely treatment is extremely pertinent to the patient's ability to recover and their overall long-term health.

Organizational Background

Medical Teams International is a faith-based NGO, headquartered in Portland, Oregon. The organization provides a range of services from refugee medical care, disaster relief, maternal child health, and dental care domestically and globally, with active programs in Colombia, Guatemala, Uganda, Tanzania, Bangladesh, Lebanon, Ethiopia, and Sudan. Currently, Medical Teams provides SGBV programming within settlements in Uganda, Tanzania, Bangladesh, and Ethiopia, working in partnership with different NGOs to provide clinical care to SGBV injuries. A major provision of the SGBV programming include clinical management of rape (CMR) services provided by the Medical Teams staff in conjunction with other NGO partners within the

settlement facilities. The protocol for CMR services is to provide the five elements of the treatment package to those being seen for clinical care, followed by the appropriate non-clinical referrals according to the survivor's needs and circumstances. The five elements of the treatment package consists of post-exposure prophylaxis (PEP), pregnancy prophylaxis, wound care, STI screening/treatment, and psychosocial care. Medical Team's country office staff assist, administer, and document the clinical provisions of the CMR services and work to improve the treatment/reporting process in order to provide quality care to all survivors receiving clinical care.

Focus and Scope

The quality of SGBV care provided to survivors is dependent on a multitude of factors, including reporting by the survivor and the capacity of the centers to provide and track the five treatment elements. Treatment tracking refers to the documentation of the five elements offered within the standardized treatment package per case reported. Reporting and treatment tracking are significant components of a facility's ability to provide optimal SGBV care to the survivors. Reporting is the first step in triggering a survivor's access to clinical care, psychosocial care, legal care, and protection included in the SGBV reporting process. In order to adequately provide the clinical provisions, the availability of the necessary medications and treatments need to be present, to increase the effectiveness of preventative medications and timely administered treatment. A cohesive treatment tracking system allows the staff to document each survivor's treatment timeline, referrals, and follow-up needs.

Medical Teams International measure their progress through their established global indicators. A new addition of a SGBV global indicator states,

" The percentage of SGBV survivors who receive a full package of treatment (PEP, pregnancy prophylaxis, STI treatment, wound care, and psychosocial support." (Medical Teams International, 2021)

In order to assess the ability of country offices to meet the SGBV global indicator, there was a need to evaluate the current practices and gaps of the CMR services offered in settlements within Uganda, Bangladesh, and Tanzania. Qualitative data was collected through online individual interviews with an SRH/HIV officer representing each designated settlement. The primary data collected explored the existing SGBV protocols around the reporting and treatment process, including methods of communication, treatment administration, and reporting practices. It also explored the guidelines used for CMR services, staff training, and the treatment tracking abilities of each facility.

Purpose Statement

The purpose of the special studies project is to assess the readiness of Medical Teams International to meet their SGBV global indicator across settlements in Uganda, Tanzania, and Bangladesh. Analyzing the current practices and challenges will help provide the organization with a better understanding of how to better support each settlement facility in the provision of quality CMR services to rape survivors. Performing an assessment of the current treatment and reporting process and protocols will highlight the current issues and gaps that require programmatic changes, in order to provide adequate quality clinical care to survivors of rape. The research will address the following questions:

Research Questions

1. What are the existing practices and gaps of the CMR treatment package rape survivors receive when reporting in Bangladesh, Tanzania, and Uganda?

2. What are the current practices and gaps in existing protocols around SGBV reporting in Bangladesh, Tanzania, and Uganda?

Programmatic Significance

The research will provide Medical Teams with the most updated information on the reporting and treatment practices across the settlements, as well as insight into the current challenges and gaps. The data will enable Medical Teams to make evidence-based decisions when considering programmatic changes, in preparation to meet the new SGBV global indicator. The research will provide the organization with a better understanding of the current scope and capacity of each settlement's operations, to prioritize the more urgent areas of need. Programmatic changes could help improve the SGBV reporting process in each settlement facility and increase the rate of CMR service utilization amongst rape survivors. Assessing and combating the current challenges could encourage CMR service utilization from hidden populations lost to the barriers of the reporting and treatment process within the settlements. The research questions help the organization understand how they might increase the quality of care provided to survivors while considering the appropriate context of each settlement.

LITERATURE REVIEW

Introduction

The United Nations of High Commissioner for Refugees (UNHCR) defines sexual gender based violence (SGBV) as any act that is perpetrated against a person's will based on their gender, rooted in gender inequalities, unequal power dynamics, and harmful norms (UNHCR, 2003). Types of SGBV include physical violence, emotional/psychological violence, harmful traditional practices, sexual violence, and socio-economic violence such as denial of resources and access to services (UNHCR, 2003). Vulnerability to violence increases with the intersectionality of sexual orientation, gender identity, race, ethnicity, religion, economic status, and disability (Simon-Butler & McSherry, 2019). Depending on the political, social, and cultural history of an environment, particular groups belonging to one or more identities face higher risks of sexual violence. Sexual gender-based violence, however, tends to disproportionately affect women and girls due to male and female gender roles that subject women to male-dominated power and control structures, dictating their social presence and roles within their community (Simon-Butler & McSherry, 2019).

Complex humanitarian crises can exacerbate the prevalence of SGBV among women and girls as they are at high risk due to the changing dynamics of the environment, with the increased lack of social and physical protection, unsafe access to services, as well as being targeted as weapons of war (Simon-Butler & McSherry, 2019). During times of conflict, a common response for the population at risk is displacement, within or outside of their country of origin, to seek safety and asylum at refugee camps/internally displaced persons (IDP) sites. SGBV can be observed at every passage point of the refugee experience, from the violence within the origin country, the passage to the resettlement site, to the resettlement within the settlement (Wirtz et

al., 2013). With increased economic and physical vulnerabilities, women and girls are met with sexual violence, harassment, coercion, and sex trafficking throughout their experience. Within the camps, perpetrators of SGBV consist of not only intimate partners, family members, and close friends but also consist of community members, security forces such as peacekeepers, humanitarian aid workers, and institutions established to serve the population (UNHCR, 2003 & Wirtz et al., 2013).

SGBV amongst women and girls has grown in recognition and priority for its major human rights violations, resulting in international work seen in *The Convention on the Elimination of All Forms of Discrimination against Women, United Nations Declaration on the Elimination of Violence against Women, and United Nations Security Council Resolution 1325* (UNHCR, 2003). Among the types of SGBV experienced, rape still stands as one of the most common forms of SGBV experienced within refugee camps globally (Oladeji et al., 2019). Rape can be defined as "*The invasion of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body by force, threat of force, coercion, taking advantage of a coercive environment, or against a person incapable of giving genuine consent*" (ICC Women, 2001). The health consequences of rape for women and girls, range from short term to long term physical, mental, and psychological problems (Jina & Thomas, 2013). Unfortunately, incidence reports of rape are low and lack accuracy due to different reporting barriers presented within the refugee camps/IDP sites (Oladeji et al., 2019). This literature review intends to explore the presence of SGBV within complex humanitarian settings, the clinical management of rape (CMR), the barriers to reporting SGBV, and the context of its occurrence and management in Bangladesh, Tanzania, and Uganda's settlements.

Repercussions of Experiencing SGBV

Sexual Reproductive Health Repercussions

Experience of sexual violence can lead to different sexual reproductive health consequences, from contraction of human immunodeficiency virus (HIV)/sexually transmitted infections (STIs), development of reproductive complications, to unintended pregnancies. Coercive and unprotected sex exposes women and girls to a high risk of STIs such as chlamydia, gonorrhea, and hepatitis (Undie et al., 2016). STIs have the potential to cause pelvic inflammatory disease (PID), infertility, tubal/ectopic pregnancy, cervical cancer, and complications in infants born to infected mothers (NIH, 2015). With the risk of contracting STIs, there is also an increased likelihood of contracting HIV (NIH, 2015). STIs increase the likelihood of transmission and susceptibility of HIV through its effect on HIV shedding and viral diversity (Galvin & Cohen, 2004). Left untreated, HIV can lead to a compromised immune system, allowing for other opportunistic infections to develop, with the potential progression towards acquired immunodeficiency syndrome (AIDS) (Mayo Clinic, 2020).

Female survivors of rape face concerns of unexpected pregnancy while facing stressors of the economic and social burdens, depending on their decision to keep or abort the pregnancy (UNFPA, 2019). Safe abortion services may not be available to women or can not be afforded within their settlement, therefore, women may seek to undergo unsafe abortions for their unwanted pregnancies (UNFPA, 2019 & Oladeji et al, 2021). Unsafe abortions can lead to severe health complications and infections such as hemorrhages and sepsis, as well as poor wound healing, infertility, internal organ injury, and bowel resections (Haddad & Nour, 2009). If women are already pregnant at the time of the assault, they are more susceptible to miscarriages, hypertension during pregnancy, and premature delivery (UNFPA, 2019).

Mental Health and Other Physical Health Repercussions

The experience of rape can cause emotional and psychological trauma among female survivors, developing a range of mental health disorders such as post-traumatic stress disorder (PTSD), sleeping/eating disorders, and suicidal ideations (UNHCR, 2002; Vu et al., 2014). A majority of survivors develop severe post-traumatic symptoms of anxiety, self-blame, uncontrollable emotions, depression, mood swings, panic, and at times, experience difficulty completing their daily tasks (Friedman, 1992; UNHCR, 2002). This can further exacerbate their situation within the refugee camps, especially if they carry the responsibility of working, cooking, and/or caretaking within their families. The experience can also cause suicidal ideation and suicidal attempts as the assault may cause feelings of hopelessness, guilt, and shame, in addition to the stigma and potential isolation from community knowledge of the incident (Friedman, 1992; UNHCR, 2002).

The physical repercussions are a consequence of the forceful and violent nature of SGBV, as survivors may be left with different types of physical wounds depending on the circumstances of their incident. The more immediate physical injuries female survivors face are pelvic pain, vaginal bleeding, cuts/abrasions, bruising, damaged tissues, and other physical injuries as a result of using objects/weapons (UNHCR, 2002). Female survivors, who experience SGBV, have reported more severe injuries such as fractures and broken teeth due to the physical violence experienced during the incidents (Laisser et al., 2011).

Importance of SGBV Clinical Care

Significance of Timely Treatment for SGBV Injuries/Incidents

The availability of services and medications of SGBV clinical care is dependent on factors including funding, shipment of supplies, staffing, and health service availability within refugee camps/IDP sites. Different guidelines have been created different non-profit agencies within the sites to set the standard of quality SGBV clinical care practice for survivors. Guidelines have been created to respond on an individual and systematic level seen in the *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons (UNHCR), Inter-Agency GBV Case Management Guidelines (GBVIMS), Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action (IASC), and The Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies (UNFPA)* (Block et al., 2019). The guidelines mainly emphasize the importance of providing quality SGBV care during complex humanitarian settings, creating an appropriate environment to respond and treat the survivors in a timely manner, while providing essential support throughout the process (Block et al., 2019).

One of the biggest components of providing quality SGBV clinical care is the ability to treat injuries promptly. SGBV clinical care usually consists of providing a package treatment of post-exposure prophylaxis (PEP), pregnancy prophylaxis, wound care, HIV/STI treatment, and psychosocial care. The treatments vary in urgency depending on the clinical care the patients require, therefore, the severity of health consequences is dependent on when the patients seek out SGBV services. If a patient presents a case of sexual violence, PEP and pregnancy prophylaxis may be administered within 72 hours of contact, to prevent the contraction of HIV and unwanted pregnancy (MSF, 2020). Survivors should also be tested and treated with the recommended antibiotics for any sexually transmitted infections or wounds and if requested by the survivors, they are referred to psychosocial care(UNHCR, 2002). Patients requiring any of the provisions

listed must be able to receive the care within each treatment's time window. If patients are unable to meet the window of treatment, they may be ineligible to the preventative benefits of PEP or pregnancy prophylaxis, and they may suffer from more severe health consequences leaving wounds, HIV/STIs, and psychological needs untreated (MSF, 2020).

Short Term and Long Term Effects of Untreated SGBV Injuries/Incidents

SGBV survivors are prone to a range of short-term and long-term physical, mental, and sexual reproductive health (SRH) consequences when SGBV injuries are left untreated. The immediate physical wounds upon arrival require the survivor to be treated and stabilized for pain and/or bleeding, to avoid infection (Jina & Thomas, 2013). Depending on the wound, the injury could progress into deeper infections that could prolong not only the immediate injury, but the wound could develop into more serious injuries to other parts of the body (UNHCR, 2002).

The mental and emotional trauma developed after the SGBV incident can manifest in the survivor, from symptoms of withdrawal, guilt, shame, fear, and isolation, to lack of trust in those around them (Friedman, 1992). Usually, the development of PTSD is immediate and has the potential to extend out to a year or more if untreated (Jina & Thomas, 2013). If the psychological and emotional traumas are left unattended, the survivor may also develop long-term anxiety, depression, panic disorders, and eating/sleeping disorders (Jina & Thomas, 2013). Women who experience sexual violence are at higher risk for attempting suicide, as well as, developing cardiopulmonary and neurologic type symptoms such as chronic pain, hyperventilation, chest pain, migraines, fatigue, and weakness (Jina & Thomas, 2013).

Sexual reproductive injuries require immediate attention in order to prevent unwanted pregnancies, HIV/STIs, and other gynecological complications (UNHCR, 2002). Left untreated,

women are prone to immediate symptoms of vaginal bleeding or infection, genital irritation, pelvic pain, premenstrual syndrome, and urinary tract infections (Jina & Thomas, 2013). STIs may cause irritating symptoms for survivors such as itching/burning, pelvic pain, unusual discharge, and bleeding (NIH, 2015). STIs such as gonorrhea, syphilis, chlamydia, genital herpes, and human papillary virus (HPV) has the potential to lead to severe long term consequences of PID, infertility, birth defects, cancer, heart disease, blindness, bone deformities, brain damage, and/or death (NIH, 2015).

Sexual Gender Based Violence in the Context of Complex Humanitarian Settings

Complex humanitarian crises magnify the unequal power dynamics and inequalities experienced by women and girls, intensifying vulnerabilities and risks for SGBV (Block et al., 2019). Refugee camps/IDP sites change the conditions and circumstances for how women and girls experience SGBV, not only introducing them to new resettlement challenges but new exposures to perpetrators and types of SGBV. In addition to navigating gender inequalities and unequal power relations within their community and home, women and girls become especially vulnerable to sexual violence while utilizing facilities such as water, sanitation, and hygiene (WASH) facilities, medical services, and food distribution (Olsen & Scharffscher, 2004). The camps may not adequately be equipped with the security and patrols to oversee the safety of the facilities, and the risk of sexual violence may increase when women and girls utilize the facilities during night time (Olsen & Scharffscher, 2004).

The perpetrators within complex humanitarian settings can present beyond just familial members, partners, and close friends. Perpetrators within the sites extend to other camp residents, community leaders, religious leaders, authority figures, NGOs, camp staff, police, and

security guards (Wirtz et al., 2013). Perpetrators attempt to take advantage of vulnerable women living in the camps, exploiting their safety, resources, services, and economic opportunities. NGOs/camp staff, police, and security guards have been known to take advantage of women's increased needs for shelter, health services, jobs, food rations, and supplies, exploiting women's survival necessities in exchange for sexual favors (Mwenyango, 2021; Wirtz et al., 2013). In a refugee camp in Ethiopia, single women who live alone or with small children were often targeted by perpetrators for their homes' lack of structural protection (Wirtz et al., 2013). The women were often coerced and exploited into having sex in exchange for basic housing repairs (Wirtz et al., 2013).

The heightened risks of sexual violence and exploitation for women in humanitarian settings call for the prioritization of safety and protection against SGBV in refugee camps/IDP sites. Displaced women and girls have a right to safety, health, respect, and non-discrimination, yet in camp settings, such rights have been vastly suppressed through abuses of power, weak legal systems, and inadequate camp response/prevention measures (UNHCR, 2022). The need to combat SGBV in humanitarian settings is pertinent to protecting the basic human rights of women and girls, ensuring their safety and health.

Increased Clinical Management Needs of Rape Survivors

The high prevalence of sexual violence in refugee camps require increased clinical management needs to provide comprehensive treatment for rape survivors. The trauma that follows rape incidents may put the survivor in a state of agitation or depression, followed by emotions of fear, guilt, shame, and/or anger (UNHCR, 2002). The emotional state of the survivor calls for accommodating clinical management care that requires sensitivity, patience, and

confidentiality, while still administering the necessary treatments essential to the survivor's injuries. CMR requires not only the clinical treatment of the SGBV injuries, but it requires forensics collection, legal referrals, and psychological care referrals (UNHCR, 2002). It requires specific measures to alleviate the survivor's immediate health needs, collect evidence for legal pursuits against the perpetrator, and follow up to further treat any long term health consequences of rape. As different humanitarian crises arise, displaced populations enter in surges, creating higher demands for CMR health services and resources (Araujo et al., 2019). Depending on the site, the facilities may lack the capacity to provide quality health services to the population in need (Araujo et al., 2019).

Clinical Management of Rape (CMR) Services Offered in Refugee Camps/IDP Sites

The SGBV sectors of refugee camps/IDP sites often follow the UNFPA guidelines, in conjunction with the host country's ministry of health protocols when standardizing CMR services offered. The Minimum Initial Service Pack (MISP) for Reproductive Health in Crisis Situations is a well-known and widely utilized tool to structure the clinical management approach for survivors of rape around the world (Smith et al., 2013). The MISP established different measures within the camps to prevent and manage sexual violence, reduce HIV transmission, and plan for comprehensive SRH services (Smith et al., 2013). The guidelines have set the standard treatment package offered in camps, consisting of PEP, pregnancy prophylaxis, wound care, STI treatment, and psychosocial care (Smith et al., 2013; UNHCR, 2002). CMR services provide physical/genital examination of the survivor, collection of forensic evidence, administration of emergency medications, wound care, testing/treatment for STIs, counseling, and follow-up care (UNHCR, 2002). If requested by survivors, an extension of the CMR services

include referral to legal and psychosocial services through the camp's established referral system (UNHCR, 2002).

A survivor's timely access to CMR services is vital in combating the adverse consequences of rape, however, large gaps within the process pose a barrier to the level of quality care that can be administered (Smith et al., 2013). Facilities often lack the appropriate structures to protect the privacy and confidentiality of survivors to speak openly about their incidents (Chowdhury et al., 2021). The availability of female clinicians and staff are limited or may not be present at all, therefore discouraging the utilization of the CMR services by women and girls (Amiri, 2020). The clinicians and staff may not be equipped with the necessary language skills and training to navigate the visit according to the survivors' needs (Jesuthasan, 2019). The lack of knowledge of CMR services within the community and the stigma of utilizing the services has deterred displaced women from accessing health facilities (Dirisu, 2020; UNHCR Uganda, 2019). Lastly, underreporting of rape incidents has remained one of the biggest issues within refugee camps as the true prevalence is severely underestimated, weakening the camp's ability to combat SGBV (UNHCR Uganda, 2019).

Reporting

Reporting is defined as a formal account of a survivor's SGBV incident to an associated facility within the camp's SGBV system, including NGOs, police, hospitals/clinics, community centers, and community leaders. A survivor's ability to report their incidents often dictates the quality of clinical care the individual can receive. The current reporting protocol within complex humanitarian settings is based on self-reporting, requiring the survivor to expose their identity in order to pursue services (Mogga, 2017). Reporting is pertinent to the data collection of SGBV

prevalence within the refugee camps/IDP sites, allowing the camp to gauge their gaps and strengthen their clinical response/preventative measures to meet the needs of the camp population.

Recommendations for creating an optimal environment for survivors to report their incidents comfortably lie in the structures of the facility, the approach of the staff and clinicians, and the success of processing their SGBV incidents through the clinical, psychological, and judicial phases (UNHCR, 2002). The facility requires a dedicated area or room for the survivor to report their incident and be examined with full privacy and confidentiality, to alleviate worries of others being able to identify the survivor and their story (UNHCR, 2002). The clinician and staff are recommended to be trained in survivor-centered care to build rapport and trust with the survivor, creating a safe environment to speak openly about their injuries, needs, and next steps (UNHCR, 2002). Depending on the survivor, referrals to request psychological care and/or pursue a legal case against their perpetrator would be processed through the referrals systems (UNHCR, 2002). The success and speed in which the case processes through the legal system influence a survivor's tendency to report, as it may seem hopeless to report if there's no justice (MacTavish, 2020). Unfortunately, rape incidents are difficult for survivors to report due to different barriers of cultural norms/stigma, access and knowledge of CMR services, language barriers, facility capacity, distrust of the SGBV system, and overall privacy and confidentiality of the reporting process (Chowdhury et al., 2021; Dworkin & Weaver, 2021; Krause, 2015; Wirtz et al., 2013).

Cultural Norms/Stigma

The stigmatization of rape is heavily influenced by community perception of sexual violence toward women, generating hesitation among survivors to report in fear of the societal consequences. In some collectivistic cultures, familial reputation is key to the survival of a family, influencing their future social and economic opportunities. Families have been known to conceal rape to avoid stigmatization that could result in family indebtedness to their daughter's future suitors as well as the survivor being deemed unfit for marriage (Dworkin & Weaver, 2021; Jina & Thomas, 2013). The survivor faces consequences of being isolated from their family and friends as a result, and in some cases, they're married to their rapist in order to protect their reputation (Jina & Thomas, 2013). The collectivist values push survivors to prioritize the needs of their family over their own, discouraging the identification of their perpetrator within their cultural group in fear of the stigma it could bring to their broader community and in return, their family (Dworkin & Weaver, 2021).

On the other hand, male perpetrators often fewer consequences due to the normalization of sexual violence between male and female counterparts, lessening the severity of punishment for males (Dworkin & Weaver, 2021). Some cultural groups often view SGBV as a community issue, therefore they believe incidents of sexual violence should be handled within the community, rather than reported to involve outside interference (MacTavish, 2020; Odwe et al., 2018). However, social and cultural attitudes toward sexual violence often normalize and even tolerate sexual violence, placing women and girls at a disadvantage to report in fear of retribution from the perpetrator and lack of justice from the SGBV system (Odwe et al., 2018). The normalization of violence manifests into lower health-seeking behavior and a negative association with reporting (Odwe et al., 2018).

Access and Knowledge of SGBV Clinical Management Services

Although refugee camps and IDP sites offer CMR services, there are infrequent reporting patterns among survivors due to the lack of knowledge of the availability and benefits of clinical management services (Krause, 2015). Survivors may be unaware of the CMR services available and the health benefits of treating their injuries, due to the lack of health promotion around the subject of SGBV (Krause, 2015). As a result, there isn't a perceived benefit for women and adolescent girls to report their SGBV injuries. The role of cultural taboo around the conversation of sex and sexual violence prevents the survivors from discussing where to seek help, the significance of receiving immediate treatment, and the availability of legal and psychosocial care offered (Krause, 2015). Survivors may feel shame reaching out to others in their community, in fear of further stigmatization. Survivors are left unaware of the urgency to pursue CMR services to prevent long-term health consequences, disincentivizing the need to report (Tappis et al., 2016).

Gender roles and expectations place barriers to women accessing healthcare facilities due to their restricted mobility and decision making (Dirisu, 2020 & MacTavish, 2020). Depending on their cultural expectations and gender norms, women are often limited in their decision-making, at times, needing permission from family members in order to attend different facilities (Dirisu, 2020). This presents a challenge to the survivor as they may want to keep the incident confidential and fear the potential consequences of having family members know about the incident. Limited mobility to freely access the facilities plays a large barrier to utilizing reporting structures as it may be required the survivor to be accompanied by a family member (MacTavish, 2020). In some cases, the perpetrator may be a family member, putting the survivor in an uncomfortable position to report without full privacy disclosure.

Language Barrier

A major component of reporting relies on the reported information to be accurate and understood in its communication from the survivor to the SGBV facility. Refugee camps/IDP sites are home to several ethnic groups who speak different languages and dialects. Unfortunately, the facilities may not have access to interpreters with the language fluency and expertise to meet the needs of all survivors. During the reporting process, translation is pertinent in building rapport and trust for the provider to understand the full extent of the experience and the needed treatment for their injuries (Chowdhury et al., 2021). At times, describing pain, bodily functions, and taboo subjects such as sexual violence, is spoken through idioms and expressions unique to the survivor's culture and language (Jesuthasan et al., 2019). This becomes difficult for translators to understand as they may not be trained to understand medical interpretations or medical terminology, and they cannot fully translate the deeper meanings to the survivors' words due to a lack of cultural context (Chowdhury et al., 2021).

Facility Capacity to Support the Population

When facility structures and available resources fail to meet the capacity needs of growing displaced populations, this furthers hesitancy of the survivor to report the incident as the facility is deemed unfit to administer quality clinical care. Women's limited mobility and access to facilities become increasingly difficult if the reality of reporting requires long waits at the clinic, with limited operating hours(MacTavish, 2020). The skills set and composition of the staff influences the quality of care a survivor receives, which determines better help-seeking behavior for survivors to report. The staff may lack professional training in survivor-centered care to accommodate the sensitivities and empathy required to report and seek treatment (Amiri, 2020).

Interactions between staff and survivors are key to building trust, therefore, the absence of female staffing reveals a hesitation to report because of the shame and cultural hesitancy to speak about sexual violence with a male provider (Chowdhury et al., 2021).

Consistent drug supplies of PEP, pregnancy prophylaxis, and STI treatment become scarce with the increasing population and the facility's inability to meet demands (Krause, 2015). Shipment problems from difficult road access due to conflict or logistic problems can halt access to medications for weeks and months on end (Omanyondo et al., 2005). As a result, survivors lack adherence to treatments due to low stock of essential drugs (UNHCR Uganda, 2019)

Distrust of the SGBV System

The reluctance to report to the SGBV system is attributed to the low rates of success of reporting, neglect from the clinical staff, and the distrust of police and NGO workers. Refugees have faced cycles of discrimination, health negligence, and abuse by workers within the SGBV system, making it difficult for survivors to report openly to health professionals (Chowdhury et al., 2021). In addition, women and girls may not always receive the help that's promised when pursuing legal action against their perpetrators (Mogga, 2017). If the case is pursued legally, the perpetrator may receive minimal to no legal punishments for their crimes, further solidifying the SGBV system's failure to bring justice to the survivor's SGBV cases.

Large mistrust of the SGBV system is also a result of who the survivor's perpetrator is. Reporting becomes difficult when the survivor's perpetrators belong within the SGBV system. NGO staff, clinicians, police officers, and guards have had a history of taking advantage of displaced women and girls within refugee camps and IDP sites (Wirtz et al., 2013 & MacTavish, 2020). The unequal power dynamics between the two groups put survivors in difficult situations,

as reporting may threaten their access to health services, safety, and jobs overseen by the perpetrators (MacTavish, 2020).

Privacy and Confidentiality of the Reporting Process

Facilities face structural barriers to supporting the privacy of the survivors. Depending on the refugee camp/IDP site, the facilities may lack a dedicated SGBV unit to provide a private room for reporting and examination of the survivor. Survivor testimonies from an Ethiopian refugee camp show how survivors may withhold full details of the SGBV experience in fear of other community members at the facility overhearing about their experience (Wirtz et al., 2013). The physical structure of the facility can be made of thin material such as bamboo, or may not even have proper walls, limiting privacy (Chowdhury et al., 2021). During reporting and counseling sessions, the interpreters or clinical staff may be members of the community as well, risking the confidentiality of the survivor.

Background on Bangladesh/Tanzania/Uganda

Country Context: Bangladesh

Surges of violence and conflict have left thousands displaced and seeking refuge in multiple registered and unregistered camps in Bangladesh (Guhathakurta et al., 2016). For decades, Myanmar has systematically oppressed Rohingya Muslims through the deprivation of basic rights to education, marriage, civic participation, right to bear children to the denial of citizenship (Parmar et al., 2019). In the 1970s, the brutality of religious persecution and armed attacks increased, displacing Rohingya Muslims to its bordering country, Bangladesh (Parmar et al., 2019). Currently, the refugee population continues to grow and resettle in Bangladesh's

camps, in response to the continued conflict surrounding the ethnic cleansing and genocide of Rohingya Muslims (Guhathakurta et al., 2016; UNHCR Bangladesh, 2019). Bangladesh has two registered refugee camps in Kutupalong and Nayapara, with the largest camp in the Cox Bazar (UNHCR Bangladesh, 2019). According to a 2019 UNHCR report, Bangladesh hosts approximately 914,998 individuals in the Cox Bazar refugee camp, composed of 52% females (UNHCR Bangladesh, 2019).

Sexual Gender-Based Violence in Bangladesh's Settlements

Since resettlement, refugee women and girls have reported experiences of sexual violence in Myanmar, and now face high risks of SGBV within the refugee camps in Bangladesh (UNHCR Bangladesh, 2018). The new living conditions have exposed women and girls to higher risks of sexual assault during the utilization of WASH facilities and food distribution points (IRC, 2021). It has become increasingly dangerous for adolescent girls to take particular routes toward these collection points, as they become targets of sexual assault by male community members (IRC, 2021). Healthcare workers have recognized patterns of sexual violence against Rohingya women and girls to be in the form of multiple perpetrators such as gang rape, as well as sexual violence followed by acts of beatings, shooting, and the killing of family members (PHR, 2021). Patients have recognized the perpetrators to be members of Myanmar military, men in uniform, and the police (PHR, 2021). Reports show12.8% of women and girls have experienced forced sexual favors, and 8.1% experienced forced and unwanted sex within the camps (Joarder et al., 2020).

Many individuals in Rohingya and Bangladeshi host communities lean towards more of a conservative perspectives and decision-making culture, creating a reluctance to recognize and

discuss sexual violence within their homes and in their community (PHR, 2021 & Parmar et al., 2019). Rohingya women and girls are usually expected to have limited to no interactions with male strangers, therefore, experiences of rape can be extremely devastating to the reputation and honor of a survivor (Parmar et al., 2019). Sexual violence against women and adolescent girls is extremely stigmatized and socially paralyzing as survivors may face possible rejection and blame for the incident by their own families and communities (PHR, 2021). The reporting of sexual violence could place the survivor in danger, as retaliation from the survivor's family and the community is a reality for women and adolescent girls (PHR, 2021).

Currently, the Cox Bazar has multiple structures in place for SGBV reporting and response in complement to the CMR services provided at the health facilities. The camp has a number of different medical facilities to provide PEP, STI treatment, and pregnancy prophylaxis for rape survivors, with a majority of staff being trained in clinical management of rape (UNHCR Bangladesh, 2018). According to a 2018 UNHCR report, the Cox Bazar currently has a team of four psychologists working with different organizations to provide mental health and psychosocial support (MHPPS) to SGBV survivors (UNHCR Bangladesh, 2018). The camp has seven counseling centers and nine community centers to provide case management support and referrals to health, psychosocial, and legal services (UNHCR Bangladesh, 2018). Fourteen safe spaces have been established for survivors or women/adolescent girls at risk of sexual violence to seek shelter until their safety is no longer threatened (UNHCR Bangladesh, 2018).

Country Context: Tanzania

Tanzania hosts approximately more than 200,000 refugees in their nine refugee camps placed in the Ngara and Kigoma subregions of western Tanzania, with the most concentrated

populations in Nduta and Nyarugusu (HRW, 2000). Nyarugusu camp remains the largest refugee camp in northwest Tanzania, hosting about 53.1% of the total refugee population (HRW, 2000). For decades, Tanzania has been receiving massive influxes of refugees from countries such as Rwanda, Burundi, and the Democratic Republic of the Congo (DRC) (Gwamagobe, 2013). Refugees from the DRC have settled within Tanzanian refugee camps for decades, with major surges in 1996 and 2002-2005 (Fletcher et al., 2021). More recently, there has been a large surge of Burundi refugees entering Tanzania, with most members belonging to the Hutu ethnic group (Gwamagobe, 2013). Members of the Hutu ethnic group sought refuge in Tanzania from 1993-1996 to escape the armed attacks and large-scale violence that erupted from the civil war in Burundi, followed by the 1996 coup (Gwamagobe, 2013). Burundian refugees continue to escape to Tanzania as conflict between the Burundian army and rebel forces intensify (Gwamagobe, 2013).

Sexual Gender-Based Violence in Tanzania's Settlements

Across major refugee camps in Nyargusu, Nduta, and Mtendeli, reports have revealed over 95% of all reported incidents of SGBV are submitted by women and girls (UNHCR Tanzania, 2016). The SGBV incident reports attributed a portion of the SGBV to internal familial problems such as a partner's alcohol and drug abuse, polygamous marriages, early marriage, and family conflicts over reproductive rights (UNHCR Tanzania, 2016). A large majority of the reports come from new arrivals reporting about recent SGBV experiences from traveling into the settlement or within their origin countries (UNHCR Tanzania, 2016). Within the Tanzanian settlements, women and girls are often targeted while carrying out daily tasks such as firewood collection, collecting food items, farming, or even seeking employment from local Tanzanian villagers (HRW, 2000). Poor shelter conditions, such as tents, create physical

vulnerability for women and children, increasing their risk of being targeted by perpetrators (HRW, 2000).

The stigmatization of rape is high among the different ethnic groups presented within the Tanzanian settlements, as the combination of victim-blaming and collectivistic norms create difficulties to women and girls to report SGBV incidents. Burundian women face threats of self-shame, hostility, rejection, and further violence from their community (HRW, 2000). In many instances, women are often blamed for the rape incident, receiving further abuse as punishment for tarnishing their family's reputation (HRW, 2000). If the survivor does report their incident, they may face negative attitudes and discriminatory treatment from some healthcare providers who reflect the same cultural values on violence (Mgopa et al., 2021). Acts of sexual violence are often preferred to be resolved within the family, avoiding solutions that threaten the family unit and its reputation in the community (Mgopa et al., 2021).

Women and girls are able to report to UNHCR facilities, camp authorities, the police, or the SGBV health facilities within the settlements (HRW, 2000). SGBV incidents are recorded in the GBV information management system to ensure surveillance over SGBV data collected to create progress reports and maintain the privacy of the survivor (UNHCR Tanzania, 2016). Facilities are in place to respond to the medical, legal, safety, and psychosocial needs of survivors through case management services (UNHCR Tanzania, 2016). Referrals for legal services and psychosocial care are available to survivors during their treatment visits at healthcare facilities (UNHCR Tanzania, 2016).

Country Context: Uganda

Since the arrival of Polish refugees in Uganda during World War II, Uganda has continued to host new arrivals from its neighboring countries, making it one of the largest refugee hosting countries in Africa (Fukui, 2021). Uganda currently hosts 28 refugee settlements, with approximately 1,394,678 refugees and asylum seekers as of January 31st, 2020 (UNHCR ODP, 2020; UNHCR OPD, 2021). A majority of the displaced populations come in from the bordering countries of the Democratic Republic of Congo (DRC), South Sudan, Burundi, and Somalia (Fukui, 2021; UNHCR ODP, 2020). As a result of the South Sudanese civil war in 2013, major concerns of famine, violence, and human rights violations began to intensify in 2017, causing a large migration of refugees to Uganda, with over 800,000 Sudanese refugees occupying refugee settlements (Fukui, 2021; UNHCR ODP, 2020). Major offenses and violence within Uganda and in its surrounding region continue to fuel the movement of displaced populations toward Uganda's refugee settlements (Fukui, 2021).

Sexual Gender-Based Violence in Uganda's Settlements

In a UNHCR SGBV 2019 report, it was recorded that out of the 4,452 SGBV incidents reported in Uganda's refugee settlements, about 87% of the survivors were female (UNHCR Uganda, 2019). The percentage composition of the SGBV reporting reveals the prevalence of the sexual violence perpetrated against refugee women and adolescent girls. The prevalence of sexual violence becomes especially significant considering the total number of the incidents is most likely underreported, exposing a large gap of untreated survivors of SGBV. Incidents of SGBV have been attributed to tensions within family structures such as unequal power imbalances between members of the family, multiple partners, low household income, alcohol abuse, and disagreements on the distribution of cash and food (UNHCR Uganda, 2019). Conditions within refugee camps can threaten the family structure, as families struggle with

challenges of resettlement, unstable income, and changing roles that go against the expected gender roles of wife and husband. Refugee women and girls in Uganda encounter higher risks of SGBV while traveling long distances to fetch firewood or utilize the camp's facilities (UNHCR Uganda, 2019). The limited access to basic necessities creates a gap for many perpetrators to fill, abusing women and girls in exchange for provisions of basic survival items such as sufficient hygiene kits (UNHCR Uganda, 2019).

The hesitancy for reporting SGBV incidents roots from the social and cultural attitudes toward sexual violence, influencing the survivors' health-seeking behaviors in Ugandan settlements (Odwe et al., 2018). In a study administered in Rwamwanja refugee settlement, it showed that a higher percentage of women (56%) presented more normative perceptions on the acceptability of violence than men themselves (20%) (Odwe et al, 2018). The cultural expectations of women meeting the needs of their male partners translate into the justification of men's violence as a reaction to being angry or denied sex, food, or money from their partner (Odwe et al., 2018). The subject of SGBV is viewed as a personal matter, therefore open knowledge of the incident could put the survivor at risk of stigmatization, experiencing shame and negative familial reaction/dissolution to the incident (UNHCR Uganda, 2019)

If survivors do choose to report their SGBV incident, the settlements have a dedicated SGBV Response unit within the health facilities, tasked with coordinating the survivor's care, whether it be clinical, psychological, shelter, or legal aid (UNHCR Uganda, 2019). The health center is staffed with a physician, nurses, and clinical officers, with the number of staff varying by facility (UNHCR Uganda, 2019). The facilities have the ability to provide physical and genital examinations, collect forensic evidence, and provide emergency medication according to the needs of the survivor (UNHCR, 2019).

Conclusion

The literature establishes the international community's recognition of the severity and gaps around sexual gender based violence reporting and response in complex humanitarian settings. An immense amount of research has gone into understanding and exposing the perspectives around the subject of SGBV amongst the survivors, humanitarian aid workers, and surrounding community members. Recommendations have been implemented and standardized to create a comprehensive SGBV system within the camps according to guidelines created by multiple INGOs and health departments. However, the reality of how these interconnecting facilities function and sustain themselves when responding to clinical, psychological, safety, and legal needs of the survivors lack detailed examination. Many of the interventions to prevent and respond to SGBV rely on self-reporting of the survivors, with little knowledge around SGBV reporting for the survivor by observers or friends/family of the survivor. There's little knowledge around the timelines and process of the safety protocols and safe spaces set in place when survivors continue to face threats from their community or perpetrator after reporting. Literature also lacks further analysis of how the legal processing of rape cases translate within the camp settings according the country's laws and the reality of the punishments set in place for the perpetrators. However, a common theme throughout the literature recognized the need to improve reporting amongst survivors, as underreporting is one of the largest causes of untreated SGBV injuries and underutilization of the SGBV response system set in place within the camps/IDP sites

There is a need to improve the SGBV reporting process and to promote the utilization of services among rape survivors to combat underreporting within the IDP/RC settlements under Medical Team International's care. Medical Teams International provides SGBV case

management services to multiple settlements across Tanzania, Uganda, Bangladesh, and Ethiopia. However, Ethiopia's audit was put on hold, due to the intensifying circumstances and unstable communication with staff in the country. The goal is to assess Medical Teams' current SGBV protocols around the current process, guidance, training, and treatment tracking across Bangladesh, Tanzania, and Uganda. The research aims to gauge the readiness of Medical Teams International in meeting their SGBV global indicator of providing CMR treatment package of wound care, STI/HIV testing, PEP, pregnancy prophylaxis, and psychosocial care. The research will attempt to answer the questions of "What are the existing practices and gaps in the CMR treatment package rape survivors receive when reporting in Bangladesh, Tanzania, and Uganda?" and "What are the current practices and gaps in existing protocols around SGBV reporting in Bangladesh, Tanzania, and Uganda?"

METHODS

Study Design

The research utilizes a qualitative study approach to gauge the existing practices and gaps around current SGBV reporting and treatment process in Mtendeli and Nyarugusu, Tanzania, Adjumani, Palorinya, Kyangwali, Mbarbara, Kyaka II, and Rwamwanja, Uganda, and Cox's Bazar, Bangladesh. The primary purpose is to assess the readiness of Medical Team's country offices to meet their SRH global indicator *"% of SGBV survivors who receive a full package of treatment (PEP, pregnancy prophylaxis, STI treatment, wound care, and psychosocial support*)." The study employed qualitative data collection through interviews with six SRH/HIV officers overseeing the nine settlements in Bangladesh, Tanzania, and Uganda. One-on-one interviews were conducted between June 2021 and August 2021 utilizing video conferences to explore the strengths, gaps, and practices of the CMR services. The qualitative study employed largely a deductive analysis of the key informant interviews from the three countries.

Study Setting

The research took place in three different countries, Bangladesh, Tanzania, and Uganda. Within each country, Medical Teams International has offices located in regions of high need, where the team can maintain communications with headquarters, as well as provide services to support the displaced populations. In Bangladesh, Medical Teams mainly operate in the Kutupalong refugee camp, in the Cox Bazar. In Tanzania, the organization provides support to the refugee camps of Mtendeli and Nyarugusu, in the northwestern region of Tanzania. In Uganda, the team oversees six different settlements; Adjumani, Palorinya, Kyangwali, Mbarbara, Kyaka II, and Rwamwanja. The research was conducted virtually over an online communication

platform utilized by all Medical Teams staff, Microsoft Teams. The interviews were conducted over a three month time period from June 2021 to August 2021, based on each country office's staff availability to meet.

Population and Sample

Through online discussions with the Medical Teams health advisors and country directors, SRH/HIV officers overseeing the settlements were established as the best source to collect the data information for the project. The SRH/HIV officer position has oversight and interaction with the facility's the treatment/reporting process and documentation, staff's line of function, and updated knowledge of the current process, making them the main focal point for treatment tracking/reporting. A list of the main SRH/HIV officers for each settlement and their contact information was compiled in order to initiate first contact. The list consisted of six participants for the interviews, with one individual per Bangladesh and Tanzania. Uganda consists of multiple settlements, with some participants assigned to oversee more than one settlement at a time. Therefore, Uganda had four participants, grouped by settlements of Adjumani & Palorinya, Kyaka II & Rwamwanja, Kyangwali, and Mbarbara.

The project was presented to the participants as a baseline audit needed to measure each country offices' readiness to meet the organization's new global indicators pertaining to SGBV. The information obtained would be analyzed for potential considerations to help the offices better meet the SRH indicator. The expectation of participating in the interviews was strongly encouraged by the health advisors, however, it was discussed with the participants that the interviews were of lower priority in comparison to their main responsibilities as SRH/HIV officers. Initial communications from the primary investigator (PI) to each focal point were done

through email, and each interview time was organized according to each focal person's availability with flexibility due to time zone differences.

Interview Conduct

The primary investigator (PI) for the research was Michelle Nguyen. The PI has had past experience conducting in-depth interviews for other research projects on SGBV topics such as sexual reproductive health history, infectious diseases such as STI/HIV, trauma, and utilization of PEP/pregnancy prophylaxis. The PI has experience working with diverse populations, including refugee populations across Africa and Asia, as well as collaborating with providers, clinics, and large health systems for healthcare coordination. The background allows for a clinical understanding of the CMR services being offered, as well as qualitative experience to conduct the interviews with the participants. The PI has received training on in-depth interview conduct and ethical considerations, to ensure the appropriate approach and environment while discussing sensitive topics.

The in-depth interviews were implemented virtually via Microsoft Teams video call, with interviews ranging between 30 minutes to 1 hour. The interviews consisted of one-on-one video calls between the PI and the participant, to promote the privacy and comfortability of the participant when discussing the sensitive topics within the interview guide. The interview guide was shared with the participant before the virtual interview, in order to allow the participant to understand the scope of the information that will be needed for the meeting and collect any necessary information needed to answer the questions. The PI recorded responses to open-ended interview guide questions during the interviews, with secondary communications with the participant through email if further clarifications were needed.

Each interview began with about 5-8 minutes of rapport building, with introductions between PI and the participant, consisting of their roles at Medical Teams Internationals and their overall work experience and interests. The interview was administered verbally, with the interview guide shared on the video screen to help the participant verbally and visually comprehend the questions being asked. The participants were permitted to screen share during the interview, to visually share any documentation that would help them elaborate on their answers. Cameras were usually kept on during the interviews, but if issues of internet connection arose, the interviews would go off-camera to help with the audio quality of the interview.

The interviews were conducted during the participant's work hours, therefore, their participation was compensated by their pay on company time.

Interview Content

The interview guide objectives were drafted by the PI in collaboration with Medical Team's health advisors, Dr. Trina Helderman & Dr. Joy Wright. The PI developed the interview guide questions, with final revisions made by both health advisors. The guide covered topics of the current process for reporting and treatment, the type of guidance utilized by the staff to treat survivors, staff training, treatment tracking, and COVID-19 (See Appendix I). The interview questions were all written in English due to the English language proficiency of all the participants.

The interview begins with introductions of the context and purpose of the research, emphasizing the end goal of obtaining the information for organizational improvement and potential policy change. Potential risks and discomforts from the interview questions and discussion of the topics were explained, and verbal consent to continue was obtained before proceeding. The participants were informed the discussions would be shared with the Technical

Team, with the potential of being shared with the Field Operations department. Asides from the participant's name, any personal and identifiable information about the participant and the settlements' patients discussed during the interview were to be redacted from the form. It was discussed that the participant's position would not be compromised in relation to the information they provided, however, if the principal investigator identified any potential dangers and unethical behavior were identified during the interview, it was to be reported to the Technical Team's director and health advisors.

The guide starts with general questions around the overall knowledge of the existing protocols and administrative components of reporting and treatment to understand the facility's current process. It then explores the participant's experience around the challenges of providing quality CMR services, documentation of the treatment package, guideline utilization for reporting/treatment, staff preparation for treatment, and the effects of COVID-19 on reporting/treatment.

Data Analysis

The discussion and responses of the participant were collected through data collection forms with open-ended responses. The qualitative data collected from the six interviews were individually cleaned and coded by the PI. A deductive codebook (see Appendix II) was developed to be responsive to the central thesis research questions and was informed by the literature review on SGBV reporting and CMR services in humanitarian settings. Additional codes were added to the codebook when different themes outside the original interview guidelines and literature review were identified from the key informant interview data. The

codebook was used to code all six interviews, with the use of the comment function in Microsoft Word to code sections of data.

Ethics

The research was a proposed project by the organization for internal usage by Medical Team's Technical Team to better support the country offices. However, prior to participating, sites were notified the information could be shared with the Field Operations Department and open access to outside partners, as the NGO ascribes to transparency in their operations. The interviews did not require direct contact and data collection from the refugee population. The potential risks and discomforts from the interviews, such as becoming emotionally upset or uncomfortable, were discussed with each participant before each interview to provide full transparency to the participant. In order to maintain confidentiality and privacy, questions did not require the participant to share names or any identifiable information that could put those involved in the reporting/treatment at risk of exposure. During the interviews, if the PI observed issues of ethics within the practices and protocols of the reporting or treatment process, the issue was to be reported directly to the Technical Team's Director and the PI's supervisor during their weekly update meetings. The observation of a potential ethical issue was observed once, pertaining tothe legal component of seeking out the survivor's perpetrator, and it was immediately highlighted as a concern to the health advisors, Technical Team director, and the PI's supervisor.

RESULTS

One-on-one interviews were conducted with six participants (1 female and 5 male). The participants were composed of six SRH//HIV officers whose established role is to oversee their assigned settlements, consisting of Mtendeli and Nyarugusu in Tanzania, Adjumani, Palorinya, Kyangwali, Mbarbara, Kyaka II, and Rwamwanja in Uganda, and the Cox's Bazar in Bangladesh. All six participants have professional experience with SRH programming, with two of the participants being practicing physicians in the field. They summarized the existing practices and gaps in the reporting and treatment process for rape survivors across all nine settlements. To preserve the confidentiality of the programs and SRH/HIV officers who provided responses, for purposes of this thesis, I herein reference the sites as "Site A" through "Site I."

Reporting

Location/Setting

When participants were asked about their respective facility's capacity to provide a designated area for survivors to speak in a private and confidential manner, three of the six participants answered "*yes*" and three answered "*no*." In Site D, the facility was noted to be small, with a temporary room used for examination and reporting, and described as "*the extent of locational privacy the survivor receives*." In Site E and Site F, the facilities hosted both SGBV and maternal child health (MCH) programming; the area was described as crowded as each department administered operations in one joint facility. In Site A and Site B, the presence of a designated area for reporting was dependent on the clinician present, who would "*create a space for survivors to take down the details*." In Site I, the settlement was able to provide each survivor an assigned room for confidentiality, but disclosed there were potential breaches of confidentiality. The crowded atmosphere within the facility potentially allowed family members

or community members present within the facility to overhear the survivor. In Site G and Site H, the participant stated "*the room provided to report these incidents encourages privacy*," however, also discussed the need for more facility space.

Facilitator/Reporting Authority

Survivors' preferences for the facility and individuals to whom they report their SGBV cases varied by country. A participant stated that Site I offers about four types of facilities to report to clinics, health posts, primary health care facilities, and the COVID-19 center. The survivors in Site G and Site H's settlements preferred to report to Medical Team's partnered NGO and often preferred to speak with a female nurse. Staff gender was a key factor in survivors reporting comfort, "*therefore, male clinicians are usually accompanied by female nurses/midwif*e". In Site E and Site F, survivors often reported to the police first, with the second preference being Protection Partners or the Medical Team's facility. In Site A and Site B, survivors are observed to report to both the camp's community leaders and the police and express a greater preference for reporting to the police. Survivors within Site C extended their reporting to not only the police, but also community leaders, designated refugee welfare leaders, and community health workers.

Communication

The communication method most commonly utilized during reporting was verbal communication between the survivor and the facilitator/reporting authority, with the language barrier most commonly cited as a communication barrier for all settlements. In Site I the facility had visual methods of communication such as pictures, however, the most common methods are verbal reporting, gestures, and notes. In Site G and Site H, the diversity of the settlement caused issues of translation as the staff present may not have been language proficient in Swahili,

Burundian, and/or English. As a result, the facility referred to incentive workers to help translate or the survivors may bring someone to aid the translation. The participant expressed hesitation with this route of communication, as the confidentiality of the survivor's reporting may not be guaranteed. Survivors accompanied by their parents may prefer the utilization of gestures, pictures, or written notes as an alternative to verbal reporting. The children felt uncomfortable explaining the details of the incident in front of their parents due to the stigma attached to the subject, in combination with feeling shame from the incident. In Site E and Site F, the participants described the large reliance on translators for communication, stating, "*This does threaten confidentiality of the survivor as another individual must be there to translate and tell the survivor's story*." The survivors' education levels limited their ability to use writing as a communication method for reporting.

In Site C, it was noted that translation affected the confidentiality. The usage of family members posed a challenge for the survivor to disclose all details, due to the sensitivity of the topic. In Site D, training was provided to translators to ensure privacy and confidentiality when working with survivors, with at least one translator per facility, preferably a female translator. The staff and translators aren't able to master all the dialects and languages needed to meet the population's needs due to the diverse refugee population. The participant stated, "S*taff with long term experience with the team can overtime master some languages or acquire basic understanding of different dialects/languages*."

Support Systems

Four participants described the main support system to aid survivors in reporting their SGBV incidents were parents. In Site A and Site B, the participant observed parents reporting in place of the survivor. In Site C, if the survivor is 18 and under, a relative or a police officer was

brought in to aid the survivor during reporting. The participant from Site G and Site H presented the parent and child relationship as a barrier to reporting, stating, "*Children are often not comfortable explaining the incident details in front of their mom*". The participant discussed how the age demographic determines who reports the SGBV incident; for example, if the case pertains to children, the parent reports for the survivor, rather than the survivor themself. Depending on the relationship between the survivor and perpetrator, the relationship can create hesitancy to access SGBV services if there isn't assured privacy for the survivor.

"In the Burundian community, there is usually an association or some form of relationship between the survivor and perpetrator, therefore it's difficult for girls to come alone."

Emergency Shelter/Protections

Participants discussed protection protocols during the reporting/treatment process and access to protection facilities (emergency shelters) during the interviews. In Site I, there was a designated outside facility in which the survivors can access the women-friendly and child-friendly spaces; however, the participant stated there is a lack of knowledge among survivors of the process for accessing the protection facilities. In Site G and Site H, the designated protection facility was described as confidential and safe, with constant staff oversight; however, access to the compound was complicated by a long approval process. In Site E and Site F, the participants stated protection protocols were lacking within the settlements, as the protection facilities were often temporary and not well-established. In Site A, Site B, and Site C, the survivor had the option of being accompanied by a police officer to all their clinical and referral appointments for protection.

Prioritizing Justice Over Clinical Wellbeing

In Site E and Site F, survivors were observed to prioritize access to legal services during reporting before clinical treatment. Thus, the survivors tend to forget about the clinical care portion of the referral process. At times, the communities tended to settle the incident and seek justice within their community.

Referral

All six participants mentioned the utilization of the Referral Pathway, an established referral system for clinical, legal, and psychological services for survivors during the reporting process. Referrals could be given at any point of the reporting process, by the Medical Team's facility, NGOs, and the protection sector. In Site I, resources outside of common clinical, legal, and psychological services were provided by the UNFPA and usually in English. The English resources posed a language barrier to survivors who did not have reading proficiency in English.

Treatment

Initial treatment

The steps of providing clinical management of rape services were consistent across all six interviews, with prioritization of STI screening/treatment, PEP, pregnancy prophylaxis, wound care, and psychosocial referral. In order to receive treatment, the survivor must first report the incident.

In Site I, the necessary component of self-identifying to pursue treatment was observed as a challenge to treatment, as the survivor often faced different societal pressures and stigma as a result of the experience.

In Site G and Site H, the design of the rooms and departments in the facility made movement between the departments "*cumbersome*". The participant provided the example of how a urine sample needed to be carried between departments, and the movement impacted the

level of confidentiality, due to the possibility of people overhearing or passing by, during the specimen collection and exchange.

In Site E and Site F, late reporting of cases resulted in the inability to provide the survivor with emergency contraceptives such as PEP and pregnancy prophylaxis and sometimes resulted in an unwanted pregnancy. The survivors also faced the challenge of community stigma and lack of protection when pursuing treatment for their rape incident.

In Site A and Site B, community perceptions of the survivors and the cultural beliefs around how the incident should be handled posed a barrier to the treatment process. The participant provided an example of cultural complexity, describing how some but not all tribes normalize the culture of elders marrying adolescent girls with parental consent. Therefore, it was difficult for the adolescent girls to come forth due to the relationship status of the survivor and their perpetrator.

In Site D, the survivors faced challenges of stigma and discrimination from the community, with a preference to keep the rape incident as a community issue. The late reporting resulted in unwanted pregnancies, abortion, and mental health problems. The participant discussed the community's overall lack of knowledge of the SGBV services offered within the settlement, including available psychosocial services, referral pathways, and clinical care.

Follow-up

All six participants discussed their respective settlement's protocol for follow-up, with the survivor's follow-up treatment timeline dependent on the survivor's condition and needs. In Site I, the follow-up timeline was dependent on the wound severity of the participant. The facility ran into the challenge of losing survivors during follow-up as some survivors experienced shame after being seen for the initial treatment. Follow-up in Site E and Site F was

considered "*easy*" with proper management of the survivor's appointments, however, the settlements reported survivors "*disappearing within the community at times*." In Site A and Site B, if the survivor was lost to follow-up, staff initiative was taken to reach out to the survivor's family.

Tracking

Site I tracked the five elements of the treatment package through a gender-based violence (GBV) register book, documenting PEP, pregnancy prophylaxis, STI treatment, wound care, and psychosocial care. The most difficult elements of the treatment package to track were reported to be STI treatment and pregnancy prophylaxis due to challenges of privacy and confidentiality. The stigma attached to contracting STIs and unwanted pregnancies discouraged the survivors from attending follow-up visits to ensure the successful administration of the treatment.

The documentation of treatment in Site G and Site H was stored in an inventory book, recording pregnancy prophylaxis, STI treatment, and PEP. Psychosocial referrals were documented in the survivor's medical records. The participant was unsure of the treatment tracking for wound care, as wound care documentation is recorded in a different room by a different staff member. A challenge Site G and Site H faced in regards to treatment tracking was the loss of follow-up, in which survivors did not return to complete their medication intake or seek further care for their injuries.

In Site E and Site F, four of the five treatment package items were recorded in a dedicated register book, except for psychosocial care. Psychosocial care was provided by a variety of partners, therefore difficult to track. Lack of attendance to follow-up appointments posed a barrier to treatment tracking as the facility was unaware of how successful the treatment was without follow-up.

In Site A and Site B, the settlements recorded all treatment administered in the GBV register book, except for wound care. Wound care documentation varied depending on the facility. The stigmatization and lack of familial support challenges discouraged follow-up, affecting the facility's treatment tracking.

A required component of CMR services is the required paperwork documentation of each treatment administered to the survivor. In Site C, the settlement faced challenges of consistent documentation, making it difficult to track a survivor's treatment plan. There was a reported lack of consistency in terms of documenting every step of a survivor's treatment process. The participant referred to the issues as "*more of a staff issue as it is on the staff member to remember to fill out the forms and capture the data*".

Staff Training/Guidelines

All settlements were observed to follow the UNFPA guidelines as the standard protocol for providing CMR services, with their staff trained on CMR protocols and survivor-centered care. A participant suggested the current guidelines for Site A and Site B may need adjustments to reflect the changing contexts of COVID-19 on the SGBV system, affecting the responses and referral pathways of the SGBV services. The participant overseeing Site D discussed the need for UNFPA guidelines to be integrated with Uganda's Ministry of Health guidelines, as the country may not always have access to the UNFPA-recommended medications.

Overall Capacity

The participant overseeing Site E and Site F discussed their site experiencing a shortage of supplies, specifically kits for forensic evidence as barriers to the facility's capacity to provide treatment. The participant discussed potential delays in transport as reasoning behind the shortage of supplies. In Site C, supplies of kits (HIV, syphilis, and hepatitis B test kits) and

medication stock for STI treatment and wound care posed challenges in providing treatment. The participant also discussed the challenge of short-term employee contracts, which resulted in a time-intensive process of retraining employees and affected the quality of the work and confidentiality of the process.

DISCUSSION

Sexual gender-based violence within complex humanitarian settings has gained recognition on the global stage for its cruel manifestations within refugee/IDP sites. In response to the growing cases, a SGBV system has been established within each settlement to provide survivors with access to the necessary legal, clinical, and psychosocial care (UNHCR, 2002). Unfortunately, survivors face a multitude of challenges that often lead to a lack of or limited SGBV service utilization (Oladeji et al., 2019). Survivors are then at high risk of suffering short-term and long-term physical, mental, and SRH health consequences as a result of their untreated SGBV injuries (Jina & Thomas, 2013).

The research was designed by Medical Teams to explore the current practices and gaps in the reporting and treatment process across nine different settlements in Tanzania, Bangladesh, and Uganda. The findings provided insight into existing challenges that discourage SGBV reporting and survivor utilization of CMR services in complex humanitarian settings. Medical Teams will be able to use the results to further their understanding of each country office's readiness to meet the organization's SGBV global indicator and how they can better support the offices in the necessary next steps to help improve the quality of CMR services and SGBV programming.

Key Findings

Reporting

Location/Setting

All nine settlements were observed to share the common issue of their facility's physical structure impacting the level of privacy and confidentiality provided during the reporting process. The structural design of a facility can influence how comfortable a survivor may be in

disclosing full details of their SGBV incident. Current literature observed similar hesitations of reporting in crowded atmospheres, as observed in Site I, in which survivors were unable to fully disclose details of their incident, in fear of family or community members overhearing their report (Wirtz et al., 2013). However, current literature does not capture the structural challenges observed in Site E and Site F, in navigating two programmatic operations within one facility space. Shared facility spaces struggle to ensure full privacy and confidentiality of the survivor as the availability of rooms and waiting areas are less secure and consistent based on the programmatic activities of each department that day.

Communication

The different communication methods utilized during the reporting process varied from verbal, written, visual, to gestural reporting. Verbal reporting was observed as the most common form of communication across the nine settlements. As discussed in the literature, those who translate a survivor's report have a large impact on how the incident and the needs of the survivor are understood by the provider and staff (Chowdhury et al., 2021). Survivors often face challenges of language barriers, as the available translators and staff may not be proficient in the necessary languages/dialects needed to record and comprehend the survivor's report. The quality of care a survivor receives can be impacted by the translator's or staff's interpretation of the verbal report, therefore the survivor must be fully understood in their disclosure of incident details as well as any current symptoms or injuries. As a solution, survivors tend to bring someone along to aid them in communication, but participants express concern about the inability to ensure privacy and confidentiality with this route of translation. Clinicians, staff, and translators are obligated to follow the privacy and confidentiality protocols, while there are no established means for holding outside translators accountable for following such protocols.

Guidelines under World Health Organization (WHO) and UNHCR have suggested utilizing the survivor's companion of choice or another female health/social worker during the examination in case of a language barrier between the provider and the survivor (WHO, 2020). There is a lack of recommendation on how to mitigate language barriers in the case that the survivor comes in to report alone and requires translation.

Support Systems

Observed across five settlements, participants described a common pattern of parents aiding the survivor during the reporting process, with exception of Site A and Site B, where parents were observed to report in place of the survivor. . The presence of a parent or a relative can affect the survivor's ability to fully disclose the incident, in fear of punishment, shame, or rejection. However, some survivors are limited in their ability to access the SGBV services due to their age and/or gender, requiring the survivor to be accompanied by a family member, as observed in Site C, where minors must be accompanied by a relative or police officer (MacTavish, 2020). The literature discusses how the relationship between the perpetrator and the survivor can further limit a survivor's access to SGBV services, as the accompanying party may be the perpetrator or have some connection to the perpetrator (MacTavish 2020). This relationship dynamic was noted in Site G and Site H, where the participant observed survivors to have some form of relationship or connection to their perpetrator, therefore discouraging the girls' access to SGBV services.

Treatment

Initial Treatment

Barriers to initial treatment were often attributed to the stigma/cultural norms of the communities and lack of knowledge of the benefits and urgency of treating SGBV injuries. In

order to initiate the treatment process, it was required that survivors self-report, potentially exposing the SGBV incident to their family and community. In return, survivors were often left to face stigmatization, shame, as well as a lack of protection from their perpetrators, family, and community. Some communities perceive SGBV as an issue to be handled and kept within the community, viewing outside actors as an unnecessary involvement. Social and cultural attitudes towards sexual violence can manifest into lower health-seeking behaviors from the survivor and a negative association with pursuing treatment (MacTavish, 2020; Odwe et al., 2018). The cultural norms, in combination with a lack of knowledge of the available CMR services and referral pathway, creates treatment hesitancy, leading to the late reporting observed in the majority of the sites. As a result, late reporting decreases the settlements' ability to successfully treat injuries and administer emergency medications such as PEP and emergency prophylaxis within the treatment window.

Follow Up

Lost to follow-up after initial treatment was a common theme across the sites as one of the main challenges to treatment. Depending on the survivor's SGBV needs, the treatments administered may require more than one visit to confirm the success of the treatment or require multiple dosages of a medication (UNHCR, 2002). The literature discusses the significance of timely treatment, as any survivor that waits beyond the time window for each treatment, may be deemed ineligible for its preventative benefits (MSF, 2020). Two of the sites discussed the shame from their incident often discourages survivors from following up after initial treatment, at times completely cutting off communication and contact from the facility. The unstable treatment completion and visit compliance create gaps in treatment tracking and the quality of CMR services.

Tracking

The literature doesn't discuss the significance of treatment tracking, however, it is established as a major component of providing high-quality CMR services to the survivors in the interview guideline. Each settlement had its standard documentation protocols, in the form of an inventory book or GBV register, to record the five pieces of the treatment package. In Site C, the staff's ability to consistently document the five pieces of the treatment package was observed as a challenge to treatment tracking. The attached paperwork to administer and document each treatment piece can become hard to organize and track, as the treatment has multiple operating functions, administered by different staff. The paperwork is important in establishing a treatment timeline for survivors, however, the paperwork has the potential to slow down staff capacity and operations, affecting the quality of care. Therefore, treatment tracking protocols can help guide and establish a cohesive treatment process, with access to the survivor's most updated and accurate medical information.

Overall Capacity

Treatment adherence is not only dependent on the survivor, but it is dependent on the facility's overall capacity to provide the necessary medications and treatments, as well as the staff's ability to provide quality care during the treatment process. Site E and Site F discussed experiencing shortages of supplies and transportation delays, lacking the necessary kits to collect forensic evidence. Transportation delays can be attributed to logistical problems or road access, decreasing treatment adherence or CMR service utilization due to low stock of medication (UNHCR Uganda, 2019). Site C discussed how the capacity to provide quality care can be halted by the length of employee contracts. The process of training the staff is time-intensive, therefore,

short-term employee contracts create a burden of constant re-training of staff, increasing potential breaches of confidentiality during the training process.

Strengths and Limitations

The structure of the research allowed for qualitative data collection of a diverse sample population, with participants overseeing nine settlements in three different countries. The project provides comparative data on the strengths and gaps of each settlement, with considerations of different and similar humanitarian contexts, settlement demographics, and reporting/treatment operations.

The interview guidelines were developed by the PI in conjunction with Medical Team's health advisors. The health advisors' professional expertise in clinical practice and programming in complex humanitarian settings, helped create a concise interview guideline that would target the required data needed to measure each settlement's readiness to meet the organization's SGBV global indicator. The PI's role, as both the lead on the project and the interviewer in the data collection process, provides an advantage of understanding the context and details of each interview when producing the analysis.

A limitation of the study was the narrow scope of people interviewed. The interviews were administered to participants with the specific role of SRH/HIV officer of their settlement. The data collected excludes the viewpoint of the survivors, other working staff, and NGO partners that help administer the CMR services. The SGBV system consists of legal, clinical, and psychosocial services, however, the research only provides access to one step in the SGBV reporting process, the CMR services. The research lacked insight into the details of the psychosocial services and legal care available to the survivors.

Lastly, the project was limited in its ability to reach all country offices targeted for the assessment. The original sample population involved collecting data from four different countries; Uganda, Tanzania, Bangladesh, and Ethiopia. However, due to the growing humanitarian context in Ethiopia at the time of the project, the team decided to pause data collection in response to the staff's unstable communications with the Ethiopia team.

Future Considerations

With knowledge of the existing practices and gaps to the reporting and treatment process, the development of potential projects, funding considerations, and updated protocols may help strengthen the overall quality of CMR services offered. Future projects such as stigma work within the settlement communities would aid in destigmatizing and dismantling the cultural norms around SGBV topics, which lead to late reporting and under-utilization of CMR services. The implementation of health promotion and educational projects around the available SGBV services and utilization of the reporting/referral pathway process is pertinent to alleviating the lack of access and knowledge of SGBV services experienced within the settlements. In terms of funding considerations, the improvement of facility structures would allow for a higher quality reporting and treatment experience for the survivor, while increasing performance efficiency amongst the staff administering each process. The development of a new protocol for managing the process of follow-up treatment and documentation would allow the organization to better meet their global SGBV indicator on treatment tracking.

.

PUBLIC HEALTH IMPLICATIONS

Research

The project helped highlight the reporting and treatment gaps of each settlement, while exposing the remaining knowledge gaps that could help inform future research projects. The findings within this project helped inform the clinical aspect of the SGBV system within settlements, however, the SGBV system is composed of multiple sectors that each have their own challenges. The sector of mental health and psychosocial support (MHPSS) is a high needs area for research, as the guidelines and tools are available, but the success rate of referrals and treatment is not well known.

A major challenge to reporting and treatment was the stigmatization of SGBV within the different communities. Further research into understanding of the cultural norms around SGBV, among major ethnic groups within the settlements, has the opportunity to inform stigma work.

Policy

Understanding the existing practices and gaps of the reporting and treatment process will help inform policy reform to improve the operations of the SGBV system. The research can help further policies around topics of ensured survivor protection, reporting, MHPSS, and CMR. The data available can strengthen the urgency of implementing the appropriate mandates and tools to help increase the quality of care administered to survivors of rape.

Programming

The research may be utilized as a guiding framework to develop and strengthen the current SGBV practices and protocols in place during the reporting and treatment process. The programmatic needs highlighted within the research can help facilitate the development of protocol for facility capacity, staff training, and operational cohesiveness within the SGBV

departments and across other departments as well. The varying strengths and achievements across the nine settlements provide potentially applicable solutions to other settlements with similar contextual challenges to the reporting and treatment process.

This project helped further knowledge around the factors that lead to underreporting in refugee camps/IDP sites. However, further research and work is still necessary in order to understand the intersectional barriers that exacerbate the horrific SGBV experiences women and children endure in complex humanitarian settings. Prioritization of combating SGBV within refugee camps/IDP sites is imperative to protecting the livelihoods of women and children from danger and harm globally.

REFERENCES

Araujo, J. D. O., Souza, F. M. D., Proença, R., Bastos, M. L., Trajman, A., & Faerstein, E. (2019). Prevalence of sexual violence among refugees: a systematic review. Revista de saude publica, 53.

Bangladesh Refugee Emergency: Sexual & gender-based violence factsheet (as of December 2018) - bangladesh. UNHCR. (2018, December 31). Retrieved November 18, 2021, from https://reliefweb.int/report/bangladesh/bangladesh-refugee-emergency-sexual-gender-based-violence-factsheet-december-2018.

Block, K., Nasr, H., Vaughan, C., & Alsaraf, S. (2019). What responses, approaches to treatment, and other supports are effective in assisting refugees who have experienced sexual and gender-based violence. Institute for Research into Superdiversity (IRIS), University of Birmingham

Chowdhury, S. A., Green, L., Kaljee, L., McHale, T., & Mishori, R. (2021, January 27). Sexual violence, trauma, and neglect: Observations of health care providers treating Rohingya survivors in refugee camps in Bangladesh. Physicians for Human Rights. Retrieved February 6, 2022, from https://phr.org/our-work/resources/sexual-violence-trauma-and-neglect-observations-of-health-care-providers-treating-rohingya-survivors-in-refugee-camps-in-bangladesh/

Clinical management of survivors of rape: a guide to the development of protocols for use in refugee and internally displaced person situations (2002). UNHCR. (No. WHO/RHR/02.08). World Health Organization.

Dirisu, O. (2020). Understanding barriers to clinical management of rape (CMR) services among survivors of rape in crisis settings in Borno state.

Dworkin, E. R., & Weaver, T. L. (2021). The impact of sociocultural contexts on mental health following sexual violence: A conceptual model. Psychology of violence, 11(5), 476.

Emergency Handbook: Sexual and gender based violence (SGBV) prevention and response. UNHCR. (2022, February 5). Retrieved February 5, 2022, from https://emergency.unhcr.org/entry/60283/sexual-and-gender-based-violence-sgbv-prevention-and-response

Jesuthasan, J., Witte, Z., & Oertelt-Prigione, S. (2019). Health-related needs and barriers for forcibly displaced women: A systematic review. Gender and the Genome, 3, 2470289719895283.

Krause, S., Williams, H., Onyango, M. A., Sami, S., Doedens, W., Giga, N., ... & Tomczyk, B. (2015). Reproductive health services for Syrian refugees in Zaatri camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the minimum initial services package. Conflict and health, 9(1), 1-10.

Facts and figures: Humanitarian action. UN Women. (2017). Retrieved from http://www.unwomen.org/en/what-we-do/humanitarian-action/facts-and-figures#notes

Factsheet Sexual and Gender Based Violence (SGBV) Situation in Nyargusu, Nduta and Mtendeli refugee camps - 31 October 2016 - United Republic of Tanzania. UNHCR. (2016, October). Retrieved November 17, 2021, from https://reliefweb.int/report/united-republic-tanzania/factsheet-sexual-and-gender-based-violence-sgbv-situation-1.

Fletcher, E. K., Gitter, S. R., & Wilhelm, S. (2021). Generational Norms of Reporting Violence in Nyarugusu Refugees Camp. *The European Journal of Development Research*, 1-22.

Friedman, A. R. (1992). Rape and domestic violence: The experience of refugee women. Women & therapy, 13(1-2), 65-78.

Fukui, M. (2021). Women Peace and Security: Sexual Gender-Based Violence Survivor Support in Refugee Settlements in Uganda. In Risks, Identity and Conflict (pp. 277-305). Palgrave Macmillan, Singapore.

FY22 Global Indicators (2021). *Medical Teams International*. Microsoft Excel file.

Galvin, S. R., & Cohen, M. S. (2004). The role of sexually transmitted diseases in HIV transmission. Nature Reviews Microbiology, 2(1), 33-42.

GBV trends among Rohingya refugees in Cox's Bazar, January 2021. International Rescue Committee. Retrieved November 18, 2021, from https://www.rescue.org/sites/default/files/document/5553/gbvtrendsamongrohingyarefugeesincoxsbazar-covid-19update.pdf.

Guidelines for health staff: Caring for gender-based violence survivors - including protocol for clinical management of rape [en/ar] - turkey. ReliefWeb. (2019, March 11). Retrieved January 30, 2022, from https://reliefweb.int/report/turkey/guidelines-health-staff-caring-gender-based-violence-survivors-including-protocol

Guhathakurta, M., Begum, S., & Rahman, S. (2016). A needs assessment of UMNs population and capacity assessment of service providers in makeshift settlements with a focus on Sex and Gender Based Violence (SGBV).

Gwamagobe, S. (2013). Atrocities on women and female children at refugee camps in Tanzania: a case study of Nyarugusu refugee camp (Doctoral dissertation, The University of Dodoma).

Haddad LB, Nour NM. Unsafe abortion: unnecessary maternal mortality. Rev Obstet Gynecol. 2009;2(2):122-126.

HIV/AIDS. (2020, February 13). Mayo Foundation for Medical Education and Research. Mayo Clinic. Retrieved February 3, 2022, from https://www.mayoclinic.org/diseases-conditions/hiv-aids/symptoms-causes/syc-

20373524#:~:text=Untreated%20HIV%20%2F%20AIDS%20can%20cause,depression%2C%20anxiety%20and%20difficulty%20walking.

Jesuthasan, J., Witte, Z., & Oertelt-Prigione, S. (2019). Health-related needs and barriers for forcibly displaced women: A systematic review. Gender and the Genome, 3, 2470289719895283.

Jina, R., & Thomas, L. S. (2013). Health consequences of sexual violence against women. Best Practice & Research Clinical Obstetrics & Gynaecology, 27(1), 15-26.

Joarder, T., Sutradhar, I., Hasan, M. I., & Bulbul, M. M. I. (2020). A record review on the health status of Rohingya refugees in Bangladesh. Cureus, 12(8).

Laisser, R. M., Nyström, L., Lugina, H. I., & Emmelin, M. (2011). Community perceptions of intimate partner violence-a qualitative study from urban Tanzania. BMC women's health, 11(1), 1-12.

MacTavish, E. (2020). Barriers of Reporting Sexual Violence in Syrian Refugee Camps. Journal of Academic Perspectives Volume, (1), 1.

Médecins Sans Frontières Medical protocol for sexual violence care 2020. Médecins Sans Frontières (MSF) International. Retrieved January 23, 2022, from https://www.msf.org/sexual-violence

Mgopa, L. R., Rosser, B. S., Ross, M. W., Mohammed, I., Lukumay, G. G., Massae, A. F., ... & Leshabari, S. (2021). Clinical Care of Victims of Interpersonal Violence and Rape in Tanzania: A Qualitative Investigation. International Journal of Women's Health, 13, 727.

Mogga, R. (2017). Addressing gender based violence and psychosocial support among South Sudanese refugee settlements in northern Uganda. Intervention, 15(1), 9-16.

Mwenyango, H. (2021). Gendered dimensions of health in refugee situations: An examination of sexual and gender-based violence faced by refugee women in Nakivale refugee settlement, Uganda. International Social Work, 002087282110039.

Odwe, G., Undie, C. C., & Obare, F. (2018). Attitudes towards help-seeking for sexual and gender-based violence in humanitarian settings: the case of Rwamwanja refugee settlement scheme in Uganda. BMC international health and human rights, 18(1), 1-12.

Oladeji, O., Owoaje, E., Oladeji, B., & Fatiregun, A. (2019). A community-based intervention for improving utilization of medical services by rape survivors in refugee camps in Zambia. Journal of Community Medicine and Primary Health Care, 31(1), 11-21.

Oladeji, O., Oladeji, B., Chamla, D., Safiyanu, G., Mele, S., Mshelia, H., & Agbor, J. (2021). Sexual violence–related pregnancy among internally displaced women in an internally displaced persons camp in northeast Nigeria. Journal of interpersonal violence, 36(9-10), 4758-4770.

Olsen, O. E., & Scharffscher, K. S. (2004). Rape in refugee camps as organisational failures. The International Journal of Human Rights, 8(4), 377-397.

Omanyondo, O Marie-Claire. (9-29 September, 2005). Sexual Gender-Based Violence and Health Facility Needs Assessment (Lofa, Nimba, Grand Gedeh, and Grand Bassa Counties) Liberia.World Health Organization. https://www.who.int/hac/crises/lbr/Liberia_RESULTS_AND_DISCUSSION13.pdf

Parmar, P. K., Jin, R. O., Walsh, M., & Scott, J. (2019). Mortality in Rohingya refugee camps in Bangladesh: historical, social, and political context. Sexual and reproductive health matters, 27(2), 39-49.

Population Factsheet : UNHCR, Bangladesh, Cox's bazar- as of 30 September 2019. UNHCR Operational Data Portal (ODP). (2019, September 30). Retrieved February 8, 2022, from https://data2.unhcr.org/en/documents/details/71790

Seeking protection: Addressing Sexual and Domestic Violence In Tanzania's Refugee Camps. Human Rights Watch. (2000). Retrieved January 23, 2022, from https://www.hrw.org/reports/2000/tanzania/

Sexual violence, trauma, and neglect: Observations of health care providers treating Rohingya survivors in refugee camps in Bangladesh. Physicians for Human Rights. (2021, January 27). Retrieved February 1, 2022, from https://phr.org/our-work/resources/sexual-violence-trauma-and-neglect-observations-of-health-care-providers-treating-rohingya-survivors-in-refugee-camps-in-bangladesh/

Sexually transmitted diseases. (2015, August) U.S. Department of Health and Human Services. National Institute of Allergy and Infectious Diseases. Retrieved February 3, 2022, from https://www.niaid.nih.gov/diseases-conditions/sexually-transmitted-diseases#:~:text=In%20addition%2C%20STDs%20can%20cause,infants%20born%20to%20infected%20mothers.

Simon-Butler, A., & McSherry, B. (2019). Defining sexual and gender-based violence in the refugee context. IRiS working paper series, 28. Birmingham: Institute for Research into Superdiversity.

Smith, J. R., Ho, L. S., Langston, A., Mankani, N., Shivshanker, A., & Perera, D. (2013). Clinical care for sexual assault survivors multimedia training: a mixed-methods study of effect on healthcare providers' attitudes, knowledge, confidence, and practice in humanitarian settings. Conflict and health, 7(1), 1-10.

Tappis, H., Freeman, J., Glass, N., & Doocy, S. (2016). Effectiveness of interventions, programs and strategies for gender-based violence prevention in refugee populations: an integrative review. PLoS currents, 8.

The International Criminal Court Act 2001 (Elements of Crimes) Regulations 2001. ICC Women. (2001). Definitions of crimes of sexual violence in the ICC. Retrieved February 3, 2022, from http://www.iccwomen.org/resources/crimesdefinition.html

Uganda: Refugee Settlements. UNHCR. (2021, December 31). UNHCR Operational Data Portal (ODP). Retrieved February 9, 2022, from https://data2.unhcr.org/en/dataviz/19

Uganda: UNHCR Monthly Protection Update - Sexual and Gender Based Violence (SGBV) (December 2019) - uganda. UNHCR. (2019, December). ReliefWeb. Retrieved November 17, 2021, from https://reliefweb.int/report/uganda/uganda-unhcr-monthly-protection-update-sexual-and-gender-based-violence-sgbv-december.

Undie, C. C., Birungi, H., Namwebya, J. H., Taye, W., Maate, L., Mak'anyengo, M., ... & Karugaba, J. (2016). Screening for sexual and gender-based violence in emergency settings in Uganda: an assessment of feasibility.

United Nations High Commissioner for Refugees. (2003, May). Sexual and gender-based violence against refugees, returnees and internally displaced persons. guidelines for prevention and response, UNHCR (SGBV guidelines). UNHCR. Retrieved February 2, 2022, from https://www.unhcr.org/en-us/protection/women/3f696bcc4/sexual-gender-based-violence-against-refugees-returnees-internally-displaced.html

UNHCR Uganda January 2020 Fact Sheet. UNHCR Operational Data Portal (ODP). (2020, 31 January). Retrieved February 9, 2022, from https://data2.unhcr.org/en/documents/details/74400

Vu, A., Adam, A., Wirtz, A., Pham, K., Rubenstein, L., Glass, N., ... & Singh, S. (2014). The prevalence of sexual violence among female refugees in complex humanitarian emergencies: a systematic review and meta-analysis. PLoS currents, 6

World Health Organization. (2020). Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. World Health Organization. Retrieved April 18, 2022 from https://apps.who.int/iris/handle/10665/331535.

Wirtz, A. L., Glass, N., Pham, K., Aberra, A., Rubenstein, L. S., Singh, S., & Vu, A. (2013). Development of a screening tool to identify female survivors of gender-based violence in a humanitarian setting: qualitative evidence from research among refugees in Ethiopia. Conflict and health, 7(1), 1-14

APPENDICES

APPENDIX I: INTERVIEW GUIDE

Case Management of Rape (CMR) Services Offered and Data Recording

Country Office:

General Health Indicator:

% of SGBV survivors who receive a full package of treatment (PEP, Pregnancy prophylaxis, STI treatment, wound care, and psychosocial support)

Definition:

# of SGBV survivors registered in health facilities or through community health who received PEP, levonorgestrel, treatment for gonorrhea and chlamydia, wound care, and PFA or referral for psychosocial care / # of SGBV survivors recorded in health facility registers

Current Process

- What is the current process for rape survivors?
    - Communications/Reporting
        - Survivor to team communication
            - Who can the survivor report to?
            - Designated areas to speak for confidentiality?
            - What are the methods of communication a survivor could utilize to speak about a sensitive issue or in confidence? (codes, gesture, written note, etc)
            - Who provides the treatment – is it one person or a team?
- Staff to staff communication per case
    - What is the current treatment process?
    - How does the staff document the # of survivors in the facilities?
    - Are there resource referrals provided to survivors during the process?
    - Is there a follow up process for the survivor after the treatment process?
    - Are there protection protocols put in place for the survivor's safety during the process?
    - How does the team maintain confidentiality of process and survivor?
- What are the current challenges in providing adequate care for rape survivors?
- What is needed in order to improve the process?

Guidance

- What are the current guidelines being used for the CMR services?
    - UNFPA?
- Are there preferences in the guidelines used?

Training

- How have the staff been trained on clinical management of rape protocols?
  - How many?
  - Survivor-centered care?

Treatment Tracking

The questions pertain to the following items listed below.

1) PEP

2) Pregnancy Prophylaxis

3) STI treatment

4) Wound Care

5) Psychosocial care (PFA or referral for psychosocial care)

- What is the team's capacity to track and document those five pieces of care?
  - Most difficult items to track? Easiest items to track?
- Challenges to treatment tracking?

COVID-19

- In what ways has the COVID-19 pandemic changed the process of reporting/tracking?

Additional Comments:

APPENDIX II: CODEBOOK

Qualitative Codebook

Code Name	***Definition***
1. Treatment	Description of the medical care given to the survivor by the facility/staff
1a. Practice	Mention of the current treatment process given to survivors
1b. Follow Up	Mention of the follow-up treatment for survivors after being seen in the facility
1c. Tracking	Mention of how the facility documents and tracks the survivor's treatment process
1d. Staff Training 1e.i Guidelines	Mention of the type of training staff receive to treat survivors [Ex: survivor-centered care training, clinical management of rape training, sensitivity training] Mention of the specific health guidelines used to standardize the CMR services [Ex: Ministry of Health Guidelines, UNFPA guidelines]
1e. Overall Capacity	Mention of the facility/staff ability to provide treatment to the survivor [Ex: staff to patient ratio, hours of operations, treatment stock, available trained professionals]
1f. Psychosocial Referral	Mention of referral for psychosocial care after CMR services
1g. Legal Referral	Mention of referral for legal care after CMR services
2. Reporting	Description of the survivor's written/spoken account of their SGBV incident to the camp/staff/facilities
2a. Location	Mention of where the survivor reported their incident
2b. Facilitators	Mention of who the survivor reported to
2c. Communication	Mention of the communication methods used by staff and survivor during reporting
2d. Protection	Mention of the protection measures implemented for the survivor's safety
2e. Justice	Mention of the legal measures pursued after reporting

2f. Referral	Mention of referrals given to the survivor after reporting (clinical, psychosocial)
2g. Support Systems	Mention of any support systems that aided reporting
3. Challenges to Reporting/Treatment	Description of the barriers survivor face that discourage SGBV reporting and the barriers the facility/staff face in providing treatment to the survivors
3a. Cultural Norms/Stigma	Mention of cultural norms or stigma being a barrier to the reporting/treatment process
3b. Access to SGBV Services	Mention of the community/survivor's ability to access the SGBV services in the camp [Ex 1: Participant is discouraged from accessing SGBV services as they require a familial or male chaperone Ex 2: Transportation to the facility is unsafe]
3c. Knowledge of SGBV Services	Mention of the community/survivor's knowledge of the existing SGBV services provided in the camp [Ex: The services are poorly promoted within the site]
3d. Language Barrier	Mention of language being a barrier during the reporting/treatment process
3e. Distrust of SGBV System	Mention of the community or survivor's distrust towards the camp's SGBV system
3f. Privacy and Confidentiality 3f.i Structural	Mention of the privacy and confidentiality of the survivor during the reporting and treatment process Mention of the structural components of the facility being a challenge to privacy and confidentiality
3g. Stock & Supply	Mention of the facility's unstable supply of PEP, emergency prophylaxis, STI treatment
3h.Organization	Mention of facility's inability to organize and track treatment documentation or survivors
3i. Follow-Up	Mention of a survivor's lack of follow-up to their appointment
3j. Funding	Mention of funding being a barrier to providing quality care for survivors
3k. COVID-19	Mention of how COVID-19 may have affected the reporting/treatment process