Chapter 7
Evaluating Survivors of Sexual and Gender-Based Violence

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Introduction

Sexual and gender-based violence (SGBV) is a ubiquitous phenomenon [1] affecting people around the world, primarily women and girls [2]. A lifecycle of violence has been described affecting women living in almost every nation and belonging to every ethnicity [3, 4]. While the specific forms of violence may vary, the constant threat can be pervasive. In 1948, the Universal Declaration of Human Rights (UDHR) was adopted by the United Nations highlighting equality and special protections for women and girls; however, in the ensuing decades, increasing evidence showed that women and girls faced unique barriers to equality and specific forms of abuse which were not fully enumerated in the UDHR. As a result, in 1979 the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was adopted by the United Nations (UN) with 189 signatories as of 2015 [5]. It is noteworthy that the United States has signed, but never ratified CEDAW.

The UN defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" [6].

The World Health Organization (WHO) describes SGBV as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work [7]. Multiple human rights violations fall under these

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definitions and the spectrum includes a wide array of acts ranging in severity from verbal harassment, to daily physical or sexual abuse, to female genital mutilation/cutting (FGM/C), to rape, honor killing, and femicide [8] (Table 7.1).

When evaluating a survivor for SGBV, it is important to note that such violence is not limited to penetration of sexual organs or the physical invasion of bodily cavities. Additionally, survivors usually report having experienced more than one form of SGBV. Most experience multiple forms simultaneously or sequentially across time.

Settings with increased risks of SGVB include areas with a high prevalence of poverty, conflict and post-conflict zones, natural disaster zones, refugee camps, and

Table 7.1 Types of sexual and gender-based violence [9] (Adapted from United Nations. International protocol on the documentation and investigation of sexual violence in conflict best practice on the documentation of sexual violence as a crime or violation of international law. 2017, March. https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/06/report/international-protocolon-the-documentation-and-investigation-of-sexual-violence-in-conflict/International_Protocol_2017_2nd_Edition.pdf.)

Type	Description
Intimate partner violence (IPV)	Any physical, sexual, or psychological abuse perpetrated by an intimate partner
Rape (completed, attempted, or threatened)	Included vaginal and anal penetration by a body part or an object, or oral penetration by a sexual organ, by the perpetrator or the victim Threats and attempts of any form of rape or threats and attempts of other sexual assault
Genital mutilation or cutting	Cutting or mutilation of the vulva, labia, clitoris Forced elongation of the labia Mutilation of breast and nipples Male genital mutilation or amputation, or other types of violence directed at sexual organs
Sexual slavery	Sexual slavery, including conjugal slavery or concubinage
Sexual torture	Sexual torture, including electrocuting genitals or pinching nipples, or being forced to watch a partner or child be sexually abused
Forced prostitution	Forced prostitution
Reproductive coercion	Reproductive coercion can include forced pregnancy, forced abortion, and forced sterilization [10] Forced pregnancy may occur in the setting of intimate partner violence, forcible withholding of contraception, and/or in situations of genocide coupled intentional "repopulation" via rape of the conquered/minority women and girls Forced abortion may be part of a violent relationship, or it may be part of a broader, systematic strategy of reproductive control over women and girls who have been trafficked into the sex trade Forced sterilization is a worldwide practice, usually perpetrated upon minority women, disabled women, and women with certain diseases like HIV
Dowry deaths [11]	Killing or suicide of married women due to continuous harassment and torture by their husbands and in-laws over a dispute about their dowry
Honor killing [12]	The killing of a family member (usually girl or woman) due to the belief that the victim has brought shame or dishonor to the family
Human trafficking [13]	The use of force, fraud, or coercion to obtain some type of labor or commercial sex act, though the use of use violence, manipulation, or false promises of well-paying jobs or romantic relationships to lure victims into trafficking situations

Table 7.1 (Continued)

Type	Description
Child Marriage [14, 15]	Any marriage occurring in which either party is under the age of 18 It is a practice affecting both boys and girls, however, the vast majority of affected individuals are girls While child marriage is illegal in many parts of the world, 33,000 child marriages a day continue to take place because of lack of legal enforcement and/or parental consent exceptions Girls most vulnerable to this practice are poor and/or live in rural areas, and it has been shown to increase during humanitarian crises Girls who are married as children are more likely to be deprived of education, to experience childbirth complications, and to experience intimate partner abuse
Virginity testing [16]	An inspection of the female genitalia (specifically the hymen) meant to determine whether a woman or girl has had vaginal intercourse The examination has no scientific merit or clinical indication The practice is a human rights violation is associated with both immediate and long-term consequences

areas dominated by gangs and gang violence. [15] At the time of this writing, the worldwide COVID-19 epidemic is raging, and there is abundant evidence that because of enforced social isolation, coupled with long-standing structural inequalities, SGVB is on the rise [17].

Prevalence

According to a 2020 Report of the United Nations Secretary-General [2], "Data on violence against women and girls indicate that it affects women in all countries and across all socioeconomic groups, locations and education levels." Data from many sources indicate that the most dangerous place for women and girls is in their home [15, 18, 19]. Physical violence may begin as early as infancy, when cultural preferences for male children can result in the withholding of food and education, as well as domestic servitude and corporal punishment. The cycle of violence continues for girls and women as they enter into relationships with male partners. A 2013 report from the World Health Organization reports on data from 106 countries and concludes that approximately 30% of women will experience violence by a partner in their lifetime [20].

SGBV also affects the LGBTQ community, with some important differences, which will be discussed at length in Chap. 8 of this book. For the remainder of this chapter, we will use the terms "women" and "girls" to refer largely to cis-gendered individuals who identify as female.

The Impact of Sexual and Gender-Based Violence

SGBV often has long-lasting physical, psychological, social, behavioral, and spiritual impact on survivors. The physical and psychological effects may include (but are not limited to) those outlined in Tables 7.2 and 7.3 (Adapted from United Nations.

Table 7.2 Some physical effects of SGBV

All genders	Physical injury (internal/external)	*Sexually transmitted infections*: GC, CT, HIV, Hep C, etc.	Permanent physical disability	Sexual dysfunction	Malnutrition due to food restriction
Women/girls	Vulvar, pelvic, rectal injuries	*Pregnancy related*: Unplanned pregnancy complications Complications from unsafe abortion Complications from miscarriage Infertility			
Men/boys	Testicular, penile, rectal injury	Atrophy of organs due to ligation			

Table 7.3 Some psychological effects of SGBV

Acute stress disorder	High-risk sexual behavior	Sleeping disorders
Anger	Low self-esteem	Suicidal thoughts/behavior
Anxiety	Post-traumatic stress disorder	Substance abuse
Chronic fatigue syndrome	Poor impulse control	
Depression	Personality disorders	
Dissociation	Self-blame	
Fear	Sexual dysfunction	
Flat affect/emotional numbing	Shame	

International protocol on the documentation and investigation of sexual violence in conflict best practice on the documentation of sexual violence as a crime or violation of international law. 2017, March. https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/06/report/international-protocol-on-the-documentation-andinvestigation-of-sexual-violence-in-conflict/International_Protocol_2017_2nd_Edition.pdf.)

US Asylum Law and SGBV

The granting of asylum in the United States on the basis of sexual and gender-based violence is a relatively new phenomenon. Case precedent was first established in 1996 with the Matter of Kasinga [21], and grew steadily until 2016. Nevertheless, it is still very difficult to win asylum on the grounds of IPV or SGBV, and the legal landscape often changes. The grounds for asylum on the basis of SGBV was further eroded by the 2020 Department of Justice guidance: *Procedures for Asylum and Withholding of Removal; Credible Fear and Reasonable Fear Review* [22] in which many of these grounds for relief were explicitly revoked. While these developments are discouraging, they also make the role of the clinician–evaluator even more important in the asylum process [23], and particularly so in sexual and gender-based violence cases.

One of the barriers faced by asylum seekers is documentation of efforts to seek protection through law enforcement or government agencies. This absence of reporting is often seen by the United States asylum adjudicators as evidence that either the abuse did not occur or that it was not severe. There are many reasons for underreporting of SGBV, including fear of reprisal, dependence on the abuser, shame, and stigma. Widespread underreporting makes the documentation of scars/injuries, and long-term sequalae much more critical.

The Evaluation

The evaluation of a survivor of SGBV should follow trauma-informed care [24, 25] guidelines. Special consideration should be given to having a gender-congruent clinician and interpreter. All consent procedures should be strictly followed before and during the evaluation.

History Taking

When interviewing the client, begin with a routine medical, gynecological, surgical, and social history. When inquiring about incidents of SGBV, the evaluator should ask specific questions about the physical acts endured by the client. These include (but are not restricted to) the survivors' body parts involved (e.g., genital, anal, oral); the perpetrator's body parts involved in the incident (e.g., penis, fingers); use of foreign objects; the number of perpetrators; use of ligatures or strangulation [26] (can be common with IPV and SGBV); and co-occurring violent acts (e.g., kicking, beating, stomping, pushing). Inquire about any resulting pregnancy or pregnancy loss from the assault, or subsequent sexually transmitted infections (STIs). Document details of symptoms that immediately followed the assault, as well as those which became chronic conditions, such as genital bleeding, discharge, itching, sores, pain, urinary symptoms, anal pain, urinary or fecal incontinence, abdominal pain, etc.

In addition to an assessment of the physical and psychological scars inflicted by the abuser(s) on the client, it is vital to elucidate the cultural context in which the abuse(s) occur. It is incumbent on the evaluator, in cooperation with the attorney, to educate the adjudicator on in-country conditions as they relate to the experiences of the client. With respect to SGBV, clients should be asked about traditional family structure in which they lived, including patrilocal living arrangements, permitted daily activities, ability to leave the home/family compound alone, and polygamous households. History regarding restriction of educational opportunities, arranged and/or forced marriage, child marriage, dowry/ bride price, female genital cutting, and cultural tolerance of intimate partner violence should also be obtained from the client. The credibility of the client's experience of any of these harmful practices should be supported with scholarly sources on and expert analyses of the prevailing conditions in the client's home country whenever possible.

Physical Examination

There is a traditional division of the physical forensic evaluation into "medical" and "gynecological" spheres, which is a false dichotomy. When a forensic evaluator performs a physical evaluation, we do not serve our clients if we do not do a full exam of her entire body, including the genitals, when relevant. Furthermore, recognizing that forensic evaluations are often re-traumatizing [27–29], it is incumbent to minimize this exposure as much as possible. As such, we encourage "gynecological" evaluators to perform "head to toe" examination of all client, if they feel comfortable doing so, thus eliminating the need for an additional physical evaluation.

Importantly, when it comes to evidence of rape or sexual assault, there is often no remaining sign of genital injury, especially if the incident is not acute. Always ask yourself if a genital examination is necessary. If it is not necessary to further the forensic evaluation, genital exams should not be performed. Of particular concern is the sometimes "expected" examination of the hymen. In some settings, clinicians refer to changes in the hymen to confirm a history of consensual or nonconsensual sexual intercourse. However, an examination of the hymen is not an accurate or reliable test of a previous history of sexual activity, including sexual assault [30].

As described elsewhere in this book, documentation of injuries should be precise and in accord with the guidance offered by the Istanbul Protocol [31]. Photographs should be taken whenever possible after the provision of consent. However, genital injuries/scars should not be photographed. Photographing the genitals for the purpose of the asylum application may be traumatic and humiliating. Furthermore, it is critical to recall that the adjudicator will have the affidavit in front of him/her while they are speaking with the applicant: The inclusion of genital photographs would be highly inappropriate. Instead, the use of illustrations from a variety of sources (e.g., the WHO FGM/C typology or obstetrics and gynecology texts) is preferred (Appendix 2 also includes body diagrams).

The use of a chaperone during evaluations that include genital exams is not universal. On one hand, a chaperone's presence may offer a sense of safety to the client. On the other hand, it introduces yet another individual into the exam room at a time when the client may feel particularly vulnerable and possibly ashamed. The use of a chaperone should be discussed with clients and their attorneys in advance, with an assessment the client's preferences and emotional needs prior to the evaluation.

The Affidavit

In addressing SGBV cases, the task before the forensic examiner is somewhat different than those presented by cases which are centered on a basis of political opinion, nationality, or religion [32] because of the complexity and duration of abuse, as well as the cultural context in which the abuse took place. As with other asylum

applications, evaluators must consider the nature of injury inflicted, the severity of the harm, patterns of abuse by a perpetrator, and the existence of permanent or serious mental or physical health sequalae. Each of these should be addressed in the affidavit as it relates to the individual applicant's experience.

In writing this type of affidavit, it is reasonable to assume that the adjudicator is not familiar with the cultural/national behavioral norms experienced by the applicant. Describing the cultural setting for the adjudicator is important because they may not believe that behavior/abuse so different from what they consider "typical" is common or plausible.

Finally, the organization of the affidavit is particularly important in SGBV cases. Because women seeking asylum have often experienced a lifetime of overlapping types of violence in a variety of settings [33], it can be more difficult to describe and document a linear trajectory of persecution and abuse. However, it is incumbent on the clinician evaluator to make clear the co-occurring and extended nature of abuse often suffered by asylum seeking women. This may be best accomplished by dividing the affidavit into sections, with headers indicating each abuse type. This helps to give structure to a possibly complex narrative, and also serves to highlight the types of violence experienced by the applicant.

Special Consideration: Female Genital Mutilation/Cutting

Anecdotal information suggests that hundreds of women every year seek asylum in the US based on FGM/C status [34]. The practice has very specific and unique features that require specialized knowledge both of the sociocultural aspects of the practice, as well as the anatomical and morphological features of the external female genitalia, pre- and post-FGM/C. For this reason, we are providing a separate section dedicated to this type of evaluation.

Background

The practice of FGM/C affects an estimated 200 million women and girls worldwide. Accurate, up-to-date statistics are difficult to obtain because, while widely practiced, most nations have legislation banning the practice, thus making data collection difficult. It is estimated that more than 500,000 women and girls currently residing in the United States are at risk of or have undergone FGM/C [35]. FGM/C has been recognized as a human rights violation under several UN declarations and conventions including the Convention for the Elimination of Discrimination against Women [6], in which FGM/C is considered to be an extreme form of discrimination against women; is both physical and psychological abuse; the Convention on the Rights of the Child [36] (as FGM/C is usually carried out on minors); and the

UDHR [37] as a violation of the "rights to health, security and physical integrity of the person, the right to be free from torture and cruel, inhumane or degrading treatment." Furthermore, FGM/C is associated with child marriage and other harmful traditional practices in many regions [38].

The WHO has described four classes of FGM/C with several subcategories [37]. While there is ongoing discussion about the adequacy of the current classification, it is currently the authoritative standard and should be used in the affidavit to

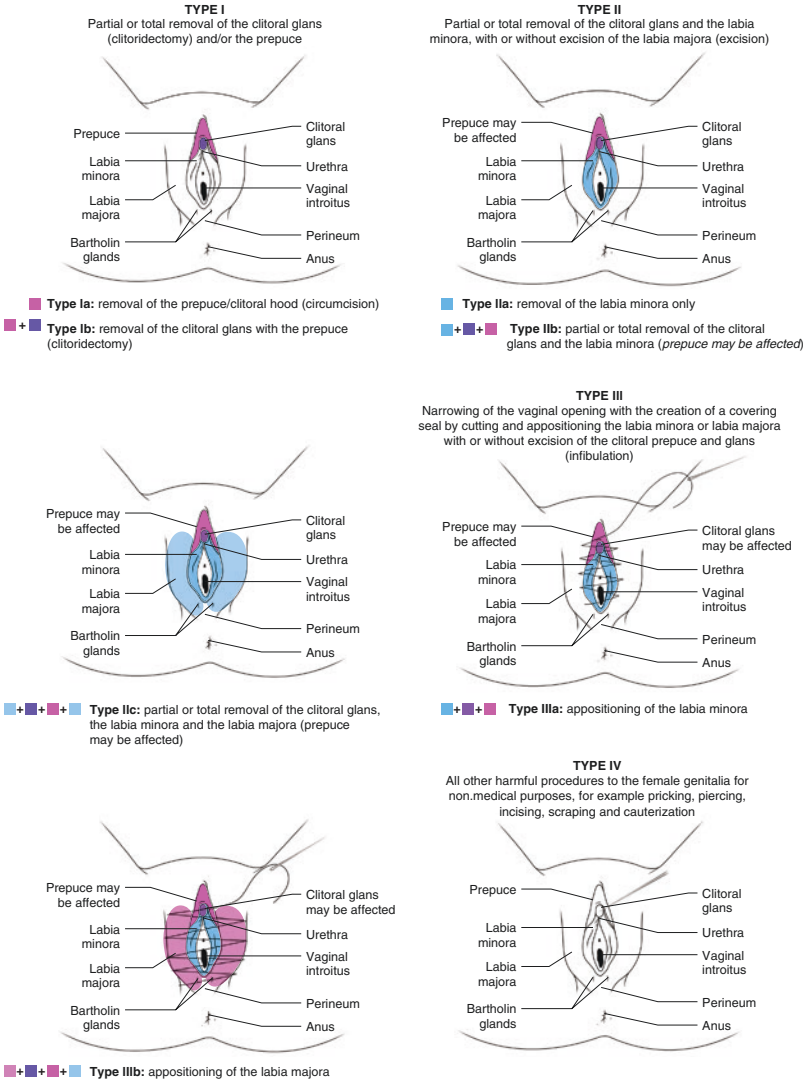

Fig. 7.1 World Health Organization FGM/C classes (Reprinted with permission from [37])

describe and categorize the parts of the external genitalia which have been removed (Fig. 7.1).

History Taking

When obtaining history about FGM/C, it is important to document not only the physical and psychological impact of the practice, but also the social history and details of the specific circumstances surrounding the cutting. A full description of

Table 7.4 Possible acute health consequences of female genital mutilation or cutting

Pain
Tissue swelling
Urinary retention
Genitourinary infection (local or disseminated)
Impaired wound healing
Hemorrhage
Shock (due to sepsis or hemorrhage)
Human immunodeficiency virus infection
Tetanus
Psychological trauma
Fractured pelvis, clavicle, or femur due to restraints
Death

Table 7.5 Possible chronic health consequences of FGM/C

Manifestation	Higher risk of
Genital	Chronic genital infections, including bacterial vaginosis
Human immunodeficiency virus infection	Due to genital trauma during intercourse
Infertility	Due to recurrent/chronic ascending genital infections
Menstrual	Dysmenorrhea, difficulty passing menses
Obstetric	Cesarean delivery, higher risk of hemorrhage, episiotomy or prolonged labor, obstetric tears and lacerations, instrumental delivery, labor dystocias, stillbirths, early neonatal deaths, prolonged hospital stay, infant resuscitation at delivery, obstetric fistula
Pain	Chronic vulvar, clitoral, vaginal, or pelvic pain
Psychological	Post-traumatic stress disorder, anxiety, depression
Sexual function	Dyspareunia, decreased sexual satisfaction, reduced sexual desire and arousal, decreased lubrication, anorgasmia
Skin	Scarring, keloids, cysts
Urinary	Recurrent urinary tract infections; painful urination due to obstruction

Table 7.6 FGM/C evaluation recommended history elements [40]

History element	Specific questions	Reasons
Ethnic, tribal, and religious history	Ask about ethnic/tribal and religious affiliation of the client, her spouse, parents, grandparents	Ethnic, tribal, and religious variations exist, and are reflected in different FGM/C prevalence rates. The client data can be compared to published statistics Family members' affiliations may be an important element in discussions about fear of the practice being forced on daughters The role of patrilocal marriage traditions should be ascertained as well. Anecdotally, we have seen cases when even if a girl's parents did not believe in the practice, she was forced to undergo the practice in deference to the groom's parents' demands
Geographic location	Ask about place of birth (country, village/town, region) and residence prior to migration	Regional variations exist in FGM/C prevalence. The client's personal information can be presented in the context of published regional statistics Bear in mind that the geographic distribution of ethnic/tribal groups does not always fall neatly within national borders. A high prevalence ethnic group may reside in a low prevalence nation
FGM/C status of other female family members	Inquire about the FGM/C status of sisters, mother, grandmothers, daughters	This information may help establish the community social norms about FGM/C as well as the potential threat of FGM/C if the asylee is, as yet, uncut
The procedure	Obtain detailed information about the practice the client has undergone: At what age? How do they know about the details? (What do they personally recall versus what a family member told them happened) Who did it (grandparent, midwife, medical professional) The social situation surrounding it Where was it done (village, hospital, house) Was it done in a group? If so, did anyone die? Was there kidnapping/trickery involved? Was it done with parental consent or against their wishes? What tools were used?	Such details offer more data that can be described in context with common practices published in the literature Such details can also offer additional hints to facilitate further probing about acute and chronic complications Type IV FGM/C may not be visible on physical examination, but is still considered a human rights violation Labial minora elongation (LME) is practiced in some countries (Rwanda, Uganda, Mozambique) and is considered a form of FGM/C in some contexts

Table 7.6 (continued)

History element	Specific questions	Reasons
	Memories of restraints (ropes or held down) What kinds of hygiene measures were taken? What was done immediately after the procedure for hemostasis, pain control Ask about other genital modification practices such as use of caustic substances, pricking, nicking, and labial elongation practices	
Acute complications	Ask the client to recall any acute reactions or complications suffered during or immediately after the procedure, including bleeding, pain at the wound, pain with urination, infections, musculoskeletal injuries, fear, anxiety Inquire about how those were addressed (use of local remedies, need to see physician, hospitalizations)	This information may establish the severity of the event (especially if linking it with allegations of torture) The history of intense fear, anxiety, and panic at being removed from loved ones or being injured by one's loved ones, held down against one's will, and injured painfully contribute significantly to the chronic psychological effects, such as PTSD
Chronic complications	Inquire about long-term physical and mental health complications the client associates with undergoing FGM/C Inquire about difficulty with routine reproductive health activities such as use of tampons, undergoing preventive health exams, and pap smears	Those may include chronic pelvic pain, sexual dysfunction (vaginismus, low/no sexual satisfaction, inability to achieve an orgasm), chronic urinary problems, scars/keloids, PTSD, anxiety and depression, permanent avoidance of marriage or intimacy, which may result in rejection and anger by a husband if married, or if single, ostracization by family and social group, as being single is not acceptable This information may help establish lasting physical and mental health effects of the practice
Issues related to pregnancy and delivery	Assess whether the client had any pregnancy-related complications potentially related to FGM/C during the prenatal, perinatal, and postnatal periods Inquire about a history of undergoing defibulation and when Inquire about a history of reinfibulation and if done, at whose request it was carried out.	For example: whether a cesarean or an episiotomy was required; whether the birth attendant attributed the need for the intervention to the FGM/C specifically; or whether they recall a significant tear/laceration requiring lengthy repair, which may be from FGM/C There are some (low quality) studies and case reports about an association between FGM/C and stillbirth, C-section, need for assisted delivery

(continued)

Table 7.6 (continued)

History element	Specific questions	Reasons
Other human rights violations	Assess whether the client has experienced other forms of sexual and gender-based violence, such as child marriage, forced marriage, rape, IPV, sexual assault	Some studies suggest that FGM/C co-occurs with other forms of gender-based violence Such information may help establish the need for protection under the "specific social group" criteria
Status of daughters	Inquire about the asylum-seeker's daughters' FGM/C status, and, if not cut, assess their risk of being cut if forced to return to the family's country of origin	This may help establish fear of future persecution and may offer an opportunity to also assess the risk to daughters of "vacation cutting" and associated legal issues
Activism	Ask about any political, social, advocacy, anti-FGM/C activities the client may have been involved with	This may help bolster claims of persecution due to political activities
Status of friends/family	Ask about deaths or significant morbidity/chronic complications witnessed directly after FGM/C or in childbirth due to FGM/C	May bolster claims of harm from the practice

the particular sequalae affecting a particular client is critical to the evaluation, as it speaks to the issue of "ongoing harm" as a result of an abuse.

Tables 7.4 and 7.5 describe some common acute and chronic manifestations of FGM/C [39].

Table 7.6 includes recommended elements of the history when evaluating a client seeking asylum based on FGM/C [40].

It is also important to ask about second cuttings. If the initial cutting is deemed to be unsatisfactory or insufficient, girls may be subjected to a second procedure: This may occur days or years after the initial event. For women and girls who have undergone FGM/C Type III (infibulation), a second procedure may be required to enlarge the vaginal opening in order to allow for sexual intercourse. This is often done by the same practitioners who perform FGM/C is often performed without anesthesia. Finally, some traditions require that women be re-infibulated after childbirth.

Lifelong psychological effects [41, 42] may also be experienced by FGM/C--affected women. Importantly, the degree of psychological distress is not related to the severity of the cutting itself, and some women do not express psychological harm at all. Feelings of betrayal, shame, humiliation, and distrust may manifest shortly after the procedure. Longer-term consequences may include anxiety, depression, and post-traumatic stress disorder. In addition to the psychological effects of their own FGM/C experience, asylum applicants may also experience trauma and distress after witnessing the FGM/C procedure and complications endured by others, including sisters, cousins, and friends.

While the majority of asylum seekers evaluated for FGM/C will be adult women, it is important to recognize that this is, in fact, a pediatric phenomenon [43]. The vast majority of individuals who will undergo the procedure are under the age of 15.

Those asylees who have female children often request protection, in part, to prevent their daughters from being forced to undergo the procedure over parental objection. Whenever possible, it is important to evaluate the children in order to attest to the fact that their genitals are (or are not) altered. If the child/children are prepubertal and you are not familiar with pediatric gynecologic exams/anatomy, it is best to request assistance from a local expert in the field.

Conclusion

Significant levels of inequality persist globally, resulting in many women and girls experiencing multiple and intersecting forms of discrimination, vulnerability, marginalization, and violence throughout their life course. Clinicians who conduct medicolegal evaluations are uniquely positioned to provide evidence of many elements of an applicant's story as well as supporting documentation. Medicolegal affidavits are also an opportunity to educate the immigration judge or asylum officer specifically about the effects of the abuse a particular asylee has suffered, as well as about the more general in-country conditions faced by women and girls from the same region.

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