Norad Report 21/2011 Discussion

Sexual Violence in Conflict and the Role of the Health Sector

Scoping Paper

Cover photo: Jan Speed
DR Congo: Women who have survived sexual violence and have been provided help and treatment are dancing at a support centre in Masisi.

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ISBN 978-82-7548-606-4
ISSN 1502-2528

Sexual Violence in Conflict and the Role of the Health Sector

Scoping Paper

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SUMMARY

Sexual violence continues to be an integrated part of modern warfare, both through the strategic use of rape as a method of warfare and through opportunistic violence as a result of deteriorating social norms and the lack of the rule of law.

After a review of concepts, actors and the role of the health sector in the field of sexual violence in conflict settings, the report discusses how this issue can be more systematically addressed through partners and programmes supported by Norway and how sexual violence can be integrated in the work plan for the United Nations Secretary-General's Global Strategy for Women's and Children's Health.

Norway was one of the first countries to develop a national action plan for implementing United Nations Security Council Resolution 1325 (SCR 1325) on women, peace and security, which was adopted in 2000. This report is part of the follow-up to the Government's Strategic Plan 2011-2013 for the work with Women, Peace and Security. In this plan it is stated that Norway wants to contribute to a stronger emphasis on the work against sexual violence in global and multilateral health institutions and that Norway shall work to strengthen women's access to health services during and after conflict. Prevention of sexual violence and support for survivors corresponds very well with Norway's priorities in development cooperation and humanitarian assistance, as it addresses the gender concerns as well as the substantial health and Millennium Development Goals priorities of the Government.

Most organizations and institutions dealing with sexual violence do <u>not</u> work in the context of war or other conflict settings. Humanitarian agencies have traditionally focused on the provision of food and medicine, and have not prioritized prevention of and response to sexual violence. The health sector has a very important role to play in terms of prevention, treatment and rehabilitation. The established networks and channels can be used to build political will and commitment in countries affected by conflict. Prevention of and response to sexual violence must be part of any comprehensive agenda for improving reproductive health in crises. Survivors of sexual violence urgently require a range of health services, from treatment for physical and psychological trauma and long-term physical and mental health consequences, to rehabilitation services. Making relevant health services available and visible not only reduces the threshold for seeking help but also contributes in reducing stigma, shame and social exclusion. Services related to sexual violence should be integrated in primary health care and with the general health system to avoid stigmatization and facilitate access.

Conflict-related sexual violence has received increased attention over the last years, and many organizations have initiated activities and programmes for prevention and response. However, these activities are often uncoordinated and *ad hoc*. UN agencies are coordinating their efforts through UN Action. There are three different international initiatives established to promote access to reproductive health services in armed conflicts and humanitarian settings that should be built upon: Reproductive Health

Response in Crises Consortium (RHRC), The Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative and the Inter-agency Working Group (IAWG) on Reproductive Health in Crises.

Sexual violence is an area with a need for better documentation and reliable statistics. These are needed both to estimate the scale of the problem and to establish knowledge, including through research, about successful interventions for prevention, treatment and rehabilitation. Building evidence on good practice for rehabilitation programmes and reaching marginalised groups (geographically and socially) with health services should have high priority.

The report recommends that sexual violence-related activities must be included in the United Nations Secretary-General's emerging 2011 workplan – Advancing the Global Strategy for Women's and Children's Health. UNFPA should take the lead in building momentum, mobilizing support and implementing commitments at country level, together with the other H4+ partners. It should also support capacity building in high-burden countries within the ministries of health, education and legal affairs, among others.

Introduction

After the civil wars in former Yugoslavia and Rwanda, and reports of extensive use of the rape of women as a tactic of war, the international community began to pay increased attention to the issue of sexual violence in conflict settings. United Nations Security Council Resolution 1325 (SCR 1325) on women, peace and security was adopted in 2000 to increase women's participation in all efforts related to peace and security, and to strengthen the protection of women in armed conflicts. Norway was one of the first countries to develop a national action plan for implementing SCR 1325. In June 2008, the United Nations Security Council adopted Resolution 1820, recognizing for the first time that sexual and gender-based violence and their consequences pose a threat to international peace and security and require a security response from a broad range of actors. Just over a year later, the Security Council adopted Resolution 1888, which mandates the appointment of a Special Representative of the Secretary-General to lead system-wide action.

This report is part of the follow-up to the Government's Strategic Plan 2011-2013 for the work with Women, Peace and Security.[1] In this plan it is stated that Norway wants to contribute to a stronger emphasis on the work against sexual violence in global and multilateral health institutions and that Norway shall work to strengthen women's access to health services during and after conflict.

The health sector has an important role to play in treatment and rehabilitation of victims of sexual violence and also in preventive work. After a review of concepts and actors, the report discusses how sexual violence can be integrated in the United nations

[1] *Women, Peace and Security - Norway's Strategic Plan 2011-13*. Norwegian Ministry of Foreign Affairs, 2011.

Secretary-General's Global Strategy for Women's and Children's Health (the Global Strategy), and how this issue can be more systematically addressed through partners and programmes supported by Norway.

The Global Strategy, led by the United Nations Secretary-General, is a roadmap that identifies the finance and policy changes needed, as well as critical interventions that can and do improve health and save lives. The Global Strategy lays out an approach for global, multisector collaboration. The document was developed under the auspices of the United Nations Secretary-General with support and facilitation by The Partnership for Maternal, Newborn & Child Health (PMNCH). Leaders from government, international organizations, business, academia, philanthropy, health-professional associations and civil society have come together to develop this strategy, recognizing that the health of women and children is key to progress on all development goals. At a special United Nations event to launch the Global Strategy in September 2010, stakeholders pledged over US$40 billion in resources for women's and children's health.[2]

Concepts and definitions

The increased attention paid internationally to sexual violence in conflict settings has led to a considerable growth both in the literature and in the number of programmes and projects. The range of terms and concepts used to talk about similar or related acts and behaviours may lead to confusion. Together with "sexual violence" and "violence against women", "gender-based violence" is used interchangeably. Various international organizations and institutions have tried to establish definitions and delimitations.

The **first** point to be made is that <u>sexual violence</u> is much more than rape:

> It is insufficient to understand **"sexual violence"** solely in terms of rape. Sexual violence also encompasses: sexual slavery; enforced prostitution; forced pregnancy; enforced sterilization; or any other form of sexual violence of comparable gravity, which may include indecent assault; trafficking; inappropriate medical examinations; and strip searches (see 1998 Rome Statute of the International Criminal Court). The "Elements of Crimes" of the ICC defines sexual violence as follows: "The perpetrator committed an act of a sexual nature against one or more persons or caused such person or persons to engage in an act of a sexual nature by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person or persons or another person, or by taking advantage of a coercive environment or such person's or persons' incapacity to give genuine consent".[3]

[2] http://www.who.int/pmnch/activities/jointactionplan/en/index.html
[3] Addressing Conflict-Related Sexual Violence – An Analytical Inventory of Peacekeeping Practice. Published by the United Nations, New York, June 2010.

The **second** point is that sexual violence is only one of the various forms of violence against women or of gender-based violence:

> Some of the most common and most severe forms of **violence against women**: intimate partner violence; sexual abuse by non-intimate partners; trafficking, forced prostitution, exploitation of labour and debt bondage of women and girls; physical and sexual violence against prostitutes; sex-selective abortion, female infanticide and the deliberate neglect of girls; and rape in war.[4]

Third, it should be emphasized that men are also exposed to various forms of sexual violence, such as rape and mutilation. Men are sexually abused and can be forced to carry out unwanted sexual acts. Circumstances where men are victims of sexual violence can also include a man being harassed, beaten or killed because he does not conform to a view of masculinity that is accepted by the society.[5] However, there is a serious dearth of studies concerning the nature and the extent of sexual violence against men. Existing documentation is mostly anecdotal. An OHCHR study from the Democratic Republic of the Congo (DRC) concludes:

> There are a number of male victims of sexual violence in the DRC, and it is difficult for them to come forward and speak about what happened to them. Like the women who have been raped, men who have been raped suffer from stigmatization, which can take a somewhat different form. The male victims interviewed by the panel talked of being raped as being treated "like a wife", and they are humiliated by others for identifying or being identified with a group of victims who are virtually all women.[6]

Five types of **sexual and gender-based violence** have been identified: Sexual violence, physical violence, emotional and psychological violence, harmful traditional practices (including genital mutilation) and socioeconomic violence.[7]

Sexual violence can further be divided into nine types: rape and marital rape; child sexual abuse, defilement and incest; forced sodomy/anal rape; attempted rape or attempted forced sodomy/anal rape; sexual abuse; sexual exploitation; forced prostitution (also referred to as sexual exploitation); sexual harassment; and sexual violence as a weapon of war and torture.[8]

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[4] Charlotte Watts, Cathy Zimmerman: *Lancet* 2002; 359: 1232–37

[5] http://www.irinnews.org/InDepthMain.aspx?InDepthId=20&ReportId=62847

[6] *Report of the Panel on Remedies and Reparations for Victims of Sexual Violence in the Democratic Republic of Congo to the High Commissioner for Human Rights*. United Nations High Commissioner for Human Rights, 2011.

[7] The United Nations' Office of the High Commissioner for Human Rights' Committee on the Elimination of Discrimination against Women (CEDAW) defines "gender-based violence" as "violence that is directed against a *woman* because she is a woman or that affects women disproportionately", in its General Recommendation 19. This includes acts that inflict physical, mental or sexual harm or suffering, the threat of such acts, coercion and other deprivations of liberty. However, this does not mean that all acts against a woman are gender-based violence, or that all victims of gender-based violence are female.

[8] UNHCR, May 2003: Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons. http://www.rhrc.org/resources/gbv/gl_sgbv03_01.pdf

The Bonn International Center for Conversion has developed **a typology of rapes** in conflict settings with three major categories:

- Perpetrated by members of an armed group toward members of the same armed group or armed force
- Perpetrated by an armed group or armed force against a member of the civilian population.
- And perpetrated by members of one armed group towards members of another armed group (see annex for details).[9]

The war in former Yugoslavia brought much attention to what has been termed “sexual violence as **a weapon of war and torture**” which may be described as:

> Crimes against humanity of a sexual nature, including rape, sexual slavery, forced abortion or sterilisation or any other forms to prevent birth, forced pregnancy, forced delivery, and forced child rearing, among others. Sexual violence as a form of torture is defined as any act or threat of a sexual nature by which severe mental or physical pain or suffering is caused to obtain information, confession of punishment from the victim or third person, intimidate her or a third person or to destroy, in whole or in part, a national, ethnic, racial or religious group.[10]

The different types may spring out of different motives. Research has identified a range of motives and purposes:

> Sexual violence can amount to **a tactic of war** when used to “humiliate, dominate, instil fear in, disperse and/or forcibly relocate civilian members of a community or ethnic group” (Security Council Resolution 1820, preamble).[11]

More specifically, in crisis settings:

> Rape may be used as a weapon of war and a method of ethnic cleansing by forcing women and girls to bear children of different religions or ethnic groups. Women and girls may be coerced into providing sex to ensure access to basic needs such as food, water and medicine.[12]

It should be emphasized, however, that recent research has found that sexual violence occurring in conflict settings is not necessarily used as a strategy of war. Very frequently – maybe mostly – it is simply opportunistic rape, associated with traumatic experiences and extreme psychological stress. However, lasting violent conflicts increase the overall level of violence in a society, and in particular sexual violence. Reports from DRC, Uganda and Colombia indicate that long-lasting conflicts have led to a disruption of

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[9] Isikozlu, Elvan and Millard, Ananda S.: brief *43* Towards a Typology of Wartime Rape. BICC, September 2010. Bonn International Center for Conversion
[10] http://www.irinnews.org/InDepthMain.aspx?InDepthId=20&ReportId=62847
[11] Addressing Conflict-Related Sexual Violence – An Analytical Inventory of Peacekeeping Practice. United Nations, New York, June 2010.
[12] http://www.raiseinitiative.org/services/#gbv

social norms and a normalization of rape in the civilian population. There are numerous reports of women being raped by men from their own community.

The scale and scope of the problem

There are no accurate data on rape during war, and it is probably impossible to obtain more than very approximate figures. For example, estimates of the number of Muslim women raped by Serb soldiers during the 1992-1995 conflict in Bosnia-Herzegovina vary from 20 000 to 50 000, i.e. by as much as 1-2% of the total pre-war female population.[13] It is estimated that between 250 000 and 500 000 Tutsi women survived rape during Rwanda's 1994 genocide.[14] A new study published in *The American Journal of Public Health*, estimates that nearly two million women have been raped in DRC, but most of these rapes took place outside the conflict zones.[15] Many rape victims never report being assaulted because of the shame and stigma, and because health and judiciary services are inaccessible. A recent publication points out that together with misinterpretation of small-scale studies overcounting also is a concern. The authors ask for more accurate, comprehensive studies.[16]

Some main **health consequences** of sexual and gender-based violence are:[17]

- Injury, disability, death
- STIs and AIDS
- Reproductive health disorders
- Problem pregnancy, difficult labour
- Miscarriage
- Unwanted pregnancy
- Unsafe abortions
- Depression and chronic illness
- Shock
- Infection, chronic infections
- Excessive bleeding.

In addition there are emotional and psychological consequences that may need to be addressed by health services, such as anger, fear, grief, resentment, self-hate, depression, anxiety, sleep and/or eating disorders and mental illness.

Many girls and women are gang-raped during or after war. Some are very young, even infants, others are very old. As a result they suffer multiple physical injuries. Sometimes

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[13] Watts, Charlotte and Zimmerman, Cathy: Violence against women: global scope and magnitude. *Lancet*. Vol 359. April 6, 2002
[14] Association of Widows of the Genocide (Avega), *Survey on Violence Against Women in Rwanda*, Kigali, 1999.
[15] http://www.nytimes.com/2011/05/12/world/africa/12congo.html?_r=1&scp=2&sq=congo&st=cse
[16] Peterman, Amber et al.: Rape Reporting During War. *Foreign Affairs*, August 1, 2011.
[17] http://www.rhrc.org/resources/gbv/gl_sgbv03_04.pdf

the effects are felt immediately, while others take years to manifest. Among the injuries are abrasions and tears:

- Fistula – a tear in the walls separating hollow internal organs such as the vagina and the rectum. This causes very painful eliminations and incontinence, along with strong odours. Many of these women suffer family and community rejection.
- Broken bones – as a result of torture and gang rapes. Many of these are not treated properly because of a lack of access to public health. This results in life-long disability.
- Amputations – used as a brutal reminder to victims of the enemy's 'intent' (used often during the civil war in Sierra Leone).
- Back pain and migraines - sometimes immediate, but often long-term, chronic effects of brutal attacks.[18]

Sexual violence results not only in physical injuries and mental suffering among the victims but is also in many ways a social problem. This fact must be well understood when designing interventions:

> Programming and funding on wartime rape should not exclusively target individuals or families affected by wartime rape.
>
> Stand-alone programmes targeting individuals or families raped in war may deepen stigmatization and create a fake market. We know from interventions in other fields, such as assistance to landmine amputees and reintegration support for child soldiers, that singling out these groups for support and assistance can have unintended negative consequences. These consequences can include further victimization of individuals by publicizing the suffering they have undergone. These targeted interventions can also serve to entice individuals who have not been victimized in a particular way, but who require similar support, to fake their own victimization in order to attain certain services. There is evidence that this may already be occurring at health centers servicing raped women in the DRC (cf. Kelly, 2009).[19]

Actors

Most organizations and institutions dealing with sexual violence do not work in the context of war or other conflict settings. Humanitarian agencies have traditionally focused on the provision of food and medicine, and have not prioritized prevention of and response to sexual violence or gender-based violence more broadly.

[18] http://www.irinnews.org/InDepthMain.aspx?InDepthId=20&ReportId=62825
[19] Isikozlu, Elvan and Millard, Ananda S.: brief *43* Towards a Typology of Wartime Rape. BICC, September 2010. Bonn International Center for Conversion.

Within the United Nations system, the main programmes of relevance are grouped together in the campaign **Stop Rape Now – UN Action Against Sexual Violence in Conflict (UN Action)**. UN Action unites the work of 13 United Nations entities with the goal of ending sexual violence in conflict.[20] It is a concerted effort by the United Nations system to improve coordination and accountability, amplify programming and advocacy, and support national efforts to prevent sexual violence and respond effectively to the needs of survivors. This initiative builds on many initiatives of United Nations entities and other actors, including the Call to Action of the June 2006 International Symposium on Sexual Violence and Beyond.[21] In February 2010, the United Nations appointed Margot Wallström as the Special Representative on Sexual Violence in Conflict, a newly created position with a two-year mandate to provide leadership on United Nations efforts to address conflict-related sexual violence.

The main United Nations entities when it comes to reproductive health and services relevant for victims of sexual violence are the United Nations Population Fund (UNFPA) and the World Health Organization (WHO). **UNFPA** is addressing various aspects of sexual violence in humanitarian settings: prevention, response, clinical management of rape, and coordination. In late September 2005, as part of the humanitarian reform process, UNFPA was tasked with coordinating gender-based violence issues in humanitarian settings. **WHO** has a range of activities and programmes addressing the issue of violence against women but they are mostly not related to conflict settings.[22] WHO is collecting data and documenting the scope of the problem and has a role in developing education programmes and protocols.[23] It should also be mentioned that **UN Women** has developed a multi-country programme on community-led approaches to prevent sexual violence.

Furthermore, there are three major initiatives for the promotion and coordination of efforts to improve reproductive health services in crises and humanitarian settings. The Reproductive Health Response in Crises Consortium (RHRC) is dedicated to the promotion of reproductive health among all persons affected by armed conflict. It consists of seven members: American Refugee Committee (ARC), CARE, Columbia University, International Rescue Committee (IRC), JSI Research and Training Institute (JSI), Marie Stopes International (MSI), and Women's Refugee Commission. The Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative is a global endeavour designed to catalyze change in how reproductive health is addressed within relief organizations, field services and global decision-making.

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[20] United Nations Action Against Sexual Violence in Conflict comprises the following 13 United Nations entities: the Department of Political Affairs (DPA), the Department of Peacekeeping Operations (DPKO), the Office for the Coordination of Humanitarian Affairs (OCHA), Office of the High Commissioner for Human Rights (OHCHR), the Joint United Nations Program of HIV/AIDS (UNAIDS), The United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Refugee Agency (UNHCR), the United Nations Children's Fund (UNICEF), the United Nations Development Fund for Women (UNIFEM), the World Food Programme (WFP), the World Health Organization (WHO) and the United Nations Peacebuilding Support Office (PBSO).

[21] www.unfpa.org/emergencies/symposium06/.

[22] See http://www.who.int/hac/techguidance/pht/SGBV/en/index.html for crisis specific activities.

[23] http://www.who.int/reproductivehealth/topics/violence/sexual_violence/en/index.html

Finally, the Inter-agency Working Group (IAWG) on Reproductive Health in Crises was formed in 1995 to promote access to quality reproductive health care for refugee women and others affected by humanitarian emergencies. It originally comprised more than 30 groups, including United Nations agencies, universities and governmental and nongovernmental organizations, and was led by the United Nations High Commissioner for Refugees (UNHCR), WHO and UNFPA.

Norwegian organizations and institutions

A number of Norwegian nongovernmental organizations are involved in activities related to sexual violence in crises and conflict settings, most notably in East Congo, the major ones being Christian Relief Network (CRN) and Norwegian Church Aid (NCA).[24] The focus of the programmes is to offer health services and rehabilitation programmes to the women, but there are also projects for mobilizing community leaders and local groups in preventive work.

In 2010, Randi Solhjell conducted a mapping exercise in order to present an overview of Norwegian actors and agencies in the field of sexual and gender-based violence in war and conflict situations. It presents the efforts of relevant actors in Norway, and the current limitations preventing these actors from achieving best practice. She finds that:

> "The Norwegian NGOs active in the field are especially attuned to the situations of survivors of SV [sexual violence]. Their main priorities are basically medical, psychosocial, empowerment and/or legal aid with a strong emphasis on women and children. Medical and psychosocial aid to victims of SV in war and conflict situations could be a focus for Norway, since within the country's health sector there are many capacities based on extensive work and research experience related to SV in Norway and abroad." (p.7).**[25]**

Some of the other findings most relevant for this context show there is a lack of systematic approaches to sexual violence – within the organizations, across institutions, and among and between personnel/institutions at the operational level. Research on the subject is in several important respects incomplete and unsystematic, and there is an alarming lack of attention paid to men in all areas (research, treatment, policy, empowerment projects). There is a need to apply context-sensitive approaches, including humility and understanding of the society in need, to ask questions about what has worked previously in the relevant setting to curb the level of sexual violence, and to ask why these mechanisms are not currently functioning.[26]

[24] Fafo (Bjørkhaug et al.) did a mapping of work against sexual violence in the Great Lakes region but the report provides few details and omitted the HEAL Africa Hospital in Goma that includes response to sexual violence services.

[25] Solhjell, Randi: *Sexualised violence in war and conflict: a qualitative mapping study of Norwegian capacities, potential and challenges*. Noref, October 2010.

[26] Norad/AHHA has also commented that questions may be raised concerning the quality and longer term effects of reintegration programs in DRC since there is little documentation and a lack of systematic evaluations.

Some Norwegian medical staff are working for Médecins Sans Frontières (MSF) in various conflict-ridden and crises-stricken zones.

Health sector response

The health sector has a very important role to play both in terms of prevention, treatment and rehabilitation. Prevention of and response to sexual violence must be part of any comprehensive agenda for improving reproductive health in crises.[27] Survivors of sexual violence urgently require a range of health services, from treatment for physical and psychological trauma and long-term physical and mental health consequences, to rehabilitation services. Making relevant health services available and visible not only reduces the threshold for seeking help but also contributes to reducing stigma, shame and social exclusion.

Medical treatment is critical for someone who has been sexually assaulted. In crisis zones, there is a need for emergency reproductive health kits containing the medical equipment, supplies and medicine that humanitarian workers need to address the immediate physical impact of sexual violence. Survivors need antibiotics to prevent infection and may require treatment for abrasions, tears or a traumatic fistula. The latter is a devastating but operable injury that may occur as a result of sexual assault.

In addition to physical injury, women and girls who are raped may be at risk of unwanted pregnancy or sexually transmitted infection, including HIV. If provided in time, emergency contraception can prevent an unwanted pregnancy, and post-exposure prophylaxis can prevent the transmission of HIV and other sexually transmitted infections. Victims of rape who have become HIV positive may need antiretroviral (ARV) treatment and/or prophylaxis for prevention of mother-to-child transmission (PMTCT).

Women who are raped and impregnated in situations of armed conflict have increased rates of maternal mortality and risk of resorting to unsafe methods of abortion. States have an obligation to provide non-discriminatory medical care to the wounded and sick under Common Article 3 of the Geneva Conventions, Additional Protocols I and II, and customary international law. Abortion services and counselling constitute medically appropriate interventions for survivors of rape who have been impregnated. The denial of abortion to women who become pregnant as a result of being raped has been considered to constitute torture or cruel, inhuman or degrading treatment. Consequently, the denial of the full range of medically appropriate care to victims of rape in situations of armed conflict constitutes a violation of their rights under applicable international law.[28]

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[27] http://www.raiseinitiative.org/services/#gbv

[28] As part of the Human Rights Council's Universal Periodic Review (UPR) of the United States in November 2010, Norway recommended that the US remove its “blanket abortion restrictions on humanitarian aid covering the medical care given women and girls who are raped and impregnated in situations of armed conflict”.

Psychological trauma and mental ill-health is a common effect of being exposed to sexual violence. The perpetrators are also commonly suffering from trauma and depression. Consequently, there is great need for psychosocial counselling and treatment combined with programmes for social rehabilitation and reintegration. Mental health services in emergency settings include:

- Conduct assessments of mental health and psychosocial issues.
- Care for people with severe mental disorders.
- Protect and care for people with severe mental disorders, and other mental and neurological disabilities, living in institutions.
- Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices.
- Minimise harm related to alcohol and other substance use.
- Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers.[29]

When the word ***prevention*** is used, it is usually in reference to secondary and tertiary prevention – helping women get out of violent situations and preventing further violence. Less attention has been given to *primary* prevention – addressing the root causes with the goal of reducing the number of new cases. Recent publications have called for increased investment in primary prevention.

The health sector can help prevent sexual violence by:

- Screening health-care patients to identify those most at risk of sexual and gender-based violence and to prevent further trauma and harm to victims/survivors.
- Implementing reproductive health activities, including discussions about gender, relationships and sexual and gender-based violence, that target men and adolescents as well as women (awareness raising about HIV/AIDS prevention should also be included as part of this effort).
- Engaging traditional birth attendants as partners in reproductive health activities. Traditional birth attendants can be a valuable source of information and can help disseminate prevention and protection messages.[30]

When dedicated health services are made available to victims of sexual violence, it may help to prevent or reduce the silence and shame surrounding this phenomenon. This, in turn, may have the effect of making sexual violence a less effective weapon of war. Victims of sexual violence commonly blame themselves for what has happened to them and risk social exclusion, while perpetrators do not seek help for fear of punishment. Creating safe, confidential and accessible spaces for both victims and perpetrators is crucial to help people come to terms with their experiences, or change negative behaviour.

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[29] IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. IASC, 2007.
[30] UNHCR, May 2003: Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons. http://www.rhrc.org/resources/gbv/gl_sgbv03_03.pdf

Prevention of sexual violence and the provision of confidential clinical care for rape survivors is part of the Minimum Initial Service Package of Reproductive Health in Crises (MISP).[31] As soon as the MISP is in place, reproductive health officers and programme managers, in collaboration with other relevant sectors/clusters, must work to expand clinical and psychological care and social support for survivors of rape and other forms of gender-based violence, as well as support initiatives to prevent it.

Since 2005, UNFPA and UNHCR have partnered to train health-care providers working with refugees and internally displaced persons, and in other humanitarian settings, on the clinical management of rape survivors. The two-day curriculum includes modules on taking a survivor's history, collecting forensic evidence, examining a survivor and prescribing treatment, including emergency contraception, treatment of sexually transmitted infections and post-exposure prophylaxis to prevent the transmission of HIV. To date, UNFPA has conducted four regional training-of-trainers workshops in Geneva, Johannesburg, Nairobi and Cairo. Of those who have been trained as trainers, many are now actively engaged in training health providers in Nepal, Haiti, Liberia, Sudan, Zimbabwe and Cote d'Ivoire (among other countries).[32]

The health sector has a key role in **monitoring and documenting** the extent and consequences of sexual violence. Liberian health-care workers played a crucial role in documenting violence against women by soldiers and other fighters during the Liberian civil conflict. The documenting and subsequent publication of information can have a significant preventive effect, by creating openness about the issue, strengthening accountability and motivating both victims and perpetrators to seek help. Documenting sexual violence includes **collecting forensic evidence** to enable victims to bring their cases to court. This may also have a preventive effect.

Finally, the health sector may also **advocate** on behalf of victims/survivors for protection, security and safety, and for changes in host country laws and policies that may conflict with victim/survivor rights and/or needs.

Interventions: Good practices and possibilities for scaling up

Despite the high number of actors in this area, there is a lack of solid research using reliable and valid methods, and particularly of studies that go beyond self-reporting and interviews with victims. Particularly there is a need to identify good practices for *prevention* of sexual violence and for rehabilitation and reintegration of victims and perpetrators. A literature review commissioned by the USAID Interagency Gender Working Group (IGWG) in 2004 concluded that "most gender violence programs in humanitarian settings have not been rigorously evaluated, making it difficult to assess

[31] MISP is described in chapter two in the *Inter-agency field manual on reproductive health in humanitarian settings*.
[32] http://www.unfpa.org/emergencies/violence.htm

their effectiveness" (p.77).[33] This observation is still valid. Moreover, the multiplication of actors, programmes and projects and an absence of systematic approaches has led to a situation where there is a very strong need of better coordination and leadership. UNFPA is doing important work in that sense but has limited financial and human resources and several country offices are reported to be weak.

There are two authoritative manuals/guidelines that spell out which services should be provided to victims of sexual violence in humanitarian settings and emergencies.

The *2010 Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* is an update of the 1999 *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*, the authoritative guidance on reproductive health interventions in humanitarian settings. The updated information in this Field Manual is based on normative technical guidance of the World Health Organization. It also reflects the good practices documented in crisis settings around the world since the initial field-test version of the Field Manual was released in 1996, followed by the 1999 version. The last edition contains a new chapter on Safe Abortion Care.

The Inter-Agency Standing Committee (IASC) developed the more general *Guidelines for Gender-based Violence Interventions in Humanitarian Emergencies: Focusing on Prevention and Response to Sexual Violence* to meet the need for a coherent and participatory approach to prevent and respond to gender-based violence. This is a tool for field actors to establish a multisectoral, coordinated approach to gender-based violence programming in emergency settings.

According to the *IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings*, when *preparing* for emergency the health services should:

- Map current services and practices.
- Adapt/develop/disseminate policies and protocols.
- Plan and stock medical and reproductive health supplies.
- Train staff in gender-based violence health care, counselling, referral mechanisms and rights issues.
- Include gender-based violence programmes in health and community service contingency planning.

The minimum response *during an emergency* is to:

- Ensure women's access to basic health services.
- Provide sexual-violence-related health services.
- Provide community-based psychological and social support for survivors/victims.

In the more *stabilized phase*, the health services should:

[33] Guedes, Alexandra: *Addressing gender-based violence from the reproductive health/hiv sector. A literature review and analysis*. LTG Associates, Inc./Social & Scientific Systems, Inc., May 2004.

- Expand medical and psychological care for survivors/victims.
- Establish or improve protocols for medico-legal evidence collection.
- Integrate gender-based violence medical management into existing health-system structures, national policies, programmes and curricula.
- Conduct ongoing training and supportive supervision of health staff.
- Conduct regular assessments on quality of care.
- Support community-based initiatives to support survivors/victims and their children.
- Actively involve men in efforts to prevent gender-based violence.
- Target income generation programmes to girls and women.

It should be emphasized that stand-alone programmes targeting individuals or families raped in war may deepen stigmatization. Services for victims of sexual violence should be integrated in primary health care and with the general health system. Victims of sexual violence also need access to types of services that are not linked to exposure to violence.

Conclusion and recommendations

Prevention of sexual violence and support for survivors corresponds very well with Norway's priorities in development cooperation and humanitarian assistance, as it addresses the gender concerns and the substantial health and MDGs priorities of the government.

The area has received increased attention over the last few years and many organizations have initiated activities and programmes for prevention and response. The UN has initiated the Stop Rape Now campaign (UN Action) to improve coordination among the UN entities. However, the activities are still fragmented and uncoordinated, and good models for scaling up are lacking. There are three different international initiatives/consortia established to promote access to reproductive health services in armed conflicts, relief aid and humanitarian settings – RHRC, RAISE and IAWG – and these should be built upon.

Sexual violence is an area with a continuous need for better documentation and reliable statistics – both in terms of estimating the scope of the problem and in establishing knowledge, including research, about successful interventions for prevention, treatment and rehabilitation. Building evidence on good practice for rehabilitation programmes and reaching marginalized groups (geographically and socially) with health services should have high priority.

In post-conflict settings, it is particularly important to go beyond basic health services and contribute to primary prevention in order to reduce the level of sexual violence, which tends to increase in periods of violent conflict. When the society is stabilizing,

there is more opportunity to address the root causes of gender-based violence, such as consistent discrimination against women, violent ideals of masculinity, deep poverty and lack of employment opportunities. Building up and strengthening health services and systems with a focus on primary health care and reproductive health is a crucial element in post-conflict settings to improve living conditions and stabilize fragile states.

Both in ongoing conflict and post–conflict settings, health-sector interventions should be coordinated and linked with interventions in other sectors, particularly basic education, judicial and penal, water and sanitation and programmes for training and income-generating activities.

Recommendations

Show leadership and maintain a high political profile in international meetings (including bi-lateral meetings with state leaders) around the need to address reproductive health needs in conflict settings. This is particularly relevant for victims of sexual violence and for pregnant women, the newborn and adolescents.

Work systematically with international organizations (the United Nations Secretary-General, WHO, UNFPA, UN Women and major International Nongovernmental Organizations) to make them pay more attention and allocate resources to address the issue. The field has an acute need for better coordination and research to establish systematic, evidence-based approaches that go beyond the distribution of reproductive health kits. Better coordination at global level will trickle down to better coordination among actors in the field.

Pick key issues where there is a need for a lead advocate and sponsor. Access to safe abortion and sexual and reproductive health services for young people are areas where Norway has potential to play an important role, since other major donors and actors are reluctant to do so or not allowed to address these critical issues. Many (or most) of the NGOs offering health services in conflict and humanitarian settings rely on funding from the US, which does not allow funds to be used on abortion services.

Support provision/expansion of services and procurement/distribution of commodities and drugs, particularly in remote, hard-to-reach areas.

Advocate for, and support building of, evidence on the burden of health in conflict settings and the need for reproductive health services and successful interventions (good practices).

Support and promote the normative frameworks established by WHO and its partners, mainly the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*.

Prevention of and response to sexual and gender-based violence in conflict and post-conflict settings should be integrated in the United Nations Secretary-General's Global Strategy for Women's and Children's Health. It should be flagged as a major concern,

and a field suffering from weak coordination, leadership and funding as compared to the needs. Activities to combat sexual and gender-based violence must be included in the United Nations Secretary-General's emerging 2011 workplan – Advancing the Global Strategy for Women's and Children's Health. UNFPA should take the lead in building momentum, mobilizing support and implementing commitments at country level – together with the other H4+ partners. It should also support capacity building in high-burden countries within the ministries of health, education and legal affairs, among others.

ANNEX A

Resources and actors

UN Action Against Sexual Violence in Conflict: www.stoprapenow.org

The United Nations Population Fund (UNFPA) is addressing various aspects of sexual violence in humanitarian settings: prevention, response, clinical management of rape and coordination. In late September 2005, as part of the humanitarian reform process, UNFPA was tasked with coordinating gender-based violence issues in humanitarian settings. www.unfpa.org/emergencies/violence.htm

The State of World Population 2010 highlights how women in conflict and post-conflict situations – as well as in emergencies or protracted crises – are faring a decade after the adoption of United Nations Security Council Resolution 1325. It shows what has been accomplished in places affected by ongoing conflicts or by military occupation, as well as the special challenges of countries that have endured both political instability and natural disaster. www.unfpa.org/swp/index.html

The World Health Organization (WHO) has a range of activities and programmes addressing the issue of violence against women but they are mostly not related to conflict settings.[34] WHO is collecting data and documenting the scope of the problem. WHO has a role in developing education programmes for *Clinical management of rape survivors in humanitarian settings*, and protocols for *Clinical management of rape survivors*, for use with refugees and internally displaced persons.[35] WHO has also published ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. They are meant to complement existing internationally agreed ethical guidelines for research, and to inform ethics review processes.

WHO is giving increased attention to the primary prevention of intimate partner violence and sexual violence. The guide, *Preventing intimate partner and sexual violence against women: taking action and generating evidence*, outlines the nature, magnitude, risks and consequences of intimate partner and sexual violence. It outlines strategies to prevent these forms of violence against women and describes how these can be tailored to the needs, capacities and resources of particular settings.

WHO has published *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*. The ethical and safety guidelines (or recommendations) in this document are meant to complement existing

[34] www.who.int/reproductivehealth/topics/violence/sexual_violence/en/index.html
See http://www.who.int/hac/techguidance/pht/SGBV/en/index.html for crisis specific activities.
On HIV/AIDS and conflict: http://www.who.int/gender/en/infobulletinconflict.pdf
[35] http://www.who.int/reproductivehealth/topics/violence/sexual_violence/en/index.html

internationally agreed ethical guidelines for research, and to inform ethics review processes.

The **Pan American Health Organization (PAHO),** which serves as the regional office for WHO for the Americas, has a long history of working to address violence against women, as documented in publications such as *Violence against women: the health sector responds*. PAHO has, together with the International Planned Parenthood Federation / Western Hemisphere Region, published the second edition of the publication: *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*.

UN Women has developed a multicountry programme on Supporting Women's Engagement in Peace building and Preventing Sexual Violence: Community-Led Approaches. This aims to create enabling environments for women's effective participation in peace building and post-conflict recovery by engaging community decision-makers, local police and informal institutions. It further seeks to strengthen knowledge on effective prevention strategies and support services for survivors of sexual violence.
www.unifem.org/gender_issues/women_war_peace/conflict_related_sexual_violence.php

The Reproductive Health Response in Crises (**RHRC**) **Consortium** is dedicated to the promotion of reproductive health among all persons affected by armed conflict. It consists of seven members: American Refugee Committee (ARC), CARE, Columbia University, International Rescue Committee (IRC), JSI Research and Training Institute (JSI), Marie Stopes International (MSI), and Women's Refugee Commission.
www.rhrc.org

The **Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative** is a global endeavour designed to catalyze change in how reproductive health is addressed within relief organizations, field services and global decision-making. Developed by Columbia University's Heilbrunn Department of Population and Family Health in the Mailman School of Public Health and Marie Stopes International (MSI), the RAISE Initiative aims to address the full range of reproductive health needs for refugees and internally displaced persons (IDPs) by building partnerships with humanitarian and development agencies, governments, United Nations bodies, advocacy agencies and academic institutions.
www.raiseinitiative.org/

The **Inter-agency Working Group (IAWG) on Reproductive Health in Crises** was formed in 1995 to promote access to quality reproductive health care for refugee women and others affected by humanitarian emergencies. It originally comprised more than 30 groups, including United Nations agencies, universities and governmental and nongovernmental organizations, and was led by the United Nations High Commissioner for Refugees (UNHCR), WHO and UNFPA. www.iawg.net/

The **Sexual Violence Research Initiative** (**SVRI**) aims to promote research on sexual violence and generate empirical data that ensures sexual violence is recognised as a

priority public-health problem. One of its objectives is to increase awareness of sexual violence as a priority public-health problem through evidence-based communication and information. www.svri.org/

The **GBV Prevention Network** is a group of activists and practitioners committed to preventing gender-based violence in the Horn, East and Southern Africa. It has 220 members coming from 24 different countries. www.preventgbvafrica.org/

Hands Up For Health Workers is the campaign call from Merlin, the UK's leading charity specializing in international health. Merlin's campaign is calling for urgent investment in health workers in crisis countries, demanding that they get the training, equipment, pay, support and protection they need. www.handsupforhealthworkers.org/

International Rescue Committee: www.rescue.org/our-work/providing-health-refugees

Sexual Violence Research Initiative, www.svri.org/

Health and Human Rights Info on gender-based violence: www.hhri.org/thematic/gender_based_violence.html

Engaging Boys and Men in GBV Prevention and Reproductive Health in Conflict and Emergency-Response Settings: A Workshop Module. CARE, EngenderHealth, March 2009. www.rhrc.org/resources/Conflict%20Manual_CARE_for%20web.pdf

MONUSCO: http://monusco.unmissions.org/Default.aspx?tabid=4078

Conflict and health in DRC: www.conflictandhealth.com/content/3/1/3

The Global Justice Center (GJC), a human rights legal organization that develops innovative strategies to enforce international law. www.globaljusticecenter.net/

Guidelines and manuals

The 2010 Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*:* www.iawg.net/resources/field_manual.html

Guidelines for Prevention and Response: Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons. UNHCR, May 2003. www.rhrc.org/resources/gbv/gl_sgbv03.pdf

Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies. Inter-agency Standing Committee (IASC), September, 2005. www.humanitarianinfo.org/iasc

Guidelines on Mental Health and Psychological Support in Emergency Settings. IASC, 2007.

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ANNEX B

Typology of rapes

The Bonn International Center for Conversion (BICC) has developed a typology of rapes in conflict settings with three major categories.

Category A: Rape perpetrated by members of an armed group toward members of the same armed group or armed force.

This category of wartime rape is perhaps the least publicized, but by no means the least common. Its principal characteristic is that both the rapist and the raped person belong to the same armed group. Generally speaking there appear to be rules to govern sexual assault within an armed group or army, but in many cases the rules do little to prevent or bring justice to this kind of event.

Category B: Rape perpetrated by an armed group or armed force against a member of the civilian population.

This is the most well-known and recognized category of wartime rape. Within this general category eight different types of rape with different *modi operandi* were identified:
B-1: Rape by an ally; B-2: Sexual slavery; B-3: Rape as a military strategy; B-4: Rape by a neighbour; B-5: Rape camps; B-6: Rape in detention; B-7: Opportunistic rape; B-8: Targeted rape.

Category C: Rape perpetrated by members of one armed group towards members of another armed group.

Unlike in Category A, rape is not perpetrated against members of the same armed group, but rather against members of another or an opposing armed group

Source: Isikozlu, Elvan and Millard, Ananda S: brief *43* Towards a Typology of Wartime Rape. Bonn International Center for Conversion, September 2010.

Developing a Response to the Health/Medical Needs of Victims/Survivors

The type of violence and the length of time between the incident and the time the victim/survivor arrives at the health facility will determine the type of care that can be provided. It is most important for the survivor to visit the health facility as early as possible after the incident so as to receive the best possible care.

Provide comprehensive health care that is easily accessible.
Medical examination and treatment should be performed by trained staff, ideally from the same sex as those in need of the service. Appropriate protocols and adequate equipment, supplies, and medicine should be used to:

- prevent disease (sexually transmitted infections and others);
- prevent unwanted pregnancy;
- treat injuries;
- collect forensic evidence;
- provide counselling and treatment for psychological trauma;
- screen health care patients for sexual and gender-based violence.

Refer and provide transport to appropriate levels of care, when needed.
Provide follow-up care.
Provide medical evidence (testify where appropriate) in court proceedings arising from a victim/survivor opting to seek legal redress.

Collaborate with traditional health practitioners to identify, report, refer and provide adequate primary level support to victims/survivors.

Document, collect and analyse data.
Monitor health-care services, including equal access for women, men and adolescents and quality of service provided.
Monitor the health needs of victims/survivors.
Identify and design strategies to address contributing factors, such as alcoholism.

Advocate on behalf of victims/survivors.

- for protection, security, safety;
- for changes in host country laws and policies that may conflict with victim/survivor rights and/or needs.

Collaborate with health-facility staff, traditional health practitioners and the community on training and sensitization.

Planning to Meet the Psychosocial Needs of Victims/Survivors

After an incident of sexual and gender-based violence, the victim/survivor may experience many different emotional and psychological responses, including fear,

shame, guilt, depression and anger. She or he may adopt strong defence mechanisms, such as forgetting, denial and deep repression of the traumatic event she survived. Family members may also experience a variety of emotions and need to receive support during this traumatic period.

Victims/survivors should be treated with empathy and care.
Community-based activities are most effective in helping to relieve trauma. These activities may include:

- Identifying and training traditional, community-based support workers;
- Developing women's support groups or support groups specifically designed for victims/survivors of sexual violence and their families;
- Establishing "drop-in" centres where victims/survivors can receive confidential and compassionate care, information and counselling.

In addition, psychosocial workers should:

- Offer crisis counselling (listening, emotional support, reassurance) for victims/survivors and their families, with referrals for longer-term emotional support;
- Encourage the resumption of positive traditional healing or cleansing practices used successfully in the home country in response to traumatic or painful events;
- Advocate on behalf of victims/survivors with health-care providers, police/security forces, the legal/justice system and other service providers;
- Develop group activities for victims/survivors and other women that focus on building support networks, reintegrating into communities, building skills and confidence and promoting economic empowerment. Launch income-generation and micro-credit projects to help (re-)establish a sense of self-sufficiency.

Source: *Guidelines for Prevention and Response: Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons.* UNHCR, May 2003

ACTION SHEET

8.1 Ensure women's access to basic health services
Sector: Health and Community Services
Phase: Minimum Prevention and Response

Background

In times of crisis, health care services are often severely affected or disrupted. Lack of coordination, overcrowding, security constraints, and competing priorities can contribute to an even greater decrease in available and accessible health services, especially for women and children. Well-functioning and accessible health services also make a difference to women's ability to reduce risks to their and their children's health. Being able to protect her own and her family's health will not only promote women's general well-being, but it will also contribute to information sharing and community awareness of reproductive health issues, including prevention and response to sexual violence.

Although most survivors/victims of sexual violence do not disclose the abuse to anyone, some will talk with a health provider if health services are physically/geographically accessible, confidential, sensitive, accommodate private consultations, and of good quality. Health centres may serve as a first "neutral" location to provide information and counselling on women's and girls' reproductive health. Women may be more able to access this type of information if it is within the context of basic health care, and not provided by specialty or separate programmes.

Services must also be available for immediate assistance to survivors/victims (see also Action Sheet 8.2, Provide sexual violence-related health services) to minimise the harmful consequences of sexual violence. Consequences include severe emotional and physical trauma; unwanted pregnancies; complications of abortions; complications of pregnancy due to trauma or infections; complications of delivery and neonatal problems such as low birth weight, for which emergency obstetric care services need to be put in place.

Key Actions

The following actions apply to the health sector; that is, organisations implementing health programmes, including Primary Health Care (PHC). The health sector identifies a focal point who participates regularly in the GBV working group and reports on the sector's achievement of the key actions. The focal point participates in cross-cutting functions led by the GBV coordinating agencies and working groups, as described in Action Sheets for Coordination, Assessment and monitoring, Human resources, and Information education communication.

1. Implement the Minimum Initial Service Package of reproductive health in emergency situations (MISP). The MISP is a series of actions needed to prevent reproductive health-related morbidity and mortality in the early phase of emergency situations. See Action Sheet 1.3, Ensure Sphere Standards are disseminated and adhered to and the IAWG *Inter-Agency Field Manual for Reproductive Health in Refugee Situations,* chapter 2. The objectives and activities of the MISP are:

- Identify an organisation(s) and individual(s) to facilitate the coordination and implementation of the MISP.
- Prevent and manage the consequences of sexual violence.
- Reduce HIV transmission by:
  - Enforcing respect for universal precautions against HIV/AIDS
  - Guaranteeing the availability of free condoms.
- Prevent excess neonatal and maternal morbidity and mortality by:
  - Providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries
  - Providing midwife delivery kits to facilitate clean and safe deliveries at the health facility
  - Initiating the establishment of a referral system to manage obstetric emergencies.
- Plan for the provision of comprehensive reproductive health services, integrated into primary health care as the situation permits.

2. Conduct or participate in rapid situational analyses. (See Action Sheet 2.1, conduct coordinated rapid situation analysis.) A rapid analysis of the health services should take place to address the accessibility for women and the availability and capacity of health services to respond to the needs of women. The analysis should include questions related to:

- The number, location, and health care level of functioning health facilities
- Numbers of health staff at the different levels, disaggregated by sex
- The range of services provided related to reproductive health
- Obstructions to women's and children's access to the services, such as issues of discrimination, security, costs, privacy, language, cultural (e.g. need for permission or accompaniment of male relative)
- Known reproductive health indicators and existing challenges to women's health

3. Ensure health services are accessible to women and children.
   - Make basic health care services available to all affected populations, including refugee, internally displaced, and host populations.
   - Locate health services within walking distance of communities and on safe access roads. (See Action Sheet 7.1, Implement safe site planning and shelter programmes.)
   - Make opening times convenient for women and children (household duties, water and wood collection, school times).
   - Set up a private consultation/examination room for women and girls.
   - Recruit female staff where possible.
   - Provide 24-hour access for complications of pregnancy and sexual violence services.
   - Ensure that all languages in the ethnic subgroups are represented among health providers or that there are interpreters for each ethnic subgroup.
   - Establish evacuation plans for medical reasons, or mobile clinical services where locally available services cannot provide the needed clin4@ical services.
   - Carefully consider access for girls, taking into consideration cultural issues. For example, girls of a certain age, or unmarried, may not be permitted to participate in reproductive health services, so girls' presence in those areas of a health centre will be noted and questioned, which prevents anonymity, confidentiality, and access.

4. Motivate and support staff.
   - Ensure all staff are aware of and abide by medical confidentiality. (See Action Sheet 4.2, Disseminate and inform all partners on codes of conduct.)
   - Provide staff at health centres and hospitals with clear protocols and sufficient supplies and equipment.
   - Inform health staff on female genital mutilation, which may affect the health of women and girls, and make protocols available on how to manage health consequences.
   - Put in place an efficient and supportive supervisory system.

5. Involve and inform the community.
   - Involve women in decisions on accessibility and on an appropriate, non-offensive, non-stigmatising name for sexual violence services.
   - Make the community aware of services available at the health centre. (See Action Sheet 10.1, Inform community about sexual violence and the availability of services.)
   - Ensure men's access to health care and counselling, and provide them with information about women's reproductive health and about the health risks to the community of sexual violence.

Key Reference Materials

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