An increase in sexual violence in insecure situations is well recognised. Displacement, uprootedness, the loss of community structures, the need to exchange sex for material goods or protection all lead to distinct forms of violence, particularly sexual violence against women.

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CHAPTER FOUR

Sexual and Gender-based Violence

Contents:

Special Notes:

- ✔ This Chapter draws much of its content from "Sexual Violence Against Refugees, Guidelines on Prevention and Response", UNHCR, Geneva, 1995.
- ✔ Though the Chapter concentrates on sexual violence, the guidance given can be applied to other forms of gender-based violence.
- ✔ The term "victim" is used in some portions of this Chapter as a convenient shorthand despite its negative association with powerlessness. The word "survivor" is also used, where appropriate, to convey the meaning that women have survived a violation of their human rights and dignity.

Sexual and Gender-based Violence

The magnitude of the problem is difficult to determine. Even in normal situations, sexual violence often goes unreported. The factors contributing to under-reporting–fear of retribution, shame, powerlessness, lack of support, breakdown or unreliability of public services, and the dispersion of families and communities–are all exacerbated in refugee situations.

In general, field staff should act on the assumption that sexual violence is a problem, unless they have conclusive proof that this is not the case. Preventive measures should be established, and appropriate protective, medical, psychosocial and legal responses should be organised. The refugees themselves, especially women, should be fully involved in organising and reviewing protective and preventive measures and appropriate responses.

This chapter focuses on sexual violence against women. Most reported cases of sexual violence amongst refugees involve female victims and male perpetrators. It is acknowledged that men and young boys may also be vulnerable to sexual violence, particularly when they are subjected to detention and torture. Even less is known about the true incidence of sexual violence against men and boys than against women and girls in refugee situations.

The Nature, Extent and Effects of Sexual Violence

There are various forms of sexual violence. Rape, the most often cited form of sexual violence, is defined in many societies as sexual intercourse with another person without his/her consent. Rape is committed when the victim's resistance is overwhelmed by force or fear or other coercive means. However, the term sexual and gender-based violence encompasses a wide variety of abuses that includes sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, involuntary prostitution (sexual bartering), torture, insertion of objects into genital openings and attempted rape. Female genital mutilation and other harmful traditional practices (including early marriage, which substantially increases maternal morbidity and mortality) are forms of sexual and gender-based violence against women which cannot be overlooked nor justified on the grounds of tradition, culture or social conformity.

Since perpetrators of sexual and gender-based violence are often motivated by a desire for power and domination, rape is common in situations of armed conflict and internal strife. An act of forced sexual behaviour can threaten the victim's life. Like other forms of torture, it is often meant to hurt, control and humiliate, while violating a person's physical and mental integrity.

Perpetrators may include fellow refugees, members of other clans, villages, religious or ethnic groups, military personnel, relief workers and members of the host population, or family members (for example, when a parent is sexually abusing a child). The enormous pressures of refugee life, such has having to live in closed camps, can often lead to domestic violence. In many cases of sexual violence, the victim knows the perpetrator.

Because incidents of sexual and gender-based violence are under-reported, the true scale of the problem is unknown. The World Bank estimates that less than 10 per cent of sexual violence cases in non-refugee situations are reported.

Two principal types of under-reporting are found in refugee situations:

- under-reporting by the victims, which can lead to distorted figures that suggest there is no problem; and
- an absence of figures relating to sexual violence within official statistics.

(The number of recently reported rape cases in stabilised refugee settings can be found in Table 1.)

It is essential to know that the problem of sexual violence is serious. Reporting and interviewing techniques should be adapted to encourage both victims and relief workers to report and document incidents. Reporting and follow-up must be sensitive, discreet and confidential so no further suffering is caused and lives are not further endangered.

In reporting, it is recommended that definitions (such as confirmed rape cases or sexual violence, in general) are provided and a rate calculated (for example, the number of reported cases per 10,000 people over a given period of time). This rate would allow for monitoring of trends and comparisons with other areas.

Sexual and gender-based violence has acute physical, psychological and social consequences. Survivors often experience psychological trauma: depression, terror, guilt, shame, loss of self-esteem. They may be rejected by spouses and families, ostracised, subjected to further exploitation or to punishment. They may also suffer from unwanted pregnancy, unsafe abortion, sexually transmitted diseases (including HIV), sexual dysfunction, trauma to the reproductive tract, and chronic infections leading to pelvic inflammatory disease and infertility.

CHAPTER FOUR

Causes and Circumstances of Sexual Violence

Sexual and gender-based violence can occur during all phases of a refugee situation: prior to flight, during flight, while in the country of asylum, during repatriation and reintegration. Prevention and response measures must be adapted to suit the different circumstances of each phase.

In conflict situations, sexual violence may be politically motivated–when, for example, mass rape is used to dominate or sexual torture is used as a method of interrogation.

It may result from long-standing tensions and feuds and the collapse of traditional societal support. In situations in which the refugees are considered to be materially privileged compared to the local population, neighbouring groups may attack the refugees.

The psychological strains of refugee life may aggravate aggressive behaviour towards women. Male disrespect towards women may be reinforced in refugee situations where unaccompanied women and girls may be regarded by camp guards and male refugees as common sexual property.

TABLE 1

Review of Reported Cases of Rape[1] in Refugee Situations Goma-Zaire, Dadaab-Kenya and Ngara, Kibondo-Tanzania 1996 and 1998

Situation	Goma	Dadaab	Ngara	Kibondo
Population	740,000	109,000	110,000	76,740
✔ Actual Rape Cases Reported (Number of Months)	140 (7)	128 (12)	24 (12)	129 (12)
✔ Adjusted Number of Rapes for 12 month period [2]	240	128	24	129
✔ Year Reported	1996	1998	1998	1998
✔ Cases of Rape/10,000 population/year	3.24	11.74	2.16	17.08

1. It is assumed that the cases reported here are confirmed rapes

2. Actual cases of rapes reported for part of the year and projected for remaining months by taking the average number of rapes per month.

If men are responsible for distributing goods and necessities, women may be subject to sexual exploitation. Those women without proper personal documentation for collecting food rations or shelter material are especially vulnerable.

Women may have to travel to remote distribution points for food, water and fuel; their living quarters may be far from latrines and washing facilities; their sleeping quarters may be unlocked and unprotected.

Lack of police protection and lawlessness also contribute to an increase in sexual violence. Police officers, military personnel, relief workers, camp administrators or other government officers may themselves be involved in acts of abuse or exploitation. If there are no independent organisations, such as UNHCR or NGOs, to ensure personal security within a camp, the number of attacks often increases.

Prevention of Sexual and Gender-based Violence in Refugee Situations

A multi-sectoral team approach is required to prevent and respond appropriately to sexual and gender-based violence. A committee or task force should be formed to design, implement and evaluate sexual violence programming at the field level. Refugee representatives, UNHCR, UN partners, NGOs and government authorities should be members of this task force. Each member of the task force, representing relevant sectors/partners (such as protection, health, education, community services, security/police, site planning, etc.), should identify his/her role and responsibilities in preventing and responding to sexual and gender-based violence.

Involvement of Refugees, Especially Refugee Women

The most effective measures require that the refugee community participates in promoting a safe environment for all. Women leaders need to be involved; and women's refugee committees and groups should be established to represent women's interests and to help identify and protect those most vulnerable to sexual violence. Traditional birth attendants (TBAs) can be a valuable source of information and a channel for disseminating protection messages. It is important to have at least one trained female protection officer at the site. Host countries and international relief organisations have a responsibility to provide the refugee community with funding, technical assistance and the safety measures necessary to allow the refugees to design and implement responses to the problem.

Experience has shown that community-based groups, commonly called anti-rape or crisis intervention teams, should be established. These groups can help raise awareness of the problem, identify preventive measures and be at the forefront of providing assistance to survivors.

Information, Education and Communication

Public information campaigns on the subject of sexual violence should be launched (while respecting cultural sensitivities). Topics could include preventive measures, seeking assistance, laws prohibiting sexual violence, and sanctions and penalties for perpetrators. Pamphlets, posters, newsletters, radio and other mass media programmes, videos and community entertainment can all be used to transmit information about preventing sexual violence. The refugee community and health workers must understand the importance of the problem and have the confidence to report all cases of sexual violence as soon as possible.

Design, Location and Practical Arrangements

Refugee camps can be designed to enhance physical security. Alternatives to closed camps should always be sought. When designing and organising camp facilities, help protect refugees by:

- locating latrines, water points and fuel collection areas in accessible places;
- making special arrangements for housing unaccompanied women, girls and lone heads of households;
- locking washing facilities;
- providing adequate lighting on paths used at night;
- providing security patrols; and by
- avoiding shared communal living space with unrelated families.

Distribution of Food, Materials for Shelter and Assistance

Essential items, such as food, non-food and shelter materials, should be distributed directly to women. That way, women will not have to exchange sexual favours for these items. Women should be involved in, if not administer, the food distribution system.

Protection of Detainees

Women and men should not be detained together unless they are family members. Appropriate organisations must be allowed access to detainees to monitor their safety and living conditions.

Social and Psychological Factors

Life in refugee camps can lead to a breakdown of traditional social structures, frustration, boredom, alcohol and drug abuse, and feelings of powerlessness that may contribute to aggression and sexual violence. Therefore, educational, recreational and income-generating activities must be promoted.

Responding to Sexual Violence

The response to each incident of sexual violence must include **protection, medical care and psychosocial treatment.**

Protection

Immediately following an incident of sexual violence, the physical safety of the survivor must be ensured. All actions must be guided by the best interests of the survivor and her wishes must be respected at all times. Wherever possible, the identity of the survivor should be kept secret and all information kept locked and secure from outsiders.

Health workers should give the survivor as much privacy as she needs and reassure her about her safety. She may want a family member or friend to accompany her throughout the procedures**.** She should not be pressured to talk or be left alone for long periods. If the incident occurred recently, medical care may be required. The survivor should then be escorted to the appropriate medical facilities. It also may be necessary to contact the police, if the survivor so decides.

The likely course of events and all the procedures that may follow should be carefully explained to her to ensure informed consent and preparedness.

Medical Care

The key elements of a medical response to sexual violence are described below. Health care professionals must be specially trained to undertake post-sexual violence medical care. Psychosocial support should begin from the very first encounter with the survivor. A protocol should be adopted to guide the medical and psychosocial care provided to survivors.

Ensure a Same-Sex Health Worker is Present for any Medical Examination and Ensure Privacy and Confidentiality.

A doctor (or qualified health worker) of the same sex should conduct the initial examination and follow-up. The survivor should be prepared for the physical examination and perhaps accompanied (if she so wishes) by a staff member who is familiar with the proceedings, or by a family

member or friend. Strict confidentiality is essential. Staff dealing with the survivor must be sensitive, discreet and compassionate.

Take a Complete History and Do a Physical Examination.

The survivor should not shower or bathe, urinate or defecate, or change clothes before the medical examination, as evidence may be destroyed.

A detailed history of the attack should be documented, including the nature of the penetration, if any, whether ejaculation occurred, recent menstrual and contraceptive history, and the mental state of the survivor. Procedures for medical examination after rape should be established and follow national laws, where they exist.

The results of the physical examination, the condition of clothing, any foreign material adhering to the body, any evidence of trauma, however minor, scratches, bite marks, tender spots, etc., and results of a pelvic examination should be documented. Health workers should collect materials that might serve as evidence, such as hair, fingernail scrapings, sperm, saliva and blood samples.

Perform the Tests and Treatments as Indicated

The following tests may be indicated to establish pre-existing conditions: syphilis blood test, pregnancy test and HIV test.

Treatment for common sexually transmitted diseases (STDs), such as syphilis, gonorrhoea and chlamydia, may be indicated. A tetanus vaccination should be considered.

Provide Emergency Contraception, if Appropriate, Along with Comprehensive Counselling.

1. Emergency contraceptive pills (ECPs) can prevent unwanted pregnancies if used within 72 hours of the rape. As described by WHO “emergency contraceptive pills (ECPs) work by interrupting a woman’s reproductive cycle–by delaying or inhibiting ovulation, blocking fertilisation or preventing implantation of the ovum. ECPs do not interrupt pregnancy and thus are not considered a method of abortion.” WHO acknowledges that this description does not command consensus and that some believe that ECPs are abortifacients. Women and health workers holding such belief may be precluded from using this treatment and women who request this service need to be offered counselling so as to reach an informed decision.

ECPs should not be seen as a substitute for regular use of contraceptive methods. Women should be counselled concerning their future contraceptive needs and choices.

See Annex 1 for details on using ECPs.

2. Copper-bearing IUDs can be used as a method of emergency contraception. They may be appropriate for some women who wish to retain the IUD for long-term contraception and who meet the strict screening requirements for regular IUD use. When inserted within five days, an IUD is an effective method of emergency contraception.

However, IUD insertion requires a much higher degree of training and clinical supervision than ECPs. Clients must be screened to eliminate those who are pregnant, have reproductive tract infections, or are at risk of STDs, including HIV/AIDS.

As for ECPs, some women and health workers may be precluded from using this treatment and women who request this service need to be offered counselling so as to reach an informed decision.

Provide Follow-up Medical Care

A woman should be counselled to return for follow-up examinations one to two weeks after receiving initial medical care. Health care providers should monitor her follow-up care. Fur-

ther tests and treatment, such as testing for or treatment of STDs or referral to other RH services, may be indicated during follow-up. Further visits may also be required for pregnancy and HIV testing.

Psychosocial Care

Survivors of sexual violence commonly feel fear, guilt, shame and anger. They may adopt strong defense mechanisms that include forgetting, denial and deep repression of the events. Reactions vary from minor depression, grief, anxiety, phobia, and somatic problems to serious and chronic mental conditions. Extreme reactions to sexual violence may result in suicide or, in the case of pregnancy, physical abandonment or elimination of the child.

Children and youth are especially vulnerable to trauma. Health care providers, relief workers and protection officers should devote special attention to their psychosocial needs.

Survivors should be treated with empathy, care and support. In the long term, and in most cultural settings, the support of family and friends is likely to be the most important factor in overcoming the trauma of sexual violence. Community-based activities are most effective in helping to relieve trauma. Such activities may include:

- identifying and training traditional, community-based support workers,
- developing women's support groups or support groups specifically designed for survivors of sexual violence and their families, and
- creating special drop-in centres for survivors where they can receive confidential and compassionate care. See Further Readings.

These activities must be culturally appropriate and must be developed in close cooperation with community members. They will need on-going financial and logistical support and, where appropriate, training and supervision.

Quality counselling by trained workers, such as counsellors, nurses, social workers, psychologists or psychiatrists–preferably from the same background as the survivor–should also be provided as soon after the attack as possible. Reassurance, kindness and total confidentiality are vital elements of counselling. Counsellors should also offer support if the survivor experiences any post-traumatic disturbances, if she has difficulty dealing with family and community reactions, and as she goes through any legal procedures.

The objectives of counselling are to help survivors:

- understand what they have experienced,
- overcome guilt,
- express their anger,
- realise they are not responsible for the attack,
- know that they are not alone, and
- access support networks and services.

Special Issues

Sexual Violence in Domestic Situations

Caution should be exercised before intervening in domestic situations because the survivor and/or other relatives could be subjected to further harm. If the survivor has to return to the abuser, retaliation may follow, especially if the abuser learns that the matter has been reported. Each situation needs to be individually assessed in close cooperation with colleagues to determine the most appropriate response. Health care providers may choose to refer the matter to a disciplinary committee, inform the authorities, or provide discreet advice to the survivor about her options.

Children Born as a Result of Rape

These children may be mistreated or even abandoned by their mothers and families. They must be closely monitored and support should be offered to the mother. It is important to ensure that the family and the community do not stigmatise either the child or the mother. Foster placement and, later, adoption should be considered if the child is rejected, neglected or otherwise mistreated.

Legal Aspects

The government on whose territory the sexual attack occurred is responsible for taking remedial measures, including conducting a thorough investigation into the crime, identifying and prosecuting those responsible and protecting survivors from reprisal. In all cases, the wishes of the survivor should be respected when pursuing the legal aspects of the case. Confidentiality must be ensured.

All agencies should advocate the enactment and/or enforcement of national laws against sexual violence in accordance with international legal obligations. These should include prosecution of offenders and the implementation of legal measures to protect the survivor.

The local UNHCR Protection Officer must be familiar with the national criminal and civil law on the subject of rape and sexual violence before an incident occurs so he/she will know what procedural steps should be taken and what advice should be given to survivors. (See Appendix Two.)

Monitoring

Monitoring cases of sexual violence should be a routine task of health care providers, protection officers and others, as appropriate. In addition, there should be regular assessments of the providers' ability to offer comprehensive medical and psychosocial care for rape survivors. Ideally, care should be given as soon after a rape as possible.

Sexual Violence Indicators

✔ **Indicators to be collected from the health-facility level**

- Incidence of sexual violence (reported cases/10,000 population)
- Coverage of services for survivors
- Timely care for survivors

✔ **Indicators that might be measured annually**

- Prosecution of sexual violence offenders
- Coverage of health-worker training that serves survivors of sexual violence

(Refer to Chapter Nine–Monitoring and Surveillance.)

Emergency Contraceptive Pill Regimens

- ✔ **When pills specially packed for emergency contraception are available as supplied in the New Emergency Health Kit 98, or when high-dose pills containing 0.5 mg ethinylestradiol and 0.25 mg of levonorgestrel are available:**
  - two pills should be taken as the first dose as soon as convenient but no later than 72 hours after the rape. These should be followed by two more pills 12 hours later.

- ✔ **When only low-dose pills containing 0.3 mg ethinylestradiol and 0.15 mg of levonorgestrel are available:**
  - four pills should be taken as the first dose as soon as convenient but no later than 72 hours after the rape. These should be followed by four more pills 12 hours later.

- ✔ **Emerging data indicate that alternative hormonal regimes consisting of levonorgestrel-only pills are equally effective and have significantly fewer side effects. When pills containing 0.75 mg levonorgestrel are available:**
  - one pill should be taken as the first dose as soon as convenient but no later than 72 hours after the rape. This should be followed by another pill 12 hours later.

Managing Side Effects
Nausea occurs in about 50 per cent of clients using combined ECPs and 25 per cent for those using levonorgestrel only. Taking the pills with food may reduce nausea. Routine prophylactic use of anti-emetics is not recommended in settings with limited resources. If vomiting occurs within two hours of taking ECPs, repeat the dose.

Contraindications
There are no known medical contraindications to the use of ECPs. The dose of hormones used in ECPs is relatively small and the pills are used for a short time. Contraindications associated with continuous use of hormonal contraceptives do not apply.

ECPs should not be given if there is a confirmed pregnancy. ECPs may be given when pregnancy status is unclear and pregnancy testing is not available, as there is no evidence of harm to the woman or to an existing pregnancy.

Checklist for Sexual Violence Programme

Key Interventions–Preventing Sexual Violence

- ✔ Ensure proper documentation for women
- ✔ Increase availability of female protection officers and interpreters and ensure that all officers have knowledge of UNHCR Protection Guidelines and UN Security Guidelines for Women
- ✔ Facilitate the use of existing women's groups or promote the formation of women's groups to discuss and respond to issues of sexual violence
- ✔ Improve camp design for increased security for women
- ✔ Include women in camp decision-making processes, especially in the areas of health, sanitation, reproductive health, food distribution, camp design/location
- ✔ Distribute essential items such as food, water and fuel directly to women
- ✔ Train people at all levels (NGO, government, refugee, etc.), to prevent, identify and respond to acts of sexual violence.

Key Interventions–Responding to Sexual Violence

- ✔ Develop/adapt protocols and guidelines that would limit further traumas to survivors of sexual violence
- ✔ Engage socially and culturally appropriate support personnel as a first contact with people who have been subjected to sexual violence
- ✔ Provide prompt and culturally appropriate psychosocial support for survivors and their families
- ✔ Provide medical follow-up immediately after an attack that also addresses STDs, HIV infection and unwanted pregnancy
- ✔ Establish closer links among protection officers, women's groups, TBAs and community leaders to discuss issues related to the attacks
- ✔ Document cases while respecting survivors' wishes and confidentiality.

CONFIDENTIAL

Sexual Violence Incident Report Form

Camp: _____ Reporting Officer: _____ Date: _____

1) Affected Person:

Code(*): _____ Date of Birth: _____ Sex: _____
Address:

_____

Civil Status: _____

If a Minor: Code/Name of Parents/Guardian: _____

2) Report of Incident:

Place: _____ Date: _____ Time: _____

Description of Incident:
(Specify type of sexual violence)

Persons Involved:

3) Actions Taken:

Medical Examination Done: ❑ Yes ❑ No By Whom: _____
Major Findings and Treatments Given:

Protection Staff Notified: ❑ Yes ❑ No
If no, reasons given:

If yes, actions taken:

Psychosocial Counselling given: ❑ Yes ❑ No
By whom and actions taken

4) Proposed Next Steps

5) Follow-up Plan

- ❑ Medical Follow-up _____
- ❑ Psychosocial Counselling _____
- ❑ Legal Proceedings _____

Adapted from Ngara, Tanzania–HOW TO GUIDE on Crisis Intervention Teams

* Code numbers should be used rather than names to ensure confidentiality.

Further Readings

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