

Chapter 3

Prevent and Manage the Consequences of Sexual Violence

Historically, sexual violence has consistently been a result of situations of conflict and forced migration, including natural disasters, and it continues to be so today.³⁰ It is therefore urgent that all actors responding in an emergency are aware of this issue and put protective measures in place immediately—proper layout of facilities such as latrines, for example, can reduce women’s exposure to risk. Women and girls who have experienced sexual violence should receive health care as soon as possible after the incident in order to avert preventable consequences, such as unwanted pregnancies and life-threatening infections. If left unaddressed, sexual violence may have serious negative personal and social consequences for women and girls, as well as for their families and the larger community. Thus, psychosocial services that help to heal and empower/rehabilitate women are necessary. Protection and community services staff should also be involved in offering legal support to survivors of sexual violence.

An important resource that outlines the set of minimum multi-sectoral interventions to prevent and respond to sexual violence in emergency settings is the IASC *Guidelines for Gender-based Violence Interventions in Humanitarian Emergencies*. These guidelines provide recommended interventions for all sector areas before an emergency, during the acute phase of an emergency and once the immediate crisis subsides. A reference matrix of these guidelines is also available.³¹

³⁰ Ward, J., *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-Conflict Settings*. A Global Overview, RHRC Consortium, 2002. Available from <http://www.rhrc.org/resources/ifnotnow.pdf>.

³¹ Inter-agency Standing Committee, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, 2005. Available from <http://www.humanitarianinfo.org/iasc/downloadDoc.aspx?docID=4402>.

THE OBJECTIVE

TO PREVENT AND MANAGE THE CONSEQUENCES OF SEXUAL VIOLENCE BY:

- Putting in place measures to protect affected populations from sexual violence;
- Making clinical care available for survivors of rape; and
- Ensuring the community is aware of the available clinical services.

What is sexual violence?

Sexual violence is any non-consented action of a sexual nature, including rape, attempted rape, sexual exploitation and sexual abuse. Sexual violence is a subset of the broader category of gender-based violence (GBV). GBV is an umbrella term for any harm that is perpetrated against a person's will that results from power inequities that are based on gender roles. Violence may be physical, sexual, psychological, economic or socio-cultural.³²

The reason for addressing sexual violence in the MISP is to prevent rape and sexual exploitation and abuse, provide medical care for rape survivors and to ensure the availability of essential psychosocial services. Once a situation stabilizes and all components of the MISP have been implemented, attention can be given to preventing the wider array of violence issues, including domestic violence; early and/or forced marriage; female genital mutilation/cutting; forced sterilization or forced pregnancy; forced or coerced prostitution; trafficking of women, girls and boys; and additional forms of GBV.

Why is preventing sexual violence a priority?

Although sexual violence is common even during peacetime, natural disasters and conflict may increase the risk of rape and other forms of sexual violence. This dire reality is reflected in an increasing number of documented reports and research. Women and adolescents are especially vulnerable to sexual abuse committed by combatants. The use of rape as a strategy of war has been documented in several conflicts as an effective means of controlling, degrading and humiliating a community.³³ It is important to recognize that sexual violence may increase after natural disasters as well; it is therefore imperative to ensure that prevention and response mechanisms are also in place in these settings.

It is critical to prevent sexual violence because it is a human rights violation. Survivors may suffer from depression and anxiety, attempt/complete suicide, contract HIV or other STIs, become pregnant, or may be shunned by their families or communities. Moreover, the impact of sexual violence is multifold: it impacts the survivor's physical and mental health and social well-being, while also having possible consequences for the survivor's family and wider community.

³² Ward, J., *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-Conflict Settings*. A Global Overview, RHRC Consortium, 2002. Available from <http://www.rhrc.org/resources/ifnotnow.pdf>.

³³ See, for example, Human Rights Watch, *Climate of Fear*, July 2003; UNFPA, *Women suffer brunt of conflict in western Sudan*, UNFPA warns, May 6, 2004; Human Rights Watch, *The War Within the War: Sexual violence against women and girls in Eastern Congo, 2002*; Hynes, M. et al., *Field test of GBV survey in East Timor and Kosovo: Lessons learned*, 2003; Physicians for Human Rights, *War-Related Sexual Violence in Sierra Leone: A Population-Based Assessment*, 2002; Shan Women's Action Network and Shan Human Rights Foundation, *License to Rape*, 2002; UNDP, *Situation of Gender-based Violence Against Women in Latin America and the Caribbean: National Report*, 2001; Association of Widows of the Genocide (Vega), *Survey on Violence Against Women in Rwanda*, 1999.

Who is impacted most by sexual violence?

Sexual violence in crisis-affected settings does not happen in a vacuum. Most reported cases of sexual violence among crisis-affected communities—and in most settings around the world—involve male perpetrators committing violent acts against females.³⁴ However, men and boys may also be at risk of sexual violence, particularly in conflict settings and when they are subjected to detention or torture. While all women in crisis-affected settings are susceptible to sexual violence, adolescent girls are exceptionally vulnerable as they are often targeted for sexual exploitation and rape. In addition, sexual violence, even if exclusively perpetrated against women and girls, often affects and undermines the entire community—including the fathers, brothers, husbands and sons of the survivor. It is important to recognize that anyone can be a survivor of sexual violence (women, girls, boys and men of all ages) and to ensure that services are available and accessible to all.

Who are the perpetrators of sexual violence?

Perpetrators may be others who have been displaced by the conflict or disaster; members of other clans, villages, religious groups or ethnic groups; military personnel; rebel forces; humanitarian workers from UN agencies or NGOs; members of the host population; the community; or family members. Perpetrators may also be male or female. In short, anyone can perpetrate sexual violence. Rape may be used as a strategy of warfare to intimidate and traumatize a population, in which case the perpetrators are enemy combatants, but perpetrators of opportunistic rape can be anyone acting with impunity in the climate of lawlessness that accompanies armed conflict and after natural disasters.

When does sexual violence occur?

Sexual violence can happen anytime during displacement, including prior to fleeing one's home area, during flight, while in the country of asylum and during repatriation and reintegration. It can occur in crisis-affected communities after a natural disaster, even among those not displaced from their homes. In addition, sexual violence frequently escalates in displaced settings as normal social structures are disrupted. Immediate prevention and response measures must be adapted to suit these different circumstances.

What are the key actions that should be taken to reduce the risk of sexual violence?

As part of the work of the overall health sector/cluster mechanism, the RH Officer and RH program staff must:

- ✦ Ensure women, men, adolescents and children have access to basic health services, including sexual and RH services;
- ✦ Design and locate health facilities to enhance physical security, in consultation with the population and in particular with women and adolescents;
- ✦ Consult with service providers and patients about security in the health facilities;

³⁴ United Nations High Commissioner for Refugees, *Sexual Violence against Refugees: Guidelines on Prevention and Response*, Geneva, 1995. Available from <http://www.unhcr.org/3b9cc26c4.html>

- ✦ Locate separate male and female latrines and washing areas in the health facility in a secure location with adequate lighting at night, and ensure doors lock from the inside;
- ✦ Ensure all ethnic subgroup languages are represented among service providers or interpreters are available;
- ✦ Hire female service providers, community health workers, program staff and interpreters;
- ✦ Inform service providers of the importance of maintaining confidentiality and have them sign and abide by a code of conduct against sexual exploitation and abuse; and
- ✦ Ensure that codes of conduct and reporting mechanisms on sexual exploitation and abuse by health staff are in place, as well as relevant punitive measures to enforce them.

Urban Settings: With all stakeholders to the humanitarian response, identify the specific risks for sexual violence in the setting and develop targeted protection measures. Displaced populations, particularly women and girls, may be at additional risk of rape and sexual exploitation and abuse in an unfamiliar urban setting as they struggle to obtain their basic and survival needs. As it may be difficult to identify and access displaced women in urban settings, it is important to discover creative ways to reach out to inform them of where and why to receive services after rape. Working with a local women's organization to establish a hotline where displaced women can speak to someone (in their own language) about sexual violence, for example, may be helpful.

Adolescents: Provide adolescent-friendly care for survivors of sexual violence at health facilities and encourage adolescent participation in any multi-sectoral GBV prevention task force.

What are the key actions that should be taken to respond appropriately to survivors?

RH Officers and program staff must:

- ✦ Establish a private consultation area with a lockable filing cabinet;
- ✦ Put in place clear protocols and sufficient supplies and equipment;
- ✦ Hire male and female service providers fluent in local languages, or, where this is not possible, hire trained male and female chaperones and translators;
- ✦ Involve women and male and female adolescents in decisions on accessibility to services and on an appropriate name for the services;
- ✦ Ensure that services and a referral mechanism to a hospital for life-threatening complications are available 24 hours a day/seven days a week;
- ✦ Once services are established, inform the community why, where and when (as soon as possible after a rape) these services should be accessed. Use communication channels appropriate to the setting (e.g., through midwives, community health workers, community leaders, radio messages or information leaflets in women's toilets); and

✦ Ensure service providers are skilled. Where needed, organize information sessions or short refresher trainings on clinical care for survivors of rape. Clinical management of survivors of rape should include the following components:

- ❖ Supportive communication
- ❖ History and examination
- ❖ Forensic evidence collection as relevant
- ❖ Compassionate and confidential treatment, including:
 - ▶ Emergency contraception
 - ▶ Treatment of STIs
 - ▶ Post-exposure prophylaxis (PEP) to prevent HIV transmission
 - ▶ Care of wounds and prevention of tetanus
 - ▶ Prevention of hepatitis B
 - ▶ Referral for further services, e.g., health, psychological and social.

A useful resource that provides guidance to health care providers for medical management after rape of women, men and children is the 2004 *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations*.³⁵ In addition, the WHO, UNHCR and UNFPA e-learning Program on *Clinical Management of Rape Survivors* is a complementary online tool which is available in English and French.

Who is responsible for preventing and managing incidents of sexual violence?

A multi-sectoral approach is required to prevent and respond appropriately to sexual violence. The global protection cluster under the leadership of UNHCR is responsible for ensuring that protection is mainstreamed and integrated with other sectors and that support is provided as requested to the country-level protection cluster. The protection cluster working group (PCWG) is sub-divided with five additional AoR, including child protection under the leadership of UNICEF and GBV under the leadership of UNFPA/ UNICEF. The stated overarching objective of the GBV AoR is “to develop effective and inclusive protection mechanisms which promote a coherent, comprehensive and coordinated approach to GBV at the field level, including regarding prevention, care, support, recovery, and works to hold perpetrators accountable.” Clinical care for survivors of rape falls within the purview and accountability of the health sector/cluster with the designated lead RH agency.³⁶

Coordination at the field level to address sexual violence should encompass all technical sectors (such as protection, health, education, community services, security/police, site planning, etc.) and all geographic areas. Representatives of the displaced community, including women and girls, UN partners, NGOs and government authorities, should inform and/or participate in relevant sector/cluster coordination meetings and identify her/his role and responsibilities in preventing and responding to sexual violence. It is important for the RH Officer to participate in GBV coordination mechanisms and collaborate with the GBV focal point, if one is appointed, to prevent and respond to sexual violence.

³⁵ World Health Organization, United Nations High Commissioner for Refugees, *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations*, 2004. Available from http://www.rhrc.org/resources/Clinical_Management_2005_rev.pdf.

³⁶ Inter-agency Standing Committee, One Response, available from <http://onerresponse.info/COUNTRIES/Pages/default.aspx>.

The Reality of Implementing the MISP in Kenya³⁷

The Women's Refugee Commission's 2008 MISP assessment in Kenya showed that planning to prevent sexual violence, including sexual exploitation and abuse, were strong at the national level but still inadequate at the field level. Poor security measures were noted at all but one camp and the assessment team received numerous disturbing reports of sexual exploitation and abuse by humanitarian workers, police and others.

Mechanisms to respond to sexual violence, including sexual exploitation and abuse, were also weak at the field level. Displaced persons and representatives of humanitarian organizations reported a general atmosphere of impunity toward perpetrators of sexual violence. Health workers also suggested that many of the displaced did not know the importance of seeking treatment for sexual assault or where it was offered. Many displaced women slowly sought care several months after the height of the violence.

Noted Practices in Preventing and Managing the Consequences of Sexual Violence Observed in Darfur³⁸ include:

- ◆ Clinic staff in North Darfur distributed emergency contraception (EC) to village midwives in addition to a flyer (in Arabic) developed by the RH Officer on why and where women and girls can access care for rape.
- ◆ African Union (AU) commanders in North Darfur were informed by the RH Officer to refer all rape survivors who reported to them to a local clinic for treatment. The AU civilian police (CIVPOL) patrol also distributed information flyers (in Arabic) on the benefits and availability of care for survivors of sexual violence after an attack.
- ◆ In North Darfur, the RH Officer conducted meetings with CIVPOL members about the importance of the clinical management of rape survivors.
- ◆ In West Darfur, midwives were identified as sexual violence protection "focal points" and let internally displaced women know they could approach these focal points confidentially; these focal points then referred women to receive medical care.
- ◆ In North Darfur, traditional birth attendants (TBAs) delivered messages on sexual violence to the community.
- ◆ In South Darfur, women's health teams conducted community outreach to survivors of sexual violence.
- ◆ Some agencies immediately established women's centers in camps to provide a safe place for women and girls. These camps also provided a space for survivors of sexual violence to receive confidential, holistic care in an environment that minimized the social stigma.

³⁷ Women's Refugee Commission, Reproductive Health Coordination Gap, Services Ad hoc: Minimum Initial Service Package (MISP) Assessment in Kenya, September 2008. Available from http://www.womensrefugeecommission.org/docs/ken_misp.pdf.

³⁸ The Women's Refugee Commission sub-granted to international agencies to coordinate the implementation of the MISP in the three states of Darfur, North Sudan from 2005 to 2006. Some practices observed by the Women's Refugee Commission's field team are listed.



What are some situations that put women and girls at risk of sexual violence?

It has been shown that women without their own personal documentation for collecting food rations or shelter materials are vulnerable because they may be dependent on males for their daily survival. It also has been demonstrated that when men (fellow displaced persons or humanitarian actors) alone are responsible for distributing food and other essential goods, women and children may be forced to perform sexual favors in order to obtain their survival needs.

Women and girls may have to travel to remote distribution points for food, firewood for cooking fuel and water. Their living quarters may be far from latrines and washing facilities. Their sleeping quarters may be unlocked and unprotected. Lighting may be poor. Male and female latrines and washing facilities may not be separate or these facilities may be located in insecure areas of a camp. Given the stressful circumstances of displacement, women and girls may also be at increased risk of intimate partner violence. All of these circumstances leave women and girls vulnerable to abuse and sexual assault.

Lack of police protection and lawlessness also contribute to an increase in sexual violence. Police officers, military personnel, humanitarian workers, camp administrators or other government officers may themselves be involved in forcing women and girls to engage in sexual activity for security, services or other support. If there are no independent organizations, such as UNHCR or NGOs, to help ensure personal security within a camp, the number of incidents often increases. It is important that female protection officers are available since women and girls are often more comfortable reporting protection concerns and incidents of violence to another woman.

Why are incidents of sexual violence often not reported?

Even in non-crisis settings, sexual violence often goes unreported due to a range of factors, including fear of retribution, shame, stigma, powerlessness, lack of support, the unreliability of public health and other services, lack of trust in the services and the lack of confidentiality and unfamiliarity with the services. All of these circumstances are exacerbated in humanitarian settings, increasing the likelihood that incidents of sexual violence within the population will go unreported. While ensuring that clinical management and other services is an essential part of the response, addressing sexual violence goes beyond this and must also include an environment where women are protected, supported and able to access this care.

Code of Conduct

A Code of Conduct (CoC) against sexual exploitation and abuse (SEA) is a set of agency guidelines that promotes respect by staff of the agency for fundamental human rights, social justice, human dignity and respect for the rights of women, men and children. The CoC also informs staff that their obligation to show this respect is a condition of their employment. An enforceable CoC is a critical component of humanitarian accountability to beneficiaries. A good resource for agencies to develop these guidelines is the *InterAction Step by Step Guide to Addressing Sexual Exploitation and Abuse*.³⁹ Agencies involved in MISP implementation (and indeed any aspect of humanitarian response) should have a CoC in place. Agencies should ensure that all staff are committed to adhering to the guidelines and have been oriented to their responsibilities to prevent SEA. A CoC is relevant for international staff. Agencies must also ensure that any staff hired from local organizations or persons contracted from the local community sign the CoC and receive regular orientation to and opportunities for discussion about the CoC. Beneficiaries/persons of concern also need to be informed and become familiar with the CoC rules and the relevant site-specific systems so they can invoke them in case of violation. The RH Officer should support the development of a system for confidential reporting and follow-up of SEA.

The IASC Task Force on Protection from Sexual Exploitation and Abuse has developed six core principles for inclusion in UN and NGO CoCs. They are:

- ✦ Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- ✦ Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defense.
- ✦ Exchange of money, employment, goods or services for sex, including sexual favors or other forms of humiliating, degrading or exploitative behavior, is prohibited. This includes the exchange of assistance that is due to beneficiaries.
- ✦ Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- ✦ Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, s/he must report such concerns via established agency reporting mechanisms.
- ✦ Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.⁴⁰

³⁹ InterAction, *Step by Step Guide to Addressing Sexual Exploitation and Abuse*, June 2010. Available from <http://www.interaction.org/document/interaction-step-step-guide-addressing-sexual-exploitation-and-abuse>.

⁴⁰ Cited in InterAction, *Step by Step Guide to Addressing Sexual Exploitation and Abuse*, June 2010. Available from <http://www.interaction.org/document/interaction-step-step-guide-addressing-sexual-exploitation-and-abuse>.

Complaints Mechanism

Complaints of sexual exploitation and abuse must be taken very seriously. Agencies should develop a response system to correctly handle any complaints that are brought to the attention of the agency. These mechanisms should be safe, confidential, transparent and accessible. Often, such systems are best situated in broader response mechanisms for employee misbehavior.⁴¹

- ✦ The agency office can have clear and established internal complaints procedures so that staff and beneficiaries know how and when to confidentially report cases of sexual exploitation and abuse. This is particularly important if your agency is the only organization providing services in the community. Beneficiaries/persons of concern should be a part of the process to develop a system that is safe and accessible for everyone.
- ✦ Agencies should create a workplace culture that encourages discussion and questioning of appropriate behavior regarding protection of beneficiaries from exploitation and abuse. Such a culture allows staff to bring questionable behavior to a supervisor's attention.
- ✦ Staff and beneficiaries need to be informed that making a false complaint of sexual exploitation and abuse may constitute misconduct, just as the failure to report suspected sexual exploitation and abuse may also constitute misconduct.⁴²
- ✦ Reports of sexual exploitation and abuse must be quickly and properly referred for investigation. Agencies can make sure they are prepared to provide strong, committed investigations when cases of sexual exploitation and abuse are reported. They must respond quickly to provide help to the survivors of these cases.⁴³
- ✦ Employees who are accused of sexual exploitation and abuse need to be disciplined and penalized appropriately.⁴⁴ This can include termination of contract, demotion, fine and suspension without pay, among other sanctions.
- ✦ The agency office should keep all original documents of allegations of sexual exploitation and abuse in the appropriate files for the record. The documents must be kept confidential in locked file cabinets and only accessible by relevant personnel.

If you know someone who has been sexually exploited or abused, report the incident in a confidential manner to a relevant authority as predetermined in the established complaints mechanism.

Noted Practices

One agency conducts an orientation on its CoC for its entire staff and then six weeks later provides a brief refresher session so that staff may share examples from their work of issues discussed during the orientation. This is a promising way to ensure that staff do understand the CoC and can assist the agency in making any necessary modifications to it in relation to the local context.

An agency in Darfur had a focal point that conducted orientations on the CoC and was also the go-to person for all staff with questions and concerns.

⁴¹ United Nations, "Addressing Sexual Exploitation and Abuse," *Protection from Sexual Exploitation and Abuse*. 2008. Available from <http://cdu.unlb.org/Portals/0/Documents/KeyDoc13.pdf>.

⁴² United Nations, Interpretation Guide for ST/SGB/2003/13: *Secretary-General's Bulletin on special measures for protection from sexual exploitation and abuse*. Draft under review, 2010.

⁴³ United Nations, *Comprehensive Strategy on Assistance and Support to Victims of Sexual Exploitation and Abuse by United Nations Staff and Related Personnel*. March 7, 2008. Available from <http://cdu.unlb.org/Portals/0/Documents/KeyDoc13.pdf>.

⁴⁴ United Nations, "Addressing Sexual Exploitation and Abuse," *Protection from Sexual Exploitation and Abuse*. 2008. Available from <http://cdu.unlb.org/Portals/0/Documents/KeyDoc13.pdf>.

MISP Coordination Monitoring Checklist

- ✦ Multisectoral coordinated mechanisms to prevent sexual violence are in place
- ✦ Confidential health services to manage survivors of rape are in place, including:
 - Emergency contraception
 - PEP
 - Antibiotics to presumptively treat STIs
 - Care of wounds and prevention of tetanus (tetanus toxoid/tetanus immunoglobulin)
 - Hepatitis B vaccine
 - Wound care
 - Referrals to health, psychological and social support services
- ✦ Number of incidents of sexual violence reported to health services
- ✦ Information on post-rape care and access to services has been disseminated to community

Which supplies are needed or which Inter-agency RH Kit(s) could be ordered to address this issue?⁴⁵

Number	Name	Color
Kit 3:	Rape Treatment Kit	Pink
Kit 9:	Suture of Tears and Vaginal Examination Kit	Purple

** At times drugs in the kits may not be the same as those that are in the relevant national medical protocol. This should be discussed in the health sector/cluster meeting.*

⁴⁵ The Reference and Training Package, a library of resource materials, is included with each kit order. Please see Chapter 8 for the list of materials in this package. The RH Kits booklet is available from <http://www.rhrc.org/resources/rhrkit.pdf>.

Challenges and Solutions

1. *The provision of psychosocial services can be challenging to implement in the early stages of an emergency. What if the members of the staff have low capacity and lack the basic skills to provide these services?*

Local staff will likely be able to help identify the most appropriate local persons with nonjudgmental, supportive attitudes and good communication skills for this role. It is crucial that all staff that come into contact with a survivor respect the survivor's wishes and ensure that all related medical and health status information is kept confidential and private, including from the survivor's family members. Staff members need to communicate with the survivor in a way that both ensures accurate information and reflects a caring, uncritical attitude. Training programs on psychosocial support can be established once the situation is stable. Good resources that focus on engagement strategies for work with GBV survivors include: *Clinical Management of Rape Survivors*,⁴⁶ *Caring for Survivors Training Module*,⁴⁷ *Communication Skills in Working with Survivors of Gender-Based Violence*,⁴⁸ *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*,⁴⁹ *Establishing GBV Standard Operating Procedures (SOP) Guide*⁵⁰ and the *Workshop Package for the Gender-based Violence Standard Operating Procedures Guide*.⁵¹

2. *What can be done in settings where talking about sexual violence is taboo and/or where there is strong resistance to addressing sexual violence by local health workers and community members?*

Even in settings where discussing sexual violence is strongly discouraged, it is important to find innovative ways to address it as it is a life-saving intervention. For example, one local NGO working with an extremely conservative refugee population organized "family health" workshops for refugee women that covered a wide variety of health issues, including sexual violence. In this way, the community gained knowledge on sexual violence, including why, where and when to seek medical care if they or someone they know is assaulted.

⁴⁶ World Health Organization, United Nations High Commissioner for Refugees, United Nations Population Fund, *Clinical Management of Rape Survivors*, 2009. Available from <http://iaawg.net/cmor>.

⁴⁷ United Nations Children's Fund, *Caring for Survivors Training Manual*, 2010. Part One of this series of training modules focuses on how multi-sectoral actors can engage with survivors in a supportive and ethical way. Part Two addresses medical interventions for sexual assault survivors and is based on the WHO Guidelines. Available from <http://www.rhrc.org/resources/index.cfm?sector=gbv#209>.

⁴⁸ Family Health International (FHI), *Communication Skills in Working with Survivors of Gender-Based Violence*, RHRC Consortium, 2004. Available from http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html.

⁴⁹ Global Protection Cluster Gender-based Violence Area of Responsibility Working Group, *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*, 2010. Available from [http://onerresponse.info/GlobalClusters/Protection/GBV/publicdocuments/GBV%20Handbook%20Long%20Version\[1\].pdf](http://onerresponse.info/GlobalClusters/Protection/GBV/publicdocuments/GBV%20Handbook%20Long%20Version[1].pdf).

⁵⁰ Inter-agency Standing Committee Sub-Working Group on Gender and Humanitarian Action, *Establishing GBV Standard Operating Procedures (SOP) Guide*, May 2008. Available in English and in French from the Protection cluster website at <http://onerresponse.info/GlobalClusters/Protection/GBV/Pages/Gender-Based%20Violence.aspx>.

⁵¹ Global Protection Cluster Gender-based Violence Area of Responsibility Working Group, *Workshop Package for the Gender-based Violence Standard Operating Procedures Guide*. GBV SOP Guide. Available in English and in French from the Protection Cluster website at <http://onerresponse.info/GlobalClusters/Protection/GBV/Pages/Gender-Based%20Violence.aspx>.

Chapter 3 Quiz

(Answers on pages 104-105)

1 *The RH Officer should:*

- a. Support multi-sectoral/inter-cluster coordination of actions to prevent (and respond to) sexual violence.
- b. Conduct a community-wide IEC campaign about gender-based violence.
- c. Ensure communities are informed about the benefits of seeking clinical care for rape as well as the location and hours of clinical care service.
- d. Identify and support the development and functioning of systems to address sexual exploitation and abuse.
- e. a, c and d

2 *Which of the following groups are potential perpetrators of sexual violence?*

- a. UN personnel
- b. Family and community members
- c. Armed militia groups
- d. Women
- e. All of the above

3 *A good resource for guiding agencies on how to address sexual exploitation and abuse is:*

- a. CERF *Life-saving Criteria and Sectoral Activities*
- b. IEC Universal Templates
- c. InterAction's *Step by Step Guide*
- d. MISP cheat sheet
- e. RHRC Consortium *Field Friendly Guide to Emergency Obstetric Care*

4 *Which situation may put women at risk for sexual violence?*

- a. Women participating in distribution of food and other goods
- b. Latrines that lock from the inside
- c. Lack of cooking fuel available in or near households
- d. Most, but not all, on-site protection officers being female
- e. International and local NGOs abiding by CoC against sexual exploitation and abuse

5 *Which of the below is **not** a MISP-related service for women and girls who survive sexual violence?*

- a. Psychosocial care
- b. Antenatal care
- c. Ensured physical safety
- d. Access to emergency contraception
- e. Access to post-exposure prophylaxis to prevent HIV