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CHAPTER EIGHT

Gender-based Violence

1 Introduction

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females.

Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many forms of GBV are illegal and criminal acts in national laws and policies. Around the world, GBV has a greater impact on women and girls than on men and boys.

The term "gender-based violence" is often used interchangeably with the term "violence against women" and "sexual and gender-based violence". The term, "gender-based violence" highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, including sexual violence (SV), particularly when they are subjected to torture and/or detainment.

GBV includes:

- Sexual violence, including rape, sexual abuse, sexual exploitation and forced prostitution
- Domestic violence
- Forced and early marriage
- Harmful traditional practices such as female genital mutilation, honour crimes, widow inheritance
- Trafficking

Gender-based Violence

Box 30: Gender-based Violence in Humanitarian Settings*

- Approximately 50 000 to 64 000 internally displaced women in Sierra Leone reported experiencing sexual violence at the hands of armed combatants. And half of internally displaced women who had face-to-face contact with combatants reported experiencing sexual violence.
- Twenty-five percent of Azerbaijani women surveyed in 2000 by the U.S. Centers for Disease Control and Prevention acknowledged being forced to have sex; those at greatest risk were among Azerbaijan's internally displaced populations.
- According to a 1999 government survey, 37% of Sierra Leone's prostitutes were under age 15; of those, over 80% were unaccompanied or children displaced by the war.
- The majority of Tutsi women in Rwanda's 1994 genocide were exposed to some form of gender-based violence; of those, it is estimated that between 250,000 and 500,000 survived rape.
- It is estimated that between 20 000 and 50 000 women were raped during the war in Bosnia and Herzegovina in the early 1990s.
- In the aftermath of natural disasters, field reports of social impacts include abuse, as in this account of an Australian flood: "Human relations were laid bare and the strengths and weaknesses in relationships came more sharply into focus. Thus, socially isolated women became more isolated, domestic violence increased and the core of relationships with family, friends and spouses were exposed". Increased violence against women was also noted in reports from the Philippines after the Mount Pinatubo eruption; in Central and North America after Hurricane Mitch; and in several countries after the 2004 tsunami.

* *From:* 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), 2005.*

The nature and extent of specific types of GBV vary across cultures, countries and regions. Although GBV in humanitarian settings is underreported, it has been documented during humanitarian crises (see Box 30).

The consequences of GBV can result directly from violent acts or can be the result of long-term effects:

- The **physical consequences** range from relatively minor injuries to severe injuries leading to death or permanent disabilities; unintended pregnancies; unsafe and complicated abortion; adverse pregnancy outcomes, including miscarriage, low birth weight and fetal death; sexually transmitted infections, including HIV; pelvic inflammatory disease, infertility, chronic pain syn-

dromes; urinary tract infections.
- **Psychological consequences** include: anxiety disorders, including post-traumatic stress disorder (PTSD); depression; feelings of inferiority; inability to trust; fear; increased substance use and abuse; sleep disturbances; eating disorders; sexual dysfunction; and suicide.
- GBV also has a large impact on the **social health** of the individual and the community in terms of stigma, isolation and rejection (including by husbands and families); losses in women's income potential; interrupted education of adolescents; and homicide (e.g. honour killings or female infanticide).

2 Objectives

This chapter focuses on the responsibility of RH officer, programme staff and service providers in preventing and responding to health consequences related to GBV. The objectives of this chapter are to assist them to

- be aware of the different types of GBV;
- understand the multisectoral approach to prevention and response to GBV;
- support the integration of GBV prevention and response elements into the health sector/cluster.

3 Programming

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 (see Chapter 2: MISP). As soon as the MISP is in place, RH 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 GBV, as well as support initiatives to prevent GBV.

3.1 Coordination

To date, the **multisectoral programming model** forms the "best practice" for prevention of and response to GBV in humanitarian settings. Key characteristics of the multisectoral model include full engagement of the affected community, interdisciplinary and interorganizational cooperation and collaboration and coordination among health, psychological, legal and security services when responding to the needs of survivors of GBV.

The underlying principle of this model recognizes the rights and needs of survivors of GBV as paramount in terms of access to respectful and supportive services, guaranteed confidentiality and safety, and the ability to determine a course of action for addressing the GBV incident.

Because of the importance of multisectoral collaboration in GBV programming, RH officers and programme managers must actively participate in a process to clarify roles and responsibilities and collaboration within and among sectors to prevent and respond to GBV. The outcome of this process is sometimes referred to as Standard Operating Procedures (SOPs) for GBV. Developing agreed-upon SOPs must be **a collaborative process that occurs through a series of consultations** with key stakeholders and actors in the setting (see Further Reading).

While all sectors/clusters have a role to play in prevention of and response to GBV, at a minimum, this process should include representatives from health, psychosocial, safety/security and legal/justice/protection sectors (UN agencies, national and international NGOs, community-based organizations and relevant government authorities when appropriate).

Representatives from other sectors/clusters (including education, food and nutrition, camp management/shelter/site planning and water/sanitation) should also participate in the development of SOPs.

Within the multisectoral model, the responsibilities of the heath sector/cluster include: providing care of the health and psychological needs of survivors of rape, female genital mutilation (FGM) or other forms of GBV; collecting forensic evidence where appropriate; referring survivors for further health or psychosocial support; providing testimony in cases where a survivor chooses to pursue legal action; and raising awareness of GBV.

3.2 Needs assessment

Integrate GBV considerations into needs assessments for comprehensive RH service planning. Within the multisectoral framework, RH officers and programme managers are part of the health sector/cluster and must collaborate with other sector/cluster actors involved in GBV programming to collect the following information:

At the community level:

- level of awareness about the health consequences of GBV and when and where to access relevant health services.

At the programme level:

- international and local actors working on GBV;
- the existence of national, multisectoral and interagency operating procedures, protocols, practices and reporting forms;
- location and type of services providing care for survivors of GBV (health, community support, social, psychological, legal);
- the extent of adherence to ethical and safety standards in health services (safety, privacy, confidentiality, respect);
- RH programme staff and health-care provider training needs;
- types and number of cases of GBV reported at health services.

It is generally accepted that GBV, and in particular sexual violence, is underreported almost everywhere in the world. Survivors fear potentially harmful social, physical, psychological or legal consequences if they disclose the event. In settings characterized by instability, insecurity, loss of autonomy, breakdown of law and order and widespread disruption of community and family support systems, disclosure is even less likely. Any available data, in any setting, about GBV reports from police, legal, health or other sources will represent only a very small proportion of the actual number of incidents of GBV.

Any inquiry into SV and other forms of GBV must be designed and carried out with an understanding of the situation and take into consideration how the information will be used, who will see it, how the information will be reported, to whom and for what purpose and who will benefit from it. Consider ethical and safety issues at all times when involved in collecting, analysing and reporting on GBV information (see Box 31).

At the national level:

- national protocols related to GBV medical care and referral;
- national laws related to GBV: Types of GBV mentioned (for example, female genital mutilation/cutting, forced marriage, honour crimes, sexual assault, sexual abuse of children, forced prostitution);
- the legal definition of rape. The legal age of consent for sexual activity. Does it differ for boys and girls?
- national laws on termination of pregnancies resulting from sexual assault;
- mandatory reporting laws for cases of sexual abuse and sexual assault;
- cadres of health service providers authorized to collect forensic evidence and the range of forensic evidence admissible in courts of law;
- national plans/policies to eliminate GBV. What types of GBV does the plan target?

3.3 Reproductive health care for GBV survivors

RH officers and programme managers must en-

Box 31: Safety, Ethical and Methodological Recommendations for Documenting and Sharing Information on GBV Cases Reported to RH Services

When documenting information:

- Basic care and support for survivors must be available before commencing any activity that may involve individuals disclosing information about their experiences of GBV.
- The safety and security of service providers involved in gathering information about GBV is of paramount concern and in humanitarian settings in particular should be continuously monitored.
- The confidentiality of individuals who provide information about GBV must be protected at all times and they must give informed consent before their information is documented.
- RH service providers caring for GBV survivors must be carefully selected and receive relevant and sufficient specialized training and ongoing support.
- Additional safeguards must be put into place if children (i.e. those under 18 years) are involved.

When sharing data:

- Keep in mind the audience and possible use of the data and offer guidance on interpretation of the data.
- Provide the context for all reported data. If known, and safe to do so, provide information on the camps/clinics/districts from where cases are reported. Be specific, e.g. "reported cases from x number of health facilities".
- Only share a comprehensive description of the incident if this cannot be linked back to individual survivors (precise date and location, information on the victim, ethnicity, age, sex, medical findings, should only be included when safe to do so).
- Provide additional information which may have contributed to changes in the number of reported cases from the previous reporting period. For example, more services available, public information campaigns, upsurge in violent attacks. Whenever possible, information on when incidents took place should be collected and the information reported along with aggregated numbers.
- Label all tables and reports appropriately to avoid the information being taken out of context.

Adapted from: WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies and Stop Rape Now. UN Action against Sexual Violence in Conflict. Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries, "Do's and Don't's".

Box 32: Gender-based Violence: Some Definitions

Sexual violence (SV)
Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.

Sexual violence includes:

Rape/attempted rape
Rape is an act of non-consensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force and/or coercion. Efforts to rape someone that do not result in penetration are considered attempted rape.

Sexual abuse
Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. (See also "sexual exploitation.")

Sexual exploitation
Any actual or attempted abuse of a position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. (See also "sexual abuse".)

Domestic violence (also referred to as intimate partner violence)
Domestic violence takes place between intimate partners (spouses, boyfriend/girlfriend) as well as between family members (e.g. mothers-in-law and daughters-in-law). Domestic violence may include sexual, physical and psychological abuse. Other terms used to refer to domestic violence perpetrated by an intimate partner include "spousal abuse" and "wife battering".

Female genital mutilation
Female genital mutilation constitutes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. These practices are sometimes also referred to as "female circumcision" or "female genital cutting""

Forced early marriage
This occurs when parents or others arrange for and force a minor to marry someone. Force may occur by exerting pressure or by ordering a minor to get married, and may be for dowry-related or other reasons. Forced marriage is a form of GBV because the minor is not allowed to, or is not old enough to, make an informed choice.

From: Guidelines for GBV Interventions in humanitarian settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, Inter-agency Standing Committee (IASC), 2005 and GBV Tools Manual for Assessment and Programme Design, Monitoring and Evaluation in conflict-affected settings, RHRC Consortium, 2004

sure that service provider are trained to provide competent, confidential and compassionate clinical care for survivors of GBV and that they have the supplies to do so.

For definitions of different types of GBV, see Box 32.

Rape

Rape is often underreported or not reported at all, including in humanitarian settings. However, RH service providers in all settings must be prepared to provide care to survivors of rape from the onset of the humanitarian response. Prevention of and response to sexual violence is a component of the MISP. For more information on clinical management of rape survivors, see Chapter 2: MISP, paragraph 3.2.3, p. 25.

Domestic/intimate partner violence

In a WHO study on women's health and domestic violence it was found that between 15% and 71% of women report physical or sexual violence by a husband or partner; between 4% and 12% of women reported being physically abused during pregnancy; trafficking of women and girls for forced labour and sex is widespread and often affects the most vulnerable; and up to one in five women and one in ten men report experiencing sexual abuse as children.*

RH providers can play a crucial role in detecting, referring and caring for women living with violence. Abused women often seek health care, even when they do not disclose the violent event. Thus, interventions by RH providers can potentially mitigate both the short- and long-term health effects of GBV on women and their families. In collaboration with health coordinators, ensure that:

- all clinic and reception staff are aware of GBV issues;
- all staff understand and apply the four guiding principles of **safety, respect, confidentiality and non-discrimination**;
- posters and leaflets that condemn violence and information on support groups are displayed.

Train all RH providers to recognize signs of domestic violence and how to respond to suspected or reported abuse, including:

- If abuse is suspected (if the provider sees unexplained bruises or other injuries), providers may probe for more information in a private, caring and nonjudgemental manner, for example: "Has your partner or another person important to you ever hurt or physically harmed you in any way (such as hitting, kicking or burning you)?" or "Are you afraid of your partner?"
- Maintain confidentiality because the survivor and/or other relatives could be subjected to further harm. Make sure the survivor has a safe place to go to. If she has to return to the abuser, retaliation may follow, especially if the abuser learns that the matter has been reported. Help her to assess her present situation: "Are you or your children in immediate danger?" "Do you feel safe to go home?" "Would you like some help with the situation at home?"
- Offer information and referral for legal advice, social or other services. Help her to identify sources of support such as family and friends, local women's groups, shelters and legal services. Make it clear to the survivor that she is not alone.
- Refer her for post-rape services or other medical treatment if needed.

Female genital mutilation/cutting

An estimated 100 to 140 million girls and women have undergone some form of female genital mutilation (FGM) and 2 million girls are at risk of being subjected to the practice each year The majority of these girls and women live in sub-Saharan Africa, although some live

* Fact sheet N°239, Violence against women. WHO, November 2008. www.who.int/mediacentre/factsheets/fs239/en/print.html.

in the Middle East, Asia and other regions. RH officers and programme managers must be aware that FGM and health consequences related to FGM may be common among the population in the setting they work in.

FGM is classified as follows:

> **Type I:** Excision of the prepuce of the clitoris with or without excision of part or all of the clitoris.
> **Type II:** Excision of the clitoris with partial or total excision of the labia minora.
> **Type III:** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). Approximately 15% of women and girls who are subjected to FGM undergo this type.
> **Type IV:** Unclassified. This type includes pricking, piercing or incision of the clitoris and/or labia, burning of the clitoris, scraping of the vaginal orifice or cutting of the vagina, and any other procedure performed on a woman's genitalia for non-medical reasons.

Health consequences

Girls and women undergoing the more severe forms of FGM are particularly likely to suffer serious and long-lasting complications. Some of the effects are immediate; others become apparent only years later. Documentation and studies are available on the nature of the physical complications, but there has been little study of the sexual or psychological effects of FGM or of the frequency with which complications occur. The mortality rate of girls and women undergoing FGM is unknown.

Immediate complications include: haemorrhage (one of the most common complications); shock; infections — including tetanus and HIV; urine retention; injury to neighbouring organs, such as the urethra, vagina or the rectum; fistulae.

Long-term complications include: bleeding after deinfibulation (opening up of the vagina to allow sexual intercourse of childbirth); menstrual difficulties; difficulty in passing urine; recurrent urinary tract infections; incontinence; chronic pelvic infections causing abortion or infertility; abscesses and dermoid cysts; increased risk of transmission of HIV and other sexually transmitted infections (STIs); reduced sexual sensitivity; and painful intercourse. Problems during pregnancy and childbirth are common in women who have undergone Type III FGM, because of the rigidity and obstruction of scar tissue. Prolonged or obstructed labour, neonatal asphyxia, maternal lacerations, haemorrhage, fistulae and infection may result.

The psychological trauma of the procedure may leave an emotional scar for life and reduced trust in care givers. The physical and psychological impact of FGM may for some also contribute to the development of problems in sexual relationships.

It is important to remember that not all women who have undergone FGM will experience any particular related health problem. On the other hand, women may be unaware that the health problems they suffer are the result of FGM.

Clinical care

RH service providers must be able to interview and conduct a physical examination of women who have undergone FGM, recognize and provide appropriate information, counselling, support, treatment and/or referral for further management of the complications of FGM in a confidential, private and nonjudgemental manner.

In settings where Type III FGM is common, RH programme managers must ensure that RH

> The medicalization of FGM — willful damage by health professionals to healthy organs for nontherapeutic reasons — is a misguided and unethical step that fails to address the fundamental injustice of FGM.

service providers are trained in opening up an infibulation when indicated, or know when and where to refer for this procedure.

Family planning is as appropriate for girls and women with FGM as it is for any other client (see Chapter 5: Family Planning). Women who have undergone infibulation may have difficulties in using a method that has to be inserted vaginally, such as an intrauterine device (IUD), female condoms or vaginal rings. Since women with FGM of any type are often prone to infections of the genital tract, an IUD can be inserted only after careful consideration.

Ensure RH service providers who have midwifery duties are trained to assess and manage women with complications due to FGM during **pregnancy, labour and delivery and the postpartum period**. (For more information see Chapter 6: Maternal and Newborn Health.)

Prevention

Where FGM is widely practised, it is supported by both men and women and can be understood as a social convention, governed by rewards and punishment. The practice is often upheld by beliefs relating to religion, women's maturity and sexual morality, and considered necessary for marriageability. Therefore RH programme managers must work in close collaboration with local stakeholders, particularly women's NGOs, as well as professional organizations, aiming at a joint decision by the community to abandon the practice. Organize discussion and information sharing in the community aimed at empowerment, respect for girls and women and problem solving, providing information on women's body functions, the harmful consequences of the practice and the benefits of abandoning it. Care for women with FGM must be included in the programme.

Forced early marriage

Where early marriage is common, ensure that RH providers are aware of the RH risks for adolescents, including pregnancy-related complications such as obstructed labour and sexually transmitted infections, including HIV. RH providers should be trained in appropriate counselling for adolescents and understand how early marriage can alter a girls' mobility and her participation in school. The information provided on first contact with young married girls is critical because she might not be able to access RH services frequently. For more information see Chapter 4: Adolescent Reproductive Health.

3.4 Psychosocial support

Note: This section is adapted from *Guidelines for Gender-based Violence Interventions in Humanitarian Settings,* Action sheet 8.3. Inter-Agency Standing Committee (IASC), 2005.

Survivors of GBV may experience an array of psychological consequences, such as sadness and depression; self-blame; somatic distress; sexual problems; mood swings, anger and anxiety-related problems (sleeplessness, fearfulness, stress, and fear of "going crazy"). For most survivors, these experiences are normal emotional responses to trauma. Especially with social and emotional support, many survivors learn to cope and the distress decreases over time.

There are also social consequences. Most societies tend to blame victims of sexual violence. Social stigma, isolation and rejection — including by husbands and families — are serious consequences, often making emotional recovery difficult due to withdrawal from day-to-day activities and from social support.

Ensure close coordination between clinical and psychosocial support services. Psychosocial support should begin from the very first encounter with the survivor. Providers at all health and community services must be trained to listen and provide emotional support whenever a survivor discloses or implies that she has experienced GBV, give information and refer as needed and agreed by the survivor.

In most cultural settings, the support of family and friends is likely to be a key-factor in overcoming the trauma of violence. Providers must facilitate participation and integration of survivors in the community Community-based activities that can be appropriate are:

- Identify and train appropriate existing resources in the community, such as TBAs, midwives, women's groups, religious leaders and community services programmes. to know how to support survivors.
- Develop women's support groups. (In some contexts it may be appropriate to have support groups specifically designed for survivors of sexual violence and their families; however, great care must be taken not to increase social stigma by singling out one group of people).
- Create special drop-in centres for survivors where they can receive confidential and compassionate care.
- Provide material support as needed via health or other community services.
- Encourage use of appropriate traditional resources. If feasible, collaborate with traditional healers or clergy who, respectively, may conduct meaningful cleansing ceremonies or prayer for sexual violence survivors. Many such practices can be extremely beneficial; however, ensure that they do not perpetuate blaming-the-victim or otherwise contribute to further harm to the survivor.

These activities must be culturally appropriate and must be developed after consultation (and if possible in cooperation) with community members. They will need ongoing financial and logistical support and, where appropriate, training and supervision.

Psychosocial supports are also needed for survivors of FGM and women who were forced into early marriage. The organization and labelling of such support must be adapted because FGM and early marriage are socially sanctioned and people may not see themselves as survivors.

4 Human rights and legal considerations

GBV goes against many fundamental human rights and can be a serious impediment to the realization of human rights and fundamental freedoms. A number of human rights principles contained in various international human rights instruments serve as the basis for protection from GBV. These include the rights to:

- **life, liberty and security of the person** — this right is threatened when a person is raped or subjected to female genital mutilation (FGM);
- **the highest attainable standard of physical and mental health** — this right may be restricted if a person is denied access to appropriate medical care following rape;
- **freedom from torture or cruel, inhuman or degrading treatment or punishment** — FGM, rape, severe forms of domestic violence, forced sterilization and forced abortion, as well as denial of access to safe abortion services to women who have become pregnant as a result of rape and human trafficking violations, can constitute torture or cruel, inhuman or degrading treatment or punishment;
- **be free from all forms of discrimination** — this right may be restricted where laws fail to protect women and girls from gender-based violence and/or where they must be accompanied by a husband or father to obtain medical treatment after rape. All forms of violence against women are a manifestation of discrimination against them;
- **enter into marriage with free and full consent and the entitlement to equal rights to marriage, during marriage and at its dissolution** — forced marriage is a denial of this right;
- **freedom of movement, opinion, expression and association** — these are restricted when someone is trafficked, subjected to forced confinement or is prohibited by a husband or parent from accessing health or

other services.

Girls are particularly at risk of GBV due to their sex, as well as their young age. The Convention on the Rights of the Child states that **children have the right to protection from all forms of physical or mental violence, including from sexual abuse**, whether the abuse takes place in the family or in institutions, as well as from organized sexual abuse. Children also have the right to be protected from harmful practices, such as FGM.

The survivor of GBV has the **right to seek medical treatment** without cumbersome procedural requirements. Therefore, preventing the survivor from accessing and obtaining medical treatment by requiring her to present a marriage certificate, have the authorization of the husband or file a police report is a denial of this right. Where adolescents are involved, States should ensure legal provisions that provide for the possibility of medical treatment without parental consent for adolescents.

All agencies should advocate for the enactment and/or enforcement of national laws against GBV in accordance with international legal obligations, including prosecution of offenders and the implementation of legal measures to protect and support the survivor.

4.1 Challenges and opportunities

At times, RH programme managers and service providers may face difficult decisions when caring for survivors of GBV. They may find that their ability to provide services is restricted by national legislation or social or cultural norms. For example:

- In some societies, it is common that the family and/or the authorities force the woman or girl to marry the perpetrator in cases of sexual violence.
- In communities where a woman's virginity at the time of marriage is considered very important, the family of a survivor may ask service providers to conduct a "virginity test".
- If patient confidentiality is compromised, services provided to the survivor can put her at risk of reprisals and continued violence.
- A service provider may suspect or know that the perpetrator of violence is someone related to or close to the survivor and may feel that the survivor's safety is not guaranteed.

Guiding principles

Reproductive health managers or service providers facing a similar dilemma must prioritize the safety of the client, as well as their own and their colleagues' safety. Other principles to ensure are respecting the wishes of the client, ensuring non-discrimination and guaranteeing confidentiality. These guiding principles also have to be taken into account when assisting minors.

Then, they may:

- talk to their supervisor;
- discuss options with their client;
- discuss advocacy options and strategies within their organization or clinic structure;
- explore linkages with and referrals to local organizations that might be able to help the client;
- while respecting the confidentiality of their client, discuss with colleagues how to avoid such situations/handle them in the future;
- raise these concerns/challenges in health coordination meetings.

5 Monitoring

Monitoring and reporting on cases of GBV, information sharing; incident documentation and data analysis must be agreed upon as part of the Standard Operating Procedures. Collecting and analyzing information on GBV can provide valuable information if it is conducted and shared ap-

propriately (see also Box 31, p. 161).

Indicators to be collected at the health-facility level:

- Number of reported cases of sexual violence reported to health services (per month).
- Timing of emergency contraception (EC) provision (percentage of eligible rape survivors presenting to the health services within 120 hours who receive EC pills).
- Timing of PEP provision (percentage of eligible rape survivors who present to the health services within 72 hours and receive PEP).

Indicators to measure annually:

- Number of health workers trained in clinical management of rape survivors.

6 Further reading

Essential

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), 2005. http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/default.asp?bodyID=1&publish=0

GBV Resource Tool: Establishing GBV Standard Operating Procedures (SOP Guide). IASC Sub-Working Group on Gender & Humanitarian Action, May 2008. http://clinicalcare.rhrc.org/docs/gbv_sop_guide_final_may_2008.pdf

Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons. Revised edition. UNHCR/WHO, 2004. http://www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/

Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery, a teacher's guide. Geneva, World Health Organization, 2001. WHO/RHR/01.16. http://www.who.int/reproductivehealth/publications/fgm/RHR_01_16/en/index.html

Additional

Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

Guidelines on Mental Health and Psychological Support in Emergency Settings. IASC, 2007. http://www.who.int/hac/network/interagency/news/mental_health_guidelines_checklist/en/index.html

Gender-based Violence Tools Manual for Assessment & Programme Design, Monitoring & Evaluation in conflict-affected settings. RHRC Consortium. 2004. http://www.rhrc.org/resources/gbv/gbv_tools/manual_toc.html

Multi-country study on domestic violence. http://www.who.int/gender/violence/who_multicountry_study/en/index.html

Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries: Dos and Don'ts (UN Action Guidance Note). www.stoprapenow.org/pdf/UN%20ACTION_Dosand-Donts.pdf