

OPINION NOTE

Responding to the needs of survivors of sexual violence: do we know what works?

Doris Schopper

Doris Schopper is a Professor at the medical faculty of the University of Geneva and Director of the Center for Education and Research in Humanitarian Action (CERAH). She has been involved with Médecins Sans Frontières since 1982 and has chaired the MSF Ethics Review Board since 2002. She is member of the International Committee of the Red Cross.

Keywords: evidence-based programming, medical care, psychosocial support, effectiveness, evaluation, research, sexual violence.



During the past twelve months, the issue of sexual violence in conflict and emergencies has received an unprecedented amount of attention at the highest political and institutional levels. In 2013, the United Kingdom's Department for International Development (DFID) launched a Call to Action to mobilize donors, UN agencies, non-governmental organizations (NGOs) and other stakeholders on protecting women and girls in humanitarian emergencies, culminating in the high-level event "Protecting Girls and Women in Emergencies" in November 2013. As of August 2014, over forty partners (including governments, United Nations (UN) agencies and NGOs) had made commitments to the Call to Action. Furthermore, in June 2014 the "Global Summit to End Sexual Violence in Conflict", co-chaired by the UK Foreign Secretary and Angelina Jolie, Special Envoy for the UN High Commissioner for Refugees (UNHCR), gathered 1,700 delegates and 129 country delegations. In his summary, the chair of the Global

Summit states: “We must apply the lessons we have learned and move from condemnation to concrete action. We must all live up to the commitments we have made.”¹ In September 2014, the United States organized a Call to Action event in New York during the UN General Assembly with the purpose of sharing progress on commitments made in November 2013. It thus seems that efforts to raise awareness about sexual violence in conflict and emergencies and advocate for a much stronger commitment to action are well under way. But is this enough? Is there enough evidence from lessons learned to allow us to increase and improve our response?

The number of guidelines developed in recent years on many aspects of sexual violence in humanitarian settings seems to indicate that we know what to do. The UNHCR first published *Sexual Violence against Refugees: Guidelines on Prevention and Response* in 1995. The implementation of these guidelines was evaluated through an inter-agency process which led to the development of the 2003 *UNHCR Guidelines for the Prevention of and Response to Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons*.² Around the same time, the Inter-Agency Standing Committee had finalized guidance on protection from sexual exploitation and abuse by UN staff³, but its members expressed concern about increasing reports of sexual violence in conflict situations and the lack of a coherent and participatory approach to prevent and respond to this issue. This led to the development in 2005 of the *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*,⁴ which are currently under revision. Since then, more specific aspects have also been addressed in guidance documents.⁵ In addition, many *ad hoc* trainings and some online courses have been developed and implemented in recent years.⁶

- 1 “Chair’s Summary – Global Summit to End Sexual Violence in Conflict”, UK Foreign and Commonwealth Office, 13 June 2014, available at: www.gov.uk/government/publications/chairs-summary-global-summit-to-end-sexual-violence-in-conflict/chairs-summary-global-summit-to-end-sexual-violence-in-conflict (all internet references were accessed in September 2014).
- 2 UNHCR, *Guidelines for the Prevention of and Response to Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons*, May 2003, available at: www.unhcr.org/3f696bcc.html.
- 3 The Inter-Agency Standing Committee Task Force on Protection from Sexual Exploitation and Abuse in Humanitarian Crises was established in March 2002. It provided guidelines for investigations and adopted six standards of behaviour to be included in UN and NGO codes of conduct. In October 2003, the Secretary-General issued a Bulletin entitled *Special Measures for Protection from Sexual Exploitation and Sexual Abuse*, ST/SGB/2003/13, available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N03/550/40/PDF/N0355040.pdf?OpenElement>.
- 4 Interagency Standing Committee (IASC), *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*, September 2005, available at: www.unhcr.org/453492294.html
- 5 See, *inter alia*, World Health Organization (WHO), *Mental Health and Psychosocial Support for Conflict-Related Sexual Violence: Principles and Interventions*, 2012, available at: http://apps.who.int/iris/bitstream/10665/75179/1/WHO_RHR_HRP_12.18_eng.pdf; International Rescue Committee (IRC), UNICEF, *Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings*, 2012, available at: www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf; UNHCR, *Handbook for the Protection of Women and Girls*, March 2008, available at: www.unhcr.org/protect/PROTECTION/47cfae612.html.
- 6 UNFPA offers an e-learning course entitled “Managing Gender-Based Violence Programmes in Emergencies”; see <https://extranet.unfpa.org/Apps/GBVinEmergencies/intro/player.html>. Johns Hopkins University has developed “Confronting Gender-Based Violence”, a course focusing on clinical and

However, recent reviews of interventions to prevent and respond to sexual violence in humanitarian settings have repeatedly pointed to the lack of evidence on which to base interventions. One of the most cited and thorough scientific reviews was published in 2013, examining the impact of initiatives to reduce incidence, risk and harm from sexual violence in conflict, post-conflict and other humanitarian crises, in low- and middle-income countries. Only forty studies were identified in a twenty-year period from 1990 to September 2011. The authors noted that “most interventions addressed opportunistic forms of sexual violence committed in post-conflict settings. Only one study specifically addressed the disaster setting. Actual implementation of initiatives appeared to be limited as was the quality of outcome studies.”⁷ A follow-up review analyzing further evidence of good practice in prevention and response to gender-based violence in humanitarian contexts found that only fifteen of the approximately 100 guidelines, tools, papers, evaluations, studies and other documents reviewed were deemed robust enough to be included on the basis of their quality and relevance.⁸ The authors highlight the lack of evidence on quality and outcomes of interventions and of evidence from regions other than Africa. This has been echoed again by a recent special report in the *Lancet*, which states that “sexual violence in conflict remains a tenaciously difficult problem to study and therefore to address”.⁹

From a public health perspective, this apparent lack of an evidence base for responding effectively to the needs of survivors of sexual violence is worrisome. Evidence-based public health is defined as the development, implementation and evaluation of effective programmes and policies in public health through the application of principles of scientific reasoning, including systematic uses of data and information systems.¹⁰ This provides assurance that decision-making is based on scientific evidence and effective practices, and is particularly important when implementing new programmes. I would like to illustrate the lack of evidence on which humanitarian actors base their responses, and why it matters, with some examples related to different elements of the response; I will then discuss how we could improve the evidence base.

psychosocial care for women and men who are survivors and/or are at risk of gender-based violence; see <http://moodle.ccghe.net/enrol/index.php?id=58>.

- 7 Jo Spangaro, Chinelo Adogu, Geetha Ranmuthugala, Gawaine Powell Davies, Léa Steinacker and Anthony Zwi, “What Evidence Exists for Initiatives to Reduce Risk and Incidence of Sexual Violence in Armed Conflict and Other Humanitarian Crises? A Systematic Review”, *PLOS ONE*, Vol. 8, No. 5, 2013.
- 8 Rebecca Holmes and Dharini Bhuvanendra, “Preventing and Responding to Gender-Based Violence in Humanitarian Contexts”, Network Paper, Humanitarian Practice Network, Overseas Development Institute, No. 77, January 2014.
- 9 Ted Alcorn, “Responding to Sexual Violence in Armed Conflict”, *The Lancet*, Vol. 383, No. 9934, 2014, pp. 2034–2037.
- 10 Ross C. Brownson, Elizabeth A. Baker, Terry L. Leet and Kathleen N. Gillespie, *Evidence-Based Public Health*, Oxford University Press, New York, 2003.

Lack of evidence informing responses to sexual violence

Medical and psychosocial care

Medical care is recognized as a non-negotiable component of programmes to address the needs of survivors of sexual violence. The package of medical care to be provided is well codified and based on scientific evidence.¹¹ This has been adapted to displacement situations by the World Health Organization (WHO)/ UNHCR,¹² and to the needs of a medical humanitarian organization by Médecins Sans Frontières (MSF).¹³ So the question is not *what to do* to prevent and mitigate the health consequences of a sexual assault, but if and how this can effectively be *delivered* in humanitarian settings.

Accessibility of care

One of the main issues is unimpeded and timely access to services, in particular after rape, as some interventions will only be effective in the hours (e.g. treatment of injuries) or few days (e.g. HIV prophylaxis, emergency contraception) after the assault. Post-exposure prophylaxis (PEP) for HIV infection¹⁴ has to be started within seventy-two hours. If the patient presents after seventy-two hours, HIV testing should be offered, with careful explanation that PEP will not be provided, as it is not proven effective after seventy-two hours. Emergency contraceptive pills can effectively prevent pregnancy within the first seventy-two hours after unprotected sexual intercourse. From seventy-two to 120 hours (five days) the preventive treatment can still be given, but the effectiveness is reduced.

Two studies in South Kivu in the Democratic Republic of the Congo (DRC) exemplify how difficult timely access to services can be. A retrospective registry-based study of sexual violence survivors presenting to Panzi Hospital shows that the mean time delay between sexual assault and seeking care was 10.4 months.¹⁵ A different study based on another medico-social support programme for rape survivors showed that only 3% came within seventy-two hours.¹⁶ On a slightly more positive note, in a post-conflict setting in Liberia, 41% of survivors coming to clinics offering care to sexual violence survivors did so within seventy-two

11 WHO, *Guidelines for Medico-Legal Care for Victims of Sexual Violence*, 2003.

12 UNHCR and WHO, *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons*, revised ed., 2004.

13 MSF, *Medical Protocol for Sexual Violence Care*, 2nd ed., May 2014 (unpublished but available on demand).

14 PEP consists of a short-term antiretroviral treatment (twenty-eight days) to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse.

15 Susan A. Bartels, Jennifer Scott, Jennifer Leaning, Jocelyn T. Kelly, Nina R. Joyce, Denis Mukwege and Michael J. Vanrooyen, "Demographics and Care-Seeking Behaviors of Sexual Violence Survivors in South Kivu Province, Democratic Republic of Congo", *Disaster Medicine & Public Health Preparedness*, Vol. 6, No. 4, 2012, pp. 393–401.

16 Birthe Steiner, Marie T. Benner, Egbert Sondorp, Peter Schmitz, Ursula Mesmer and Sandrine Rosenberger, "Sexual Violence in the Protracted Conflict of DRC Programming for Rape Survivors in South Kivu", *Conflict and Health*, Vol. 3, 2009.

hours.¹⁷ Improved uptake of services is mainly judged by an increased number of survivors seeking care, but with no indication of how this relates to overall needs. The study mentioned above explicitly states: “The study limitations are that no data were available about the prevalence of sexual violence or survivor characteristics in the general population in Liberia, and therefore, we cannot accurately quantify which groups were, or were not, seeking care.”¹⁸ While it is difficult to compare between these studies, the higher percentage of survivors accessing services in a timely manner in Liberia could be due to the urban location (three clinics in Monrovia) and to extensive awareness-raising activities within the community.

The reasons for difficulties and delays in access have been documented in various settings. For example, a study in the DRC found that lengthy delays in seeking care were explained mainly by patients waiting for physical symptoms to develop or worsen before seeking medical attention, lack of means to access medical care, concerns that family would find out about the sexual assault, stigma surrounding sexual violence, and being abducted into sexual slavery for prolonged periods of time.¹⁹ However, there is little published evidence on how such issues could be successfully addressed. One programme in an urban slum in Nairobi shows that some of the barriers to early access and to high-quality medical care can be overcome.²⁰ Four years into the operation of a clinic for sexual violence survivors, the number of persons seeking care had greatly increased between 2007 (seven patients) and 2011 (866 survivors treated). In 2011, 73% of patients accessed services within seventy-two hours. Access to care has been facilitated by the geographical proximity of the clinic helping to avoid lengthy travel times, by twenty-four-hour opening times all days of the week (most patients come between 6pm and midnight),²¹ and by the fact that the clinic is well established, having run for several years.²² This model may be replicable in other urban or camp settings. While this project is undeniably a remarkable achievement, however, there is no indication how it relates to the prevalence of sexual violence and care needs in a population of 2.2 million.

To address barriers to access, a community-based programme in the DRC is using mobile clinics in six rural villages.²³ The case study describes how the programme has improved service provision and claims that it allows health

17 Katie Tayler-Smith, Rony Zachariah, Sven Hinderaker, Marcel Manzi, Eva De Plecker, Pieter Van Wolvelaer, Tatiana Gil, Stephan Goetghebuer, Helga Ritter, Luke Bawo and Charlyn Davis-Worzi, “Sexual Violence in Post-Conflict Liberia: Survivors and Their Care”, *Tropical Medicine & International Health*, Vol. 17, No. 11, 2012, pp. 1356–1360.

18 *Ibid.*, p. 1358.

19 S. A. Bartels *et al.*, above note 15.

20 V. Buard, R. Van den Bergh, K. Tayler-Smith, P. Godia, A. Sobry, R. J. Kosgei, E. Szumilin, A. D. Harries and M. Pujades-Rodriguez, “Characteristics, Medical Management and Outcomes of Survivors of Sexual Gender-Based Violence, Nairobi, Kenya”, *Public Health Action*, Vol. 3, No. 2, 2013, p. 110.

21 Personal communication, Dr Annick Antierens, MSF, Geneva, 11 November 2014.

22 Susan A. Bartels, “Sexual and Gender-Based Violence”, *Public Health Action*, Vol. 3, No. 2, 2013, p. 93.

23 Anjalee Kohli, Maphie Makambo, Paul Ramazani, Isaya Zahiga, Biki Mbika, Octave Safari, Richard Bachunguye, Janvier Mirindi and Nancy Glass, “A Congolese Community-Based Health Program for Survivors of Sexual Violence”, *Conflict and Health*, Vol. 6, No. 1, 2012, p. 5.

workers to reach members of the population that are difficult to access; however, it provides no clear evidence for this.

An overarching question thus is how access to and uptake of medical and psychosocial services can be improved in general. Organizations trying to respond to the needs of survivors find that many of them will never come forward to seek help. Stigma, shame, fear of rejection, lack of information, physical distance from the treatment centre, and lack of time and/or money are some of the barriers. While several elements of response have been proposed, the main elements seem to be guaranteeing safety, confidentiality and raising awareness about service availability.²⁴ Spangaro *et al.* hypothesize, based on evidence from the few available studies, that two distinct mechanisms are at play – “There is help for the problem” and “It is safe to tell” – and that both are required to operate concurrently for survivors to use services.²⁵ “There is help for the problem” implies that in order for survivors of sexual violence to get help, it is essential that they are made aware of the availability of services or other responses to provide support or redress. “It is safe to tell” means that survivors of sexual violence can determine that they can safely report assaults or receive help for the problem, without risk of punishment or sanction. The hypothesis is that these two mechanisms will operate positively with respect to survivor care, livelihood, and personnel and legal strategies. It will be important to further deepen this analysis in future studies and to test how these mechanisms can most effectively be operationalized.

Effectiveness of medical care

Beyond early access to service, the completion of follow-up visits is crucial to complete preventive treatments such as hepatitis B and tetanus vaccination and to test for pregnancy and HIV seroconversion²⁶. The above-mentioned study in Nairobi documented a very high attrition rate for follow-up injections for hepatitis B and tetanus vaccination after a high initial take-up. Only 46% of patients received the second follow-up injections for hepatitis B, and even less, 14%, for tetanus. Less than a third of patients returned for repeat HIV testing.²⁷ Similarly, the study conducted on a community-based programme including mobile clinics in the DRC found that 72% of patients returned for the first follow-up visit, with a dramatic drop for the second and third visits.²⁸ This drop occurred despite the provision of mobile clinic consultation four times during

24 MSF, *Shattered Lives: Immediate Medical Care Vital for Sexual Violence Victims*, Brussels, 2009.

25 Jo Spangaro, Anthony Zwi, Chinelo Adogu, Geetha Ranmuthugala, Gawaine Powell Davies and Léa Steinacker, “What Is the Evidence of the Impact of Initiatives to Reduce Risk and Incidence of Sexual Violence in Conflict and Post Conflict Zones and Other Humanitarian Crises in Lower- and Middle-Income Countries? A Systematic Review”, EPPI-Centre, Social Science Research Unit, Institute of Education, University of London, 2013.

26 HIV seroconversion is the interval, after HIV infection, during which antibodies are first produced and rise to detectable levels. Seroconversion takes place within three weeks in most infected individuals.

27 V. Buard *et al.*, above note 20.

28 A. Kohli *et al.*, above note 23.

one month. The authors hypothesize that this may be due to patients “feeling better” and not understanding the need for follow-up consultations.²⁹

Lack of follow-up points to another important issue: even if survivors seek medical care within seventy-two hours and thus are able to receive HIV PEP, is the twenty-eight-day treatment effectively taken? A systematic review of adherence to HIV PEP in victims of sexual assault shows that about 40% of patients default from care.³⁰ This is worrisome, as low adherence is related to a risk of reduced efficacy and increased resistance to antiretroviral therapy. This meta-analysis was based on twenty-four studies, none of them done in severely resource-constrained or conflict settings. The review also points to the lack of objective measures of adherence and the considerable variation in the way in which PEP is offered even in stable settings. A few studies examined causes for non-adherence to PEP, mainly identifying occurrence of side effects and lack of follow-up.

These are just some illustrations of the lack of evidence available on how to provide effective medical care to survivors of sexual violence in humanitarian settings. Further issues that would merit closer attention are prevention of pregnancy after rape and access to safe abortion services.

Mental health and psychosocial interventions

Interventions to address the mental and social consequences of sexual violence have increasingly been implemented in recent years, supported by the development of several sets of guidelines.³¹ However, the gap between widely promoted practices, such as psychological first aid, and knowledge on effectiveness of interventions is worryingly wide, as demonstrated by two recently published systematic reviews on psychosocial support interventions in conflict settings. In the first of these, a wide search of relevant articles on mental health and psychosocial support for victims of sexual violence in armed conflict settings published up to August 2011 returned 189 publications that ultimately allowed the authors to identify seven relevant studies.³² The conclusions of the authors are:

The seven studies, while very limited, tentatively suggest beneficial effects of mental health and psychosocial interventions for this population, and show feasibility of evaluation and implementation of such interventions in real-life settings through partnerships with humanitarian organizations. Robust

29 *Ibid.*, p. 7.

30 Liza Chacko, Nathan Ford, Mariam Sbaiti and Ruby Siddiqui, “Adherence to HIV Post-Exposure Prophylaxis in Victims of Sexual Assault: A Systematic Review and Meta-Analysis”, *Sexually Transmitted Infections*, Vol. 88, No. 5, 2012, pp. 335–341.

31 IASC, *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, 2007, available at: www.who.int/hac/network/interagency/news/mental_health_guidelines/en/; Kaz De Jong, *Psychosocial and Mental Health Interventions in Areas of Mass Violence: A Community-Based Approach*, MSF Guideline Document, 2nd ed., 2011, available at: www.msf.org/sites/msf.org/files/old-cms/source/mentalhealth/guidelines/MSF_mentalhealthguidelines.pdf.

32 Wietse Tol, Vivi Stavrou, Claire Greene, Christina Mergenthaler, Mark van Ommeren and Claudia Garcia Moreno, “Sexual and Gender-Based Violence in Areas of Armed Conflict: A Systematic Review of Mental Health and Psychosocial Support Interventions”, *Conflict and Health*, Vol. 7, No. 1, 2013, p. 16.

conclusions on the effectiveness of particular approaches are not possible on the basis of current evidence.

This very sobering statement is supported by the latest systematic review, published in March 2014.³³ Sixteen studies were identified, only four of which were published since 2011. Although some substantial improvements in certain outcomes could be demonstrated, the small number of studies and lack of comparability between studies does not allow any strong conclusions. The major challenges to creating a relevant evidence base for mental health and psychosocial support interventions are the large variety of interventions proposed, ranging from counselling to specific psychotherapeutic approaches or a mix of these and/or additional psychotropic drug treatment; the timing (as related to the sexual assault) and length of treatment; the differing professional level and origin (national or non-national) of health professionals; the different outcome measures used to assess effectiveness; and finally, the range of research designs, from descriptive case studies to randomized controlled trials. Another review examining evidence on mental health and psychosocial support in general in humanitarian settings (not specifically related to sexual violence) finds that the most rigorous available evidence currently supports practices that are complex and less likely to be implemented – that is, specialized interventions for Posttraumatic Stress Disorder (PTSD) and depressive outcomes.³⁴ Very little evidence exists for the most frequently promoted interventions, such as psychological first aid, community-based support and structured social activities.

Economic and legal support

Beyond medical and psychological care, survivors of sexual violence may need and wish for economic and legal support. Because victims of sexual violence are often rejected by their families and communities and are unable to work as they used to before the assault, economic support is essential in the rehabilitation process. It should allow them to meet essential needs (food, household items, etc.) and should facilitate their socio-economic reintegration (livelihood strategies, economic empowerment). Beyond immediate survival, the idea is that economic support should bolster self-esteem, facilitate the healing process and increase self-sufficiency, in particular when victims are rejected by their relatives. However, there are no published studies examining which types of short-term and medium-term economic support have achieved meaningful impacts for survivors.³⁵ This may be due to the fact that interventions in this area are much less standardized and are even more context-dependent than in the case of medical and psychosocial support.

33 Kaz de Jong, Jeroen W. Knipscheer, Nathan Ford and Rolf J. Kleber, “The Efficacy of Psychosocial Interventions for Adults in Contexts of Ongoing Man-Made Violence: A Systematic Review”, *Health*, Vol. 6, No. 6, 2014, pp. 504–516.

34 Wietse Tol and Mark van Ommeren, “Evidence-Based Mental Health and Psychosocial Support in Humanitarian Settings: Gaps and Opportunities”, *Evidence-Based Mental Health*, Vol. 15, No. 2, 2012, pp. 25–26.

35 J. Spangaro *et al.*, above note 25.

Allowing survivors to seek redress for the sexual offence is an important element of a comprehensive response. However, impunity for perpetrators of sexual violence is still widespread and access to justice for survivors is limited. Access may be hampered either because survivors of sexual violence do not seek to access justice due to the stigma, shame, humiliation and trauma involved, or because legal services and justice mechanisms are unavailable or inefficient. Survivors may have a lack of trust in national justice and police and may be afraid of experiencing further violence. A recent working paper provides a comprehensive overview of the challenges arising in investigation and prosecution of sexual violence and highlights some promising strategies in the handling of sexual violence cases.³⁶ In particular, it describes some interesting examples of strategies to improve access, mainly in the DRC, including an integrated model of medical and legal services (“one-stop shops”), using persons trained in legal issues within health facilities, setting up small legal clinics in remote areas, and establishing mobile courts. Some of these approaches have led to a remarkable increase in the number of cases filed and prosecuted, but it is not clear how this relates to overall needs and what the impact on survivors has been.

It would be well beyond the scope of this opinion note to examine in detail issues related to investigation and prosecution.³⁷ The central question here is whether legal services respond to the needs of survivors. One would want to know which type of legal set-up would best allow survivors who wish to seek redress to access the legal system; whether entering the justice system is beneficial or harmful to the survivor; and whether the outcomes are relevant to improving the quality of life of the survivor. In the review by Spangaro *et al.*, six studies examining the outcomes of legal interventions are mentioned, including global, national and local jurisdictions.³⁸ None of the studies explicitly attempt to assess the impact on the survivors. However, four studies provide some evidence of an increase in harm mainly related to lack of support during and retribution after testifying. While it has been recognized that reparations are the most significant means of making a difference in the lives of victims,³⁹ reparation programmes are largely unimplemented and their impact is not evaluated.⁴⁰

Overall it seems that while many efforts are currently under way to address the widespread persistence of impunity and to reduce risks to survivors seeking justice, the evidence on what works best, even in a specific context, is still sketchy.

36 Kim T. Seelinger, Helen Silverberg and Robin Mejia, “The Investigation and Prosecution of Sexual Violence”, Sexual Violence & Accountability Project, Working Paper Series, University of California, Berkeley, CA, May 2011.

37 On efforts to prosecute sexual violence crimes at the national level, see, *inter alia*, the article by Kim Seelinger in this issue of the *Review*.

38 J. Spangaro *et al.*, above note 25.

39 UN Security Council, “The Rule of Law and Transitional Justice in Conflict and Post-Conflict Societies: Report of the Secretary-General”, S/2011/634, 12 October 2011, para. 26.

40 Ruth Rubio-Marín, “Reparations for Conflict-Related Sexual and Reproductive Violence: A Decalogue”, *William & Mary Journal of Women and the Law*, Vol. 19, No. 1, 2012, pp. 69–104.

Addressing the needs of men and boys

The extent of sexual violence against men and boys in armed conflict has only very recently been recognized and received attention.⁴¹ In a cross-sectional population-based survey in the DRC, almost a quarter of men reported lifetime exposure to sexual violence, two thirds of which was conflict-related.⁴² However, most if not all the studies mentioned above focus on female survivors of sexual violence, mostly women, sometimes girls and adolescents. It thus appears that if the evidence base for responding to the needs of female survivors of sexual violence is sketchy, it is absent with respect to male survivors. Some guidance on how to address their needs has been recently provided by the UNHCR,⁴³ but no studies on how to address the particular challenges in supporting them and respond effectively to their needs exist.

After this rather sobering overview of the scientific evidence on which we currently base our programmatic response to the needs of survivors of sexual violence, the question is if and how we can improve this dire state of affairs.

Can we improve the evidence base?

As noted by Spangaro *et al.*, an “overarching finding” from their review “is the acute lack of rigorous impact evaluations of interventions, leading to an insufficiency of clear evidence for effective interventions to address or prevent sexual violence”.⁴⁴

It may not be surprising that the evidence to inform the response to sexual violence is rather sketchy and not well established. Sexual and gender-based violence in general have received attention in the public health world only relatively recently. In 2002 the World Health Organization (WHO) report on violence and health for the first time stated that “[s]exual violence is a common and serious public health problem”, described the extent of the problem and provided guidance for effective responses⁴⁵. Recognizing the need for more research on sexual violence, especially in resource-poor settings, the Global Forum for Health Research established the Sexual Violence Research Initiative (SVRI) with the support of WHO in 2003.⁴⁶ Acknowledging the continued dearth of systematic information

41 Dustin A. Lewis, “Unrecognized Victims: Sexual Violence against Men in Conflict Settings under International Law”, *Wisconsin International Law Journal*, Vol. 27, No. 1, 2009, pp. 1–49; Chris Dolan, “Into the Mainstream: Addressing Sexual Violence against Men and Boys in Conflict”, briefing paper for the workshop held at the Overseas Development Institute, London, 2014.

42 Kirsten Johnson, Jennifer Scott, Bigy Rughita, Michael Kisielewski, Jana Asher, Ricardo Ong and Lynn Lawry, “Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo”, *Journal of the American Medical Association*, Vol. 304, No. 5, 2010, pp. 553–562.

43 UNHCR and Refugee Law Project, “Working with Men and Boy Survivors of Sexual and Gender-Based Violence in Forced Displacement”, UNHCR, Geneva, July 2012.

44 J. Spangaro *et al.*, above note 25.

45 Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi and Rafael Lozano, *World Report on Violence and Health*, WHO, Geneva, 2002.

46 See the SVRI website at: www.svri.org/about.htm.

on the scope and effectiveness of programmes that prevent and respond to conflict-related sexual violence, WHO in collaboration with the SVRI developed a research agenda on sexual violence in conflict and post-conflict settings in 2012.⁴⁷ However, the invisibility and highly sensitive nature of sexual violence poses serious challenges for any data-gathering activity, and more so in emergency situations characterized by high insecurity, fear, dependence and a breakdown of societal structures. The question thus is which type of programmatic evidence an organization addressing sexual violence can and should gather at a minimum, and how one could move from monitoring towards methodologically sound evaluations, if not research.

Assessing the impact of programmes

Currently there is little internationally recognized guidance on how to monitor and evaluate programmes addressing the needs of survivors of sexual violence. A tools manual published by the Reproductive Health Response in Conflict Consortium in 2004 only proposes very broad “output and effect indicators”, mainly geared at refugee settings.⁴⁸ While WHO has published a remarkable document on ethical and safety issues related to data collection,⁴⁹ no similar guidance exists to date on data that should be gathered to assess the adequacy and impact of various aspects of sexual violence programmes. This implies that every organization designs its own set of indicators, data-gathering methods and impact measures, if such elements exist at all. To be able to compare implementation and impact of programmes across settings and across organizations, it would be imperative to agree on a standard set of indicators that could be complemented and enhanced depending on the specific context. This should include output (e.g. number of persons treated) as well as outcome measures, which is challenging as it implies agreeing on the desired outcome and being able to measure it. This may be relatively simple when applied to other public health problems: for example, one of the outcomes of a malaria control programme may be the number of persons cured (no longer infected) and/or a decreased malaria infection rate in the population; in the case of a nutritional programme, measurable outcomes may be improved nutritional status of individuals and of the target population (e.g. children under 5). But what are the indicators of success in a programme addressing sexual violence? In a programme providing medical care, important indicators could be, on the one hand, the proportion of all survivors accessing care, and on the other hand, the proportion of those accessing care who do so within seventy-two hours.

47 SVRI, *Executive Summary – A Research Agenda for Sexual Violence in Humanitarian, Conflict and Post-Conflict Settings*, WHO, Stop Rape Now, MRC South Africa, SVRI, available at: www.svri.org/ExecutiveSummary.pdf.

48 Reproductive Health Response in Conflict Consortium, *Gender-Based Violence Tools Manual: For Assessment & Program Design, Monitoring & Evaluation in Conflict-Affected Settings*, New York, February 2004.

49 WHO, *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, WHO, Geneva, 2007.

Regarding the first of these indicators, there is wide agreement that it is difficult to measure the extent of sexual violence in a given context. A recent systematic review of studies estimating the prevalence of sexual violence among refugees and displaced persons in humanitarian emergencies identified only nineteen studies, showing a wide range of prevalence estimates and also the enormous variation in study methodology.⁵⁰ In addition, it may be harmful and unethical to collect data on prevalence or incidence of sexual violence before responding to the needs of survivors.⁵¹ Thus, as it is rarely possible to estimate the overall number of survivors needing care, the first indicator, although desirable to indicate the impact of a programme, is probably not realistic in most settings. Therefore, we may have to rely on numbers of survivors coming for treatment and consider increasing numbers over time a success in and of itself. While such a metric will not tell us to which extent a programme covers the needs of a population, it can indicate that services are accepted and used. Regarding the second indicator proposed, the proportion of all survivors accessing care who do so within seventy-two hours is crucial to measuring the accessibility of services and gives a first indication of the potential effectiveness of services. Based on routine clinical data collected during the initial patient interview, this indicator is relatively easy to measure.

But none of these indicators will tell us if services provided are effective in achieving desired outcomes, such as prevention of HIV infection or prevention of pregnancy. We also do not know what the impact of early access to psychosocial services (psychological first aid) will be on the mental well-being of the survivor. To truly measure the effectiveness of these services, at least some more refined indicators should be determined and measured. Moreover, indicators do what they say: they indicate if an activity is achieving the desired results or not. An indicator does not tell us why these results were achieved or why we failed. It is thus essential to complement quantitative impact measures with qualitative assessments that allow us to better understand why things do not work and how they could be improved. These could include semi-structured interviews with survivors and focus group discussions in the community, with survivors, with care providers and with authorities. Such information gathering must be done with the utmost care to avoid risks to respondents and communities.⁵²

One attempt to collect, store and share data on gender-based and sexual violence should be briefly mentioned: the Gender-Based Violence Information Management System (GBVIMS).

The GBVIMS is a response to the fact that as of today, the humanitarian community does not have a system that allows for the effective and safe

50 Alexander Vu, Atif Adam, Andrea Wirtz, Kiemanh Pham, Leonard Rubenstein, Nancy Glass, Chris Beyrer and Sonal Singh, "Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: A Systematic Review and Meta-Analysis", *PLOS Currents Disasters*, Edition 1, 18 March 2014.

51 WHO, above note 49, p. 15.

52 *Ibid.*

collection, storage, analysis and sharing of GBV-related data. This affects humanitarian actors' ability to obtain a reliable picture of the GBV being reported. It also minimizes the utility of collected data to inform program decisions for effective GBV prevention and care for survivors.⁵³

The GBVIMS is mainly driven by UN organizations, the Steering Committee being made up of representatives from the International Rescue Committee (IRC), UNHCR, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and WHO. It focuses on incident reports of gender-based violence, but does not capture a survivor's data over time and cannot monitor the quality of programme interventions. Although a remarkable effort to standardize information collected on cases of sexual violence, its usefulness is thus very limited in relation to monitoring services, let alone evaluating their effectiveness.

It would already be a great step forward if monitoring and evaluation of programmes for survivors of sexual violence were implemented in a systematic, coherent and more standardized way. A set of measurable and meaningful output and outcome indicators should be developed for the different components of a programme responding to the needs of survivors, with medical and psychosocial care being at the centre of the response and thus also the central focus of monitoring and evaluation activities. A further step would be to openly share results of quantitative and qualitative evaluations, including both successes and failures, within organizations and across organizations.

Can and should we do operational research?

A question frequently asked is: what do we mean by research as compared to evaluation? Would a methodologically well-conceived evaluation not be considered as research? There may be at times confusion or overlap between evaluation activities and conducting research. An important concept to clarify in this respect is operational research. From a public health perspective, this is the search for knowledge on interventions, strategies or tools that can enhance the quality, effectiveness or coverage of programmes in which the research is being done.⁵⁴ A strong connection exists between good monitoring and evaluation of programmes and operational research. For example, routinely collected quality data on survivors and treatment outcomes can be used to do operational research. Many of the studies referenced in the sections on accessibility and effectiveness of (medical) care above have used data routinely collected during service provision to analyze in more detail some of the treatment outcomes. Retrospectively analyzing data that has already been collected is the simplest way of conducting operational research. More sophisticated, resource-intensive and

53 See the GBVIMS website at: www.gbvim.org.

54 Rony Zachariah, Anthony D. Harries, Nobukatsu Ishikawa, Hans L. Rieder, Karen Bissell, Kayla Laserson, Moses Massaquoi, Micheal Van Herp and Tony Reid, "Operational Research in Low-Income Countries: What, Why, and How?", *The Lancet Infectious Diseases*, Vol. 9, No. 11, 2009, pp. 711–717.

ethically challenging methods of operational research are cross-sectional surveys and prospective cohort analyses. Beyond methods used in operational research, randomized controlled trials are the most rigorous way of determining whether a cause-effect relationship exists between treatment and outcome and for assessing the effectiveness of a treatment. Although they can be powerful research tools, their use is limited by ethical concerns and practical constraints. Some of the studies examining the efficacy of psychosocial interventions have used a randomized controlled or just a controlled research design (comparing between two interventions without randomly allocating people to one or the other). While a (randomized) controlled trial determines the efficacy of an intervention, operational research assesses effectiveness within routine settings. In the field of sexual violence, one would thus mostly conduct operational research, a controlled trial remaining the very rare exception.

A further question is: can and should we do research in highly insecure and volatile settings? While methodologically and ethically sound evaluation of programmes for survivors of sexual violence is not an easy endeavour, the issue of research is even more complex. The difficulty of conducting research in fragile settings is illustrated by two examples. A recent review of research on the effectiveness of health interventions in humanitarian crises in general identified only three papers on gender-based violence out of 706 studies.⁵⁵ A search of the MSF's field research site retrieved five peer-reviewed papers related to sexual violence and twenty-seven related to violence in general (including sexual violence). This compares to 262 papers on an HIV-related subject. The scarcity of research may be due to the lack of attention given to the issue until very recently, to difficulties in designing methodologically sound research, and/or to ethical concerns around conducting research in unstable and highly vulnerable contexts.

The overarching considerations in answering the question of whether it is desirable to do operational research in these contexts are: (1) will the benefits to survivors and the community be greater than the risks incurred by participating in the research, and (2) can the research question only be answered in a conflict setting? The value of conducting research in conflict zones must indeed be carefully considered: if the research question(s) could as well be answered by research in post-conflict or other fragile settings, this would be ethically more acceptable.⁵⁶ I will provide two examples to illustrate my point. There is wide agreement that access, and in particular early access, to medical and psychosocial services is paramount to effectively responding to the needs of survivors. Testing new service models to increase access is essential to improving our response. These have to be tested in conflict and post-conflict settings to be relevant. However, one would rather do this research in controlled settings such as refugee camps (e.g. Syrian refugees in Jordan), in violent urban settings (e.g. Mexico,

55 Karl Blanchet, Vera Sisténich, Anita Ramesh *et al.*, "An Evidence Review of Research on Health Interventions in Humanitarian Crises", Final Report, London School of Hygiene and Tropical Medicine, London, 22 November 2013.

56 Nathan Ford, Edward Mills, Rony Zachariah and Ross Upshur, "Ethics of Conducting Research in Conflict Settings", *Conflict and Health*, Vol. 3, No. 1, 2009, p. 7.

Honduras) or in protracted conflict settings (e.g. the DRC) than in highly insecure conflict areas such as, currently, South Sudan, the Central African Republic or Syria. Similarly, research to test and compare different psychological interventions should rather be done with survivors of sexual violence in stable, post-conflict settings than during acute conflicts mainly because of ethical issues and insecurity. Promising interventions can then be applied and evaluated during a conflict. This implies that the intervention tested is to some extent replicable and can thus be adapted for survivors in different contexts.

The only publicly available research agenda for sexual violence in humanitarian, conflict and post-conflict settings is the one proposed in 2012 by WHO and the SVRI.⁵⁷ Some of the thematic areas focus on the effectiveness of programmes to respond to conflict-related sexual violence. A next step should be to refine this research agenda, involving humanitarian organizations actively engaged in the response, and to explore possible methodological approaches to answering some of the most burning questions.

Conclusion

The review of the published literature shows that we have many gaps in our knowledge. We know a small amount about providing services to female survivors of sexual violence in emergency and conflict situations, most of it from African settings. We know very little about responding to the needs of men and boys, and there are virtually no publications on the response to sexual violence during natural disasters. Amnesty International documented the dramatic increase in rape and other forms of gender-based violence in Haiti's camps after the earthquake, pointing to the inadequacy of the measures put in place to prevent and respond to sexual and gender-based violence.⁵⁸ While the increased incidence of rape and other sexual abuse of women and girls displaced in the aftermath of natural disasters has lately received more attention, and while some of the interventions may be similar to those applied in conflict settings, one would at least wish for a thorough evaluation of the response.

We thus have to be aware of the limitations of our knowledge of what works, and how it works, to address sexual violence in crises. This may imply that some of the interventions proposed and implemented do not work or are not as effective as we would hope them to be. However, this opinion note does not want to imply that we should wait for better evidence to do something. We should continue doing what we think may work using common sense and the available (scientific) information. At the same time, we should strive to do better and thus undertake much more stringent evaluations and if possible some

57 SVRI, above note 47.

58 Amnesty International, "Aftershocks: Women Speak Out against Sexual Violence in Haiti's Camps", London, 2011, available at: www.amnesty.org/en/library/asset/AMR36/001/2011/en/57237fad-f97b-45ce-8fdb-68cb457a304c/amr360012011en.pdf.

research as is suitable and feasible. As this will be a bumpy road, made of trials and errors, we must have the willingness and courage to share not only our successes but also our difficulties and failures. The sharing of lessons learned is essential to advance our common knowledge base. This may not necessarily happen during large, high-level events, but may rather need smaller workshops and conferences to allow honest and in-depth exchanges.