Monitoring Interventions to Respond to Sexual Violence in Humanitarian Contexts

Sara Davis, Doris Schopper and Julia Epps

Sexual violence in conflict settings is recognized as a war crime, constituting a grave violation of human rights. This article compares and contrasts sexual violence intervention monitoring and evaluation (M&E) tools recommended by the Inter-Agency Standing Committee and indicators used by leading international humanitarian organizations to monitor and evaluate medical care, mental health care and psychosocial support, and legal aid services for survivors of sexual violence in humanitarian contexts. We find that few organizations have published their M&E tools. Among those that have, there is a wide diversity of definitions and indicators, creating knowledge gaps on what works, especially around less-studied populations such as male survivors. This study finds methodological and epistemological questions in the use of quantitative indicators in contexts of stigma, violence, and discrimination and challenges in mainstreaming sexual violence interventions in health.

Sexual violence is recognized by World Health Organization (WHO) as having serious impacts on physical, mental, sexual and reproductive health.[1,2] Sexual violence can result in immediate and acute physical injuries, even in some cases fatalities. It can result in chronic health problems; gynecological disorders; sexually transmitted infections, including HIV; adverse mental health outcomes, including depression, suicide attempts, and anxiety disorders; and more.[3] In conflict settings, sexual violence is recognized as a war crime, constituting a grave violation of human rights.[4] Addressing these humanitarian contexts,[5] international attention by global governance agencies to the problem of sexual violence in humanitarian settings has increased in recent years.[6] This has included the recognition of sexual violence under the Rome Statute, resolutions by the United Nations (UN) Security Council, the 2009 establishment of a UN Special Representative of the Secretary-General on Sexual Violence in Conflict, and a 2014 Global Summit to End Sexual Violence in Conflict.[7] In 2016, UN member states recognized the importance of addressing sexual violence in the Sustainable Development Goals (SDGs), with target 5.2, which aims to "eliminate all forms of violence against all women and girls," presumably including in humanitarian settings.

Yet, 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. It examined the impact of initiatives in low- and middle-income countries to reduce the incidence, risk, and harm from sexual violence in conflict, post-conflict, and other humanitarian crises. Only 40 studies were identified in a 20-year period from 1990 to September 2011.[8] 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.[9]

A follow-up review, analyzing further evidence of good practices in prevention and response to gender-based violence in humanitarian contexts, found that only 15 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.[10] The lack of evidence on the outcomes of interventions, and lack of evidence from regions other than Africa, were highlighted and echoed again in a special report in the *Lancet*.[11] Similarly, a consultation with experts organized by the Georgetown University Global Women's Institute in early 2017 noted gaps in evidence, including on service mapping and utilization, baseline data, monitoring reports and evaluation results, and qualitative data, including personal accounts.[12]

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) upholds the right to the highest attainable standard of health.[13] General Comment No. 14 analyzes this right as including the elements of availability, accessibility, acceptability, and quality, with the "quality" element meaning that goods and facilities are "scientifically and medically approved."[14] Article 15 of the ICESCR also upholds the right of everyone "to enjoy the benefits of scientific progress and its applications."[15] Yet meeting, and in some cases even defining, these scientific standards in sexual violence programming poses methodological, ethical, and logistical challenges.[16]

Some of the challenges are inherent in the nature of sexual violence. While widespread, sexual violence is largely under-reported; survivors[17] tend to avoid disclosing their attacks due to stigma and fear of retaliation, and humanitarian programs have been slow to incorporate the issue into their respective mandates. In some contexts, where survivors may be blamed, expelled from their communities, or even subject to honor killings, the very process of gathering data in order to build a sounder evidence base carries the real risk of causing further harm. In humanitarian settings, where resources are constrained, there are further challenges to data-gathering: urgent priorities often take precedence over routine tasks such as monitoring and evaluation (M&E), services are frequently interrupted, and medical facilities are sometimes vulnerable to attack.[18] Even when sound M&E practices can be implemented, they may not be sustainable for the length of time needed to create robust evidence, as projects in humanitarian settings are sometimes only implemented for short time-periods.[19]

Currently, there is little internationally-recognized guidance on how to monitor and evaluate programs addressing the needs of survivors of sexual violence. Few organizations have chosen to publish their M&E indicators or tools externally. As a result, it appears that each organization designs its own set of indicators, data-gathering methods and impact measures without reference to (or often, access to) those used by peer organizations. In order to compare implementation and impact of programs across settings and across organizations in this newly-emerging area of global health governance, the evidence base for programs to meet the needs of survivors would be strengthened if there were a standard approach to M&E that could be complemented and enhanced to meet the needs of specific contexts.

In this article, we examine M&E guidance and indicators used by some leading UN agencies, intergovernmental organizations, and nongovernmental organizations (NGOs) to monitor and evaluate programs that provide medical care, mental health and psychosocial support (MHPSS), and legal aid services to survivors. Our aim is to assess whether the indicators currently published by different agencies show commonalities, where gaps exist, and where further thinking may be needed as research, monitoring, and evaluation develop in the field.

METHODOLOGY

We gathered information on guidance and tools to monitor and evaluate programs responding to sexual violence in conflict settings by writing to and/or visiting the websites of international organizations that are particularly active in this area. These included the International Committee of the Red Cross (ICRC), International Rescue Committee (IRC),

WHO, United Nations High Commissioner for Refugees (UNHCR), and the United Nations Population Fund (UNFPA).[20] Other organizations shared indicators for background use only. We also consulted guidelines developed in consultation with these and other agencies by the Inter-Agency Standing Committee (IASC) and the Reproductive Health Response in Conflict (RHRC) Consortium. While the IASC guidelines focus on prevention and mitigation of sexual violence, they include some response programs, and thus were included in this study.[21] The International Federation of the Red Cross (IFRC) has a pilot set of standards for interventions that only address prevention and mitigation, and thus these were not included in the study.[22]

Based on our review of these published and off-the-record materials, we identified 76 indicators that were classified by the organizations as used to monitor and evaluate medical care services (47 indicators), MHPSS (19 indicators), and legal aid services (10 indicators). We collected the indicators on Excel spreadsheets, following the categorization used by the organizations, although, as discussed below, these categorizations sometimes varied among organizations. While we focused on guidance that addressed M&E of programs responding to sexual violence specifically in humanitarian settings, we also consulted guidance designed for developmental and other contexts.

To compare and contrast the indicators, we begin by exploring the similarities and differences in institutional approaches and programmatic activities for sexual violence. Indicators should measure the outputs of programs and their impact, but to do so, there must be some agreement on what those programs are and how they are measured. Different programs and approaches will result in different indicators.

We then focus on analyzing indicators for three specific areas: medical care, mental health care/psychosocial support, and legal aid services. We focused on these three types of interventions as medical care and mental health care are commonly agreed to be essential services; given that sexual violence in conflict is both a violation of human rights standards and is recognized as a war crime, legal aid for survivors is also critical. We found little or no M&E guidance or indicators for some other areas commonly understood to be part of the response, such as protection.

DIFFERING INSTITUTIONAL MANDATES

Sally Merry's study of human rights indicators, in particular indicators used to measure violence against women, notes the differing institutional and cultural understandings that can shape the development of indicators used in global governance. At the global level, "conceptions of violence and of the relationships and social structures within which it occurs are highly variable. Moreover, what constitutes violence against women is highly contested."[23] Likewise, our review found that agencies position themselves differently in terms of the scope of the problem, nature of the problem, and prioritized responses for sexual violence. These differing positions in what is still an emerging field also shape interventions, language, and approaches to M&E.

For example, some organizations emphasize addressing sexual violence in conflict settings, as do the Sphere Project guidelines, which assert that humanitarian actors must respond to sexual violence as part of a minimum humanitarian standard for the emergency response.[24] Other organizations view sexual violence as one part of a larger spectrum of "sexual and gender-based violence."[25] IASC frames the issue even more broadly, defining gender-based violence as rooted in the socio-economic inequality between women and men.[26] Institutions also diverge in their understanding of whether the "gender" in "gender-based violence" (GBV) should include violence experienced by men.[27]

Institutions take different approaches to programming and measurement that reflect these differences in focus and emphasis.

DEFINING PROGRAMMATIC INTERVENTIONS

In order to compare indicators, we aimed to first identify a set of core programs that could be monitored and evaluated comparably. However, in part because of the differing institutional mandates discussed above, we found significant diversity in terms of which institutions emphasized which types of programs. Institutions that define their mandate more broadly tend to recommend a broad array of types of interventions, and recommend ways to integrate them into other programs. Institutions with narrower mandates tended to emphasize the importance of the types of programs in which they have specific expertise.

The IASC guidelines are based on a broader analysis of gender-based violence as rooted in socio-economic inequalities. Thus, the IASC guidelines emphasize integration of GBV response services into cross-cutting humanitarian programming areas. The 2015 edition of the guidelines aim to integrate GBV interventions in 13 thematic areas: camp coordination and camp management; child protection; education; food security and agriculture; health; housing, land, and property; humanitarian mine action; livelihoods; nutrition; protection; shelter, settlement, and recovery; water, sanitation, and hygiene; and humanitarian operations support sectors. However, one result of this emphasis on mainstreaming is that such technically complex areas as mental health and psychosocial support or legal aid services, normally addressed with standalone programs, are discussed only briefly as sub-topics within other thematic areas, such as child protection and housing.[28]

UNFPA's *Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies*, which draws extensively on the IASC guidelines, has its own slightly different emphasis. The UNFPA *Minimum Standards* give significant emphasis to some areas neglected in the IASC guidelines, such as MHPSS and legal aid, but do not specifically address child protection.[29] UNHCR's approach differs slightly, in that it emphasizes integration of prevention and response interventions across other humanitarian programming for refugees. UNHCR has defined a list of 48 "essential actions" for addressing sexual and gender-based violence (SGBV), selected based on the institution's review of published guidance and on consultation with other agencies.[30] The 48 essential actions include, for example, establishing medical referral systems for survivors, promoting community-based watch groups, establishing separate latrines for men and women, providing training to staff, and others.[31] UNHCR's monitoring and evaluation report on this project focuses on an initiative to place senior protection officers in diverse contexts in order to put these 48 essential actions into place, and evaluates the degree to which the 48 actions are completed. UNHCR has a broader approach to evaluating the outcomes and impact of the 48 actions, but it is not externally published.

ICRC's *Addressing the Needs of Women Affected by Armed Conflict* outlines recommended interventions within the areas of medical/health assistance, psychological support, economic assistance, social/community healing, and reporting violations. ICRC's approach to M&E differs from other organizations examined for this study in that it monitors and evaluates MHPSS and primary health care interventions for adult and child victims of violence in general, without distinguishing sexual violence.[32]

In short, there is as yet no single core package of interventions for sexual violence survivors agreed among all institutions: some emphasize mainstreaming, while others emphasize specific types of programming. There are a number of commonalities: all of the agencies emphasize access to emergency medical care and the need for adequate training and technical support for field staff; all agencies also recommended meaningfully including women in stakeholder consultation and governance mechanisms.

Given that there are diverse views among institutions on what should constitute a core package of services for survivors, it is natural that our review of indicators also found that organizations take diverse approaches to M&E.

ANALYSIS OF INDICATORS

We grouped indicators according to area of intervention (medical care, mental health and psychosocial support, and legal aid) and identified whether each was an input, output, process, or outcome indicator. Input indicators measure the resources invested in a program: availability of supplies, personnel, or facilities. Output indicators measure the quantity of services or persons served (e.g., number of completed training courses). Process indicators measure how goods and services are provided. Outcomes are the broader results of the services, whether on the program, the agency, or the community at large.

Generally, medical care M&E approaches appear most clearly defined, although they tended to focus on inputs and outputs rather than on medical outcomes. We found that there is much less definition of services and indicators for MHPSS and legal aid, although somewhat more inclusion of output indicators. In some cases, we found indicators that were irrelevant to the area being evaluated.

Medical Care

Significant evidence exists for the medical care services to be provided to sexual violence survivors.[33] Here, we found clearer alignment on interventions than in the other two areas studied. There were also more areas of overlap in terms of indicators recommended than in the areas of mental health and legal aid. However, we found an overall emphasis on input and output indicators, and little guidance on measuring health outcomes. Some indicators also appeared to rely on unclear denominators, as further explored below.

WHO's *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* provides a checklist of recommended interventions, which includes gathering forensic evidence; prevention of sexually transmitted infections (STIs) and HIV (providing care is sought within 72 hours of the incident); emergency contraception; wound care; prevention of tetanus and hepatitis B; counseling; and referrals to mental health care.[34] This set of services appears to be consistently offered by others: for instance, MSF's *Medical Protocol for Sexual Violence Care* outlines a similar list of services.[35] MSF was one of the first providers of medical care to sexual violence survivors in conflict settings, and it offers an evidence-based package of clinical services to survivors in diverse settings.[36] Since 2004, the Sphere Project's *Humanitarian Charter and Minimum Standards in Disaster Response* has also included the *Minimum Initial Service Package (MISP) for Sexual and Reproductive Health*, including many of the same services as those recommended by WHO.[37]

While overall this is commendably consistent, it was concerning that none of the medical guidelines we reviewed either addressed the medical needs of either male or transgender survivors of sexual violence or had recommendations for monitoring or evaluating services for those populations. Moreover, despite evidence of links between unsafe abortion and high rates of maternal mortality, MSF is one of the few organizations with an explicit policy on the provision of abortions.[38] WHO's guidelines only recommend that women who are pregnant as a result of rape "be offered abortion, *in accordance with national law*" (emphasis added).[39]

We collected 49 indicators that measure health services from ICRC, RHRC, IASC, and other organizations that requested their materials be used only for background reference. Many of these indicators focused on input or output of services. ICRC, IASC, and RHRC each had indicators that looked solely at the number of sexual violence or GBV reports received at health centers, as well as indicators that aimed to measure access to medical care by survivors. Consistent with the MISP, ICRC and RHRC monitor the number of rape victims to access services within 72 hours, a critical window for HIV pre-exposure prophylaxis. IASC recommends a number of indicators that measure availability of services,

coverage of supplies, and training of staff on GBV. We found relatively few process or output indicators for medical care.

We also found some areas of concern. IASC's recommended indicators for health do not monitor and evaluate medical care itself, but emphasize planning and administration: for example, the "number of non-health sectors consulted with to address GBV risk-reduction activities as a percentage of number of existing non-health sectors in a given humanitarian response" or the "number of affected persons consulted before designing a programme who are female, as a percentage of number of affected persons consulted before designing a programme."[40]

The Problem of Denominators in Medical Service Coverage

In some cases, it is necessary to have some indication of the number of survivors in order to judge whether access to medical and mental health care is assured. The UN has supported tools to facilitate this data-gathering, such as the Gender-Based Violence Information Management System (GBV IMS), an online platform for tracking GBV data by service providers.[41] However, it is methodologically challenging to establish a denominator for service coverage.

Many survivors will not report an incident to health facilities, resulting in implausibly small denominators. The ongoing displacement of populations also creates difficulties for analyzing the scope of sexual violence.[42] Davis and colleagues find that when attempting to reach stigmatized and hidden populations with health services, small denominators can result in high service coverage reports that "paint a false picture of success."[43] Additionally, Dolan cautions that male survivors are unlikely to disclose their status in many contexts, including in countries where only female rape is recognized, or where same-sex sexual behavior is criminalized.[44] Thus, unless a health facility is taking special measures to screen and find male survivors, the overall number of cases reported to a health facility may fail to include the full denominator of survivors.

Moreover, individual survivors may experience repeat incidents of sexual violence and/or multiple forms of sexual violence. This poses a methodological challenge: Should agencies strictly report only the number of individuals affected or the total number of incidents of sexual violence? If the former, then the reported victims may underrepresent the scale of violence in settings of high re-victimization.[45] This is recognized as a problem by the UN,[46] WHO, and UNFPA[47] guidelines.

In the absence of normative guidance on the question of what a change in the number of reported cases means, the meaning of changing data is also treated differently by institutions.[48] Without data on broader prevalence, indicators that monitor service coverage could mistakenly be taken to imply success. A reduction in the number of cases reported to a health facility could be a sign that sexual violence is reducing; yet, it could, on the other hand, be a sign that a health facility has failed to provide high-quality services or has violated confidentiality, and has lost the trust of survivors in the community. Thus, we found different approaches to interpreting changes in number of reported cases: while IASC recommends viewing the reduction of reported cases as a sign of a successful prevention program, RHRC views an increased number of reports as an indication of a successful access to justice program.

WHO has developed robust ethical guidance on data-gathering about sexual violence, and notes that genuine informed consent is a challenge in conflict and emergency settings.[49] Most of the guidance reviewed for this study adopts or references the WHO ethical guidance in some form.[50] However, the guidance documents we reviewed also provide a range of tools for data-gathering, including incident report forms, statistical report forms, and client feedback forms, which could jeopardize confidentiality without strict data protection policies and training for staff.

Mental Health Care and Psychosocial Support

Sexual violence in conflicts and emergencies can have profound and long-term effects on the mental health and well-being of survivors, their families, and the community at large. Survivors of sexual violence may experience diminished ability to function, post-traumatic stress disorder, depression, and suicidal thoughts, as well as numerous other impacts.[51] While these problems are well-documented, the types of interventions recommended vary among agencies, reflecting diverse institutional areas of expertise and theoretical orientations – as well as, perhaps, diverse needs of survivors.

To address the complex forms of harm to survivors, Tol and colleagues recommend a "multi-layered approach," building on the IASC pyramid, which identifies "different levels of psychosocial and mental health interventions," including specialized services for individuals, non-specialized support (such as psychological first aid), strengthening community and family supports, and addressing social considerations in basic services and security.[52] Tol and colleagues note the challenges in isolating specific effects of interventions.

Thus, apart from IRC's guidance for treating child sexual abuse survivors, we were unable to identify published technical guidance outlining one package of mental health and psychosocial support interventions specifically for sexual violence survivors in humanitarian settings.[53] Schopper notes a lack of scientific evidence for some psychosocial support interventions offered to sexual violence survivors, including "psychological first aid, community-based support and structured social activities."[54]

Among the guidance and indicators reviewed for this study, we identified 19 indicators for use in M&E of MHPSS interventions, almost all either input, output, or process indicators. These included output indicators aimed at measuring the numbers of survivors to access psychological services in a given setting (here, we encountered the same problem with lack of clear definition of denominators, as discussed above); process indicators that measure referrals to MHPSS, and output indicators measuring community ability to provide psychosocial support services; as well as number of health staff trained to provide MHPSS (an input indicator). All these indicators are measured for all victims of violence, and for children separately from adults.

ICRC had one of the few outcome indicators we found in our study: it measured numbers of patients to show reduced distress, improved functioning, and improved coping. However, from the materials provided, it was not clear how these indicators are assessed or what the time frame is for assessment.

The IASC guidelines do not provide M&E guidance for mental health and psychosocial support interventions, which, as mentioned above, are mainstreamed into other programmatic areas. RHRC's "Psychosocial: individual and community" indicators seem to be mistakenly categorized under mental health and psychosocial support when they actually focus on gender balance in community mobilization among refugees, gender equity in refugee decision-making, level of community awareness, and "survivors/women at risk engaged in reintegration and/or empowerment activities."

Legal Aid

Although almost all of the guidance on sexual violence we examined referenced the fact that sexual violence is a violation of human rights and humanitarian law, none of the institutions examined in this study offers legal aid services for sexual violence survivors. Thus we were unable to locate normative guidance on this important technical area. Rather, legal aid is sometimes referenced as being necessary, but there is little M&E guidance.

For example, UNHCR's above-mentioned 48 essential actions include the establishment of a referral mechanism for legal aid; however, UNHCR has not published an

M&E approach to assess the quality or outcome of legal aid services. Similarly, both the IASC and RHRC guidelines recommend monitoring whether free legal aid services exist and are accessible, for instance within other cross-cutting thematic areas (such as legal aid to enable women to recover housing, land, and property rights) but not whether the services are effective.[55]

Thus, indicators for legal aid offered to sexual violence survivors tend to emphasize input (availability of services), or, in some cases, process/output (RHRC has one outcome indicator to monitor the number of GBV cases with acquittal or conviction within six months).[56]

Access to justice is a long and complex process, and input or output indicators do not capture the many stages at which cases may drop out of the system after referral. The judicial process can include, depending on the legal system, processes of registering cases, investigating them, interviewing witnesses, the trial process itself, sentencing, and appeal.

A more robust approach would also consider how to evaluate the complex support that survivors need in order to be able to access services and see a case through to completion, such as know-your-rights training, counseling, and more.[57] More robust indicators could also include assessment of the legal framework's approach to sexual violence; effective enforcement of the law; knowledge and performance of police; capacity and competence of service providers (including judges); ability of relevant actors to gather and preserve forensic evidence; quality of judgments; eligibility of migrants and refugees to file a case at all in a given context; and more. Other indicators could include measurement of "successful sensitization of lawyers, judicial staff and magistrates."[58]

Measurement of the outcome of legal aid services could also be integrated into evaluations of the outcome of other services. Work on monitoring and evaluation of legal aid services for sexual violence survivors could usefully draw from the significant body of research and guidance on the impact of law on health that is published or under development in relation to human rights, gender equality, and HIV.[59]

CONCLUSION

Overall, our review found that while the leading international humanitarian agencies show commonalities on the importance of addressing sexual violence in humanitarian settings, there is work to be done to align and elaborate approaches, normative guidance, and indicators. This diversity of approaches exists because some guidelines have tended to emphasize mainstreaming sexual violence programming into other humanitarian activities while others are focused solely on the technical areas they know best, creating challenges in commensurability and in accumulating a body of evidence.

First, we found lack of clear agreement on what constitutes core interventions for survivors, especially in the areas of MHPSS and legal aid services. No UN or humanitarian agency appears mandated to provide legal aid services, leaving the provision and evaluation of these services largely in the hands of domestic NGOs that may or may not be sufficiently resourced to meet the need.

Second, there is a lack of consensus on what should be measured in order to robustly assess all three areas we examined. Some indicators rely on weakly-defined denominators; the methodological (even, epistemological) problems posed by a denominator of "cases reported to health facilities" as a basis for service coverage requires a more forthright and in-depth examination. Too few of the indicators examined attempt to evaluate the wider outcomes of the interventions, and none aimed to evaluate long-term impacts.

Third, while agencies naturally have diverse mandates and emphases, the guidance and indicators we reviewed showed that programs to respond to male and transgender

survivors still appear invisible within existing approaches to M&E, suggesting that these hidden populations may remain largely unserved.[60]

In a 2014 discussion of the evidence base for various sexual violence interventions, Schopper cautioned that "we have many gaps in our knowledge;" this study finds a continuing need to create a stronger evidence base. The development of more consistent thinking and approaches may require more inter-agency cooperation and active governance to incorporate lessons learned about which indicators work in context, ensuring that survivors of sexual violence have access to the highest attainable standard of health services.

Sara L.M. Davis *is coordinator of seminars on sexual violence at the Geneva Centre for Education and Research in Humanitarian Action (CERAH). She earned her Ph.D. at University of Pennsylvania, and was a researcher on China at Human Rights Watch. Davis founded Asia Catalyst, a health and human rights organization, and was executive director from 2006-12. She was also the first senior advisor on human rights at the Global Fund to Fight AIDS, TB and Malaria. Her publications include articles in the International Journal for Human Rights, Journal of the International AIDS Society, Health and Human Rights, Harm Reduction Journal, and others. Her first book, Song and Silence: Ethnic Revival on China's Southwest Borders, was published by Columbia University Press. She is currently writing a book on the politics of data in health finance.*

Doris Schopper *is professor of the medical faculty of the University of Geneva and director of CERAH. She obtained a medical degree at the University of Geneva (1978), trained as a specialist in Internal Medicine (1986), and completed a Doctor in Public Health at the Harvard School of Public Health (1992). Between 1982 and 1990 Doris Schopper spent several years with Médecins Sans Frontières (MSF) in the field. She was president of the Swiss branch of MSF (1991–1998) and twice president of the MSF International Council during this period. In 2001 Doris Schopper was asked to constitute an Ethics Review Board for MSF International. Since then she has chaired the Board coordinating the ethical review of MSF research proposals and providing advice on ethical matters to the organization. Doris Schopper also worked as health policy adviser in the Global Programme on AIDS at WHO headquarters in Geneva (1992-95). Further international work includes two years as senior health policy adviser at the Swiss Tropical Institute and developing several policies and strategies for WHO (e.g. guideline for policy makers on national policies for violence and injury prevention; strategy for mother-to-child transmission of HIV in Europe; WHO-wide strategy on child and adolescent health). Professor Schopper has also been responsible for the development of health policies and strategies at the national and regional level in Switzerland (e.g. Swiss National Cancer Control Programme 2005-2010; framework to prevent obesity at the national level; comprehensive health policy for the canton of Geneva). In November 2012, Doris Schopper was appointed member of the International Committee of the Red Cross (ICRC).*

Julia Epps *is a graduate of the University of Geneva, with field and clinical research experience in Israel, Cameroon, the United States, and United Kingdom.*

ACKNOWLEDGMENTS

The authors are grateful for comments by members of the CERAH Steering Committee on Sexual Violence: Wilma Doedens, Joanina Karugaba, Coline Rapneau, Sarah Rizk, and Nelly Staderini; as well as by Richard Sollom and two anonymous reviewers. Any errors remain our responsibility.

---

[1] This study addresses conflict, disaster, and post-conflict settings. For consistency, these settings are collectively referred to as "humanitarian settings" in this article.
[2] World Health Organization. *Understanding and addressing violence against women*. Geneva: World Health Organization, 2012.
[3] Ibid.
[4] Foreign and Commonwealth Office. *International Protocol on the Documentation and Investigation of Sexual Violence in Conflict. 2nd edition*. London: Foreign and Commonwealth Office, 2017.
[5] This study addresses conflict, disaster, and post-conflict settings. For consistency, these settings are collectively referred to as "humanitarian settings" in this article.
[6] Cohen, Dara Kay, Amelia Hoover Green, and Elisabeth Jean Wood. *Wartime Sexual Violence: Misconceptions, Implications, and Ways Forward*. Washington, D.C.: United States Institute of Peace, 2013. http://oclc-marc.ebrary.com/id/10689200.
[7] UN Security Council. *On Women, Peace, and Security*. Resolution 1888, 2009; UN Security Council. *On Women, Peace, and Security*. Resolution 1820, 2008; "UN Global Summit to End Sexual Violence in Conflict" https://www.gov.uk/government/topical-events/sexual-violence-in-conflict.
[8] Spangaro, Jo, Chinelo Adogu, Geetha Ranmuthugala, Gawaine Powell Davies, Léa Steinacker, and Anthony Zwi. 2013. "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* 8(5): e62600.
[9] Ibid.
[10] Holmes, Rebcca and Dharini Bhuvanendra. *Preventing and Responding to Gender-Based Violence in Humanitarian Contexts*. London: Humanitarian Practice Network (HPN), Overseas Development Institute, 2014. https://odihpn.org/wp-content/uploads/2014/02/NP_77_web.pdf.
[11] Alcorn, Ted. "Responding to sexual violence in armed conflict." *The Lancet* 383 no. 9934 (2014): 2034-7.
[12] Global Women's Institute. *Researching, Monitoring and Evaluating GBV Programs in Refugee Settings: Expert Consultation Meeting*. Washington, D.C.: Georgetown University, 2017.
[13] UN General Assembly. *International Covenant on Economic, Social and Cultural Rights*. Res. 2200A (XXI), December 16, 1966, Article 12.
[14] CESCR (Committee on Economic, Social and Cultural Rights). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*. UN Doc. E/C.12/2000/4, August 11, 2000.
[15] UN General Assembly. *International Covenant on Economic, Social and Cultural Rights*. Res. 2200A (XXI), December 16, 1966, Article 15.
[16] World Health Organization. *WHO Ethical and Safety Recommendations for Researching,* Documenting and Monitoring Sexual Violence in Emergencies. Geneva: World Health Orgnaization, 2007; Schopper, Doris. "Responding to the needs of survivors of sexual violence: Do we know what works?" *International Review of the Red Cross* 96 no. 894 (2014): 1-16; Spangaro, Jo, Chinelo Adogu, Geetha Ranmuthugala, Gawaine Powell Davies, Léa Steinacker, and Anthony Zwi. 2013. "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* 8(5): e62600; Tappis, Hannah, Jeffrey Freeman, Nancy Glass, and Shannon Doocy. "Effectiveness of interventions, programs and strategies for gender-based violence prevention in refugee populations: An integrative review." *PLoS Currents* 8 (2016).
[17] The terms "survivor" and "victim" are used in diverse ways in the literature. This study recognizes the utility of each term in different contexts and notes that different organizations prefer different terms. For the sake of simplicity, we utilize the term "survivor" here because it emphasizes individual agency and resilience.

[18] "UN health agency denounces attacks on health facilities in Syria." *UN News Centre*. November 17, 2016. http://www.un.org/apps/news/story.asp?NewsID=55580#.WPUYGlKZNE4.
[19] Vann, Beth. *Training Manual: Facilitator's Guide, Interagency & Multisectoral Prevention and Response to Gender-Based Violence in Populations Affected by Armed Conflict*. Arlington, VA: JSI Research and Training Institute and RHRC, 2004, pp. 4–9.
[20] International Committee of the Red Cross. *Integrating Programmes for Victims/survivors of Violence into Health Facilities*. International Committee of the Red Cross, 2017; Médecins Sans Frontières (MSF). *Overview of Information and Data Required as Part of MSF Care for Victims of Sexual Violence*. Médecins Sans Frontières, 2017; World Health Organization. *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*. Geneva: World Health Organization, 2007; World Health Organization. *Preventing Intimate Partner and Sexual Violence against Women: Global Trends and Determinants of Prevalence, Safety, and Acceptability*. Geneva: World Health Organization, 2010; United Nations High Commissioner for Refugees. "An Evaluative Review of the 2014-2016 Senior Protection Officer (SGBV) Deployments" United Nations High Commissioner for Refugees, n.d.
[21] Inter-Agency Standing Committee. *Guidelines for Integrating Gender-based Violence interventions in Humanitarian Action: Reducing Risk, Promoting Resiliency, and Aiding Recovery*. Inter-Agency Standing Committee, 2015; Social Science Research Council. *Methods and Systems for the Assessment and Monitoring of Sexual Violence and Exploitation in Conflict Situations*. UNFPA and World Health Organization, 2005; Reproductive Health Response in Conflict (RHRC) Consortium. *Gender-based Violence Tools Manual for Assessment and Program Design, Monitoring and Evaluation*. New York, NY: RHRC Consortium, 2005.
[22] International Federation of the Red Cross (IFRC). *Minimum Standard Commitments to Gender and Diversity in Emergency Programming: Pilot version*. Geneva: International Federation of the Red Cross and Red Crescent Societies (IFRC), 2015.
[23] Merry, Sally Engle. *The Seductions of Quantification: Measuring Human Rights, Gender Violence, and Sex Trafficking*. Chicago: University of Chicago Press, 2017 pp. 44.
[24] UN General Assembly, 66th Session. *Conflict-related Sexual Violence*. UN Doc. A /66/657*– S /2012/33*, January 13, 2012.
[25] UN High Commissioner for Refugees. *Action against Sexual and Gender-Based Violence: An Updated Strategy*. UN High Commissioner for Refugees, 2011, pp. 6; UNFPA. *Managing Gender-Based Violence Programmes in Emergencies: E-learning Companion Guide*. UNFPA, 2012.
[26] Inter-Agency Standing Committee.*Guidelines for Integrating Gender-based Violence interventions in Humanitarian Action: Reducing Risk, Promoting Resiliency, and Aiding Recovery*. Inter-Agency Standing Committee, 2015, pp. 5.
[27] Dolan, Chris. "Letting go of the gender binary: Charting new pathways for humanitarian interventions on gender-based violence." *International Review of the Red Cross* 96, no. 894 (2014): 1-17
[28] The GBV Area of Responsibility (AOR), the group under the IASC umbrella that developed the guidelines, has plans to develop global minimum standards on prevention and response to GBV in emergencies. Sascha Müller, personal communication, April 18, 2017.
[29] UNFPA. *Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies*. New York, NY: UNFPA, 2015. http://www.unfpa.org/sites/default/files/pub-pdf/GBVIE.Minimum.Standards.Publication.FINAL_.ENG_.pdf.
[30] UN High Commissioner for Refugees. *Prioritizing SGBV in Emergencies: An Evaluative Review of the 2014-16 Senior Protection Officer Deployments*. Geneva: UN High Commissioner for Refugees, 2017, pp. 17.
[31] Ibid., pp. 66-71.
[32] Coline Rapneau, ICRC, personal communication, April 18, 2017.
[33] Schopper, Doris. "Responding to the needs of survivors of sexual violence: Do we know what works?" *International Review of the Red Cross* 96 no. 894 (2014): 3.
[34] World Health Organization. *Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons*. Geneva: World Health Organization, 2013, pp. 9-27.
[35] Médecins Sans Frontières (MSF). *Medical Protocol for Sexual Violence Care*. 2nd edition. Médecins Sans Frontières, 2014, pp. 2.
[36] Tayler-Smith, K., R. Zachariah, S. G. Hinderaker, M. Manzi, E. De Plecker, P. Van Wolvelaer, T. Gil, [et al.] "Sexual violence in post-conflict liberia: Survivors and their care: Sexual violence in Liberia." *Tropical Medicine and International Health* 17 no. 11 (2012): 1357.

[37] McGinn, Therese, and Sara E. Casey. "Why don't humanitarian organizations provide safe abortion services?" *Conflict and* Health 10 (2016): 8.
[38] Ibid.
[39] World Health Organization. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.* Geneva, World Health Organization, 2013, pp. 27.
[40] Inter-Agency Standing Committee. *Guidelines for Integrating Gender-based Violence interventions in Humanitarian Action: Reducing Risk, Promoting Resiliency, and Aiding Recovery*. Inter-Agency Standing Committee, 2015, pp. 159-162.
[41] The online platform for the Gender-Based Violence Information Management System (GBV IMS) can be accessed at: www.gbvims.com.
[42] Ellsberg, Mary and Lori Heise. *Researching Violence against Women: A Practical Guide for Researchers and Activists*. Geneva, Switzerland: Washington, DC: World Health Organization and the Program for Appropriate Technology in Health (PATH), 2005, pp. 27.
[43] Davis, Sara LM, William C. Goedel, John Emerson, and Brooke Skartvedt Guven. "Punitive laws, key population size estimates, and global AIDS response progress reports: An ecological study of 154 countries." *Journal of the International AIDS Society* 20 no. 1 (2017).
[44] Dolan, Chris. *Into the Mainstream: Addressing Sexual Violence Against Men and Boys in Conflict*. London: Overseas Development Institute, 2014, pp. 5–6.
https://reliefweb.int/sites/reliefweb.int/files/resources/Into_The_Mainstream-Addressing_Sexual_Violence_against_Men_and_Boys_in_Conflict.pdf.
[45] United Nations. *Indicators to Measure Violence against Women*. Geneva: United Nations, 2007, pp. 22.
http://www.un.org/womenwatch/daw/egm/IndicatorsVAW/IndicatorsVAW_EGM_report.pdf
[46] Ibid.
[47] Social Science Research Council. *Methods and Systems for the Assessment and Monitoring of Sexual Violence and Exploitation in Conflict Situations*. UNFPA and World Health Organization, 2005, pp. 9–10.
[48] United Nations. *Indicators to Measure Violence against Women*. Geneva: United Nations, 2007, pp. 22; Social Science Research Council. *Methods and Systems for the Assessment and Monitoring of Sexual Violence and Exploitation in Conflict Situations*. UNFPA and World Health Organization, 2005, pp. 8–10.
[49] World Health Organization. *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*. Geneva: World Health Organization, 2007, pp. 9, 22.
[50] Ellsberg, Mary and Lori Heise. *Researching Violence against Women: A Practical Guide for Researchers and Activists*. Geneva, Switzerland: Washington, DC: World Health Organization and the Program for Appropriate Technology in Health (PATH), 2005, pp. 27; Durham, Helen and Tracey Gurd, eds. *Listening to the Silences: Women and War*. Leiden; Boston: Martinus Nijhoff, 2005, pp. 72.
[51] Ulirsch, J. C., L. E. Ballina, A. C. Soward, C. Rossi, W. Hauda, D. Holbrook, R. Wheeler, et al. "Pain and somatic symptoms are sequelae of sexual assault: Results of a prospective longitudinal study." *European Journal of Pain* 18, no. 4 (2014): 559-66; Hustache, Sarah, Marie-Rose Moro, Jacky Roptin, Renato Souza, Grégoire Magloire Gansou, Alain Mbemba, Thomas Roederer, Rebecca F. Grais, Valérie Gaboulaud, and Thierry Baubet. "Evaluation of psychological support for victims of sexual violence in a conflict setting: Results from Brazzaville, Congo." *International Journal of Mental Health Systems* 3, no. 1 (2009); Médecins Sans Frontières (MSF). *Final Report: Comprehensive care Project for Sexual Violence Survivors*. Médecins Sans Frontières, 2013. https://www.doctorswithoutborders.org/sites/usa/files/if-guate-eng-color.pdf.
[52] Tol, Wietse A., Corrado Barbui, Ananda Galappatti, Derrick Silove, Theresa S. Betancourt, Renato Souza, Anne Golaz, and Mark van Ommeren. "Global mental health 3: Mental health and psychosocial support in humanitarian settings: Linking practice and research." *The Lancet* 378, no. 9802 (2011): 1581; World Health Organization. *Mental health and psychosocial support for conflict-related sexual violence: Principles and interventions*. Geneva, World Health Organization, 2011, pp. 4.
[53] International Rescue Committee (IRC). *Caring for child survivors of sexual abuse.* New York, NY: International Rescue Committee, 2012.
[54] Schopper, Doris. "Responding to the needs of survivors of sexual violence: Do we know what works?" *International Review of the Red Cross* 96, no. 894 (2014): 8.

[55] Inter-Agency Standing Committee. *Guidelines for Integrating Gender-based Violence interventions in Humanitarian Action: Reducing Risk, Promoting Resiliency, and Aiding Recovery*. Inter-Agency Standing Committee, 2015; Inter-Agency Standing Committee. *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*. Inter-Agency Standing Committee, 2005; Vann, Beth. *Training Manual: Facilitator's Guide, Interagency & Multisectoral Prevention and Response to Gender-Based Violence in Populations Affected by Armed Conflict*. Arlington, VA: JSI Research and Training Institute and RHRC, 2004; Reproductive Health Response in Conflict (RHRC) Consortium. *Gender-based Violence Tools Manual for Assessment and Program Design, Monitoring and Evaluation*. New York, NY: RHRC Consortium, 2005.
[56] Reproductive Health Response in Conflict (RHRC) Consortium. *Gender-based Violence Tools Manual for Assessment and Program Design, Monitoring and Evaluation*. New York, NY: RHRC Consortium, 2005.
[57] Seelinger, Kim T., Helen Silverberg and Robin Mejia. *The Investigation and Prosecution of Sexual Violence*. Sexual Violence & Accountability Project, Working Paper Series, 2011. https://www.law.berkeley.edu/wp-content/uploads/2015/04/The-Investigation-and-Prosecution-of-Sexual-Violence-SV-Working-Paper.pdf.
[58] USAID. *Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions Along the Relief to Development Continuum*. Washington, D.C.: USAID, 2014, pp. 28.
[59] OHCHR and UNAIDS. *International Guidelines on HIV/AIDS and Human Rights*. Geneva: OHCHR and UNAIDS, 2006; UN Human Rights Council, 14th Session. *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*. UN Doc. A/HRC/14/20, April 27, 2010; Booth, Robert E., Sergey Dvoryak, Min Sung-Joon, John T. Brewster, William W. Wendt, Karen F. Corsi, Oleg Y. Semerik, and Steffanie A. Strathdee. "Law enforcement practices associated with HIV infection among injection drug users in Odessa, Ukraine." *AIDS and Behavior* 17, no. 8 (2013): 2604-14; Jürgens, Ralf, Joanne Csete, Joseph J. Amon, Stefan Baral, and Chris Beyrer. "HIV in people who use drugs 6: People who use drugs, HIV, and human rights." *The Lancet* 376, no. 9739 (2010): 475; Shannon, Kate, Steffanie A. Strathdee, Shira M. Goldenberg, Putu Duff, Peninah Mwangi, Maia Rusakova, Sushena Reza-Paul, [et al.] "Global epidemiology of HIV among female sex workers: Influence of structural determinants." *The Lancet* 385, no. 9962 (2015): 55-71; Schwartz, Sheree R., Rebecca G. Nowak, Ifeanyi Orazulike, Babajide Keshinro, Julie Ake, Sara Kennedy, Ogbonnaya Njoku, William A. Blattner, Manhattan E. Charurat, and Stefan D. Baral. "The immediate effect of the same-sex marriage prohibition act on stigma, discrimination, and engagement on HIV prevention and treatment services in men who have sex with men in Nigeria: Analysis of prospective data from the TRUST cohort." *The Lancet HIV* (2015); Davis, Sara L. M. Measuring the impact of the human rights on health in global health financing. *Health and Human Rights* 17, no. 2 (2015): 97.
[60] Watson, Callum. *Preventing and Responding to Sexual and Domestic Violence Agsinst Men: A Guidance Note for Security Sector Institutions*. Geneva: The Geneva Centre for the Democratic Control of Armed Forces (DCAF), 2014; United Nations High Commissioner For Refugees. *Working with Men and Boy Survivors of Sexual and Gender-Based Violence in Forced Displacement*. Geneva: United Nations High Commissioner For Refugees, 2012; International Rescue Committee (IRC). *Caring for child survivors of sexual abuse*. New York, NY: International Rescue Committee, 2012.