

GBV AoR HELPDESK

Gender Based Violence in Emergencies

Research Query: Supporting GBV Survivors who are Pregnant due to Rape

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Introduction

Gender-based violence (GBV), including sexual violence, occurs in every context and setting, but women and girls affected by humanitarian emergencies are particularly at risk. Sexual violence, especially rape, has been the focus of increased attention by humanitarian actors over the past 20 years, with GBV programming—including response to rape—acknowledged by the humanitarian community as “life-saving.”¹ The World Health Organization (WHO) defines rape as physically forced or otherwise coerced penetration—even if slight—of the vagina, anus or mouth with a penis or other body part. It also includes penetration of the vagina or anus with an object.² In this definition, rape includes marital rape and anal rape/sodomy. This report will focus on the issue of rape in the context of humanitarian emergencies, and its link with unintended pregnancy.

This report first provides background information on what is known about the scope and impact of the problem in humanitarian emergencies, and then offers practical guidance to enable GBV practitioners to support survivors who are pregnant or have had children due to rape. While there is a growing body of evidence about the extent of sexual violence in conflict settings, there is little peer-reviewed research about pregnancies and childbirth as a result of rape, particularly in humanitarian emergencies or in relation to supporting survivors. As a result, sources for this research query primarily comprise “grey literature” – assessments, reports and guidance published by non-governmental organizations, including abortion rights organizations, and United Nations agencies. Additional resources for practitioners are provided at the end of the report.

Scope of Rape-Related Pregnancies in Humanitarian Emergencies

The likelihood that a rape will result in pregnancy is difficult to determine. From research in the United States, based on a single random (i.e., unplanned) act of sexual intercourse, it has been estimated there is a 4 percent - 10 percent likelihood that an act of rape will result in pregnancy.³ Some evidence suggests that the incidence of

¹ Gender-based Violence Area of Responsibility (GBV AOR), Handbook for Coordinating Gender-based Violence Interventions in Emergencies, 2019. p. 30

² World Health Organization (WHO). World Report on Violence and Health, 2002.

³ Holmes MM, Resnick HS, Kilpatrick DG, Best CL. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. *Am J Obstet Gynecol.* 1996 Aug;175(2):320-4; discussion 324-5. doi: 10.1016/s0002-

pregnancy resulting from rape is much higher than from consensual sexual intercourse.⁴

The stress of becoming pregnant due to rape can be extreme for many survivors, not only because of the stigma that may be associated with the pregnancy, but also because of safety concerns. Pregnancy may be seen as ‘proof’ of sexual intercourse outside of marriage. In some settings, the survivor may be forced to marry her rapist or, in extreme cases, murdered by family members to preserve family ‘honor.’ A number of high profile so-called ‘honor killings’ of young women around the world have been tied to pregnancy.⁵

In humanitarian emergencies, sexual violence has been documented extensively in the last thirty years. In some of these emergencies, the issue of rape-related pregnancy has also been raised as a concern, as detailed further below. Medical providers have observed the demand for abortion of unintended pregnancies in humanitarian settings and have also responded to women and girls suffering from severe, potentially life-threatening effects of unsafe abortion.⁶ This suggests that number of rape-related pregnancies is higher than available data indicate.

Certain populations of females are at particularly high risk of rape and sexual violence in emergencies and pregnancy due to rape. For example, adolescent girls and young women experience higher rates of sexual violence than adult women due to intersecting vulnerabilities of age and gender and this risk is exacerbated by emergencies.⁷ Pregnancy and childbirth-related complications are the leading cause of death for girls ages 15-19 in many countries, with adolescent girls being twice as likely to die from childbirth as women in their 20’s.⁸ Women with physical and mental disabilities are also at an increased risk of sexual violence in all settings but particularly in emergencies.

Rwanda. Approximately 350,000 women were raped throughout the 1994 genocide in Rwanda.⁹ The United Nations (UN) estimated that at least 20,000 children were born of conflict-related rape from the Rwandan genocide. Referring to them “fruit of the devil,” “enfants de mauvais souvenirs” (children of bad memories) and “enfants de la haine” (children of hate), these children were often shunned by their mothers and society.¹⁰

Former Yugoslavia. During the Balkans wars of the early ‘90s, ‘rape camps’ were reportedly created to impregnate captive Muslim and Croatian women. Somewhere between 20,000-50,000 women were estimated to have been kept in confinement until their pregnancies had advanced beyond a stage at which abortion would be safe.¹¹ This systematic policy of ethnic cleansing in the former Yugoslavia caused the international

9378(96)70141-2. PMID: 8765248; Anthony Lathrop, "Pregnancy resulting from rape." *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 27.1 (1998): 2,

⁴ Anthony Lathrop, "Pregnancy resulting from rape." *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 27.1 (1998): 2
WHO, *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, 2013 and Gottschall, J.A., Gottschall, T.A. Are per-incident rape-pregnancy rates higher than per-incident consensual pregnancy rates? *Hum Nat* 14, 1–20 (2003). <https://doi.org/10.1007/s12110-003-1014-0>

⁵ CBS News, “Pregnant girl, 14, burned in alleged ‘honor’ killing in Afghanistan.” 18 July, 2018. Malik Irfanul Haq (Dawn), “Rape victims allegedly murdered by relatives in ‘honour killing’ in Pakistan.” 7 November, 2018. Pascale Harter (BBC News) “Libya rape victims face ‘honour killings’”, 14 June 2011.

⁶ MSF noted that since 2018, they provide safe abortion care at 90 projects in over 25 countries.

⁷ GBV AOR, *Handbook for Coordinating Gender-based Violence Interventions in Emergencies*, 2019.

⁸ Sara Rowbottom “Giving girls today and tomorrow: Breaking the cycle of adolescent pregnancy,” New York: UNFPA. 2007.

⁹ Danielle Paquet (Washington Post), “Rwanda’s children of rape are coming of age, against the odds.” 11 June, 2017.

¹⁰ Sue Montgomery (The Montreal Gazette) “Rwanda: Families Born of Rape,” 17 December 2014. and Denov M, Woolner L, Bahati JP, Nsuki P, Shyaka O. The Intergenerational Legacy of Genocidal Rape: The Realities and Perspectives of Children Born of the Rwandan Genocide. *J Interpers Violence*. 2020 Sep; 35 (17-18):3286-3307. doi: 10.1177/0886260517708407. Epub 2017 May 15.

¹¹ David M. Crowe, *War Crimes, Genocide, and Justice: A Global History*. Palgrave Macmillan, 2013.

community to discuss rape and forced impregnation as crimes against humanity, war crimes and even genocide in the early '90s. In the case of *The Prosecutor, v Drago jub Kunarac, Radomir Kovac and Zoran Vukovic*, rape was treated as a crime against humanity under international humanitarian law for the first time.¹²

Northern Uganda. Between 1986 and 2006, the Lord's Resistance Army (LRA) engaged in large-scale human rights abuses, including killings, mutilations, abduction of children, and systematic sexual violence in Northern Uganda. One in three females affected by the conflict reported having suffered at least one form of conflict-related sexual violence, including abduction, forced marriage, forced pregnancy, and rape. Those who were abducted were typically forced into marriage and experienced sexual assault in these unions, as well as unintended pregnancies. Research among post-conflict communities found that women and girls who had been abducted and became pregnant during the conflict found it particularly difficult to integrate back into their communities due to stigma.¹³

Democratic Republic of Congo (DRC). In DRC, a study at Panzi Hospital undertaken in 2010 noted that the number of pregnancies resulting from sexual violence was high.¹⁴ Children born out of rape are often highly stigmatized by the community because they are viewed as offspring of the enemy. In some instances, these children are abandoned because they were conceived from rape.¹⁵ Until 2018, Congolese law made no provision for abortion for women who become pregnant after rape. Women who decided to terminate a pregnancy were usually forced to do so illegally, often with the help of traditional healers.¹⁶ Now, all medical facilities have the obligation to provide termination of pregnancy for women who have been victims of rape or sexual abuse, or whose physical or mental health is at risk.¹⁷

Rohingya Women in Myanmar and Bangladesh. There was widespread rape during the 2018 Rohingya refugee influx into Bangladesh, with many women and girls reportedly becoming pregnant.¹⁸ MSF reported that of the Rohingya refugees fleeing Rakhine state, Myanmar, about 50 percent of those who come to their clinic for rape treatment were aged 18 or under, including one girl who was nine years old and several others under the age of 10.¹⁹ In Myanmar, the persecuted minority Rohingya people are often denied access to public health care. Rohingya women and girls pregnant due to rape therefore typically seek advice from traditional healers or buy medicine to end an unwanted pregnancy. Humanitarian service providers working with the Rohingya in Myanmar have reportedly seen incomplete, septic abortions with women and girls presenting while hemorrhaging and extremely sick. According to one provider, "Girls take matters into their own hands because they feel that is their only option."²⁰

No Justice No Peace: Accountability for Rape and Gender Based Violence in the Former Yugoslavia, 5 HASTINGS WOMEN'S L.J. 91. 1994.

¹² D. Buss, Case Note 'Prosecuting mass rape: The Prosecutor v. Drago jub Kunarac, Radomir Kovac and Zoran Vukovic. Feminist Legal Studies 10: 91–99. 2002.

¹³ Mahlet A. Woldetsadik, Long-Term Effects of Wartime Sexual Violence on Women and Families. Diss. PARDEE RAND GRADUATE SCHOOL, 2018.

¹⁴ Harvard Humanitarian Initiative (HHI), "Now the world is without me: Investigation of Sexual Violence in Eastern DRC", 2010.

¹⁵ UNICEF and Pole Institute "Children Born of Sexual Violence in Conflict Zones, DRC Country Study", draft internal document, cited in UNICEF, Childre and Transitional Justice, 2010.

¹⁶ HHI, "Now the world is without me: Investigation of Sexual Violence in Eastern DRC", 2010

¹⁷ MSF, "Safe Abortion Care"

¹⁸ Human Rights Watch (HRW), "All of my body was pain: Sexual Violence against Rohingya Women and Girls in Burma." 16 November, 2017.

¹⁹ Fiona MacGregor (The Guardian) "Rohingya girls under 10 raped while fleeing Myanmar, charity says", 25 October 2017.

²⁰ MSF, "Rohingya Refugees: Still Searching for Safety", 31 July 2018, no page number.

Yazidi women in Iraq. As a consequence of the protracted conflict in Iraq, there have been a high number of pregnancies in rape survivors. Many Iraqi women try to hide rapes from their families out of fear they will be stigmatized or punished by their relatives or community.²¹ When ISIS (or Daesh) attacked Sinjar, Iraq in 2014, they killed around 5,000 Yazidis and abducted 7,000 more, mostly women and girls who were forced into sexual slavery and endured forced marriage, rape, pregnancy, and forced abortions.²² Estimates of the number of children born to Yazidi mothers and Islamic State fathers in Iraq and Syria range from several hundred to more than 1,000. The spiritual leader of the Yazidis, ‘Baba Sheikh’ called on the community to welcome back the abducted women because they had been "subjected to a matter outside their control," a statement that helped survivors rejoin their community. However, the Yazidi community encouraged pregnant survivors to seek abortion. Since abortion is illegal in Iraq and not all of the women wanted to abort or had already given birth, they were forced to choose between giving up their children to return to their community or be rejected by their community.²³

Impact of Rape-Related Pregnancies on Survivors and their Children

Rape can damage survivors in many ways. Women and girls who have experienced sexual violence may suffer acute and chronic physical problems including genital and reproductive tract injuries, sexually transmitted infections (STIs) including HIV, pelvic pain, urinary tract infections, and fistula. The mental health impacts of sexual violence may include acute stress reactions, post-traumatic stress disorder (PTSD), depression, anxiety, sleep disturbances, substance misuse, self-harm and suicidal behavior.²⁴

Rape-related pregnancy can have many additional negative impacts for the rape survivor. Some studies demonstrate a higher incidence of elective abortions, spontaneous abortions, and adoptions in rape-related pregnancies.²⁵ Some women and girls’ efforts to end a rape-related pregnancy include attempting self-abortion or receiving an unsafe abortion from traditional healers or ill-trained medical providers.²⁶ The history of unsafe abortion is marked by dangerous methods such as sharp sticks inserted up through the vagina and the cervix into the uterus; ingesting toxic substances such as bleach; inserting herbal preparations into the vagina; and inflicting trauma such as hitting the abdomen, or falling.

For those who use these unsafe methods, the life-threatening consequences include severe hemorrhage, sepsis (severe general infection), poisoning, uterine perforation or damage to other internal organs. Unsafe abortion is one of the top five causes of maternal death worldwide and the only one that is wholly preventable. According to the Guttmacher Institute, at least 22,800 women die every year from complications from unsafe abortion.²⁷ Many more are injured or maimed — around 7 million women are admitted to hospitals as a result of unsafe abortion every year in developing countries, in need a blood transfusion, major reparative surgery, a hysterectomy (complete removal of the uterus), etc. Some patients may even die of septic shock.²⁸

²¹ Serri (Sura) Mahmood, “Challenges of Children Born by ISIS Rape in Iraq”, CERAH Working paper 49, 2016-2017.

²² Kate Denereaz (UK News) “COVID-19 Risks Deepen Mental Health Risks for Yazidis in Iraq”, 30 April 2020

²³ Serri (Sura) Mahmood, “Challenges of Children Born by ISIS Rape in Iraq”, CERAH Working paper 49, 2016-2017.

²⁴ WHO, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*. 2019.

²⁵ Munro ML, Foster Rietz M, Seng JS. Comprehensive care and pregnancy: the unmet care needs of pregnant women with a history of rape. *Issues Ment Health Nurs*. 2012;33(12):882-896. doi:10.3109/01612840.2012.731136

²⁶ Harvard Humanitarian Initiative (HHI), “Now, the world is without me”: An investigation of sexual violence in Eastern Democratic Republic of Congo. Harvard Humanitarian Initiative: Boston, USA, 2010.

²⁷ Guttmacher Institute, “Unintended Pregnancy and Abortion Worldwide: Fact Sheet”, July 2020.

²⁸ WHO, “Preventing Unsafe Abortion.” Fact sheet. 2018.

Women and girls pregnant due to rape may experience a number of additional health problems,²⁹ including somatic disturbances such as pelvic pain,³⁰ and an increase in common pregnancy complaints such as headache, nausea, and tiredness.³¹ Studies have also found increased rates of infection including bacterial vaginosis, chlamydia, gonorrhoea, and trichomoniasis in pregnant survivors of rape.³² Some women and girls pregnant as a result of rape may even opt for suicide rather than carrying the pregnancy.³³

The stigma and societal exclusion that can follow the discovery of a rape-related pregnancy can also amplify the negative mental health impacts of the rape, not only for the survivor, but for the children who are born. In many instances, the children of rape are perceived as objects of shame and humiliation, both by their mother and by the community and can be abandoned or neglected.³⁴

The stigma also exacerbates the stress that women and girls endure during the pregnancy; higher levels of stress-related cortisol concentrations in turn have an in-utero effect on the fetus.³⁵ Research has shown long-lasting effects on a child's physical, emotional and cognitive development resulting from maternal pre-natal and post-natal chronic anxiety, depression and stress.³⁶ Trauma experienced by the mother can also lead to infanticide,³⁷ as well as maternal rejection and consequent child malnutrition and other significant child health impacts.³⁸

What Do Service Providers Need to Do to Support Survivors Who Are Pregnant?

There is no “one size fits all” response for rape survivors who find themselves pregnant. Each survivor can have

²⁹ Elisa van Ee and Rolf J. Kleber, “Growing Up Under a Shadow: Key Issues in Research on and Treatment of Children Born of Rape”, *Child Abuse Review* Vol. 22: 386–397, 2013.

³⁰ LA Van der Hulst, GJ Bonsel, M Eske, E Birnie, E van Teijlingen, OP Bleker, “Bad experience, good birthing: Dutch low-risk pregnant women with a history of sexual abuse” *Journal of Psychosomatic Obstetrics and Gynaecology*. 2006;27(1):59–66.

³¹ M Lukasse, B Schei, S Vangen, P Oian, “Childhood abuse and common complaints in pregnancy”, *Birth*. 2009; 36(3):190–199.

³² Munro ML, Foster Rietz M, Seng JS. Comprehensive care and pregnancy: the unmet care needs of pregnant women with a history of rape. *Issues Ment Health Nurs*. 2012;33(12):882–896. doi:10.3109/01612840.2012.731136

³³ Anastasia Moloney (Thomson Reuters Foundation) “Rape, abortion ban drives pregnant teens to suicide in El Salvador”, 12 November 2014.

³⁴ Elisa van Ee and Rolf J. Kleber, “Growing Up Under a Shadow: Key Issues in Research on and Treatment of Children Born of Rape”, *Child Abuse Review* Vol. 22: 386–397. 2013, and van Ee E, Blokland J. Bad Blood or My Blood: A Qualitative Study into the Dimensions of Interventions for Mothers with Children Born of Sexual Violence. *Int J Environ Res Public Health*. 2019;16(23):4810. Published 2019 Nov 29. doi:10.3390/ijerph16234810

³⁵ Rachel Yehuda, Stephanie Mulherin Engel, Sarah R. Brand, Jonathan Seckl, Sue M. Marcus, Gertrud S. Berkowitz, “Transgenerational Effects of Posttraumatic Stress Disorder in Babies of Mothers Exposed to the World Trade Center Attacks during Pregnancy”, *The Journal of Clinical Endocrinology & Metabolism*, Volume 90, Issue 7, 1 July 2005, Pages 4115–4118,

³⁶ A. Biaggi, S Conroy, S Pawlby, CM Pariante, “Identifying the women at risk of antenatal anxiety and depression: A systematic review”, *J Affect Disord*. 2016;191:62–77.

³⁷ Infanticide is the killing of a child up to one year old, often by a mother who has not fully recovered from pregnancy and who typically suffers from some degree of mental disturbance often associated with postpartum mental illness. Women involved in neonaticide (killing of a child directly after birth) are younger, often unmarried, and less frequently psychotic than mothers who commit filicide (killing of a child up to one year old). Most neonaticides are carried out because the child isn't wanted due to illegitimacy, rape, or social stigma, rather than altruistic reasons. Neonaticide offenders are often single young women who deny the pregnancy and kill their newborn infants in an effort to avoid the social and parental pressure against an illegitimate child.” Stacey L. Shipley, Bruce A. Arrigo, “Violence in the Family” in *Introduction to Forensic Psychology (Third Edition)*, 2012 <https://www.sciencedirect.com/topics/social-sciences/infanticide>

³⁸ Rezzoug, Dalila & Baubet, Thierry & Broder, G & Taïeb, Olivier & Moro, Marie Rose, “Addressing the Mother–Infant Relationship in Displaced Communities” *Child and adolescent psychiatric clinics of North America*. 17. 551–68, viii.,2008.

very different needs, depending on their circumstances and the context where they are living. Even survivors in similar contexts may need different types of support over time. There are, however, a minimum set of actions and principles outlined by the World Health Organization (WHO) that should guide all health-care response to women suffering from sexual violence.³⁹ Other humanitarian organizations that have experience supporting GBV survivors have also developed guidance and support that can be helpful in responding to survivors who find themselves pregnant due to rape.⁴⁰ This report draws on information from a range of organizations to provide support. Resources that may be helpful for practitioners seeking to provide support to survivors who are pregnant are provided at the end of the report.

1. Perform a Context Analysis

In order to ensure a thorough and compassionate response to the survivor in a timely manner, a protocol to provide care for pregnant rape survivors should be in place. Ideally, such a protocol should be in place before the first survivor appears seeking support (but the absence of a protocol should not be a reason to delay providing care). The protocol must be informed an understanding of the social context as well as by the legal regulatory environment related to rape, termination of pregnancy, and other issues detailed below.

The socio-cultural context. Respecting local cultures is a core principle of humanitarian work. However, identifying and defining ‘the culture’ of a particular group is not a straightforward task. Even within the same community, cultural beliefs and interpretations may vary depending on an individual’s age, gender, socio-economic status and other characteristics. Furthermore, cultures are not static; they are continually being renewed and reshaped by a wide range of factors, including conflict and other humanitarian crises.⁴¹ Health actors should be aware of cultural attitudes towards rape, pregnancy (particularly for unmarried women), abortion, and general treatment of rape survivors and children born of rape. In many contexts, service-provider attitudes can be a blockage to safe and dignified care for the survivor and/or her child.

Legal frameworks on rape. It is essential for health actors to be aware of laws related to rape where they exist, and the availability of legal recourse for survivors. This should include what constitutes a sexual crime, and what rights women have in bringing charges against the perpetrator. It also includes understanding what organizations in the area offer legal services that might be helpful to a survivor. While healthcare workers cannot be expected to dispense legal advice, they should have access to basic information about patient’s rights and legal obligations. Managers of healthcare agencies should ensure that this information is available to staff and patients in an easy-to-read format.⁴²

Healthcare providers also need to know and understand their legal obligations with regards to mandatory reporting requirements related to sexual violence, as well as regulations regarding court or other access to medical records.⁴³ While in some instances mandatory reporting is intended to protect survivors (particularly children), in many cases it may conflict with the guiding principles for working with survivors, impinging on

³⁹ WHO, United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: WHO, 2019

⁴⁰ See for example, guidance from Medecins Sans Frontieres (MSF), Medecins du Monde, International Rescue Committee (IRC), IPAS, International Planned Parenthood Federation (IPPF), and Marie Stopes International.

⁴¹ UNFPA, Managing Gender-based Violence Programmes in Emergencies E-learning and Companion Guide, 2011.

⁴² For more information on addressing medico-legal issues around rape, see World Health Organization and UN Office of Drugs and Crime Strengthening the Medico-legal response to Sexual Violence.

⁴³ Sarah Bott, Alessandra Gueddes, Maria Cecilia Claramunt, Ana Guezms, “Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries,” International Planned Parenthood Federation (IPPF), 2010.

their right to self-determination in recovery from the incident. Mandatory reporting requirements may also introduce serious further harm to survivors, including retaliation, custody issues, etc. By ensuring survivors are aware of mandatory reporting requirements, health-care providers can help survivors make informed decisions about what to disclose during a health visit.⁴⁴

Legal frameworks on termination of pregnancy (abortion). In many countries, the law allows termination of pregnancy but often within a prescribed time frame.⁴⁵ In countries that do not permit legal abortion for all unwanted pregnancies, they may have laws that allow abortion resulting from rape (including incest). Some countries take into consideration the mental and physical health of the survivor. It is essential that these laws be understood, particularly in countries where abortion is highly restricted, because service providers may need to document available evidence demonstrating the pregnancy occurred due to rape.

Many abortion laws include provisions regulating who can provide abortion and where. While most countries have some legal indications for abortion, many fail to make safe services available, including for girls and young women who experience rape (including incest).⁴⁶ They may also require women and girls seeking abortion in cases of rape to report to law enforcement authorities for a “police certificate” and/or seek parental involvement, be subject to compulsory pregnancy counseling or waiting periods to receive an abortion, or to overcome other barriers.⁴⁷ Healthcare providers must understand any procedures for making a request for an abortion and whether or not these procedures are different for girls who are minors. Even healthcare providers who do not offer termination of pregnancy should determine safe abortion providers and be able to refer survivors who choose to terminate their pregnancies.

Legal frameworks on adoption or foster care procedures. If the survivor chooses to continue with her pregnancy, or if abortion is illegal or unavailable, or if the survivor is too far along in the pregnancy to access abortion, she may choose alternative care for the infant. In this case, it is important that service providers understand the legal frameworks for adoption and foster care within the context.

Adoption is the permanent placement of a child into a family whereby the rights and responsibilities of the biological parents (or legal guardians) are legally transferred to the adoptive parent(s). Domestic or national adoption is when a child is adopted by a family designated as citizens and residents of the same country as the child. Inter-country adoption refers to the social and legal process whereby a child in one country is permanently placed with a family other than the biological mother or father in another country, outside of that child’s country of origin. International adoption, while often used synonymously with inter-country adoption, refers to adoption where the child and adoptive parents are of different nationalities, regardless of where they reside.

Foster care is an arrangement administered by a competent authority, whether on an emergency, short-term basis or a long-term basis, whereby a child is placed in the domestic environment of a family who has been selected, prepared and authorized to provide such care, and is supervised and may be financially and/or non-financially supported in doing so. Informal foster care is where a child is taken into care without third-party involvement. This may also be spontaneous fostering if it is done without any prior arrangements.⁴⁸ In

⁴⁴ WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*. Geneva: WHO, 2019.

⁴⁵ For more information on abortion laws by country, see <https://www.howtouseabortionpill.org/regions/>

⁴⁶ IPAS. *Sexual Violence and Unwanted Pregnancy: Protecting the human rights of adolescent girls and young women*, 2013.

⁴⁷ WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2012.

⁴⁸ Interagency Working Group on Unaccompanied and Separated Children, *Alternative Care in Emergencies Toolkit*, published by Save the Children on behalf of the Interagency Working Group on Unaccompanied and Separated Child, 2013.

Bangladesh, humanitarian aid groups working with the Rohingya have sought to identify refugees willing to adopt newborns, but not all cases are reported.⁴⁹ Some Yazidi women living in camps in Iraq have reportedly given their newborn children to infertile Kurdish couples or community-based organizations.⁵⁰

2. Ensure the Availability of Case Management Services and a Range of Referrals for the Pregnant Survivor

Each survivor who is pregnant will have needs that are specific to her culture, her context, her family, to herself, as an individual. Support needs are best determined through survivor-led approaches. In almost every instance, however, survivors pregnant from rape will need support from across a number of sectors; for this reason, a case management approach is recommended. Case management is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process.⁵¹

Most women have already thought about their options and made their decision about whether or not to terminate a pregnancy before seeking support. Some women may ask for more information before deciding. Some women may not yet be sure they are pregnant. The role of the case manager is to listen to the survivor and provide the appropriate level of support and information, respecting her decision without judging or influencing her. Specialized services to which women and girls may be referred for additional support include:

Pregnancy testing. If a survivor finds out she is pregnant, emotional support and clear information about her choices are essential to ensure she understands the choices available to her. Service providers offering pregnancy testing should be able to discuss the different options available in clear and understandable language and ensure a safe and confidential environment to support her to make her choice.

Emergency contraception. Emergency contraception (EC) has the potential to greatly reduce the number of unintended pregnancies. However, that potential is largely unrealized because most women are unaware that this method is available, and most health care providers do not routinely discuss emergency contraception with their patients.⁵² Although it is most effective immediately and within the first 72 hours (3 days) after the incident, if EC is used within 120 hours (5 days) after the rape, it can help a woman to avoid pregnancy. A pregnancy test is *not* necessary before providing EC but can be helpful to determine whether she was pregnant prior to the rape.⁵³

Safe abortion services. WHO recommends that if a woman presents after the time required for emergency contraception (120 hours), or if emergency contraception fails, and/or the woman is pregnant as a result of

⁴⁹ Shashank Bengali (Los Angeles Times), “‘I didn’t want this baby’: Rohingya Rape Survivors face a harrowing choice”, 1 June 2018. <https://www.latimes.com/world/la-fg-myanmar-rohingya-rape-20180601-story.html>

⁵⁰ Rikar Hussein (VOA News), “Pregnant IS Victims Face Challenges Upon Returning to Iraq”, 20 August 2016.

⁵¹ GBV AOR, Interagency Gender-based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-based Violence Survivors in Humanitarian Settings, 2017. For best practices in direct case coordination to prevent harm to the health and well-being of child survivors and that promotes children’s best interest, protection and confidentiality, see UNICEF and International Rescue Committee (IRC), Caring for Child Survivors, 2012.

⁵² Heather D Boomstra (Guttmacher Institute), “Emergency Contraception: The Need to Increase Public Awareness”, 14 October 2002.

⁵³ WHO, UNFPA, UNHCR, Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: WHO, 2019.

rape, she should be offered safe abortion, in accordance with national law.⁵⁴ Some humanitarian organizations like MSF, Marie Stopes International or IPAS offer termination of pregnancy. The decision to end a pregnancy belongs to the survivor. Her decision should be respected, and there should be no judgment. The role of the health care staff is to allow her to make an informed choice, to provide safe care and a confidential environment.⁵⁵

An abortion can be provided safely with pills, also known as a medication abortion, where a combination of pills is taken that causes the uterus to contract and push out the pregnancy in a process that is similar to a miscarriage.⁵⁶ Abortion with pills will successfully work more than 9 times out of 10.⁵⁷ The chance of severe complication from a medication abortion is less than 1 percent.⁵⁸ Abortion with pills is so safe that, most of the time, women can take the medications at home—they only need to go to a hospital or clinic if they have a question or a problem.

Box 1. Improve Community Outreach and Awareness of Emergency Contraception

An important step in ensuring support for survivors is educating communities about what kinds of services and how to access them. Members of the community should know:

- what services are available for someone who has experienced sexual violence, including where to access services 24 hours a day, seven days a week;
- why survivors would benefit from seeking medical care and other services, and the importance of survivors of rape coming within 72 hours to prevent HIV and pregnancy, and for forensic evidence collection (if available); and
- that rape survivors can trust the service to treat them with dignity, to maintain their security, and to respect their privacy and confidentiality.

In particular, raising community awareness about emergency contraception (EC) and the importance of reporting within 120 hours is high as this can work to prevent unwanted pregnancy.

Post-abortion care. Many women and girls who find themselves pregnant due to rape have terminated their pregnancies themselves, by buying drugs or potions, attempting to induce through self-harm, or accessing illegal abortion. Some women are able to access somewhat safer methods like medication on the black market, but may still suffer complications due to poor drug quality, incorrect dosing or inadequate information, or a combination of these. Incomplete abortion, which is more common with medical abortion attempts, may lead to medical complications and require medical care. Common symptoms include vaginal bleeding and abdominal pain, and signs of infection.⁵⁹ Health clinics routinely treat women who have experienced incomplete abortions and seek help while bleeding heavily or suffering severe infections. It is essential to inform the community of the existence of emergency contraception and safe abortion services (or menstrual regulation) where available (see Box 1).

Post-abortion care can be safely provided by properly trained health-care providers, including non-physician providers who are trained in basic clinical procedures related to reproductive health.⁶⁰

⁵⁴ WHO, Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, 2013.

⁵⁵ MSF, “Essential Obstetric and Newborn Care”, 2019.

⁵⁶ In countries where abortion is not restricted, most doctors recommend using the medications mifepristone and misoprostol in the first 11 weeks of a pregnancy, but misoprostol by itself is also highly effective in the first 11 weeks. The symptoms of an abortion with pills are very similar to a spontaneous miscarriage, and an abortion with pills is safe for women to use privately. <https://www.howtouseabortionpill.org/about/>. WHO. “Safe abortion: technical and policy guidance for health systems”, 2012.

⁵⁷ IPAS, “Clinical Updates in Reproductive Health”, 2013.

⁵⁸ IPAS, “Clinical Updates in Reproductive Health”, 2013.

⁵⁹ WHO, Safe Abortion: Technical and Policy Guidance for Health Systems, 2012.

⁶⁰ WHO, Safe Abortion: Technical and Policy Guidance for Health Systems, 2012.

Staff at every health-care facility should be trained and equipped to treat incomplete abortion by emptying the uterus, paying attention to the possibility of hemorrhage, which might cause anemia, or infection, which would necessitate antibiotic treatment. Policy and regulatory barriers, stigma or the unwillingness of some health-care professionals to provide post-abortion care may limit the availability of post-abortion care providers in many contexts so should also be explored in the context analysis.⁶¹

For most women seeking termination of pregnancy, follow-up counseling is not needed but the woman is encouraged to return for follow up at any time if she has concerns, complications or questions. For survivors of rape, it may be useful to provide referrals for additional psychological support.

Mental health counseling. Research shows that relatively brief mental health interventions, in particular several forms of Cognitive Behavioral Therapy (CBT), may improve the psychological health of many adult female survivors of rape. The WHO notes that these mental health interventions appear to be more helpful than receiving no treatment; however, the research does not unequivocally demonstrate that one particular type of therapy is clearly superior to all others.⁶²

3. Ensure Services for Safe Delivery and Postpartum Care for Survivors who Carry the Pregnancy

If a survivor does not wish for or is unable to access termination of pregnancy, several factors must be taken into account to support a safe delivery for the survivor and the infant. The survivor has undergone a traumatic event, her physical and mental health maybe in jeopardy. Research has shown that women with PTSD, which women who have experienced rape may have, are at greater risk for adverse outcomes during childbirth including pre-term delivery, low birth weight and increased anxiety related to labor.⁶³ Young girls, whose bodies are not mature enough for labor and delivery, and women with serious pelvic injuries, (for example, from the physical damage caused by gang rape), run significantly higher risks during childbirth.⁶⁴

More than 60 percent of maternal deaths occur in the post-partum period and 45 percent of postpartum deaths occur within the first 24 hours. Women should therefore remain in the health care facility for at least 24 hours after delivery.⁶⁵ By providing comprehensive care during pregnancy to meet the unique needs of rape survivors, some of the adverse outcomes that occur during pregnancy and postpartum may be mitigated.⁶⁶

Shelter. While a pregnant woman or girl waits to deliver, it is important to give her a safe and comfortable place to stay. Due to the stigma, she may feel uncomfortable staying with her family or in her community. Most shelters for GBV survivors allow pregnant women. In Nepal, International Medical Corps has created mother and child transition homes where women wait to give birth (usually for a few weeks in advance of the delivery date as villages are often too remote to allow safe transfer at the time of labor), then rest after birth for several weeks.⁶⁷ Transition homes like these can also be connected to Women and Girl's Safe Spaces or to existing health structures. Panzi Hospital in DR Congo supports the *Maison Dorcas*, a transit home for women preparing

⁶¹ WHO, Health Workers Role in Providing Safe Abortion Care, 2015.

⁶² WHO, Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, 2013.

⁶³ Yonkers KA, Smith MV, Forray A, et al. Pregnant women with posttraumatic stress disorder and risk of preterm birth. *JAMA Psychiatry*. 2014;71(8):897-904. doi:10.1001/jamapsychiatry.2014.558

⁶⁴ HHI, "Now, the world is without me": An investigation of sexual violence in Eastern Democratic Republic of Congo. Harvard Humanitarian Initiative: Boston, USA, 2010.

⁶⁵ MSF. Essential Obstetric and Newborn Care.

⁶⁶ Michelle L. Munro, Melissa Foster Rietz & Julia S. Seng "Comprehensive Care and Pregnancy: The Unmet Care Needs of Pregnant Women with a History of Rape", *Issues in Mental Health Nursing*, 33:12, 882-896, 2012.

⁶⁷ Personal Correspondence.

for or recovering from medical procedures that integrates psychosocial support and livelihood opportunities.⁶⁸

The shelters should provide practical information and crisis support to the survivor as well as pre-and post-natal mental health support and peer support. It is important to provide childcare in case the survivor has other children. It is also important to make any shelters friendly to a diversity of women and girls, including disabled mothers with newborns.

Postpartum Counseling. Research has identified that the post-partum period can be a time of significant mental health risk for many women. This is particularly true for rape survivors. The survivor may struggle to bond with the child, as rape can negatively affect her capacity to form a loving bond. Researchers report that such circumstances may also lead to abusive parenting or neglect.⁶⁹ Caretakers of the survivor should be aware about post-partum depression and monitor her and provide support.

Post-birth ‘baby blues’ is a common syndrome that has its onset within days after the delivery and lasts usually 2 weeks. It is characterized by mood swings, crying, irritability, anxious worrying, insomnia, loss of appetite and concentration problems. These problems generally diminish within a few days with reassurance. However, postpartum depression can be severe and is often underestimated. The characteristic symptoms of depression are sadness, frequent crying, loss of self-confidence, constant concerns about the child (or, on the contrary, a feeling of indifference), feeling incompetent as a mother, and feelings of guilt (or even aggressive thoughts toward the child) combined with insomnia and loss of appetite. These symptoms last more than 2 weeks and gradually worsen, leading to a state of exhaustion. Service providers should look for possible suicidal thoughts and assess the woman’s ability and desire to take care of the child. Antidepressant medication compatible with breastfeeding may be necessary. Postpartum psychosis occurs less frequently and is characterized by the onset of psychotic symptoms after childbirth.⁷⁰

It can also be difficult for survivors to accept and follow-through with referrals to other services for a number of reasons. IPPF found that less than 5% of women who disclosed violence in their clinics followed up on an external referral.⁷¹ If possible, mental health care services should be provided in the place where the survivor is receiving care after the birth.

Alternative placement (adoption or fostering) for the child. Whether or not abortion is allowed in the context, other options of how to manage the child born of rape should be explored with the survivor through sensitive GBV case management.⁷² Options for alternative placement of the child (such as foster care or adoption) may be available if the survivor does not wish to take care of the child after the birth. It is important to have a good understanding of the limitations of adoption and foster care in the context. It is also equally important to ensure that the survivor is able to make the decision to give the child up for alternative placement freely without pressure. If possible, provide a period of time for her to re-consider after the birth. It is recommended to provide written consent for placing the child in alternative care.⁷³ Child protection professionals should be involved in an assessment if the child is at serious risk of abuse, neglect or exploitation and the survivor

⁶⁸ Panzi Foundation “The Panzi Model: Compassionate Holistic Healing for Survivors of Sexual Violence,” website, 24 November 2020. <https://www.panzifoundation.org/the-panzi-model-1#community-reintegration>

⁶⁹ Elisa van Ee and Rolf J. Kleber, “Growing Up Under a Shadow: Key Issues in Research on and Treatment of Children Born of Rape.” 2013.

⁷⁰ MSF, *Obstetric and Newborn Care*, 2019.

⁷¹ Bott et al, 2010.

⁷² WHO, *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, 2013.

⁷³ Interagency Working Group on Unaccompanied and Separated Children, *Alternative Care in Emergencies Toolkit*, published by Save the Children, 2013.

indicates that she cannot sufficiently care for the child.⁷⁴

The survivor may also need access to psychological support after the decision to place the child elsewhere has been made. GBV case management should continue after the placement is made. In some contexts, GBV organizations have worked to discretely identify mothers of abandoned babies, in order to determine if they wanted to give up their child, and where appropriate advocate with authorities to consider the extenuating circumstances in any legal action against the survivor, while also working to place the babies with new families.⁷⁵

4. Support Survivors to Care for the Child and Reintegrate into their Communities

For those survivors who choose to keep their child, several issues are important to address when supporting the survivor, as highlighted below.

Birth Registration and Legal Issues. The Convention on the Rights of the Child recognizes that registering a birth is the first legal acknowledgement of a child's existence and a right.⁷⁶ Without proof of identity, a child is invisible to the authorities. In many countries, a birth certificate is a key document to gain access to basic services and to exercise fundamental human rights.⁷⁷ Unregistered children may be at higher risk of sexual exploitation, trafficking, and recruitment into armed groups. It can also be harder for unregistered children to receive humanitarian aid. Birth registration is a key tool of protection for children in humanitarian settings.⁷⁸

Service providers should work with protection actors to ensure that birth registration of the survivor's child takes place, if possible.⁷⁹ It is especially important that particular issues for women giving birth due to rape are understood and addressed. For example, for a birth certificate to be issued, many countries require that the father to be named and the survivor may not know the father, may refuse to name him, or it may put her in danger to name him. In some countries, only the fathers or a male member of the family can register the child. In Egypt, birth registration is a right of all children, including those born outside marriage. However, in practice, the focus turns to the nature of the woman's relationship that produced the child. The issuance of birth certificates for children born outside marriage is not common in Egyptian society, and officials have social attitudes that make them unwilling to provide this service.⁸⁰ For Yazidi women who were pregnant due to rape in Iraq, the law states that the children will be treated as if they were born of adultery and the survivor does not have the right to raise them.⁸¹

Availability of support, financial and other, for survivors and/or children born of rape. For many survivors of rape it is difficult to return to their communities due to stigma. Approximately 60 percent of the women who have sought treatment at Panzi Hospital in the DRC have been unable to return to their home communities

⁷⁴ Interagency Working Group on Unaccompanied and Separated Children, *Alternative Care in Emergencies Toolkit*, published by Save the Children, 2013.

⁷⁵ Personal Correspondence with author.

⁷⁶ See <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

⁷⁷ Plan International, "Birth registration in emergencies: a review of best practices in humanitarian action" 2014.

⁷⁸ Plan International, "Policy Briefing: Universal birth registration in emergencies," April 2011.

⁷⁹ Birth registration is the official recording of a child's birth through an administrative process of the state, coordinated by a particular branch of government. It is a permanent and official record of the existence of a person before the law. A birth notification is the notice of the occurrence of a birth, during which midwives or others report to civil registrars, who in turn register the birth. A birth certificate is a personal document issued to an individual by the state to prove birth registration. Plan International, "Birth registration in emergencies: a review of best practices in humanitarian action" 2014.

⁸⁰ M. Farahat, "Children of Rape of Refugee Women, and Statelessness, in Egypt" *Forced Migration Review*. 2017.

⁸¹ Rikar Hussein (VOA News), "Pregnant IS Victims Face Challenges Upon Returning to Iraq", 20 August 2016.

because of the extent of their injuries or deep societal stigma surrounding sexual violence.⁸² If adoption or foster care is not an option for the pregnant survivor, or if she chooses to raise the child, it is essential that she be supported after the child is born. Some countries may have targeted programs that can support rape survivors, such as a program to assist disabled women and girls pregnant by rape as in Myanmar,⁸³ or livelihood initiatives to support economically impoverished survivors, like the “Pigs for Peace” microcredit program or the “Panzi Model”, both in DR Congo.⁸⁴ The *Panzi Model* at Panzi Hospital offers rape survivors specialized after-care and a community center where women and girls (and their dependent children) can receive housing, meals, and access to ongoing therapeutic care. They offer economic and community reintegration programs to support women’s livelihoods. Survivors participate in 12-month training programs that include literacy and math classes, job skills training, micro-grants and micro-loans to support the women in launching micro-enterprises, and outreach projects to rural communities.⁸⁵

Reintegration of survivor with family and community. All rape survivors need support and care to re-integrate back into their families and community. For child protection actors, it’s important to note that support developed for children conceived by rape must also include support for the survivor and their families, in order to help them recover from the rape and to accept their children and provide care for them. Caretakers of disabled survivors may also need support to take care of the survivor and the child. In Myanmar, some caretakers of disabled survivors have sent the babies to adoption centers as they were unable to take care of both the survivor and her child.⁸⁶

Cultural sensitivity is important in order to develop non-stigmatizing and supportive reintegration programs for survivors pregnant due to rape. Models may differ depending on the context. For Yazidi women in Iraq who became pregnant due to rape, the community elders have worked to build support in their communities to welcome the survivors back. However, the children born of the rape were not welcome. According to the Yazidi religion, a child cannot be counted as a Yazidi unless he or she has two Yazidi parents as decreed by the Yazidi Supreme Spiritual Council.⁸⁷ Community-based organizations are working to advocate with the Yazidi leadership on this issue. They are also trying to find options for the women who cannot give up their children.⁸⁸

Supporting survivors’ access to justice. Upholding women and girls’ rights to access justice is a core responsibility of states and international actors, including in emergencies. In 1999, the Committee on the Elimination of all Forms of Discrimination against Women (CEDAW) established that all legal measures must be taken to provide effective protection of women against GBV, including effective legal measures, (such as compensatory provisions) and protective measures, including refuges, counseling, rehabilitation and support services for survivors of sexual violence.

Supporting survivors to safely access justice is one element of multi-sectoral GBV programming in emergencies

⁸² Panzi Foundation “The Panzi Model: Compassionate Holistic Healing for Survivors of Sexual Violence,” website, 24 November 2020. <https://www.panzifoundation.org/the-panzi-model-1#community-reintegration>

⁸³ Hein Ko So (Frontier) “A Sanctuary for Single Mothers”, 1 September 2017.

⁸⁴ Danielle Kress (Johns Hopkins Hub), “‘Pigs for Peace’ microfinance program improves mental health for women in the DRC, study shows.” 3 December 2014. and Panzi Foundation “The Panzi Model: Compassionate Holistic Healing for Survivors of Sexual Violence,” 24 November 2020.

⁸⁵ Panzi Foundation “The Panzi Model: Compassionate Holistic Healing for Survivors of Sexual Violence,” website, 24 November 2020. <https://www.panzifoundation.org/the-panzi-model-1#community-reintegration>

⁸⁶ Hein Ko So (Frontier) “A Sanctuary for Single Mothers”, 1 September 2017.

⁸⁷ Louisa Loveluck and Mustafa Slim (Washington Post) “Yazidi Women Raped as ISIS Slaves Face Brutal Homecoming Choice: Give up their Child or Stay Away”, 30 July 2019.

⁸⁸ Personal Correspondence with author.

and included in the *Interagency Minimum Standards for Gender-Based Violence in Emergencies Programming*.⁸⁹ GBV survivors can face serious risks to their physical and psychological safety and well-being when they disclose their experiences to State or customary authorities and seek accountability. Justice mechanisms that do not adopt a survivor-centered approach can further harm survivors by re-traumatizing them when giving evidence about their experiences of rape, and also expose survivors to retaliation from perpetrators.⁹⁰ While many survivors are not interested in pursuing justice for these reasons, some courts can assist pregnant rape survivors to demand child support from the perpetrator with forensic and DNA testing to establish paternity. Testing should be offered free to the survivor and only conducted with full informed consent.⁹¹

Establishing a “paper trail” can also assist survivors who decide to access justice at a later time in both domestic and international courts. Medical records, medical certificates, forensic evidence including DNA can all be used. In Congo-Brazzaville, nine out of ten of the medical certificates produced by MSF and used by rape survivors in court were admitted by the judge.⁹² Given the limited infrastructure available in most humanitarian settings, some organizations such as Physicians for Human Rights (PHR) have adapted procedures to assist physicians in conducting medical forensic exams and developed a new medical certificate for use in humanitarian settings like the Eastern DRC.⁹³

In 2005, the UN adopted international guidelines to the right to remedy and reparation for victims of sexual violence.⁹⁴ Countries like Bosnia-Herzegovina,⁹⁵ Croatia,⁹⁶ and Kosovo⁹⁷ have created reparations programs for conflict-related sexual violence survivors but survivors did not receive the funds until much later after the incident of violence (sometimes as much as 20 years later). In 2011, the Colombian government created the *Victims and Land Restitution Law* that featured restitution, compensation, and rehabilitation including free medical and psychological support for registered sexual violence survivors. Of those registered, more than 5,500 were compensated financially and about 1,600 have participated in the Victim Unit’s psychological recovery program.⁹⁸

The Importance of Coordination Across Humanitarian Response

As the information above illustrates, responding to the needs of pregnant survivors requires coordinated action across different areas of humanitarian response including, but not limited to, health, child protection, and protection. Where they do not already exist, GBV coordination mechanisms in humanitarian emergencies are

⁸⁹ GBV AOR, *Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies*, 2019

⁹⁰ GBV AOR Helpdesk, *Strengthening Access to Justice for GBV Survivors in Emergencies*, 2020.

⁹¹ WHO, *Guidelines for medico-legal care for victims of sexual violence*, 2003

⁹² MSF, *Care for Victims of Sexual Violence, An Organization Pushed to its Limits: The Case of Médecins Sans Frontières*, April 2015.

⁹³ Morse, Jaimie (2014) "Documenting Mass Rape: Medical Evidence Collection Techniques as Humanitarian Technology," *Genocide Studies and Prevention: An International Journal*: Vol. 8: Iss. 3: 63-79.

⁹⁴ See <https://www.ohchr.org/en/professionalinterest/pages/remedyandrepairation.aspx> , “Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law”

<https://www.ohchr.org/en/professionalinterest/pages/remedyandrepairation.aspx>.

⁹⁵ UN Action against Sexual Violence in Conflict – Fund.

⁹⁶ In 2015, the government of Croatia passed the “Act on the Rights of Victims of Sexual Violence during the Military Aggression against Republic of Croatia in the Homeland War” to compensate war rape survivors with a monthly financial stipend and access to free counseling, as well as legal and medical aid. Taylor Gillan (Jurist Legal News and Commentary), “Croatia approves law to compensate war rape victims”, 30 May 2015.

⁹⁷ Joanna Kakissis (National Public Radio), “In Kosovo, War Rape Survivors Can Now Receive Reparations . But Shame endures for Many.” 6 April 2018.

⁹⁸ Isabelle Flisi (Pass Blue) *Reparations for Wartime Sexual Violence: Colombia’s Ambitious Program.* 18 July 2016.

often tasked with developing referral pathways and building out multisectoral programming for survivors. Interagency and intersectoral coordination should be established to ensure comprehensive care for pregnant survivors noted previously.

Working with the Health Cluster or Reproductive Health Working Group to ensure access to health services.

To support survivors pregnant due to rape, it is essential that GBV coordination mechanisms work closely with the Health Cluster or a Reproductive Health Working Group (RHWG).⁹⁹ The Health Cluster or RHWG can identify and build the capacity of reproductive health actors and medical service providers to ensure emergency contraception and post rape kits, safe termination of pregnancy and safe delivery and post-abortion care. GBV coordinators must make sure that they understand the components of the Minimum Initial Service Package (MISP) for reproductive health interventions in an emergency, which include addressing sexual violence. The GBV coordination mechanism should also work closely with the RHWG to share information and strategies, particularly during assessments, planning and funding processes and for advocacy.¹⁰⁰

Working with Child Protection to ensure services for pregnant adolescent girls as well as support for child placement.

Establishing complimentary Standard Operating Procedures (SOPs) for child protection and GBV can bridge the gaps between child protection and GBV and ensure adolescent girls who are particularly at risk are not left out.¹⁰¹ This is especially important when it comes to adolescent survivors who find themselves pregnant. There is substantial evidence to show that adolescent girls are particularly vulnerable as they can “fall between the cracks” of the Child Protection and GBV coordination groups.¹⁰²

In the best of environments, counseling birth parents and supporting child relinquishment to an alternative care setting is challenging aspect for the child and the woman. In times of humanitarian emergencies and with the additional context of sexual violence, the practice requires aggressive safeguards that recognize the risk of vulnerable women being coerced into child placement, while upholding the core principles of survivor-centered care so the survivor can make the best decision for herself.¹⁰³

According to the *Child Protection Minimum Standards*,¹⁰⁴ for children without suitable current caregivers and in need of interim care, it will usually be in the child’s best interests to be placed with extended family members or other adults known to the child who could care for him/her. These relationships must be verified, an assessment made of whether the placement is in the child’s best interests, and the placement registered. There is no single type of care placement that will meet the needs of all children. For children who do not have families to care for them or who require specialist care, child protection specialists recommend making use of trained foster caregivers, with priority given to children under 3 years of age. Child protection agencies encourage and support the community in spontaneous foster care. ‘Residential care’ (or orphanages) are not recommended if other forms of care can be found.¹⁰⁵

⁹⁹ WHO, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*. Geneva: WHO; 2019.; GBV AOR, GBV Coordination Manual, 2018.

¹⁰⁰ GBV AOR, Handbook for Coordinating Gender-based Violence Interventions in Emergencies, 2019.

¹⁰¹ GBV AOR, Handbook for Coordinating Gender-based Violence Interventions in Emergencies, 2019.

¹⁰² Lindsay Stark, Ilana Seff, Chen Reis, “Gender-based violence against adolescent girls in humanitarian settings: a review of the evidence”, *The Lancet Child & Adolescent Health*, 2020.

¹⁰³ Nicole Footen Bromfield, Karen Smith Rotabi, “Human Trafficking and the Haitian Child Abduction Attempt: Policy Analysis and Implications for Social Workers and NASW”, *Journal of Social Work Values and Ethics*, Volume 9, Number 1, 2012.

¹⁰⁴ Child Protection Working Group (CPWG), *Minimum standards for child protection in humanitarian action*, 2012.

¹⁰⁵ For more guidance, work with the child protection working group and see the *Alternative Care in Emergencies (ACE) Toolkit*, a document that is designed to facilitate interagency planning and implementation of alternative care and related services for children separated from or unable to live with their families during and after an emergency.

There has been a history of unsavory political decisions about adoption around children conceived of rape in conflict.¹⁰⁶ Particular care should be taken with any foreign adoptions to ensure that the survivor consents to giving up the child and that trafficking is not involved.¹⁰⁷

¹⁰⁶ R. Charli Carpenter, "War's Impact on Children Born of Rape and Sexual Exploitation: Physical, Economic and Psychosocial Dimensions", No Date.

¹⁰⁷ Harvard Political Review, "International Adoption's Trafficking Problem", 20 June 2012. Office of the High Commission of Human Rights, "Illegal Adoptions" <https://www.ohchr.org/EN/Issues/Children/Pages/Illegaladoptions.aspx>

Key Resources

Context Analysis, Program Management, and Coordination

- GBV AOR, *Handbook for Coordinating Gender-based Violence Interventions in Emergencies*, 2019.
- Interagency Working Group on Unaccompanied and Separated Children, *Alternative Care in Emergencies Toolkit*
- International Planned Parenthood Federation (IPPF), *Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries*.
- United Nations Population Fund (UNFPA), *Whole of Syria Adolescent Girl Strategy in the GBV Coordination Manual*
- World Health Organization (WHO), *Guidelines for medico-legal care for victims of sexual violence*.
- Women's Refugee Commission (WRC) and International Rescue Committee (IRC), *Building Capacity for Disability Inclusion in GBV Programs in Humanitarian Settings: A Toolkit for GBV Practitioners*

Medical Care for Survivors

- IRC and UNICEF, *Caring for Child Survivors*
- WHO, UNFPA, United Nations High Commissioner for Refugees (UNHCR). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*.
- WHO, *Clinical Practice Handbook for Safe Abortion Care*.
- WHO, *Medical Management of Abortion*
- WHO, *Responding to children and adolescents who have been sexually abused: WHO Clinical Guidelines*
- WHO, *Responding to intimate partner violence and sexual violence against women: WHO Clinical and Policy Guidelines*

Supporting Care for the Child born of Rape

- Child Protection Working Group, *Inter Agency Guidelines for Case Management and Child Protection*
- Interagency Working Group on Unaccompanied and Separated Children (2013) *Alternative Care in Emergencies Toolkit*, published by Save the Children on behalf of the Interagency Working Group on Unaccompanied and Separated Children.

Supporting Access to Justice

- WHO, *Guidelines for medico-legal care for victims of sexual violence*.
- GBV AoR Helpdesk, *Strengthening Access to Justice for GBV Survivors in Emergencies*

The GBV AoR Help Desk

The GBV AoR Helpdesk is a unique research and technical advice service which aims to inspire and support humanitarian actors to help prevent, mitigate and respond to violence against women and girls in emergencies. Managed by Social Development Direct, the GBV AoR Helpdesk is staffed by a global roster of senior Gender and GBV Experts who are on standby to help guide frontline humanitarian actors on GBV prevention, risk mitigation and response measures in line with international standards, guidelines and best practice. Views or opinions expressed in GBV AoR Helpdesk Products do not necessarily reflect those of all members of the GBV AoR, nor of all the experts of SDDirect's Helpdesk roster.

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