

Sexual violence, health and humanitarian ethics: Towards a holistic, person-centred approach

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Abstract

Sexual violence and rape in armed conflicts are widespread phenomena, with devastating consequences. Over the last thirty years, our understanding of these phenomena has significantly improved. Today humanitarian and health professionals understand better the reality, scale and impact of sexual violence on the personal, physical, social and mental health of individuals and communities. Rape is recognized to have a dehumanizing effect, as much as torture or mass violence. Major efforts are put into providing an effective and ethical response, with respect and sympathy to the survivors. Health and humanitarian assistance contribute to the healing and resilience of survivors and communities. Looking

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forward, programmes must be centred on the person, promoting their autonomy and dignity, and integrating medical, psychosocial and socio-economical responses.

Keywords: sexual violence, armed conflicts, humanitarian ethics, humanitarian assistance, access to health care.



Introduction: The slow recognition of sexual violence

Until quite recently, sexual violence has been a “blind spot” in the conscience of societies. It was a missing topic in the works of historians, sociologists and politicians; it was ignored by philosophers,¹ and nearly as much neglected by health and humanitarian professionals. Although rape has long been considered a serious offence, the societal and judiciary responses have been weak and inconsistent in many instances. Analyzing the history of rape in France, for instance, Georges Vigarello has observed in his seminal work that convictions for rape were exceptional in the Ancien Régime.² Despite the fact that sexual violence was, in theory, severely punished by law, in many instances perpetrators were excused or punished lightly, while the victims were ignored, rejected, ostracized, or blamed for the violence they had suffered. When sexual violence was considered a moral fault, the victim was often considered to be “contaminated” by the moral fault of the perpetrator. This was assimilated to tacit acceptance, and hence the victim was generally considered to have consented. The victim of rape was suspected of seducing the perpetrator, and of accepting or even participating in the act. This moralized understanding of victims and perpetrators contributed to the silence around sexual violence.

A similar attitude has been shown towards rape in war, which has long been considered as inevitable. Silence surrounding sexual violence in armed conflict was maintained by complacency, shame of professionals and society. While rape in war was recognized as a grave crime, reasons were found to excuse it, in order to avoid mass punishment.³

The history of addressing sexual violence reminds us of the importance of properly defining and addressing this phenomenon in order to respond effectively at the level of the victims, perpetrators and society. A major change in our understanding of sexual violence occurred when the focus shifted from the victims’ consent, to the coercion exerted against them. Looking forward, providing an effective and ethical response to survivors will require focusing on the person, promoting their autonomy and dignity, and integrating medical, psychosocial and socio-economic responses.

1 See Keith Burgess-Jackson’s Introduction in Keith Burgess-Jackson (ed.), *A Most Detestable Crime: New Philosophical Essays on Rape*, Oxford University Press, New York, 1999, p. 3.

2 Georges Vigarello, *Histoire du viol, XVIe-XXe siècle*, Seuil, Paris, 1998, pp. 73, 292–293.

3 Marianna G. Muravyeva, “Categorising Rape in the Military Law of Modern Russia”, in Raphaëlle Branche and Fabrice Virgili, *Rape in Wartime*, Palgrave Macmillan, London, 2012, pp. 17–33.

Approaching sexual violence

Definition

Defining sexual violence and rape poses conceptual difficulties, and has major practical implications. As history shows, the way societies respond to sexual violence depends on how they conceive and define it. Is it mainly considered a regrettable incident, a moral problem, a behavioural matter, or an aggression? Is it primarily viewed as a matter of sexuality, or an issue of violence? This is a central question. For instance, some states in the USA define rape as a crime of violence, without considering sex in the legal definition.⁴ At the other end of the spectrum, some experts consider principally the sexual dimension, somehow neglecting the element of violence. Others still insist on lack of consent, to the extent that a philosopher, oddly enough, defined rape as “a normal sexual activity, minus consent”.⁵ What, then, about sexual life, desires and contradictory feelings? Are these relevant criteria to take into consideration in defining a case? Is physical violence always present in rape, or are there other forms of coercion and abuse at play?

Following intense debates in the 1990s, sexual violence and rape are now generally defined by coercion in a sexual act.⁶ Force or coercion are the central elements in defining sexual violence. This approach recognizes that this is not primarily an issue of a sexual relationship that goes wrong; it is violence and abuse, in the context of sexuality.⁷

Lack of consent is often present; however, for various reasons, this element is not a central criterion for an operational definition, notably for legal, medical or public health purposes. In the presence of coercion or force, the value of consent is questionable. Likewise, in situations of generalized fear and a climate of violence, certain sexual “offers” may actually be coercive, even when women express consent to them. In addition, the question of consent puts the onus and the burden of proof on the victim. How can someone prove that he or she did not consent? Does a victim need to physically hurt the aggressor in order to express lack of consent, thus exposing her or himself to physical violence and maybe death? If the perpetrator affirms that the victim consented, then the victim must demonstrate that this was not the case, and that the perpetrator is lying; if the person is vulnerable or in a relationship of dependence with the aggressor, such a demonstration can be extremely difficult.

These questions suggest the variety of situations that might be encountered. The role and importance of coercion and consent may be influenced by other elements. First, at the individual level, there are the capacities and factors of

4 Keith Burgess-Jackson, “A History of Rape Law”, in K. Burgess-Jackson (ed.), above note 1, p. 24.

5 Quoted in Susan Brison, *Aftermath: Violence and the Remaking of a Self*, Princeton University Press, Princeton, NJ, 2002, p. 6.

6 Keith Burgess-Jackson, “A Theory of Rape”, in K. Burgess-Jackson (ed.), above note 1, p. 93.

7 Patricia Smith, “Social Revolution and the Persistence of Rape”, in K. Burgess-Jackson (ed.), above note 1, pp. 38–39.

vulnerability of the potential victim. Children, elderly persons, or persons with developmental deficiencies are exposed to higher risks, with low capacity to resist coercion or force, or to give consent. Secondly, there is the nature of the relationship between a potential victim and an aggressor, considering the elements of dependence: persons who are in a situation of poverty, displaced or detained are highly vulnerable to abuse by persons exerting economic, administrative, professional or other forms of power, including spiritual or educational. Thirdly, the social and institutional context will have an influence on the event – as mentioned above, consent has little value in a context of community violence and conflict.

Acts of “sexual violence” are generally defined in the Rome Statute of the International Criminal Court (ICC) as acts of sexual coercion directed against someone.⁸ Sexual violence encompasses rape, forced prostitution, sexual slavery, forced pregnancy, forced sterilization and other forms of sexual abuses. Under the Statute, the ICC has jurisdiction over sexual violence as a war crime and as a crime against humanity.⁹

The above legal definition is in agreement with the operational definition adopted by the World Health Organization (WHO) for public health purposes, a starting point for developing a public health approach to sexual violence.¹⁰ WHO defines sexual violence as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work”.¹¹ Rape, a specific form of sexual violence, is defined as “physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object”.¹² This operational definition is a key element of WHO’s public health approach to sexual violence – an important endeavour that involves estimating the extent of the problem, its determinants and consequences, and evaluating health-care and preventive actions.¹³

8 The *Elements of Crimes of the International Criminal Court* explicitly use the wording “coercion” and “coercive environment” to define rape and sexual violence as a war crime and a crime against humanity: “The invasion was committed by force, or by the threat of force or coercion, such as that was caused by fear of violence, duress, detention, psychological oppression, or abuse of power, against such person or another person, or by taking advantage of a coercive environment or the invasion was committed against a person incapable of giving genuine consent” (emphasis added). See e.g. *Elements of Crimes of the International Criminal Court*, The Hague, 2011, Arts 7(1)(g)-1, 7(1)(g)-6, 8(2)(b)(xxii)-1, 8(2)(b)(xxii)-6, available at: www.icc-cpi.int/NR/rdonlyres/336923D8-A6AD-40EC-AD7B-45BF9DE73D56/0/ElementsOfCrimesEng.pdf (all internet references were accessed in October 2014).

9 For the elements of the crime of rape as a war crime or crime against humanity, see *ibid.*, Arts 7(1)(g)-1, 8(2)(b)(xxii)-1, 8(2)(e)(vi)-1. For a detailed discussion of law and sexual violence in armed conflicts, see the article by Gloria Gaggioli in this issue of the *Review*.

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

11 See *ibid.*, Chapter 6, “Sexual Violence”, p. 149, available at: www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf.

12 *Ibid.*, p. 149.

13 See the WHO web page, available at: www.who.int/reproductivehealth/topics/violence/sexual_violence/en/.

Consequences on health

Sexual violence has severe consequences, potentially affecting all aspects of a person's life and health in their physical, mental, social and spiritual dimensions. Physical consequences include injuries, abrasions, burns, and abdominal or chest trauma.¹⁴ Sexually transmitted infections such as HIV/AIDS can occur. Acute or chronic pain can result from physical violence, or from other internal or psychosomatic trauma. Pain can be located in a specific region, such as the genital, anal, or abdominal region, or it can be of a general nature, with no specific location. Long-term after-effects of sexual violence also include infertility, vesico-vaginal fistulae, and an increased incidence of subsequent health problems.

Psychological and mental health consequences of sexual violence may include distress, self-blame, feelings of isolation and poor self-esteem; behavioural disorders, including sleeping or eating disorders, such as anorexia; substance abuse or high-risk sexual behaviour; and mental disorders including depression, traumatic syndromes such as post-traumatic stress disorder (PTSD), anxiety disorders including loss of speech or hearing, and suicidal ideation, suicide attempts and other forms of self-harm, potentially resulting in death.¹⁵ Many rape victims experience fear and terror as well as mixed feelings of confusion and indignity, anger and incapacity, with guilt and shame toward themselves, their family, and their deeper aspirations and spiritual beliefs.

Pregnancy following sexual violence often occurs in the context of shock, trauma, horror and confusion; it may add a further traumatic experience, and aggravate suffering and feelings of helplessness and despair.

Personal, conjugal and family life

Acts of sexual violence touch upon some of the most intimate and personal components of an individual's existence. They may damage his/her identity and self-esteem, personal history, moral life and spiritual aspirations. Rape also affects, in various ways, the spouse of the victim and his/her children. Rape is a violent intrusion into the person; it is also an aggression against marriage and conjugality. The spouse of the victim can be deeply affected, first as a witness of the traumatic event, and as a first-line listener to the traumatic narrative; but rape also directly offends the marital relationship of the spouses, their conjugality, their common projects and descendants. Studies reveal the distress of husbands, their feelings of indignity and guilt at having been unable to protect their wives, with fear and shame that they have themselves been soiled by these

14 WHO, Health Consequences: Understanding and Addressing Violence against Women, WHO/RHR/12.43, Geneva, 2012.

15 WHO, Mental Health and Psychosocial Support for Conflict-Related Sexual Violence: 10 Myths, WHO/RHR/HRP/12.17, Geneva, 2012.

dehumanizing acts. Husbands and partners can suffer deep trauma.¹⁶ In many instances rape causes repudiation or conjugal separations, during or following the conflict. Similar feelings of shock and terror affect the children, particularly if they witnessed the aggression. Rape may represent a break, a potential rupture in the person's genealogy and the path of filiation and generations. This dimension can have deep consequences also for the spouse and children, and potentially for the entire family and the community. In armed conflicts, this conjugal dimension takes a particular importance, and in some instances may be part of the intention behind acts of sexual violence.¹⁷

Women victims of rape interviewed in the Democratic Republic of the Congo (DRC)¹⁸ stressed the need for information and support to be provided to the husbands of victims, in order to avoid rejection and stigmatization and to make it possible for them to accept and raise a child born of rape. They also talked about the importance of community education, in order to provide information about sexual violence and to avoid social stigmatization and rejection of victims and children. Partners, children and witnesses need support, guidance and care, to help them overcome psychological trauma and rebuild their life and self-esteem.

Social consequences

The social consequences of sexual violence are closely related to its psychological and emotional consequences, and in turn contribute to aggravating these effects. Victims of rape are often blamed, considered as dishonoured, undignified, and stained with evil and moral fault. They are often "treated by their families and communities as if they have committed a crime".¹⁹ Strong and violent reactions occur, such as rejection of the victim, who is left isolated and unloved within the family or abandoned by family and community members. Social stigmatization and discrimination occurs, to the victims and eventually to their spouses, children and relatives.

Victims of rape suddenly find themselves in a situation of high vulnerability, with increased risks of further sexual violence, rejection or desertion of children born of rape, forced marriage, or loss of their means of subsistence.²⁰ Many live in constant fear, related to returning to the location where the violence

16 Jocelyn Kelly *et al.*, "'If Your Husband Doesn't Humiliate You, Other People Won't': Gendered Attitudes Towards Sexual Violence in Eastern Democratic Republic of Congo", *Global Public Health*, Vol. 7, No. 3, 2012, pp. 285–298.

17 Evelynne Josse, "'They Came with Two Guns': The Consequences of Sexual Violence on the Mental Health of Women in Armed Conflicts", *International Review of the Red Cross*, Vol. 92, No. 877, March 2010, pp. 177–195.

18 J. Kelly *et al.*, above note 16.

19 Richard Mollica, *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World*, Harcourt, Orlando, FL, 2006, p. 230.

20 R. Charli Carpenter, "War's Impact on Children Born of Rape and Sexual Exploitation: Physical, Economic and Psychosocial Dimensions", in R. C. Carpenter, *Born of War: Protecting Children of Sexual Violence Survivors in Conflict Zones*, Kumarian Press, Hartford, 2007.

took place. Death may eventually result from abandonment and deprivation, diseases such as AIDS, further violence and murder, or suicide or other self-harming behaviour.

Dehumanization, moral and social death

Whether we look at it from the perspective of the aggression itself, from the experience of the victim, or from the consequences on the personal, relational and social dimensions of life, rape is one of the gravest attacks on human integrity, life and dignity. Like torture, slavery or extreme violence, rape is dehumanizing. The philosopher Mari Mikkola explores rape as a paradigm case of dehumanization.²¹ She defines dehumanization as “an act or a treatment ... which is an indefensible setback on our legitimate human interests, and constitutes a moral injury”. This rather abstract definition corresponds in some way to the experience of victims of rape. Many describe themselves as being dead – as being humanly, morally lifeless. “This was just the first of many incidents in which I felt as if I was experiencing things posthumously”, writes Susan Brison, who survived rape and near-murder. For several months, she adds, “I felt as though I’d somehow outlived myself.”²² Many victims no longer feel like they are themselves – they feel like strangers to themselves and to their bodies, to their personal lives and their community. They feel soiled, having lost their dignity and their value as humans, and that they are not part of humanity anymore. This state is often aggravated by a massive reaction of denial from family and friends.²³ Victims are isolated, alone and misunderstood, in a world which has become insecure, violent and threatening for them.

At the social and community levels, sexual violence may radically transform social relationships and result in cultural annihilation.²⁴ Like mass violence or torture, these events appear to be sometimes planned and purposefully aimed at the annihilation of individuals, societies and nations.²⁵

Pregnancy and children born after rape

In this adverse and traumatic context, some women and girls soon discover that they are pregnant as a result of the rape. They often face an extremely difficult and painful situation, with major challenges and high risks to their health and survival. In recent conflicts in which the International Committee of the Red Cross (ICRC) has been active, some women and girls have been forced to carry pregnancies following rape. Many of them have abandoned babies. Among those who kept the child, many have faced ostracism and severe poverty; some have

21 Mari Mikkola, “Dehumanization”, in Thom Brooks (ed.), *New Waves in Ethics*, Palgrave Macmillan, Basingstoke, 2011, pp. 128–149, 141.

22 S. Brison, above note 5, p. 8.

23 *Ibid.*, p. 9.

24 R. Mollica, above note 19, p. 66.

25 *Ibid.*, p. 63.

been killed by their families or committed suicide. Many women and girls who have become pregnant as a result of sexual violence have had to abandon their family and community and move to another place in order to survive.

In some contexts, children born following rape, sexual slavery or sexual exploitation in wartime have been victims of abuse, neglect or, in some cases, infanticide; many have been rejected, stigmatized, discriminated against and deprived of their rights to education, family, identity and physical security. Some children have also suffered health and developmental problems, related to the circumstances of the pregnancy and birth and the psychosocial trauma of their mothers.²⁶ Some children born following sexual violence have been abandoned and placed in institutions or orphanages.

Responding to sexual violence and rape in armed conflicts

Humanity: respect and sympathy

Because of the moral trauma and feelings of dehumanization involved, sexual violence poses major medical and ethical challenges to health and humanitarian professionals. In addition to, and perhaps above, the medical and psychosocial needs, there are the profound moral wounds, aggravated by isolation or rejection from family and community and the need to survive in armed conflict, in a world of violence and direct threats against the most vulnerable.

A priority concern in building a response for survivors of sexual violence is to treat them with respect and sympathy – in a word, with humanity.²⁷ Treating someone with respect implies considering and promoting the dignity of the individual, as a human person, despite and beyond the traumatic experience and feelings of dehumanization. To treat with sympathy involves recognizing the vulnerabilities and the suffering of the person and expressing human solidarity, concern and support, while at the same time recognizing and promoting the capacities of the person. As Paul Ricœur has formulated it, the human individual is defined by his/her identity, capacities and vulnerabilities;²⁸ the person is an “acting and suffering” being. His/her identity is expressed in his/her name and his/her history, and also in his/her religion, culture and beliefs. He or she has the capacity, notably, to say, to act, to tell, to be accountable for his/her own actions, and to promise; on the other side, his/her vulnerability calls for solicitude and care. To treat someone humanely implies recognizing all these dimensions of the human person and respecting, protecting and promoting them. It involves recognizing the individual’s identity, name and history; promoting their autonomy and capacities; and recognizing their vulnerabilities and suffering.

26 Françoise Sironi, *Psychopathologie des violences collectives*, Odile Jacob, Paris, 2007, pp. 59–62.

27 Jonathan Glover, *Humanity: A Moral History of the Twentieth Century*, Pimlico, London, 2001, p. 383.

28 Paul Ricœur, *Soi-même comme un autre*, Seuil, Paris, 1990, p. 223.

A core ethical duty in humanitarian action is to provide care and solicitude to affected persons, promoting their autonomy and their capacities. Humanitarians must avoid reducing individuals to their vulnerabilities, dependency and suffering, to a traumatic event or to health needs. The humanitarian and health-care responses should be based on the needs of the person, always respecting his/her dignity and recognizing his/her identity, history, aspirations and capacities. The response must be centred on the person, in all aspects.²⁹ Putting people at the centre implies a fundamental shift of focus for many professionals, institutions and organizations. Respecting privacy and confidentiality is crucial, as is avoiding attitudes of victim-blaming or any discrimination based on age, gender or origin. The person needs a caring relationship, with clear information, support and the promotion of her capacity to choose the most appropriate response to her particular situation and needs.

In response to a person who has been a victim of sexual violence, with severe trauma and feelings of dehumanization, the key principle is absolute respect of the person and his/her autonomy. No pressure must be exerted, notably to collect a narrative of the events or to invite the patient to follow a particular medical procedure or treatment. A respectful and caring attitude, opening to a continuous relationship of listening and providing support, is a key element to helping a person overcome grave trauma and eventually start a process of healing and resilience.

Medical care

Sexual violence is a medical emergency. Victims should have access to medical care as soon as possible, for emergency care and support. It is crucial that rape victims receive care within seventy-two hours, for the purpose of preventing sexually transmitted diseases, including HIV, and for emergency contraception. A similar time frame is recommended for specialized examination and samples for medico-legal purposes.³⁰

As soon as possible, a medical consultation is needed for a detailed history, general medical examination and, if needed and available, specialized examination and complementary laboratory tests; the patient should receive treatment for injuries and disease, counselling about possible consequences and guidance for future care. Victims of sexual violence must have access to health facilities with functioning infrastructure and management, proper resources and skilled and committed staff providing treatment and care in line with recognized good practices. Health care should be organized in order to meet the needs of the patient, in an integrated and comprehensive way, and to ensure continuity of care.

The first encounter with a health professional may also be a privileged moment for the patient to give an account of the event. This requires an open

29 WHO, "Do's and Don'ts in Community-Based Psychosocial Support for Sexual Violence Survivors in Conflict-Affected Settings", WHO/RHR/HRP/12.16, Geneva, 2012.

30 WHO, Guidelines for Medico-legal Care of Victims of Sexual Violence, Geneva, 2003.

and welcoming attitude, a capacity to listen and a professional attitude that is non-judgemental, focuses on the person's needs and expectations, and maintains a just distance between coldness or indifference and closeness and affective fusion, in order to provide support and promote the patient's autonomy.³¹ In the presence of signs suggesting the possibility of sexual violence, inviting the patient to tell their story can be helpful; however, many patients might not be able to tell such a traumatic event until much later. It is essential to respect the patient's silence and his or her will and ability to tell, without ever forcing or pushing him or her to do so.

As for any medical care activity, health professionals should keep a record of all encounters with a patient who might have been a victim of sexual violence. If the patient so requests, the health professional should deliver a summary of the medical record, stating the identity, place and date of the encounter, a summary of the history told by the patient, and a description of the medical observations. The summary should briefly mention the essential facts, but should not mention any diagnosis or interpretation of these elements. In case of a prosecution, the summary might be produced by the patient in a court of justice.

In many contexts of armed conflict and humanitarian crisis, access to timely medical care is either unavailable or represents a major challenge. In many places medical infrastructure is limited, trained staff and medicines are frequently unavailable or minimal, and victims may have to travel long distances to obtain care. A study conducted in the DRC³² showed that less than 5% of interviewed survivors of rape would have had access to care within seventy-two hours. In the experience of the ICRC, similar situations occur in regions of Colombia and in many other countries affected by armed conflict.

Besides, many victims are unaware of the need to seek medical care and to continue their treatment. Because of trauma, confusion and shame, many survivors are unable to tell anyone about the abuse, or even to think of it. They keep silent about their experience, their suffering and trauma. Not infrequently, they may ignore or hide a pregnancy. Many survivors also fear for their own security in seeking health care. They may fear that if they come to a specialized clinic, they may be identified by a relative, an acquaintance or someone related to the perpetrators, and be threatened. In order to avoid such obstacles and security threats, and also to make access easier, specialized clinics should be fully integrated in general health-care activities. To ensure the security of the victims and their protection from further violations, it is essential to implement safety measures and to provide guidance on safety and risk reduction.

31 Paul Ricœur, "La prise de décision dans l'acte médical et l'acte judiciaire", in Paul Ricœur, *Le Juste 2*, Esprit, Paris, 2001, pp. 245–255.

32 J. T. Kelly, T. S. Betancourt, D. Mukwege, R. Lipton and M. J. VanRooyen, "Experiences of Female Survivors of Sexual Violence in Eastern Democratic Republic of the Congo: A Mixed-Methods Study", *Conflict and Health*, Vol. 5, No. 25, 2001, pp. 2–8.

Mental health care and psychosocial support

Mental health care should be provided to all victims of violence, together with medical care, and certainly with the same level of quality and professionalism. With increasing awareness of the issues and their mental health consequences, various programmes have been developed to respond to sexual violence. It was assumed that these interventions could only be helpful to victims, but ill-conceived interventions can be extremely damaging, destroying personal resources and creating disease.³³ All assistance must imperatively be evaluated as to its efficacy and possible negative impact on individuals and the community.

Considerable progress has been made over the last decade in shifting attention from vulnerabilities and trauma to resilience. Resilience has been defined as “a dynamic process encompassing positive adaptation within the context of significant adversity”.³⁴ This is not equivalent to individual qualities of resistance to stress or coping with adversity – rather, resilience describes “a biological, psycho-emotional, social and cultural process, which allows a neo-development, following a psychological trauma”.³⁵ It is a process in which the person plays an active role, with the support of and in interaction with others. Two essential ingredients contribute to the process of resilience: one is the presence of positive links with others; the other is the construction of a narrative out of the lived events, and the telling of this story.³⁶ Transforming the traumatic event into a narrative contributes to the process of resilience by making sense out of chaos.³⁷ However, two notes of caution are needed here. The first is that talking about and repeating a traumatic story may be extremely counterproductive. The trauma story may contribute to healing when it tells the facts and helps the victim to understand their meaning and thereby overcome the trauma; however, professionals should be careful not to overemphasize the brutal facts, as though telling someone about them might magically cure the victim.³⁸ Secondly, resilience does not develop alone, but with others. It is a developmental and interactive process. Particular care must be given to the relationship between the affected person and those who listen to the story. Working in groups of peers, sharing not only the trauma story but also its meaning and the strategies to survive it, is most effective, and possibly one of the safest ways to achieve healing from severe trauma.³⁹ In various countries, the ICRC has developed programmes which provide care and support to victims of sexual violence and address their psychological and social needs. The *maisons d’écoute*, or “listening houses”, in

33 R. Mollica, above note 19, p. 236.

34 Suniya S. Luthar, Dante Cicchetti and Bronwyn Becker, “The Construct of Resilience: A Critical Evaluation and Guidelines for Future Work”, *Child Development*, Vol. 71, No. 3, 2000, pp. 543–562.

35 Personal communication with Boris Cyrulnik on resilience, Paris, December 2010.

36 Boris Cyrulnik, *Un merveilleux malheur*, Odile Jacob, Paris, 1999.

37 Boris Cyrulnik, “Children in War and Their Resilience”, in Henri Parens, Harold P. Blum and Salman Akhtar, *The Unbroken Soul: Tragedy, Trauma and Resilience*, Jason Aronson, Lanham, MD, 2008.

38 R. Mollica, above note 19, p. 223.

39 *Ibid.*, p. 234.

the DRC, are a particularly successful model of intervention for victims of mass sexual violence.⁴⁰

Continuity of care and regular follow-up are essential over a period of time, including medical care, mental health and psychosocial support. In addition, economic support is often a vital form of assistance to victims who have been displaced or who have lost their means of subsistence. These persons frequently require shelter and economic support to be able to survive and to rebuild their lives. It is crucial to ensure that they are not excluded and that, if and when possible, they are reintegrated into the community and their families and do not suffer further trauma through stigmatization or abandonment.

Justice

Justice is, in principle, a component of any meaningful response to sexual violence. A fair exercise of justice, implying the prosecution of suspected perpetrators in a fair trial, may help victims overcome the trauma and build resilience. The function of justice is not therapeutic, nor is it exclusively to punish; its first role is to state the law.⁴¹ It is to name values and to locate rights and wrongs, thus helping to resolve confusion.⁴² In this respect justice is due, first, to the victim, who is “publicly recognized as an offended and humiliated being”.⁴³ This recognition has both a public dimension and a personal one, which concerns self-esteem. In this way, justice may contribute to the process of mourning,⁴⁴ and possibly to the development of resilience. Justice is due also to society, to help it to move away from vengeance and to replace it with indignation. Finally, justice is also due to the perpetrator. In the trial the guilty becomes an actor, recognized as a reasonable being, the author of his own acts. The sanction, then, opens the possibility of the restoration of the convict’s capacity to become a full citizen again.⁴⁵

Access to legal support services is important, with due consideration to the context and functioning of the relevant institutions, and respecting the wishes and security of the survivor. Most survivors need information and support in this regard, and many wish to seek justice and prosecution of the perpetrators. It must be recognized, however, that in some contexts, especially in times of conflict, access to judicial institutions and the possibility of a fair trial is not available. Besides, criminal trials seem to care more about punishing those who have committed crimes than about the personal experiences of survivors, their pain and suffering

40 For more information about the “listening houses”, see, for example, ICRC, “Democratic Republic of the Congo: Taming One’s Fear, by Helping Others”, 2009, available at: www.icrc.org/eng/resources/documents/feature/2009/congo-kinshasa-feature-220509.htm.

41 Paul Ricœur, “Justice et vengeance”, in P. Ricœur, *Le Juste 2*, Esprit, Paris, 2001, p. 261.

42 Denis Salas, “L’inceste, un crime contre la filiation”, in Gérard Neyrand, *Le cœur, le sexe, et toi et moi*, Panoramiques-Corlet, Paris, 1998, p. 34.

43 Paul Ricœur, “Sanction, réhabilitation, pardon”, in Paul Ricœur, *Le Juste*, Éditions Esprit, Paris, 1995, pp. 198–199.

44 *Ibid.*

45 *Ibid.*

and their own struggle for survival and healing.⁴⁶ Furthermore, denunciation can expose survivors to acts of vengeance against their integrity and life. In a study in the DRC, survivors of rape underlined the important role of justice, in particular the denunciation and prosecution of the perpetrators, as part of their rights and their care; they acknowledged, however, that these conditions were not met in regions where the police and the judicial system were inefficient and denunciation could lead to threats and retaliation against the victims themselves.⁴⁷

Protection, education and prevention

Protection efforts are an integral part of the response to sexual violence in armed conflicts. These include, firstly, environmental measures to increase the safety of individuals and reduce their vulnerability and exposure to risk. Examples in ICRC experience include providing women with fuel-efficient stoves to minimize the time spent venturing out to collect firewood, or working with communities in drilling boreholes closer to the villages in order to reduce security risks when collecting water or firewood.

Protection activities also involve dialogue with communities to raise awareness and develop strategies for their security, and confidential dialogue with authorities and armed groups about observed or alleged facts, their consequences for the victims and communities, their legal and criminal consequences, and possible measures to take in order to identify and sanction the perpetrators, to protect the population and to decrease the risk of such aggressions.

Prevention activities involve promoting understanding and awareness of international humanitarian law, including the prohibition of sexual violence in armed conflicts. Survivors of sexual violence have stressed the importance of information and education to family members and communities. In the DRC, survivors of rape insisted that their husbands needed information and support in order to avoid rejection and stigmatization, and to make it possible for them to accept and raise a child born of rape.⁴⁸ They also stressed the importance of community and education in order to provide information about sexual violence and to avoid social stigmatization and rejection of victims and children. An effective humanitarian response should include awareness-raising activities with communities, in order to mitigate rejection and stigmatization of survivors of sexual violence.

Health related and ethical issues around pregnancy and rape

Pregnancy care and safe abortion care

Pregnancy following rape raises a number of difficult issues, on operational and ethical grounds. All health and humanitarian professionals involved in providing

46 R. Mollica, above note 19, p. 212.

47 J. T. Kelly *et al.*, above note 32.

48 *Ibid.*

care and assistance to victims of violence must be prepared and ready to respond to these situations which they face day after day, often in a context of emergency. A clear institutional policy on these matters is essential. Lack of clarity regarding pregnancy or abortion care leads inevitably to confusion and inadequacy of programmes, and potentially blocks the development of specialized programmes by an institution.

Pregnancy as a result of rape may be an added traumatic and life-threatening event. In many instances it can be emotionally, rationally and practically impossible to cope with. For many survivors, carrying on a forced pregnancy is not a viable option, and interrupting the pregnancy is a necessary choice for the sake of their survival, family, health and recovery.

In such circumstances, in situations of armed conflicts or violence, access to emergency contraception and safe abortion care can be a lifesaving measure. It is a matter of public health. Emergency contraception, also called the “morning after pill”, is authorized in many countries up to three days (seventy-two hours) following intercourse. This care is not considered as pregnancy termination and is not regulated under abortion law in most countries, though there is some variation between countries as regards legality and delays. In some countries it is authorized up to five days after intercourse; however, the effectiveness of emergency contraception declines the longer the pill is taken after intercourse. In some countries emergency contraception is legal, whereas abortion is illegal. Emergency contraception is a safe and simple form of care, and it is well accepted by women.

Access to abortion care must be ensured, whenever this is possible and authorized, so that the survivor of sexual violence can choose whether or not she wants to carry on a pregnancy. In many instances, safe abortion care can be provided medically, in safe and relatively simple ways, without traumatic procedures or invasive intervention. Access to safe abortion care is directly dependent on the legal status of abortion.⁴⁹ This status varies across countries, in relation to diverging ethical responses as regards the status of the embryo. In almost all countries, the law permits abortion to save the woman’s life; furthermore, in the majority of countries abortion is allowed to preserve her physical and/or mental health. Some countries specifically recognize the legitimacy of abortion following a rape, thus recognizing that these situations pose particular ethical challenges. There is also the possibility for a country to adopt transitory provisions, recognizing the legal possibility of abortion care in the context of an armed conflict or a situation of violence. According to data on national laws in 2011, termination of pregnancy to save a woman’s life was accepted in 97% of countries around the world. In 51% of countries, abortion was specifically allowed in the case of pregnancy following rape.⁵⁰ The legal status of

49 WHO, “Safe Abortion Care: The Public Health and Human Rights Rationale”, in *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2nd ed., Geneva, 2012, pp. 17–21.

50 United Nations, “World Abortion Policies 2013”, Department of Economic and Social Affairs, Population Division, UN Doc. ST/ESA/SER.A/329, 2013, available at: www.un.org/en/development/desa/population/publications/policy/world-abortion-policies-2013.shtml.

abortion has no effect on the likelihood that a woman will interrupt an unintended pregnancy.⁵¹ The authors of one international study explain that “some women who are determined to avoid an unplanned birth will resort to unsafe abortions if safe abortion is not readily available, some will suffer complications as a result, and some will die”.⁵² Besides legal restrictions, and those related to family or social pressures, barriers to safe abortion care include lack of available health services and medical supplies, difficulty in accessing such services, lack of competence or training on the part of health professionals, negative attitudes from professionals as regards sexual violence and/or pregnancy interruption, and medico-legal and forensic procedures requested in order to prove a rape.⁵³

Lack of, or limited access to, safe abortion care, including legal restrictions and social pressure, leads many women and girls to induce abortion themselves or seek abortion from unskilled providers.

A patient’s access to abortion care

Women who become pregnant as a result of rape and have no access to safe abortion care face major risks for their own survival and future life and health. They have a high probability of recourse to unsafe abortion practices, which entail very high risks for their health and life. Unsafe abortion is an important public health problem. It is defined as “a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both”.⁵⁴ WHO estimates that 22 million unsafe abortions take place each year. Close to 50,000 pregnancy-related deaths a year are due to complications relating to unsafe abortion.⁵⁵ One in four women and girls who undergo unsafe abortions are likely to develop temporary or lifelong disabilities requiring medical care.

Access to safe abortion care is thus a priority health-care service, both on an individual basis and from a public health perspective. Therefore, in places in which this is legally accepted, emergency contraception and safe abortion care should be made available as part of essential health-care services, including in situations of humanitarian emergency. In those places where abortion is legally accepted, making the service available is a responsibility of the public health authorities of the country; in a situation of humanitarian crisis, the humanitarian actors involved in providing health care to the affected population must also ensure that women victims of rape have access to comprehensive health care, including safe

51 WHO, above note 49.

52 Gilda Sedgh *et al.*, “Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008”, *The Lancet*, Vol. 379, No. 9816, 2012, pp. 625–632.

53 K. I. Teklehaimanot and C. Hord Smith, “Rape as a Legal Indication for Abortion: Implications and Consequences of the Medical Examination Requirement”, *Medicine and Law*, Vol. 23, No. 1, 2004, p. 91.

54 WHO, above note 49.

55 WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, 6th ed., Geneva, 2011, p. 27.

abortion care. Humanitarian actors must also conform to the national legislation and codes of medical ethics as regards abortion care.

Humanitarian and health professionals must provide the patient with all useful information and promote her autonomy; they must respect the patient's choices and provide the needed support so that the patient has effective, timely and safe access to the needed care. This ethical duty applies irrespective of whether the patient chooses to perform a pregnancy interruption, to keep the pregnancy and raise the child, or to find another option such as adoption or foster care. All these options might be positive existential and ethical choices, depending on the context and the particular situation of the patient as well as her particular preferences, beliefs and religion.

In some instances a professional may personally disagree with a particular choice on the grounds of her or his own beliefs or religion. Issues of professional conscientious objection should not, however, create any added obstacle for the patient to have access to comprehensive care. As regards rules of medical deontology, the World Medical Association recognizes that a physician has a right not to perform an abortion according to his or her personal convictions; in that case the physician "may withdraw while ensuring the continuity of medical care by a qualified colleague".⁵⁶ However, the wording "continuity of medical care" is vague, and this statement may not effectively guarantee non-discriminatory access to abortion care. It tends to give a high weight to the physician's own values, rather than honouring and respecting those of the patient. It also tends to underestimate the physician's fiduciary responsibility.⁵⁷ The personal attitude of a physician can deeply influence the health-related behaviours or choices of their patient, as many examples in preventive medicine show, including in child immunization care.

The Code of Ethics of the International Federation of Gynaecologists and Obstetricians (FIGO) conceives the physician's role and duties in a way that is more committed to the patient's needs and choice. It gives to the professional a clear duty to actively refer the patient to a suitable health-care provider in case of disagreement and conscientious objection, stating that professionals should

[a]ssure that a physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay.⁵⁸

56 World Medical Association (WMA), WMA Declaration on Therapeutic Abortion, Pilanesberg, South Africa, 2006.

57 Rosamond Rhodes, "The Professional Responsibilities in Medicine", in Rosamond Rhodes, Leslie P. Francis and Anita Silvers, *The Blackwell Guide to Medical Ethics*, Blackwell, Oxford, 2007, pp. 71–87.

58 FIGO, "Rights-Based Code of Ethics: FIGO Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights", October 2003, available at: www.figo.org/figo-committee-and-working-group-publications.

Issues related to conscientious objection and to the duties and responsibilities of health-care professionals have been the subject of important developments in medical ethics and law. Rosamond Rhodes has analyzed the fiduciary responsibility of the physician towards patients and society,⁵⁹ and asserts that while a health professional has a right to have his or her own ethical positions and values, he or she does not have any right to obstruct the patient's capacity to decide according to her own values, needs and circumstances. Julian Savulescu takes a similar stand, underlining that the primary goal of a health service is to protect the health of its recipients.⁶⁰

These debates have been developed essentially in times of peace, and in countries with widely available and accessible health-care services. The duty to provide care, and at least to ensure that the patient has the best possible access to care, is even more stringent in situations of armed conflict. Victims of rape in a situation of violence or armed conflict are in an extreme situation of vulnerability. In addition, most are in a situation of total dependency on a limited number of services, organizations and professionals. Health and humanitarian actors are often in a position of monopoly, their patients having no other choice than those they offer. The patients are in a situation of "unique dependence", similar to that described in the ethics of rescue in disaster.⁶¹ In such situations, in which a specific individual relies entirely on a professional or an organization for his or her health or survival, such professionals/organizations have a strong duty to act and to provide rescue and care, or at least to assist the patient in accessing care (including by referring her to another doctor). Misuse of conscientious objection arguments have been brought to court by women who had been denied access to lawful abortion in Colombia.⁶² A decision by the Constitutional Court of Colombia has established that health-care providers objecting to abortion have a duty to refer their patients to non-objecting providers.⁶³ Furthermore, it established that hospitals, clinics and other institutions have no rights to conscientious objection. At an international level,⁶⁴ it has been established that, in cases of developmental risks for the foetus, in countries where abortion is legal, governments have a duty to ensure that women have access to it; that a professional's responsibility to provide access to abortion care is not contingent upon his or her personal opinions; and that institutions have clear duties in this respect.

These ethical and legal conclusions confirm the centrality of the patient in health care.⁶⁵ Respecting the patient's dignity and autonomy is the first

59 R. Rhodes, above note 57.

60 Julian Savulescu, "Conscientious Objection in Medicine", *British Medical Journal*, Vol. 332, 2006, pp. 294–297.

61 Scott James, "Good Samaritans, Good Humanitarians", *Journal of Applied Philosophy*, Vol. 24, No. 3, 2007, pp. 238–254.

62 Rebecca J. Cook, Bernard Dickens and Monika Arango Olaya, "Healthcare Responsibilities and Conscientious Objection", *International Journal of Gynecology & Obstetrics*, Vol. 104, 2009, pp. 249–252.

63 See Colombia, Corte Constitucional [Constitutional Court], Sentencia T-388/09, 28 May 2009.

64 UN Human Rights Committee, *KL v. Peru*, Communication No. 1153/2003, CCPR/C/85/D/1153/2003, 22 November 2005.

65 WMA, *Medical Ethics Manual*, Ferney-Voltaire, 2005, p. 6.

consideration. The professional's duty is to respect the patient's choice, as long as this choice is recognized as good medical practice and is legal. If the professional is not willing or able to provide this care, then she or he must direct the patient to another colleague who is competent and agrees to provide the particular care.

Access to safe abortion care, with a caring relationship based on sympathy and professional counselling, allows the survivor of rape to make an informed and responsible choice regarding pregnancy. Continuous care is also needed following termination of pregnancy as a result of rape. These survivors also face major challenges in order to overcome trauma and rebuild their lives. They may face humiliation, exclusion or stigmatization for having terminated the pregnancy, and in some cases violence, even lethal violence, from family members or communities. In contexts where abortion is illegal, women may also be prosecuted and jailed.

Continuous care, pregnancy and child raising

For various reasons, many women or girls who become pregnant following sexual violence carry on the pregnancy. Their choice can be related to religious or moral convictions, cultural values or simply a personal decision. For some, this is the only possible choice due to lack of access to safe abortion care. In some cases, women have decided not to pursue an abortion following rape as an act of resistance against their victimization.⁶⁶ These persons choose to carry on the pregnancy despite the availability of safe abortion and support. Some survivors give the child to an orphanage for adoption. Others explain that they felt an urge to become the mother of these children imposed on them by violence; for them, giving a mother's love is an antidote to rape. There are a wide range of reasons, motivations and hopes which lead women and girls to carry out a pregnancy following rape and, eventually, to raise the child. In any case, the pregnancy, maternity and child raising pose particular challenges. In many instances, survivors of sexual violence and children born following rape are highly vulnerable and need particular care and support during pregnancy, at birth and throughout the child's development. Many women and girls face major difficulties related to their life and health, family links, social exclusion, isolation and poverty, in addition to the difficult process of surviving rape and attempting to recover from pain and trauma, to overcome fears and terrors and to rebuild their lives. These survivors of extreme violence have major needs, including a respectful and caring relationship, assistance, protection and guidance, and support in the difficult tasks they face in raising a child. These challenges might include building a positive and loving relationship with the child and helping the child overcome the rejection and social stigma that might eventually occur. Children born following sexual violence might themselves have specific needs – they should be considered as vulnerable children, at high risk of negative outcomes in their health and development. They might greatly benefit from

66 F. Sironi, above note 26, p. 61.

regular guidance and support from health, social or education professionals, in a regular and proactive way which starts early and is long-lasting, supporting the capacities and resources of the parent, the child and the community.⁶⁷

Humanitarian dialogue on law, pregnancy and abortion care

As a humanitarian organization active in medical care, the ICRC fully complies with the applicable law, and with the national policy and guidance of the public health authorities. In countries in which safe abortion care is not legally permitted, the ICRC respects this provision. In some contexts, the authorities have the possibility of adopting special provisions for the particular context of armed conflict or community violence, so that abortion care is legally authorized and available to women and girls who have become pregnant following rape in such a situation. These special provisions legitimate access to abortion care based on recognition of the desperate situation of the victims, the risks to their lives, the unfavourable personal, emotional and social conditions for the development of a pregnancy and a future child, and the risks related to unsafe abortion practices in the absence of safe abortion care.

Conclusion: For a person-centred and holistic approach to humanitarian care

The above overview has briefly described the evolution in our understanding of sexual violence in history, and has highlighted some practical obstacles and ethical challenges in responding to victims of sexual violence in armed conflicts and other situations of violence. Difficult challenges exist in attempting to respond to the trauma and suffering, the feeling of dehumanization and “death” experienced by the victims. There is no simple way or standardized technique to address such extreme situations of distress. The most essential duty is to treat victims with humanity, in a relationship of humanitarian care. That implies treating the person as a person, with respect and sympathy.

Providing care and assistance to victims of sexual violence, as for victims of torture or other forms of extreme violence, is a demanding activity which requires professionalism, humanity and humility. The response must be centred on the affected person and must follow a holistic approach, offering emergency medical care, medico-legal assessment, pregnancy and psychosocial care in an integrated way. It is crucial that health and humanitarian professionals are experienced in the fields of violence and of sexual and reproductive health and receive appropriate training on a continuous basis. Psychosocial support is crucial and requires particular care in listening to the trauma story, giving attention to its

67 For examples of effective programmes based on vulnerability and resilience, see Suniya S. Luthar, *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities*, Cambridge University Press, Cambridge, 2003.

meaning for the patient and to the ways he or she uses it to overcome trauma and distress. Working in groups of peers can be very helpful to survivors. Much progress has been recently achieved by moving from an approach restricted to vulnerabilities and trauma to supporting processes of healing and resilience.

The testimonies presented in this issue of the *Review*⁶⁸ illustrate in very expressive and moving ways many aspects discussed in this paper. These persons have benefited from programmes developed or supported by the ICRC, following extremely traumatic experiences. They all convey suffering, – many a sense of dehumanization, a feeling of being dead, or social exclusion, – and they highlight the importance of the care and support received, which helped them survive and to some extent overcome these events. Many express gratefulness to the professionals; some also mention the limits of the assistance received, and their current difficulties and unmet needs.

All these messages came from persons who benefited from assistance programmes, yet many victims have no such support, either because no programme exists or because they were not ready, not able, or not willing to participate in it. Despite such limitations, these messages are a unique and extremely precious encouragement to health professionals and humanitarian organizations in their efforts towards meaningful and respectful action to help victims of sexual violence. They certainly confirm the relevance of an ethical, comprehensive and integrated response, and the need to further develop the humanitarian response to sexual violence in armed conflicts.

68 See the opening section “Voices and Perspectives” in this issue of the *Review*.