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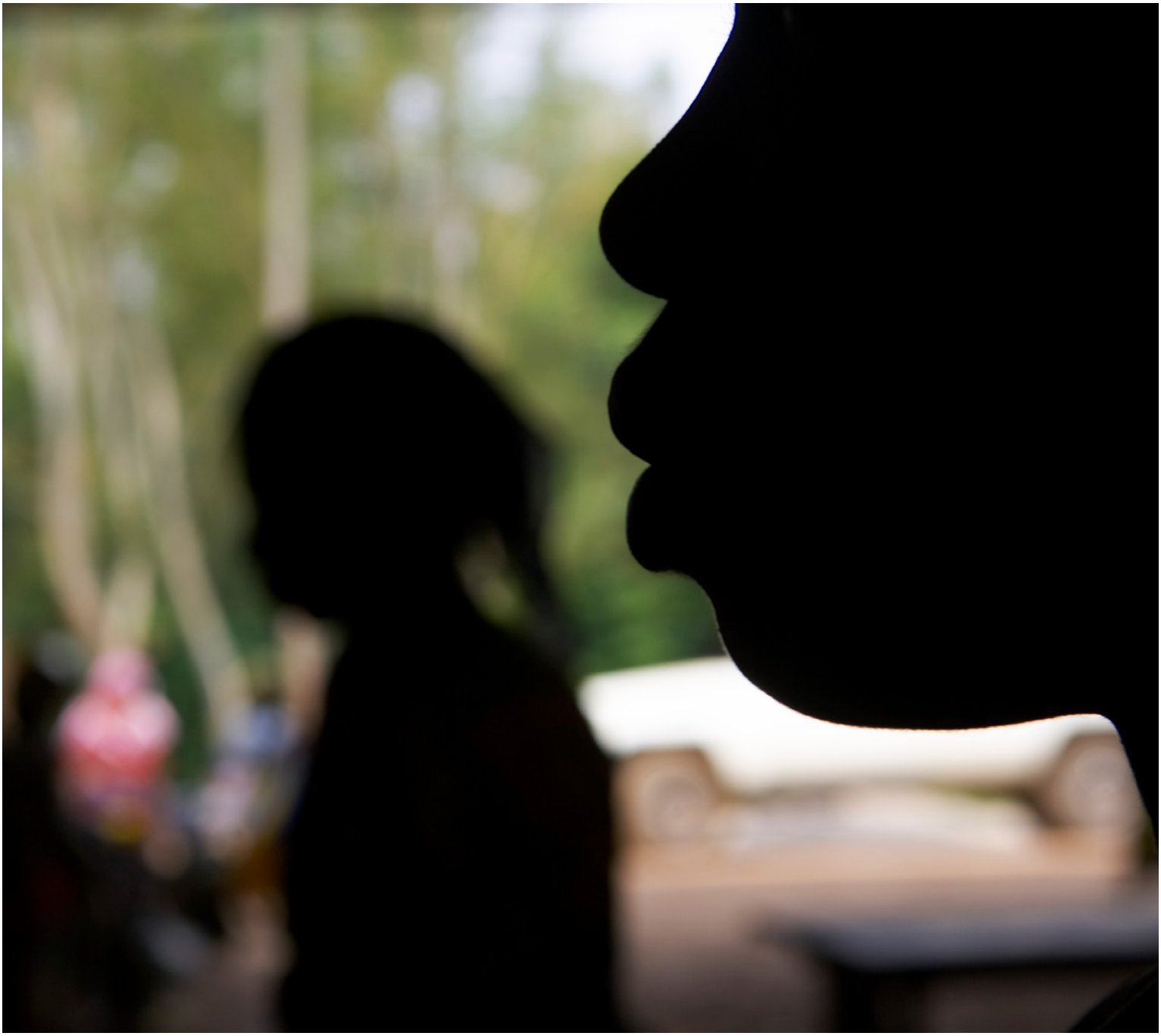

Forced to report

The humanitarian impact of mandatory reporting on access to health care for victims/survivors of sexual violence in armed conflict and other emergencies

Acknowledgements

The research was jointly commissioned by the British Red Cross and the International Committee of the Red Cross. This report was authored by Jessica Skinner, Humanitarian Policy Adviser at the British Red Cross. Special thanks go to: Maria Holmblad and Jelia Sane, who conducted the research on which this report is based, and who brought valued insight and understanding to this project. The project group: Alessandra Nervi, Amy Wragg, Anne-Sylvie Linder, Haifa Ungapen, Jessica Skinner, Marina Tondo, May Maloney, Rachael Cox, Sophie Sutrich, Sarah Cotton and Vanessa Murphy for their support, guidance and revision of this paper. The interviewees for giving their time and sharing their professional and personal experiences. Red Cross and Red Crescent staff and volunteers at the fieldwork sites who took part in focus groups, introduced the team to service providers and facilitated the field visits. Experts who reviewed drafts and provided invaluable insights, including experts from the Intersectional Legal Department of Médecins Sans Frontières.

Contents

Abbreviations

GBV	Gender-based violence
ICRC	International Committee of the Red Cross
IDP	Internally displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
IHL	International humanitarian law
IHRL	International human rights law
PEP	Post-exposure prophylaxis
STI	Sexually transmitted infection
The Movement	The International Red Cross and Red Crescent Movement
UNSCR	United Nations Security Council Resolution
WHO	World Health Organization

Executive summary

Mandatory reporting is the obligation in certain countries for health-care personnel and other professionals to report known or suspected cases of sexual or gender-based violence to designated public authorities, notably to law enforcement agencies. It includes providing identifying information, without requiring the consent of the victim/survivor. In some contexts, the victim/survivor is required to report as a precondition for accessing care. States introduce mandatory reporting to respond to their due diligence obligations to investigate, prosecute and punish violent crimes, to prevent them from occurring, and to better protect victims/survivors.

The British Red Cross and the International Committee of the Red Cross (ICRC) conducted research in health care settings in four countries affected by armed conflict or other emergencies. The research focussed on the situation for adult victims/survivors. It revealed that mandatory reporting of sexual violence in these contexts can obstruct access to health care for the victims/survivors of these crimes and may expose them to increased risk of secondary violence and harm.

This paper analyses and produces evidence of the various challenges of providing health care where mandatory reporting of sexual violence exists and details the negative humanitarian impacts in armed conflict and other emergencies. The report makes recommendations to States that have mandatory reporting regimes, as well as to donors, health-care providers and the Red Cross and Red Crescent Movement, on how to respond to these dilemmas and better protect the health, safety and well-being of survivors.

Obstructed access to health care

The research showed that **access to critical health care can be significantly obstructed by mandatory reporting**.

Sexual violence should be treated as a health emergency, with victims/survivors of rape receiving medical treatment within the first 72 hours. **The health consequences of not accessing care for sexual violence are significant and can be fatal**. Without specialised care, sexually transmitted diseases such as HIV, serious physical trauma, unwanted pregnancies and the psychological impacts of sexual violence cannot be addressed.

In the countries studied, it was **reported that victims/survivors of sexual violence sometimes avoided seeking health care in order to evade mandatory reporting**. This was of particular concern in contexts where a police report was required or requested before a victim/survivor could access health care. Furthermore, those **who did seek care risked being turned away by health-care personnel** as a direct result of mandatory reporting obligations.

Mandatory reporting can **pose significant risks to the safety of health-care personnel**. It can make them the target of retaliatory violence from perpetrators, or the community or family of the victim/survivor. These risks sometimes caused health-care personnel or institutions to deny treatment to victims/survivors or apply other mitigation strategies which restrict safe access to health care. **The security risks faced by victims/survivors and health-care personnel are exacerbated in armed conflict**, where sexual violence may be carried out by a member of State armed forces or a non-state armed group.

Some humanitarian organisations choose not to conduct medical programmes in countries with mandatory reporting laws. This is to refrain from violating medical ethics and patient autonomy, to avoid placing patients at risk of harm and to protect health-care personnel from associated risks, including violence and disciplinary sanctions. However, this decision **compromises the humanitarian principles of humanity and impartiality** which drive humanitarians to prevent and alleviate human suffering wherever it may be found, without discrimination.

Secondary violence and harm

Mandatory reporting may **expose victims/survivors to secondary violence and harm** at the hands of perpetrators, family members, the community, service providers and the State. Secondary harm may involve further sexual violence or other physical attacks. It may also include (re)traumatisation, victim-blaming, ostracism, destitution, honour crimes, self-harm, forced marriage or criminalisation of the victim/survivor (for example, under adultery laws or other crimes of a sexual nature).

The nature and severity of negative impacts were influenced by the different regimes for mandatory reporting and their application. The impacts were also influenced or exacerbated by specific contextual factors, including: the existence of an armed conflict or other emergency, shortcomings within the criminal-justice and health-care systems, and a high level of stigmatisation by communities.

Legal and ethical dilemmas

Mandatory reporting requirements present **legal and ethical dilemmas for health-care providers**. Mandatory reporting may have a severe humanitarian impact and, as such, in specific contexts **may constitute a disproportionate interference with the rights to health and privacy**. This is particularly the case where reporting does not, in practice, serve to further access to protection and justice for victims/survivors.

While certain interlocutors, including some victims/survivors, are in favour of mandatory reporting as a mechanism to ensure the scale of sexual violence is visible and addressed, it remains unclear whether mandatory reporting

is effective in achieving these aims. Where mandatory reporting dissuades victims/survivors from seeking care, these obligations may in fact be detrimental to the aim of improved reporting, care and justice. Follow-up research is recommended to assess this further.

Under certain circumstances, mandatory reporting regimes **have the potential to be incompatible with international law, medical ethics and professional standards for survivor care**, including principles of:

- confidentiality
- informed consent
- respect for the wishes and rights of the victim/survivor.

These principles are designed to protect the safety and dignity of victims/survivors and promote their recovery. Mandatory reporting requirements that do not protect confidentiality and privacy are **incompatible with survivor-centred approaches**, which promote individual victim/survivor choice in determining their own safety and recovery needs.

Ambiguous law, policy and practice

A key concern in the countries studied was the **lack of clarity and awareness among health-care and law enforcement personnel of the relevant laws** related to mandatory reporting and the obligations of medical professionals. This included:

- the belief in one country that mandatory reporting was a legal requirement, when in fact it was not prescribed by law or policy
- the practice of shifting the obligation to report from the legally mandated reporter onto the victim/survivor
- inadequate provisions to resolve the lack of coherence between mandatory reporting obligations and the duty to provide emergency medical care and respect medical confidentiality.

Prioritising health care and safety

The British Red Cross and the ICRC recognise the critical need to increase reporting and end impunity for sexual violence. Although mandatory reporting may be well-intended, the research findings illustrate that risks to victims/survivors, as well as to health-care personnel, exist as a direct and indirect result of mandatory reporting. Therefore, rather than focussing on mandatory reporting, priority should be given to building an environment for safe and effective voluntary reporting, which reduces the risk of revictimisation and secondary harm.

Where safeguarding measures are absent or incapable of guaranteeing victim/survivor safety and dignity, reporting to law enforcement should not take place without informed consent. Safe and dignified access to health care, as part of a holistic response to sexual violence, must be the ultimate priority.

Recommendations

Recommendations for conflict-affected States with mandatory reporting requirements

Relevant ministries, such as health, justice and social welfare, to work together to:

(i) Conduct in consultation with individuals and communities affected by high rates of sexual violence, health-care personnel, sexual violence case managers and other specialist service providers (in line with safeguards to protect privacy and prevent retraumatisation):

- **a.** A comprehensive survivor-centred analysis of the impacts of mandatory reporting on victim/survivors' access to health care and/or exposure to secondary harm; and on the effectiveness of mandatory reporting of sexual violence in the attainment of its stated aim of improving reporting, prosecution, protection and service delivery for victims/survivors, and reducing cases of sexual violence.
- **b.** Based on the above, a findings-based analysis of whether the level of risk posed to the health, safety and well-being of victims/survivors, as well as to the security of health-care personnel, is both necessary and proportionate to the evidenced effectiveness of mandatory reporting of sexual violence for public health and security outcomes.

(ii) Introduce an exception for sexual violence from broader mandatory reporting requirements that apply to adults, until the result of a comprehensive consultation and analysis, as detailed in point (i), has been completed and published.

(iii) Identify legal, procedural or practice-related solutions, together with victims/survivors, health-care providers and law enforcement agencies, which promote fully informed voluntary reporting and judicial procedures that promote the safety, privacy and dignity of victims/survivors. These solutions should be gender-sensitive, trauma-informed and protect against revictimsation.

(iv) Review and/or revise policy and practice to ensure that access to health care for victims/survivors of sexual violence does not depend on a police report being made first. Review and revise policies and practices to ensure law enforcement agencies have a clear duty to not interfere with the provision of emergency medical care.

(v) Define clearly within domestic legislation, in line with international standards, the rights and responsibilities of health-care personnel. For example, develop laws that regulate the information to be included in reports to law enforcement agencies, the rights health-care personnel have to refuse

to disclose information, the protections they have from prosecution or punishment, and their ethical duties. There are different ways of incorporating a definition of the rights and responsibilities of health-care personnel in domestic legislation – it could include a specific manual applicable to health-care providers.[1]

(vi) Ensure domestic legislation that applies to health-care personnel, including criminal laws and ethical duties, is coherent and consistent, and that different government procedures and protocols for managing the response to sexual violence are aligned. Develop clear provisions that aim to resolve the tension between competing duties and obligations. For example, provisions which state that emergency medical care and respect for medical confidentiality prevails over disclosure duties. Ensure that the provision of emergency medical care to victims/survivors is never criminalised and does not trigger sanctions for health-care personnel, even when a report to law enforcement personnel is required under mandatory reporting laws as a prerequisite for the provision of health care.

(vii) Provide and establish the necessary resources, special measures and training for the criminal justice system (including police, specialised gender-based violence units, prosecutors and judges), and for health-care and other relevant government personnel, to:

- **a.** Ensure that access to health care for victims/survivors of sexual violence is treated as a medical emergency
- **b.** Allow personnel to document sexual violence cases confidentially, in a way that is accessible to victims/survivors should they wish to pursue legal action in the future
- **c.** Apply a holistic survivor-centred approach, uphold medical confidentiality and make appropriate special measures available for victims/survivors of sexual violence during the prosecution process to preserve their privacy.

(viii) Carry out an assessment of national case-management procedures for sexual violence and, where relevant, incorporate ministries responsible for social welfare, women's rights or the equivalent into case management protocol and procedures. Ensure that procedures include the development of risk-mitigation plans co-developed with the victim/survivor, which take a holistic and long-term approach to safety.

(ix) Make sure that the criminal justice system effectively protects and assists victims/survivors of sexual violence by providing – and/or removing obstacles to – access to protection programmes, including shelters and victim protection.

(x) Invest in awareness-raising and community mobilisation while institutionalising a culture within government and public services to address and reduce stigmatisation and victim-blaming. Build safe environments for victims/survivors to disclose their abuse and seek safe and dignified health care, justice and recovery assistance.

Recommendations for bilateral and multilateral donors

(i) Highlight the humanitarian consequences of mandatory reporting of sexual violence in countries affected by armed conflict and other emergencies, and support States to facilitate fully informed voluntary reporting, which protects the safety, privacy and dignity of victims/survivors.

(ii) Support governments to develop survivor-centred, holistic sexual-violence service provision, through resourcing and training health, judicial and law enforcement personnel in a way that promotes privacy, confidentiality, informed decision-making and dignity.

(iii) Champion and fund further research on the impact of mandatory reporting and potential alternatives. Identify best practice and promote the development of model legislation and/or policies which facilitate safe and effective reporting (see Annex).

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(iv) Promote and facilitate inclusion of the recommendations for States, made above, into government National Action Plans on Women, Peace and Security for the implementation of the UN Security Council Resolution (UNSCR) 1325, and the related UN resolutions including UNSCR 2467 focused on access to justice.

Recommendations for humanitarian and health-care providers

(i) Engage in dialogue with the national authorities of conflict-affected countries to illustrate the humanitarian consequences of the mandatory reporting of sexual violence, including any impact on delivering humanitarian assistance.

(ii) Support the government, where appropriate, to facilitate confidential, safe, dignified and trauma-sensitive consultations with victims/survivors to understand the risks associated with mandatory reporting and to develop practical solutions to ensure safe and confidential access to health care and justice outcomes. Ensure safe and appropriate mental health and psycho-social support services are available for victims/survivors participating in such consultations.

(iii) Raise awareness among health-care personnel, the judiciary, NGOs and local organisations about the importance of responding to rape as a medical emergency, for which care is required within 72 hours.

(iv) Provide training to the judiciary, law enforcement agencies and health-care providers on the importance and application of survivor-centred holistic approaches and victim/survivor rights to privacy and confidentiality, in accordance with national laws.

(v) Sensitise communities as well as law enforcement personnel and health-care providers on the rights of sexual violence victims/survivors and, where relevant, the exceptions to or absence of any legal requirement for reporting.

(vi) Work with survivors, communities and local authorities to run awareness-raising and community mobilisation to address and reduce stigmatisation and victim-blaming, building safer environments in which victims/survivors can disclose their abuse and seek safe and dignified health care, justice and recovery assistance.

Recommendations for the International Red Cross and Red Crescent Movement

The International Red Cross and Red Crescent Movement (the Movement) should, where possible and in accordance with its Fundamental Principles, use its special features to address the humanitarian impacts of mandatory reporting of sexual violence in armed conflict and other emergencies.[2] Building on the comparative advantages of the Movement's local, national and international components – and aligned to International Conference Resolution 3 32/2015 on Joint Action for Prevention and Response to sexual and gender-based violence – the following recommendations are made:

i) The ICRC and the British Red Cross to work together to:

- **a. Sensitise** Movement personnel on the potential humanitarian impacts of mandatory reporting of sexual violence in armed conflicts and other emergencies
- **b. Provide support**, where relevant, appropriate and viable, to National Societies and Movement delegates for the development of local responses to address identified or potential barriers to health care and secondary harm as a result of mandatory reporting.

ii) The National Red Cross and Red Crescent Societies, through their officially recognised status and role as auxiliaries to their respective countries' public authorities in the humanitarian field, and in accordance with their specific experience and capacity, to:

- **a. Sensitise and support** public authorities to recognise the negative consequences of mandatory reporting on victims/survivors of sexual violence in armed conflict and other emergencies

b. **Work together** with public authorities and other components of the Movement to identify and implement legal, procedural or practice-related survivor-centred solutions

c. **Mobilise, sensitise and train their volunteer base** to implement a response, in line with the above recommendations for humanitarian and health-care providers, for the hardest-to-reach communities, where sexual violence remains largely invisible.

iii) The ICRC, the IFRC and National Societies could, where relevant, work together to:

Establish joint efforts with relevant ministries and government institutions, to develop national-level manuals or guides to strengthen respect and protection for victims/survivors of sexual violence in situations of armed conflict and other emergencies. These should be developed in consultation with victims/survivors and build on existing national legislation, checklists and reports.[3] They could set out, among other things:[4]

- The rights and responsibilities of health-care personnel under domestic and international law, including medical ethics
- Provisions to ensure coherence between the ethical duties of health-care professionals and relevant domestic legislation, for example provisions for emergency medical care and respect for medical confidentiality to prevail over mandatory reporting duties in cases of sexual violence
- Definitions and guidance for applying a survivor-centred approach, including the safe, dignified and trauma-informed provision of services
- Recommendations for protecting the safety of health-care personnel responding to sexual violence cases
- Processes for reporting barriers to accessing or providing health care to victims/survivors of sexual violence and incidents of secondary violence or harm.

[1] ICRC, **Domestic Normative Frameworks for the Protection of Health Care:** Report of the Brussels Workshop 29-31 January 2014 (2015) pp.52-53

[2] The International Red Cross and Red Crescent Movement is a global humanitarian network comprising 192 National Red Cross and Red Crescent Societies (National Societies), the International Federation of Red Cross and Red Crescent Societies (IFRC), and the International Committee of the Red Cross (ICRC). The National Societies are legally mandated auxiliaries to their public authorities in the humanitarian field, supported by large networks of volunteers. The ICRC has a special mandate in armed conflict which stems from the Geneva Conventions of 1949. All Movement actors are bound by the Fundamental Principles of the Movement. These special features are detailed in Section II of the **Statutes of the International Red Cross and Red Crescent Movement** (2006)

[3] An example of a relevant existing report would be the: Swiss Institute of Comparative Law, **Legal Opinion on the Obligation of Healthcare Professionals to Report Gunshot Wounds** (2019) (accessed 19 February 2020)

[4] A good example, although not related to sexual violence, is the Manual de la Misión Medica, Ministerio de Salud y Protección Social, February 2013 (Resolution 4481) which was adopted in Colombia to strengthen respect and protection for the medical mission in situations of armed conflict and other situations of violence. This was the result of a joint effort on the part of the Ministry of Health and Social Protection, the ICRC delegation in Bogotá, in particular the Health Department, the Colombian Red Cross Society, the Ministry of the Interior, Justice and Law and other governmental institutions.

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1.
Introduction

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Sexual violence in armed conflicts and other emergencies remains prevalent and widespread. In conflict, there are many factors that increase the incidence of sexual violence and limit access to assistance for victims/survivors.[5] These factors include:

- a climate of impunity
- proliferation of small arms and light weapons
- a rise in generalised violence
- displacement and destruction of protective community ties
- resource scarcity
- changes to social norms
- weakened State and community services.

Sexual violence also continues to be used systematically against women, girls, boys and men as a tactic of warfare globally.

At its root, sexual violence stems from harmful social norms and unequal practices related to perceptions of gender and the power dynamics surrounding these perceptions. In times of conflict and crisis, social power dynamics often change and there is significant evidence that sexual violence and other forms of gender-based violence (GBV) increase as a result.[6]

Sexual violence has devastating immediate and long-term consequences for victims/survivors, and their families and communities. Sexual violence can result in death, including suicide.[7] Other physical consequences may include pregnancy and abortion, physical trauma – including genital injuries and fistulas, urinary-tract infections and sexually transmitted infections (STIs) such as HIV. Mental health consequences include depression, post-traumatic stress disorder and self-harm. As a result of widespread stigmatisation and victim-blaming, the social cost of disclosing sexual violence is generally very high. Such stigmatisation can lead to rejection and ostracism by family and community. Physical and psychological harm and ostracism can have significant economic and social impacts, including the loss of liberty, home and livelihood for the survivor and their dependents.

Victims/survivors of sexual violence face many challenges in securing health-care, justice and safety. They are also frequently revictimised by criminal justice, law enforcement, and health-care personnel and procedures.[8] In many conflict and crisis contexts, weak judicial systems and stigma mean that many victims/survivors are reluctant to report their experience, face pressure to not report it, or are exposed to further, potentially life-threatening violence if they do.[9] Sexual violence is therefore notoriously under-reported.

Rape and other forms of sexual violence are prohibited at all times under international law and the domestic criminal law of most States.[10] Certain States have introduced mandatory reporting requirements as part of efforts to meet their obligations to investigate, prosecute and punish sexual violence. Such mandatory reporting laws, policies and practices often oblige health-care personnel and other professionals to report known or suspected cases of sexual violence to law enforcement authorities without requiring consent from the victim/survivor. In some cases, reporting to a law enforcement agency is a precondition of accessing health care.

Over time, health-care providers have grappled with the humanitarian, legal and ethical dilemmas that mandatory reporting regimes have created. That is why the British Red Cross and the International Committee of the Red Cross (ICRC) commissioned research into the humanitarian impacts of mandatory reporting on victims/survivors of sexual violence, as it relates to adults.

[5] The term "victim/survivor" is used in this report to describe a person who has been subjected to sexual violence. For legal purposes, individuals may be identified as "victims" of criminal acts. "Victim" may also be used to acknowledge that harm has been caused or to refer to someone who didn't survive. However, the term "victim" may carry stigmatising or disempowering connotations for an individual in their context. The term "survivor" affirms the ability of someone to live beyond the traumatic event and their agency to recover. The term "victim/survivor" is used to acknowledge the complex relationship between violation, vulnerability and agency, to reflect intersectional experiences and to respect the individual choice of the affected person.

[6] See: **What works to prevent violence against women and girls in conflict and humanitarian crisis: Synthesis Brief** (2019); IFRC, **The responsibility to prevent and respond to sexual and gender-based violence in disasters and crisis** (2018); Le Masson V. et al. **Disasters and violence against women and girls** ODI Working Paper (2016)

[7] Chen Reis, "**Addressing sexual violence in emergencies**", World Health Organisation/Humanitarian Practice Network, (January 2006)

[8] The term "revictimisation" is used here to describe any act that makes a victim of someone again, or renews their sense of victimhood, as a result of the earlier abuse inflicted on them. Revictimisation can be caused by disempowering, humiliating or degrading treatment, further violence, retraumatisation or psychological abuse, ostracisation, economic abuse and denial of rights, among other things.

[9] Chen Reis, "**Addressing sexual violence in emergencies**", World Health Organisation/Humanitarian Practice Network, (January 2006)

[10] In addition to being mentioned in certain provisions of the Geneva Conventions of 1949 and their Additional Protocols, the prohibition of rape and other forms of sexual violence is a norm of customary IHL applicable in both international and non-international armed conflicts. Please see Rule 93 of the ICRC's Customary IHL Study. This prohibition is reflected in similar provisions of international criminal law, which allows for perpetrators to be held individually liable for acts committed as war crimes or crimes against humanity. Sexual violence is prohibited in international human rights law (IHRL) by a number of treaties, such as (among others) the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and Article 7 of the International Covenant on Civil and Political Rights, along with "soft law" instruments, such as the Declaration on the Elimination of Violence Against Women.

2.

Research overview

The research sought to establish whether, to what extent and how mandatory reporting requirements, as they relate to adults, impact upon victims/survivors' access to health care in the context of armed conflict and other emergencies. It focussed on the impact of mandatory reporting on:

- health-seeking behaviour
- the provision of health care
- the safety and well-being of victims/survivors.

While beyond the original scope of the research, a secondary consideration was whether mandatory reporting leads to better justice and prevention outcomes.

Methodology

The research was conducted in two phases: A global scoping study in 2016 and an in-depth study of four contexts in 2019. Four conflict-affected contexts were investigated, each with a different mandatory reporting regime. In order to protect the anonymity of respondents, as well as the humanitarian work of the International Red Cross and Red Crescent Movement, the countries are referred to as Country A and Country B in Africa; Country C in Latin America and Country D in the Middle East.

A qualitative mixed-methods approach was employed. There was a literature review, legal analysis, semi-structured interviews with key informants, focus-group discussions, and consultations with experts in the field of humanitarian health-care provision, GBV case management, law and human rights. Key informants were selected based on their presumed knowledge and experience of the issue, and a 'snowball' approach was applied to identify further experts and affected individuals. Field research took place between March and August 2019. Each country visit lasted 9-12 days.

In total, more than 200 people were consulted, including 55 ICRC staff, 42 National Red Cross and Red Crescent Society staff and volunteers, 18 international humanitarian personnel, 18 local civil society personnel, 12 State health-care personnel, 11 UN staff, 10 police and members of the judiciary, nine government officials, nine human rights activists and academics including legal and medico-legal experts, and over 40 conflict-affected women, many of whom were victims/survivors of sexual violence.

Research challenges and limitations

The complexity of engaging victims/survivors of sexual violence in research and the considerable risk of retraumatisation should not be underestimated. Victims/survivors were only directly consulted in two of the four countries, where the necessary safeguarding measures could be guaranteed. This was offset where

possible by consultation with a wide range of civil society actors working directly with victims/survivors of sexual violence, including with Red Cross and Red Crescent volunteers.

The short duration of country visits combined with security constraints restricted the number of key informants that were consulted, especially State interlocuters such as national health-care personnel, police and members of the judiciary. These constraints also limited access to some locations where sexual violence is a key concern. Given the intra-country variations in the application and impact of mandatory reporting, the research would benefit from wider geographical coverage. To compensate, as many key informants as possible were consulted remotely.

While not a primary objective, the research gathered limited information on the impact of mandatory reporting on sexual violence prevention outcomes, access to justice and protection for victims/survivors. The extent to which this question could be explored was limited by time constraints and a lack of existing literature or statistical analysis within the contexts studied.

Scope of research and definitions

This report uses the term **'mandatory reporting'** to refer to laws, policies or practices that require individuals to report known or suspected criminal offences to designated authorities, without requiring the consent of the victim/survivor. Such reports generally require the disclosure of personal identifying information about the victim/survivor. The obligation may be triggered by knowledge, or suspicion on reasonable grounds, that a crime has been committed and/or the risk of future harm. Failing to report may give rise to criminal, civil and/or disciplinary sanctions against health-care personnel. The research looked at this obligation in health-care settings.

The definition of **sexual violence** used in this report refers to an act of a sexual nature committed against any person by force, threat of force or coercion. It includes rape, sexual slavery, forced prostitution, forced pregnancy, forced sterilisation and any other form of sexual violence of comparable gravity.[11] This definition is gender-neutral, in that men, women, boys and girls may be victims of sexual violence. Physical violence does not necessarily have to occur – for example, forced nudity or being forced to witness sexual violence are types of sexual violence.

National legislation was also considered. In some instances, it aligned with international law, while in others it was either narrower or broader to include other forms of GBV, such as domestic violence or intimate partner violence. In these contexts, such forms of violence may still trigger a mandatory reporting obligation.

The research was not limited to sexual violence directly linked to armed conflict. Instead, it explored the influence of armed conflict and other emergencies on the introduction, application and impact of mandatory reporting of sexual violence.

The research covered the experiences and relevant laws and policies related to sexual violence committed against adults.[12] Due to time constraints, the research did not attempt to cover mandatory reporting of sexual violence cases against children. The research was also unable to cover the situation of adults in detention. Although the research was not restricted to sexual violence against women, little was discovered about the unique experiences of male victims/survivors in relation to mandatory reporting.

[11] See the International Criminal Court Elements of Crimes, Article 8(2)(e)(vi)-6; see also Articles 7(1)(g)-6 and 8(2)(b)(xxii)-6 and ICRC, Institutional Strategy on Sexual Violence 2018-2022, p.1.

[12] The research focussed on the mandatory reporting of sexual violence cases involving adults. Some jurisdictions have special provisions for the protection of adults who lack the capacity to make informed decisions on their own for reasons of cognitive impairment such as dementia, brain injury or unconsciousness. This study does not cover these circumstances.

Features of mandatory reporting regimes

Mandatory reporting of sexual violence exists in many countries worldwide, but there are significant variations between mandatory reporting regimes in different countries. To understand the specific regime in any given context it is important to answer the following questions while considering existing laws, policies and practices:

Where are reporting obligations delineated? Mandatory reporting obligations may be written into domestic law. For some countries, though, mandatory reporting is not a formal legal requirement, but still occurs as a matter of practice, often the result of a widespread perception that such obligations exist.

Which incidents trigger mandatory reporting obligations? Certain regimes require disclosure of all violent crimes, whereas others require disclosure of specific categories of offences or offences against people facing particular risks. Mandatory reporting typically applies to firearm or knife crime, as well as to abuse or neglect of children. In some contexts, mandatory reporting applies to sexual violence and/or other forms of GBV against an adult, and it is these contexts that the research explores.

Whose duty is it to report? Mandatory reporting laws and policies generally specify a list of mandated reporters. The reporting obligation is most commonly placed on health-care personnel, but may also apply to health-care institutions such as hospitals and their administrative staff, other public officials or anyone with knowledge of the crime. In certain contexts, reportedly as a matter of practice rather than law, the obligation lies with the victim/survivor as a precondition for accessing care.

Who receives the report? Reports must generally be made to a designated public body, most commonly a law enforcement agency (e.g. the police, a prosecutor or the judiciary) or, in some cases, a social welfare actor (e.g. social services), or both.

When does the report need to be made? Depending on the regime, the obligation to report can be triggered at various stages: before a victim/survivor can access care and sometimes as a precondition for treatment; during the delivery of care; and/or after the individual has received care. In some contexts, it was identified that health-care personnel insisted on a report being made prior to the provision of care, even when it was not required by law.

What are the reporting procedures? Different jurisdictions require different types of information. Some require disclosure of personal identifying data (e.g. the name and contact details of the victim/survivor) and the clinical nature of the injuries. In other jurisdictions, such clinical information could be withheld. In Country D, mandatory reporting required an invasive forensic examination prior to the provision of specialised care. Three of the four countries studied lacked standardised procedures for reporting, which resulted in inconsistent practices.

What are the requirements for accessing specialised services? In some jurisdictions, a medical doctor is unable to treat a victim/survivor of sexual violence without first receiving a police report, police referral or order from a judge. For example, the hospital administration may request that the doctor present a police report to gain permission to administer emergency contraception or post-exposure prophylaxis (PEP) that can prevent an HIV infection.

What exceptions exist? Some jurisdictions recognise exceptions to the reporting obligation. For example, in Country C, the mandated reporter may report anonymously without including the patient's personal information if it is considered that reporting would endanger the victim, the mandated reporter or the health-care institution.

What sanctions apply? Where mandatory reporting is a legal obligation, there may be criminal, civil and/or regulatory sanctions for non-compliance. Sanctions may include fines, the loss or suspension of a medical licence or imprisonment. In Country A, where mandatory reporting is a matter of practice rather than a legal requirement, health-care personnel still feared being liable for professional negligence should they fail to report.

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3.

The humanitarian consequences of mandatory reporting

The research found that mandatory reporting of sexual violence fails to make the health and well-being of the victim/survivor the ultimate priority. There was consensus among interlocutors across the four countries that this exposes victims/survivors to significant risk of harm. What is clear from the evidence is that in contexts with fragile judicial and law enforcement institutions, the mandatory reporting of sexual violence, particularly where it occurs in connection with armed conflict, can place both the individual victim/survivor and the health-care provider at risk of further harm from perpetrators and constitutes a barrier to accessing health care.

The humanitarian consequences of mandatory reporting can be divided into three main categories:

(i) Reduced health-seeking behaviour

(ii) Obstructed provision of health care, including as a result of risks to health-care personnel

(iii) Secondary violence and harm.

(i) Reduced health-seeking behaviour

The research gathered credible evidence to demonstrate that mandatory reporting deters victims/survivors of sexual violence from seeking health care when they need it. The impact seemed particularly severe in contexts where the provision of health care is conditional upon the victim/survivor first filing a report and receiving a referral from the police.

Many victims/survivors, especially in armed conflict and other emergencies, do not wish to engage with law enforcement for a number of reasons, including:

- a lack of trust in the criminal-justice process and an absence of victim protection
- a fear that their identity will be exposed, leaving them at risk of being stigmatised in their communities, or subjected to retaliatory violence and/or honour crime
- the risk of being traumatised by invasive forensic examinations
- the risk of prosecution in jurisdictions that criminalise adultery, homosexuality or sex work.

The absence of domestic laws and policies that adequately protect victims/survivors of sexual violence and/or the presence of laws which may expose victims/survivors to the risk of prosecution, deter health-seeking behaviour in contexts where mandatory reporting applies. Similarly, victims/survivors who lack adequate civil documentation (a situation common among victims/survivors of human trafficking as well as undocumented migrants, people seeking asylum, and internally displaced or stateless persons) may also be deterred from reporting, as it could lead to arrest, detention or potential deportation. Law enforcement personnel often lack the training and material resources required to safely and confidentially receive victims/survivors of sexual violence. And the reporting process itself can expose victims/survivors to retraumatisation and revictimisation.

As a result, victims/survivors often choose not to seek health care where they know or fear that their information will be shared with the police by health-care personnel or where they are required to report to the police first. The research documented reports of victims/survivors abandoning the process of seeking care once they learned that a police report must be made. A medical doctor in Country D explained that when victims/survivors come to the emergency room the first thing they are told is to come back with proof of having filed a police report, and "not once did the survivor come back."

"When they [victims/survivors] are informed by the hospital of the reporting duty, many become afraid because they do not want the perpetrator to know that they were the ones to report or for their name to be made public. They fear reprisals and do not trust that they will be protected by the system. Often, they are living in the same areas as the perpetrator and there is little police presence. As a result, many women abandon the process and do not continue to seek care. At this point, we lose contact with many of them and we cannot really say how they then manage their health needs."

Civil society actor.

The negative impact of mandatory reporting on health-seeking behaviour was noted in all four countries, although the relative importance of this barrier varied by country and by context. Mandatory reporting was often described as one of many factors contributing to low health-seeking behaviour, with lack of confidentiality in the health profession, intimidation by perpetrators and shame also of concern. Differences between the application and impacts of mandatory reporting were also noted within countries, including a distinction between rural and urban contexts.[13]

"Many people do not seek medical attention because they are afraid that health personnel will notify the authorities."

Humanitarian actor.

"The reason they don't come [to the hospital] is mandatory reporting."

Medical doctor.

(ii) Obstructed provision of health-care services

Mandatory reporting requirements can delay or prevent the provision of emergency medical care to victims/survivors of sexual violence. There were examples in all four countries of victims/survivors being denied treatment at hospital if they could not provide a police report. In Country A and Country D, research found systematic denial of care when there was no referral from the police. Although less common, this was also reported in Countries B and C, even though a

referral from the police was not required by law, policy or common practice.[14]

> "No one will touch the patient unless they provide the hospital with the police paper."
>
> Medical doctor.

The procedure for obtaining a police report and referral to the hospital can be lengthy – in Country D, for example, a forensic examination needs to be ordered by a judge. This delay can prevent victims/survivors of rape accessing care within the critical first 72 hours, exposing them to STIs such as HIV, and unwanted pregnancies. In Country D, it was also noted that victims/survivors require civil identity documents in order to file a police report. Sexual violence victims/survivors require this police report to access specialist health services, therefore those without identity documents find their access to care restricted.

Health-care personnel in all four countries reported facing challenges in providing health-care services to victims/survivors of sexual violence as a result of mandatory reporting. Some health-care personnel preferred not to report to law enforcement agencies for fear of intimidation and/or violence by perpetrators, the victim/survivor's family members, or the community. This is particularly true in contexts where sexual violence is heavily stigmatised. These risks are reported to result in health-care personnel refusing to treat victims/survivors or resorting to non-specialised treatment in order to circumvent the reporting obligation, potentially limiting access to emergency contraception, HIV post-exposure prophylaxis (PEP) and treatment for other STIs.

Health-care providers would sometimes transfer the burden of reporting on to the victim/survivor out of a fear of becoming implicated in criminal proceedings and/or being exposed to retributory violence. In Country D, this was a widespread practice that appeared to be unofficial Ministry of Health policy to avoid putting their staff at risk.

The research indicates that risks of retaliation are elevated where the sexual violence is linked with an armed conflict. In cases where sexual violence is perpetrated by parties to conflict, mandatory reporting can be perceived to be an act of taking sides. This not only places health-care personnel at risk of retaliation, but also jeopardises safe access to conflict-affected populations for humanitarian organisations.

> "Doctors are afraid to report sexual violence cases to the authorities because they fear reprisals from armed actors. We have documented cases where doctors were warned by armed actors about making a report, and cases where the paramilitary [actor] responsible for the rape would take the victim directly to the hospital afterwards [to intimidate] the doctor into not making a later report."
>
> Civil society actor.

> "There is no protection available to medical actors and mandatory reporting puts them in danger. In all cases where health care is in danger, mandatory reporting will never work."
>
> Humanitarian actor.

Non-compliance with mandatory reporting obligations may also put health-care personnel at risk of incurring government penalties or sanctions. This was a concern expressed by health-care personnel in three of the four countries, contributing to a reluctance to provide medical care to victims/survivors. However, no incidents of penalties or sanctions being applied were identified.

In Country D, an international humanitarian organisation reported that it does not deliver clinical care to victims/survivors of sexual violence

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as doing so would trigger a reporting obligation. The organisation noted that its national health-care personnel were unwilling to avoid the reporting obligation and that reporting to law enforcement agencies could place patients at risk. National medical staff, in particular, are often unable or unwilling to circumvent the mandatory reporting requirement, fearing professional consequences, such as the loss of their medical licence. In Country C, the law makes provision for this by offering options for anonymous reporting in exceptional circumstances, where health-care personnel determine that there are risks to themselves or to the victim/survivor.

> "When doctors say they can't provide treatment there is nothing we can do."
>
> Humanitarian actor.

Health-care providers operating in environments with mandatory reporting obligations thus face a serious ethical dilemma. They must choose between a) providing clinical care to victims/survivors of sexual violence without reporting, potentially putting their staff and the organisation's operations in the country at risk; b) engaging in mandatory reporting in order to remain compliant with the country's laws, potentially deterring if not endangering their patients; or c) refraining from providing clinical services altogether, despite knowing that safe, confidential and quality care is desperately needed.

The extent of these challenges and the capacity of health-care personnel and victims/survivors to surmount them depends on the specific context, including:

- whether mandatory reporting is defined by law, policy or general practice
- how strictly it is enforced
- who is obliged to report
- at what stage of the process reporting needs to happen
- whether certain treatments or procedures are controlled by law
- whether there are provisions in place for exceptional circumstances.

(iii) Secondary violence and harm, and other consequences

In the countries studied, mandatory reporting practices are associated with a number of alarming risks for victims/survivors of sexual violence. Without provisions that govern confidentiality and victim protection, mandatory reporting can lead to serious secondary violence or harm. Mandatory reporting that triggers a criminal investigation or that takes place in contexts where confidentiality structures are weak can expose victims/survivors to retaliatory violence, stigma, ostracism and social isolation. This was an overwhelming concern in all four countries in which research was conducted.

> "It is common that when you go, people will laugh at you, men will reject you. That behaviour will make someone not want to go to seek care or report to police."
>
> Community focus group.

It is important not to underestimate the long-term impacts of ostracism and abandonment, which can have significant economic and social consequences, including loss of liberty, home and livelihood for the victim/survivor and their dependents.

Public disclosure also places victims/survivors at risk of further physical, psychological or sexual violence, including honour-based violence.[15] Where perpetrators of sexual violence are State or non-state armed actors, the risk of retaliation is particularly elevated. In certain contexts, reports of sexual violence may also result in forced marriage to the perpetrator.

> "Many fear going to seek help, as the perpetrator is likely to find out that the victim went to the police."
>
> Humanitarian actor.

For the above reasons, disclosure is frequently high risk. This is even more the case where reporting is non-consensual, where impunity is high and where there is no adequate protection – such as safe shelter, a support network and access to psycho-social and economic support services – in place.

Crucially, where mandatory reporting creates delays or barriers to accessing health care, victims/survivors face alarming damage to their health and well-being. Delayed provision of health care may expose victims/survivors to the social, psychological and economic impact of pregnancy, STIs such as HIV, fistulas, and other injuries, which, if left untreated, can lead to chronic health problems, psychological harm and even disability and death. The following section explores the legal and ethical obligations around ensuring the right to health and access to health care in safety and with dignity.

> "When the perpetrator is a soldier, he will often threaten the victim into not reporting, threatening death on her or her family."
>
> Police officer.

[13] It was noted by several respondents that mandatory reporting may not be strictly adhered to in some rural contexts, while health-care facilities and law enforcement agencies in those areas have lower capacity and are less likely to maintain confidentiality standards.

[14] The concern over delay or denial of emergency medical care is the same for the treatment of gunshot wounds in jurisdictions where prior police clearance is required before treatment, see ICRC, **Domestic Normative Frameworks for the Protection of Health Care** (2015), pp.53-55

[15] Honour-based violence or "honour" crime involves an act of violence against a person accused of bringing shame upon his/her family or community. Honour-based violence can include, but is not limited to, domestic violence, threats or acts of physical assault, sexual violence, psychological abuse, abduction, forced marriage or murder, i.e. "honour killing". Honour-based violence is not specific to any religion and takes place worldwide.

4.

Mandatory reporting and access to health care

> "The issue with [mandatory reporting] is that it risks exposing your story to many people and it delays your care."
> Humanitarian actor

The research findings clearly demonstrate several ways in which mandatory reporting can obstruct access to health care and have detrimental impacts on the health, safety and well-being of survivors/victims of sexual violence. Health and access to health care are not just 'nice to have', but are rights protected within various international and domestic legal frameworks. Health-care provision is also guided by internationally recognised medical ethics, which are often enshrined in domestic and international law.

Legal frameworks for access to health care

International law provides that everyone, including a victim/survivor of sexual violence, has the right to access, without discrimination, timely and appropriate health care, both in times of peace and of war.[16] Furthermore, the Committee on Economic, Social and Cultural Rights has underlined that the right to sexual and reproductive health is an integral part of the right to health, and includes an obligation to guarantee physical and mental health care for survivors of sexual violence.[17] Domestic legal frameworks vary as to what constitutes appropriate sexual and reproductive health care. In situations of armed conflict, international humanitarian law (IHL) requires that the wounded and sick, including victim/survivors of sexual violence, must receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. It further provides that no distinction may be made among the wounded and sick on any grounds other than medical ones.[18]

Medical confidentiality as a legal obligation

The right to confidentiality of health-related information forms part of the right to health

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and the right to privacy under international law and most domestic legislation.[19] International human rights law (IHRL) prohibits arbitrary or unlawful interference by State authorities into the private life of individuals under their jurisdiction. This is not an absolute right and it may be restricted by domestic law for reasons such as the protection of national security, public safety or the protection of the rights and freedoms of others. However, the protection from arbitrary interference requires that even interferences legitimised by law must be proportionate, conform with the object and purpose of IHRL, and be reasonable in the particular circumstances.[20] Similarly, under IHL, parties to armed conflicts must generally respect the confidentiality of information obtained by medical actors in connection with the performance of their functions. While exceptions to this protection may be enshrined in domestic law,[21] international experts recently reaffirmed that medical confidentiality is the abiding principle and notification duties are the exception.[22]

International standards for survivor care and medical ethics

Key principles and standards for care of sexual violence victims/survivors

International standards, which are frequently written into domestic protocols for the clinical management of rape, recognise that victims/survivors of sexual violence require holistic care to heal and recover. This includes clinical and mental health care, safety and security, access to justice, and assistance for socio-economic recovery.[23] Sexual violence is a recognised medical emergency as a matter of international medical best practice. International standards call for access to health care to be timely, with rape and other forms of sexual violence requiring treatment within the first 72 hours to prevent HIV and address physical complications.[24]

The key principles of case management to support victims/survivors of sexual violence include timely care, safety, non-maleficence, confidentiality, privacy, informed consent, and respect for the wishes, rights and dignity of the victim/survivor. Survivor-centred approaches, which give priority to the victim/survivor's individual informed choices, help ensure that safety and security is considered and appropriate for each case. This allows victims/survivors to re-establish power and control over their lives and helps minimise the risk of revictimisation. Survivor-centred approaches were endorsed by the UN Security Council in 2019 (Resolution 2467), with States recognising the necessity to put the needs of survivors first.[25]

Mandatory reporting can make it difficult to comply with these standards, undermining key case management principles for sexual violence.

Medical ethics

General guidance on the applicable standards of medical ethics and professional medical conduct can be derived from universal stipulations adopted by the World Medical Association. This includes its Declaration of Geneva[26] and the associated International Code of Medical Ethics.[27] While these instruments have no binding force in domestic or international law, they constitute an important starting point for analysing the meaning of medical ethics and the professional duties of medical professionals. Furthermore, in some jurisdictions these standards are codified in law.

Such reference points are necessary for the interpretation of IHL, as relevant provisions use the terms "medical ethics", "the rules of medical ethics" or "professional obligations [of persons engaged in medical activities]", without further defining these.[28] The Declaration of Geneva, which is often referred to as the modern equivalent of the Hippocratic Oath, recognises the principles of non-maleficence and of individual autonomy and dignity. Similarly, the International Code of Medical Ethics enjoins practitioners to "act in the patient's best interest" when providing care, and to "respect a patient's right to confidentiality".[29] The Code of Medical Ethics does, however, recognise an exception to patient confidentiality and provides that: "It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can only be removed by a breach of confidentiality." [30]

Objectives and justifications for mandatory reporting

Three principal arguments are put forward by States to justify mandatory reporting of criminal offences:

1. Improved access to justice, e.g. increased investigations, prosecutions and convictions
2. Fortified prevention (through deterrence), e.g. decrease in cases of sexual violence
3. Provision of victim protection and assistance, e.g. increased access to protective services such as shelter and relocation.

Sexual violence is prohibited at all times under IHL, IHRL and within domestic law. There is also a public interest in identifying and punishing perpetrators in order to reduce impunity and contribute to the prevention of crimes and the protection of society. The justifications put forward therefore contain important and valid considerations in accordance with State obligations to investigate and prosecute acts of sexual violence and ensure victims/survivors have access to health care and reparation.[31]

Mandatory reporting is also viewed by some legal and health-care personnel, as well as some victim/survivor groups and activists, as a useful tool for ensuring that sexual violence does not remain invisible in contexts with widespread under-reporting. They support mandatory reporting as a mechanism to increase the accountability of the justice system for improved responses to sexual violence.

> "Without mandatory reporting, cases are under-registered and sexual violence becomes invisible. Mandatory reporting increases the awareness around the issue of sexual violence, otherwise this type of violence is legitimised and normalised. Mandatory reporting is a way of fighting against that."
>
> Victim/survivor.

Given the many obstacles to voluntary reporting faced by victims/survivors in contexts of armed conflict and other emergencies, including lack of trust in the legal system, fear of reprisals and stigmatisation, some interlocutors argue that mandatory reporting can reduce the burden of reporting on victims/survivors. They believe that making reporting mandatory will help to address impunity and reduce sexual violence cases. However, they acknowledge that it is an imperfect system, incompatible with medical confidentiality and patient autonomy, and with potential to cause severe consequences for the health and safety of victims/survivors.

In Country C, a specific mandatory reporting law for sexual violence was introduced following advocacy and campaigning by women's rights organisations. This mandatory reporting law, specific to sexual violence, includes anonymous reporting options, which allow health-care personnel to prioritise the safety and security of the victim/survivor. In many other countries, the obligation to report is not specific to sexual violence, and therefore does not include special measures to recognise the sensitive nature of such crimes. There may therefore be different impacts on the health and well-being of victims/survivors, depending on whether the obligation to report is general or specific to sexual violence.

Furthermore, while most interlocuters highlighted the dangers of mandatory reporting for health-care personnel at risk of retaliatory violence (see Section 3.ii), others believed that mandatory reporting provided a certain level of protection to health-care personnel. This was mentioned in contexts where the victims/survivors themselves were obliged to report the crime, transferring the burden away from health-care personnel. However, no evidence was identified to support this belief.

In line with legal obligations, mandatory reporting laws, policies or procedures aim to improve access to justice, health and protection services for victims of sexual violence. This may include facilitating rapid access to victims/survivors, witnesses and potential evidence, for law

enforcement, which may otherwise be lost with the passage of time. However, it was beyond the scope of this study to conclusively determine any correlation between mandatory reporting and improved rule of law, access to justice and provision of protective and health services.

The legal and ethical dilemmas of mandatory reporting

Mandatory reporting requirements pose a number of legal and ethical dilemmas. A balance needs to be found between the negative tendency of mandatory reporting requirements to infringe on the right to health care on the one hand, and the positive outcomes which they pursue – such as facilitating the prosecution of sexual violence – on the other. Tension also exists between the mandatory reporting obligations of health-care personnel and their adherence to professional standards, including medical ethics.

Mandatory reporting does not allow the victim/survivor the autonomy to decide whether to report the crime, and may also put them in harm's way, thus infringing upon the right to professional confidentiality, and the principles of patient autonomy and non-maleficence. Professional confidentiality is the basis of the doctor-patient relationship and must only be infringed where it is necessary to prevent harm to others or to defend the public interest. Furthermore, maintaining professional confidentiality helps deliver public health objectives, by ensuring that health care is sought and that patients disclose the nature of their health concerns truthfully. While there are accepted exceptions to the maintenance of professional confidentiality, there is no widespread agreement about its application to mandatory reporting requirements for sexual violence.

While international law does not contain an absolute prohibition on the disclosure of patient-related information by medical actors, mandatory reporting regimes are potentially incompatible with international law and medical ethics where they do not meet all the requirements below:[32]

a. are not strictly prescribed by domestic law (i.e. where reporting occurs as a matter of practice rather than law)

b. do not pursue a legitimate aim (e.g. preventing the occurrence of further harm)

c. are not strictly necessary (e.g. they are ineffective in achieving the legitimate aim) and

d. are not proportionate to that aim (e.g. where mandatory reporting puts the victim/survivor at disproportionate risk of further imminent harm or requires disclosure of more information than required to achieve its legitimate aim).

Whether the potential good of mandatory reporting can justify the infringement of the rights of the individual is questionable,[33] especially when it can cause revictimisation of individuals who have already suffered severe harm and had their autonomy violated by the initial act of violence.

In addition, where no clear provision exists to resolve the tensions between competing duties and obligations – such as a rule that emergency medical care and respect for medical confidentiality must prevail over disclosure duties –health-care personnel are placed in a catch-22 situation.[34] Regardless of their conduct they will either violate the domestic mandatory reporting requirement or medical ethics.

Before concluding, it is necessary to understand the challenges of maintaining rule of law (e.g. of investigation, prosecution and punishment of offenders) in armed conflicts and other emergencies.

[16] The right to the 'highest attainable standard' of physical and health is enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights 1966; Committee on Economic, Social and Cultural Rights, General Comment No.14, 11 August 2000, para. 11. See also, Convention on the Elimination of All Forms of Discrimination against Women 1979, art 11(1)(f), 12 and 14(2)(b); Convention on the Rights of the Child 1989, art 24; African Charter on Human and People's Rights 1981, art 16.

[17] Committee on Economic, Social and Cultural Rights, General Comment No.22, 2 May 2016, para. 45. See also the Maputo Protocol to the African Charter of Human and Peoples' Rights, art 4, 12 and 14; and Committee on the Elimination of Discrimination against Women, General Recommendation No. 30, 18 October 2013; General Recommendation No. 35 updating general recommendation No. 19; and UNSC Resolution 2467 (2019), 23 April 2019, para 16.a.

[18] See the Geneva Conventions Common Article 3(2); Geneva Convention I, art 12; Geneva Convention II, art 12; Additional Protocol I, art 10(2), and Additional Protocol II, art 7(2); See also Rule 110 of the ICRC's Customary IHL Study.

[19] Committee on Economic, Social and Cultural Rights, General Comment No. 14 on the right to health, para 12.b. See the International Covenant on Civil and Political Rights 1966, art 17 (1); Convention on the Rights of the Child 1989, art 16(1); European Convention on Human Rights 1950, art 8.

[20] Human Rights Committee, General Comment No. 16 on Article 17 of the ICCPR, paras. 3-4.

[21] Additional Protocol I 1977, art 16(3); Additional Protocol II, art 10(3)-(4).

[22] ICRC, **Domestic Normative Frameworks for the Protection of Health Care**, Report of the Brussels Workshop, 29-31 January 2014 (2015), pp. 50-55.

[23] International case management standards for responding to gender-based violence, including sexual violence, can be found in a number of guidance documents, including: GBV Information Management System, **Inter-agency case management guidelines** (2017), World Health Organisation (WHO), **Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines**, (2013) and, WHO/UNHCR, **Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons** (2004)

[24] See e.g. **Guidelines for medico-legal care for victims of sexual violence**, World Health Organisation, 2003. Medical response within the first 72 hours is critical to protect against HIV, prevent unwanted pregnancies, respond to physical injury and collect forensic evidence. In addition, IHL provides that persons in need of medical care must receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. No distinction may be made among them founded on any grounds other than medical ones. See **Rule 110** of the ICRC's Customary IHL Study.

[25] On survivor-centred or holistic care, see UN Security Council Resolution 2467 (2019), preambular para. 18 and operative para. 16; CEDAW, General Recommendation 35, 14 July 2017, para. 31(a)(iii); UN Secretary General, Guidance Note of the Secretary-General: Reparations for Conflict-Related Sexual Violence, June 2014, pp. 18-19.

[26] World Medical Association, **Declaration of Geneva**, (1948, revised in 2006).

[27] World Medical Association, WMA **International Code of Medical Ethics**, (1949, revised in 2006). See also, **WMA Regulations in times of armed conflict and other situations of violence**, (2012).

[28] See e.g. Additional Protocol I, art 16(1) and Additional Protocol II, art 10(1) which prohibit punishment against any person for "having carried out medical activities compatible with medical ethics, regardless of the person benefitting therefrom". Commentary to Additional Protocol I, para 656; and General Comment 14 on the Right to Health.

[29] World Medical Association, **International Code of Medical Ethics** (1949, revised in 2006).

[30] World Medical Association, **International Code of Medical Ethics** (1949, revised in 2006).

[31] International humanitarian law (IHL) applies specifically in situations of armed conflict; the prohibition of sexual violence in armed conflict is a rule of customary IHL applicable in both international and non-international armed conflict. See **Rule 93** of the ICRC's Customary IHL Study. It is also prohibited in treaty law by the Geneva Conventions and their Additional Protocols. Sexual violence is prohibited in international human rights law (IHRL) by a number of treaty provisions including those that prohibit torture and other cruel, inhuman or degrading treatment.

[32] ICESCR, art. 4; CESCR, General Comment No. 14, paras 28-29.

[33] Sachs, J. Carolyn, American Medical Association Journal of Ethics, December 2007, Volume 9, Number 12, p. 844

[34] Certain countries have established clear provisions to clarify between competing duties in the circumstance of gunshot wounds (for example Nigeria and Pakistan). See the Swiss Institute of Comparative Law, **Legal Opinion on the Obligation of Healthcare Professionals to Report Gunshot Wounds** (2019) (accessed 19 February 2020)

5.

Mandatory reporting in armed conflict and other emergencies

The research indicated that sexual violence was, as in most contexts, vastly under-reported in the four conflict-affected countries studied. Mandatory reporting requirements, whether successful or not, are intended to address this issue of under-reporting and ultimately improve the rule of law. However, under-reporting is not the only nor even the main obstacle to addressing high rates of sexual violence in armed conflicts and other emergencies.

A range of factors may explain why national criminal justice systems often do not adequately respond to allegations of sexual violence. These factors include:

- a lack of experience, training and resources for the police and judiciary in responding to sexual violence cases and other forms of GBV
- a lack of victim or witness protection measures
- corruption
- militarisation
- general lawlessness
- law enforcement personnel's fear of retaliation by perpetrators.

These factors can be compounded by:

- close links between law enforcement and State armed forces or non-state armed groups
- a lack of respect for due process and fair trial rights
- use of alternative tribal or traditional justice mechanisms
- legislation that does not adequately protect the victim/survivor.

Examples of legislation that may not adequately protect victims/survivors include:

- narrow definitions of sexual violence
- a penal code that only recognises female victims to the detriment of male or non-binary victims/survivors
- non-judicial settlements that allow perpetrators to marry their victims to avoid criminal conviction
- provisions which accept 'honour' as a lawful defence for crimes of violence
- laws which require numerous and/or male witnesses for crimes to be successfully prosecuted.

Photo © Jamil Khaula/ICRC

These factors may be exacerbated in, or in some cases specific to, situations of armed conflict and violence, making mandatory reporting particularly harmful in such contexts. For example, the risk of retaliatory violence might be increased if reporting a crime is perceived as taking one 'side' of a conflict. There may also be a very limited law enforcement presence at the frontlines of a conflict or within opposition-held areas.

The research suggests that, as a result of these limitations, prosecutions and conviction rates for sexual violence crimes remain low in all four countries, even with mandatory reporting laws, policies or practices in place.

> "We have not seen any evidence that mandatory reporting leads to better outcomes, it is often the opposite. The victim is revictimised by the criminal justice process and may be exposed to further risks, for example the risk of retaliation. Mandatory reporting does not work in [our] context, the justice system does not respond adequately to these cases, for example there are many issues around [the implementation of] a proper chain of custody."
>
> Humanitarian actor.

Settings such as camps for refugees or internally displaced persons (IDPs), especially where freedom of movement is restricted, also pose significant mandatory reporting dilemmas. In confined camp settings it is more difficult to maintain confidentiality and harder to find protection from perpetrators of sexual violence who often live or work in the camp. In these contexts, mandatory reporting exposes victims/survivors to a higher risk of exposure and retaliation than those who are able to relocate. However, in confined camp settings the government or other competent authority has a duty of care to the rest of the population confined in the camp under their protection.

Victims/survivors among displaced populations can still be at risk even after they return to their former homes if their attackers remain at large – especially where the perpetrators are members of State armed forces or non-state armed groups. Demonstrating how public disclosure of sexual violence as a result of mandatory reporting may sometimes have delayed implications.

In many conflict contexts, health services are often the first or only point of contact between victims/survivors and service providers. If the fear of mandatory reporting requirements results in fewer victims/survivors coming forward to seek health care, this may also contribute to the under-reporting of sexual violence incidences, resulting in a lack of information on trends, which is required to develop prevention and response activities. If victims/survivors do not come forward to seek professional care, they are also less likely to access information on and make informed decisions about their legal rights and protections.

> "It should be up to the victim/survivor to decide [to report], especially if the perpetrator is a member of the State security forces as this heightens the risk of reprisals. Some people might consider that mandatory reporting is good on paper, however there are issues with the criminal justice system: there are delays, it can be revictimising."
>
> Public official.

Given the impacts of conflict and other emergencies on the ability to run effective law enforcement and justice systems, there are clear challenges in ensuring that mandatory reporting achieves its three stated objectives (improved access to justice, fortified prevention and provision of victim protection and assistance).

The fact that there are high levels of impunity for sexual violence in all four countries, despite several years of mandatory reporting, may be perceived as an indicator that it is not achieving

its stated aim. However, within the scope of this research it is not possible to determine whether mandatory reporting's lack of success relates to the regime per se, or to limitations in its application, or other contextual challenges. Given the many factors at play in determining the success of law enforcement, which lie beyond the scope of the research, we were unable to identify conclusive evidence to determine whether mandatory reporting is an effective tool to facilitate access to justice, sexual violence crime prevention or improved protection and assistance for victims/survivors.

A more solid evidence-base is required to consider the impact of mandatory reporting on the quantity and quality of reporting, prosecutions and convictions, as well as reparations for victims/survivors of sexual violence in armed conflicts and other emergencies.

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6.

Responding to mandatory reporting

Mandatory reporting of sexual violence in armed conflict and other emergencies can act as a barrier to accessing health care and may lead to secondary violence and harm to victims/survivors, as well as to health-care personnel. The research found that health-care providers and victims/survivors use various strategies to circumvent mandatory reporting requirements in order to provide or access health care.

Health-care personnel and providers sometimes refrained from asking certain questions, omitted certain information or characterised injuries as accident-related in order to be able to treat the victim/survivor without reporting.

Victims/survivors would sometimes seek general health-care services to avoid disclosing that they had been subjected to a sexual attack. They may also turn to informal healing methods or providers.

Such strategies present barriers to quality of care, and to future investigations and prosecutions where medical records are required as evidence.

Some of these solutions have the potential to cause further harm, by:

- limiting the detail of medical records, and therefore reducing victims/survivors' ability to successfully prosecute their attackers in the future
- limiting the amount of available information on trends
- limiting access to comprehensive emergency or specialised health care, including PEP
- increasing the reliance on informal or traditional health-care providers, including in some cases counterfeit, ineffective or unsafe care.

Practical solutions identified by health-care personnel as 'assistive' in both facilitating access to health care and promoting the rule of law included: the possibility to provide anonymised information on trends, measures to support survivors to voluntarily report, and the use of survivor-centred systems.

Anonymised trend data reporting systems were viewed by some as effective to allow health-care institutions to share non-identifiable incident data such as sex, age and incident location so as to monitor the levels of sexual violence

and formulate health care and law enforcement policy and practice. Such practices may ensure that the extent and patterns of sexual violence cases are visible, are addressed as part of wider government efforts to prevent violence and improve services for victims/survivors and allow health-care personnel to maintain confidentiality.

Measures to improve voluntary reporting include:

- Safe, dignified and confidential collection and storage of documentation, including forensics, to ensure that victims/survivors can choose to press charges at a future date, should they so wish
- Offering to make a report on their behalf, should they so wish
- Training and resources for law enforcement and health-care personnel to protect the confidentiality and integrity of the victim/survivor.

Survivor-centred approaches: There are numerous measures that can be introduced to ensure that victims/survivors are able to access timely and appropriate health care, as well as report cases of sexual violence in safety and with dignity. These measures involve:

- removing barriers to the provision of emergency specialised health care
- providing holistic packages of care, including risk assessments and protective measures

placing the victim/survivor front and centre of decision-making

7.
Conclusion

The evidence presented suggests that mandatory reporting of sexual violence in armed conflicts and other emergencies can significantly obstruct victims/survivors' access to health care. The consequences of not accessing care are significant and can be fatal. The research also found that those who do seek care may be exposed to secondary violence and harm as a direct or indirect result of mandatory reporting. Consequently, we conclude that the impacts of mandatory reporting on access to health care for survivors of sexual violence should be examined and addressed, and where harms outweigh benefits, should be reconsidered and revised.

Mandatory reporting has an impact on the ability of health-care providers, including humanitarian organisations, to deliver care to victims/survivors of sexual violence. Victims/survivors of sexual violence in the four countries studied sometimes avoid seeking health care in order to evade mandatory reporting obligations. They also risk being turned away by health-care providers if they do not submit a report to law enforcement agencies. Furthermore, access to critical assistance is significantly obstructed in contexts where a police report is required to access emergency or specialised medical care.

Mandatory reporting requirements that do not protect confidentiality and privacy are incompatible with medical ethics and survivor-centred approaches.

It was also revealed that mandatory reporting may pose significant risks to the safety of health-care personnel. These risks sometimes cause health-care personnel and institutions to deny treatment to victims/survivors or apply strategies that further restrict safe access to health care. The security risks victims/survivors and health-care personnel face are exacerbated in situations where sexual violence was directly linked to State armed forces or non-state armed groups.

Mandatory reporting requirements present legal and ethical dilemmas for health-care providers, and can make it difficult to comply with international law and professional standards for sexual violence case management. International law provides that everyone has the right to access, without discrimination, timely and appropriate health care, both in times of peace and of war. The right to sexual and reproductive health and the right to confidentiality are integral to the right to health. To be lawful, mandatory reporting regimes must find a balance between the infringement of this right to health, and the advantage that is pursued by the mandatory reporting regime (i.e. facilitating prosecutions in sexual violence cases).

From a legal and ethical perspective, mandatory reporting regimes are potentially incompatible with international law and medical ethics where they are not:

a) strictly prescribed by law

b) pursuing a legitimate aim

c) strictly necessary

d) proportionate to that aim.

The introduction of mandatory reporting regimes may be well-intended and pursue legitimate aims. Certain interlocutors, including some victims/survivors, are in favour of mandatory reporting to ensure that the scale of sexual violence does not remain invisible or unaddressed. However, the research findings illustrate that mandatory reporting can have severe humanitarian impacts and as a result, in specific contexts, may constitute a disproportionate interference with the rights to health and privacy. This is particularly the case where reporting does not, in practice, serve to further access to protection and justice for victims/survivors. Where mandatory reporting dissuades victims/survivors from seeking care, it may in fact be detrimental to the stated aim of improved reporting, and provision of care and justice outcomes. In countries where mandatory reporting is not prescribed by law it comes into direct opposition with international law. Further research is therefore recommended to assess the effectiveness of mandatory reporting for sexual violence in improving justice, prevention and protection outcomes.

The British Red Cross and the ICRC recognise the critical need to increase reporting and end impunity for sexual violence, but caution that several risks to victims/survivors, as well as to health-care personnel, were identified as a direct and indirect result of mandatory reporting. States should prioritise the autonomy, dignity and safety of the individual, unless such infringements on individual rights can be justified through concrete evidence of the efficacy, necessity and proportionality of mandatory reporting. The effectiveness of mandatory reporting in achieving its aims, specifically in armed conflict and other emergencies, needs to be evaluated and confirmed in any given context. Until that happens, the humanitarian consequences of mandatory reporting cannot likely be justified.

Therefore, priority should be given to building an environment for safe and effective voluntary reporting which reduces the risk of revictimisation and secondary harm. The findings conclude that safe and dignified access to health care as part of a holistic response to sexual violence must first be assured.

References

Bauer H, Mooney D, Larkin H, et al. (1999). California's mandatory reporting of domestic violence injuries: does the law go too far or not far enough? Western Journal of Medicine:17

De Dycker S, et al; The Swiss Institute of Comparative Law (2019). Legal Opinion on the Obligation of Healthcare Professionals to Report Gunshot Wounds. Lausanne: The Swiss Institute of Comparative Law. **www.isdc.ch/media/1834/17-120-final-nov19.pdf** (accessed 28 February 2020).

GBV Information Management System (2017). Inter-agency gender-based violence case management guidelines. Online: GBV Information Management System. **www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf** (accessed 28 February 2020).

International Committee of the Red Cross (2005). Customary International Humanitarian Law, Volume I: Rules. Cambridge: Cambridge University Press. **https://ihl-databases.icrc.org/customary-ihl/eng/docs/home** (accessed 28 February 2020).

25th International Conference of the Red Cross (1986). Statutes of the International Red Cross and Red Crescent Movement. Geneva: International Committee of the Red Cross. Revised version 2006. **www.icrc.org/en/doc/assets/files/other/statutes-en-a5.pdf** (accessed 28 February 2020).

International Committee of the Red Cross (2015). Domestic Normative Frameworks for the Protection of Health Care – Report of the Brussels workshop, 29-31 January, 2014 **https://healthcareindanger.org/wp-content/uploads/2015/09/icrc-002-4215-domestic-normative-frameworks-for-the-protection-heath-care.pdf** (accessed 28 February 2020).

International Committee of the Red Cross (2018). Institutional Strategy on Sexual Violence 2018-2022. Geneva: International Committee of the Red Cross.

International Committee of the Red Cross (2019). The ICRC's response to sexual violence: Special Appeal. Geneva: International Committee of the Red Cross. **www.icrc.org/sites/default/files/topic/file_plus_list/2019_specialappeal_sv_final.pdf** (accessed 28 February 2020).

International Federation of the Red Cross (2018). The responsibility to prevent and respond to sexual and gender-based violence in disasters and crisis. Geneva: **https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2018/07/17072018-SGBV-Report_Final.pdf.pdf** (accessed 28 February 2020).

Le Masson V. et al; Overseas Development Institute (2016). Disasters and violence against women and girls. London: Overseas Development Institute. **www.odi.org/sites/odi.org.uk/files/resource-documents/11113.pdf** (accessed 28 February 2020).

Murphy M et al; What Works Consortium (2019). What works to prevent violence against women and girls in conflict and humanitarian crisis: Synthesis Brief. What Works Consortium. Pretoria: South African Medical Research Council. **www.whatworks.co.za/resources/evidence-reviews/item/662-what-works-to-prevent-violence-against-women-and-girls-in-conflict-and-humanitarian-crisis-synthesis-brief** (accessed 28 February 2020).

Reis, C (2005). "Addressing sexual violence in emergencies", Humanitarian Exchange: 32. London: Overseas Development Institute. **https://odihpn.org/magazine/addressing-sexual-violence-in-emergencies** (accessed 28 February 2020).

Sachs C (2007). "Mandatory Reporting of Injuries Inflicted by Intimate Partner Violence", AMA Journal of Ethics, Vol 9, Number 12. Chicago: American Medical Association. **https://journalofethics.ama-assn.org/article/mandatory-reporting-injuries-inflicted-intimate-partner-violence/2007-12** (accessed 28 February 2020).

United Nations Secretary General (2014). Guidance Note of the Secretary-General: Reparations for Conflict-Related Sexual Violence. Geneva: United Nations. https://**www.ohchr.org/Documents/Press/GuidanceNoteReparationsJune-2014.pdf** (accessed 28 February 2020).

United Nations Secretary General (2017). Report of the Secretary General on Conflict Related Sexual Violence: S/2017/249. Geneva: United Nations. **www.un.org/en/events/elimination-of-sexual-violence-in-conflict/pdf/1494280398.pdf** (accessed 28 February 2020).

United Nations Security Council (2019). Resolution 2467, Women and peace and security: Sexual violence in conflict, S/RES/2467, 23 April 2019. New York: United Nations

WHO (2003). Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organisation. **www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en** (accessed 28 February 2020).

WHO and UNHCR (2004). Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons. Geneva: World Health Organisation. **www.who.int/reproductivehealth/publications/emergencies/924159263X/en** (accessed 28 February 2020).

WHO (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organisation. **www.who.int/reproductivehealth/publications/violence/9789241548595/en** (accessed 28 February 2020).

World Medical Association (1956). Regulations in times of armed conflict and other situations of violence. Revised October 2012. Ferney-Voltaire: World Medical Association. **www.wma.net/policies-post/wma-regulations-in-times-of-armed-conflict-and-other-situations-of-violence** (accessed 28 February 2020).

World Medical Association (1949). International Code of Medical Ethics. Ferney-Voltaire: World Medical Association. Revised October 2006. **www.wma.net/policies-post/wma-international-code-of-medical-ethics** (accessed 28 February 2020).

Appendix A: Areas for further research

1. **Detention contexts:** What is the impact of mandatory reporting requirements for sexual violence on the health-seeking behaviour of victims/survivors in the context of detention? Do mandatory reporting requirements for sexual violence in detention fulfil protective purposes? Is there likely to be an even higher risk of retaliatory violence in the context of detention?
2. **Migration and displacement contexts:** Migrants, including refugees, internally displaced persons and persons without civil documentation, face specific challenges in accessing health care. How does the presence of mandatory reporting requirements impact on access to and provision of health care for victims/survivors of sexual violence in these contexts? What measures can be developed to enable their access to health-care services?
3. **Male victims/survivors:** Are the humanitarian consequences associated with mandatory reporting of sexual violence different for men and boys? If so, what measures are required to enable their access to health-care services?
4. **Effectiveness of mandatory reporting:** More research is required on the impacts of mandatory reporting on the quantity and quality of reporting, prosecutions and convictions, and reparations for victims/survivors of sexual violence in armed conflicts and other emergencies. Does mandatory reporting reduce the incidence of sexual violence and/or improve outcomes for victims/survivors in terms of access to justice and protection?
5. **Mandatory reporting of sexual violence and non-state armed groups:** Many conflicts today involve non-state armed groups. In some cases they are in control of territories and running health-care systems. Are there examples of non-state armed groups introducing mandatory reporting of sexual violence cases, or of health-care providers automatically reporting cases to them as defacto law enforcement authorities? Are health-care personnel exposed to sanctions by the State for not reporting cases, in areas controlled by non-state armed groups? What are the risks associated with reporting sexual violence cases where the incident was perpetrated by non-state armed groups?

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Published April 2020

The British Red Cross Society, incorporated by Royal Charter 1908, is a charity registered in England and Wales (220949), Scotland (SC037738) and Isle of Man (0752). BRC20-044. Cover photo © Wojtek Lembryk/ICRC