If Not Now, When?

Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-conflict Settings

A Global Overview

Jeanne Ward

The Reproductive Health for Refugees Consortium

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List of Frequently Used Acronyms

CEDAW	United Nations Convention on the Elimination of All Forms of Discrimination Against Women
GBV	gender-based violence
IDP	internally displaced person
IOM	International Organization for Migration
IRC	International Rescue Committee
IFRC	International Federation of the Red Cross
MSF	Médecins Sans Frontières
NGO	non-governmental organization
PHR	Physicians for Human Rights
RHRC	Reproductive Health for Refugees Consortium
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Foreword

This report is one of several outcomes of a two-year global Gender-based Violence Initiative spearheaded by the Reproductive Health for Refugees Consortium (RHRC) and aimed at improving international and local capacity to address gender-based violence (GBV) in refugee, internally displaced, and post-conflict settings. The Initiative was made possible with generous funding by the U.S. Department of State's Bureau of Population, Refugees, and Migration (PRM). The Women's Commission for Refugee Women and Children (Women's Commission) and the International Rescue Committee (IRC) have jointly supervised all aspects of implementing the Initiative.

The overall objective of this report is to provide a baseline narrative account of some of the major issues, programming efforts, and gaps in programming related to the prevention of and response to GBV among conflict-affected populations worldwide. Other outcomes of the Initiative, including an extensive web-based bibliography of GBV resources (accessible at www.rhrc.org/resources/gbv/bib) and an RHRC field manual for GBV assessment, program design, and evaluation, are meant to supplement the findings of this report with practical and field-friendly tools, as well as educational and training materials.

The report is composed of twelve country profiles: three each for Africa, Asia, Europe, and Latin America. Selection of the countries was based on global representation as well as the extent to which they variously represent stages of conflict and types of GBV. Efforts were made not to investigate settings where reviews of GBV-related programming had already been widely published. For practical purposes, countries in Africa, Asia, and Europe with RHRC member field offices available to facilitate site visits were given priority.

Nine profiles—the Republic of Congo, Rwanda, Sierra Leone, Afghanistan/Pakistan, Burma/Thailand, East Timor, Azerbaijan, Bosnia and Herzegovina, and Kosovo—are the outcome of one- to two-week field investigations that included interviews with survivors, local GBV-related organizations, international humanitarian aid and human rights organizations, local and national government representatives, and United Nations personnel. Given the logistical challenges imposed by the brevity of the visits, the findings within each profile are not meant to be exhaustive but, rather, to provide an impression upon which to base further research and programming activities. Moreover, the profiles represent circumstances only as they existed during the period of the site visits, the dates of which are identified at the beginning of each profile and in the annex that follows this report. The one exception to this rule is the profile of Afghanistan/Pakistan, in which consideration was given in the recommendations to the exceptional events that have recently altered the landscape of possibility for instituting GBV-related programming.

The profiles are broadly divided into sections, including background information, GBV issues, GBV-related programming, and recommendations. The background sections exist to provide a general

context in which GBV incidents and programming occur, and subsequent sections attempt to be as specific as possible in illustrating the nature and prevalence of GBV, the activities underway, and the gaps in those activities that contribute to the perpetuation of GBV. The recommendations section is without exception based on commentary provided during site visit interviews. However, information in the profiles that originated from personal interviews is generally not cited in order to preserve the confidentiality of those offering their experiences and insights. Information taken from secondary reports is cited in the notes, and these reports have become a part of the RHRC library of GBV information.

The profiles for Colombia, Guatemala, and Nicaragua are the result of New York-based desk studies undertaken during the fall of 2001 by Melinda Leonard, graduate student of the Columbia University School for International and Public Affairs. Resources for the desk studies were primarily published reports and telephone interviews with international and local experts. Since the profiles of Latin America were not informed by site visits (because of changes in project funding), their findings focus on descriptive accounts of available information about GBV issues and programming. While organizations and initiatives have undoubtedly been overlooked in the Latin America profiles given the general difficulty in gaining access to program materials, the profiles nevertheless provide useful overviews for considering GBV prevention and response in the countries under review. They follow the general format of the Africa, Asia, and Europe profiles, with the exception that the specific recommendations generated during site visits are absent from the Latin America profiles.

Although GBV encompasses violence against boys and girls and men and women, the findings of this report focus almost exclusively on violence experienced by women and girls. The reasons for this orientation are two-fold: first, GBV programming targeting men and boy survivors is virtually non-existent among conflict-affected populations; and second, women and girls are the primary targets of GBV worldwide. This report has been produced with the sincere hope that its information will not only stimulate GBV-related programming addressing the particular vulnerabilities of women and girls but also motivate further examination of methods for prevention of and response to GBV that engages boys, girls, men, and women.

About the Reproductive Health for Refugees Consortium

The Reproductive Health for Refugees Consortium was established in 1995 to promote the institutionalization of reproductive health services in refugee settings worldwide. Consortium members represent a unique mix of advocacy, development, humanitarian relief, research, and training organizations. Four members—the American Refugee Committee, CARE, the International Rescue Committee, and Marie Stopes International—focus on working with international and local NGOs, U.N. agencies, refugees, and host country governments to provide direct reproductive health services to refugees. JSI Research and Training Institute and Columbia University Mailman School of Public Health at the Heilbrunn Department of Population and Family Health are primarily involved in project research, staff training, and technical assistance. The Women's Commission for Refugee Women and Children, as an expert resource and advocacy organization, serves as coordinator of the Consortium. Each member of the Consortium has capacity and experience in gender-based violence research, training, and programming.

Acknowledgements

The first order of thanks for the information contained in this report goes to all the survivors of GBV around the world who have provided, through their courageous testimony and advocacy, a glimpse of the atrocities that women and girls face not only in periods of conflict but also in flight from conflict, while living in refugee and internally displaced camps, and during post-conflict reconstruction. Their experiences illustrate all too clearly that the perpetration of sexual violence in war—as well as the lack of protective and other services to survivors—is inextricably bound to long-standing gender inequities that contribute to women's and girls' vulnerability to abuse, exploitation, and violence throughout their lives.

Tremendous debt for this report is also owed to all the field-based organizations and individuals who so enthusiastically shared their GBV-related expertise, and who were forthcoming with frustrations about addressing GBV in political and socio-cultural climates that more often marginalize the issue. Though the list of contributors is too exhaustive to enumerate here, many of their activities are mentioned within the narrative of each country profile, and their perspectives underpin all the recommendations set forth in this report.

Thanks are similarly due to the local government, United Nations, and international human rights and aid organization representatives who tirelessly extended themselves during my site visits in Africa, Asia, and Europe. Their generous assistance and referrals added immeasurably to my understanding of each of the countries under investigation. I was a privileged recipient of their expert knowledge and, in many cases, their considerable hospitality.

Suzanne Petroni, formerly of PRM, participated in the trip to Azerbaijan and not only offered her wisdom—the result of her long-standing commitment to confronting and reducing violence against women—but also provided helpful feedback on the Azerbaijan profile. Cari Clark, a doctoral student at the Harvard School of Public Health, joined the trip to Azerbaijan, as well as to Kosovo and Bosnia and Herzegovina. Her special knowledge of and interest in GBV research methodologies were an important contribution to the site visits, as were her patience and flexibility. Her ongoing efforts to improve GBV-related research will undoubtedly serve those who are engaged in addressing GBV among conflict-affected populations. Betsy Kovacs, a board member of the Women's Commission, was an enthusiastic participant in the trip to Bosnia and Herzegovina. Her dedication and intelligence were great assets during the site visit, and her subsequent friendship and insights have assisted me not only in writing the Bosnia and Herzegovina country profile, but also in conceptualizing some of the larger issues that inform this entire report.

Members of RHRC assisted in numerous ways—facilitating site visits, providing expert background information, and reviewing individual country profiles. Sandra Krause of the Women's Commission and Mary Otieno of the IRC are in large part responsible for this report—through the ongoing provision of guidance and recommendations, as well as through

a revolving door of support. Beth Vann, the Gender-based Violence Technical Advisor to the RHRC, has been a comrade and collaborator, sharing a level of expertise essential to my understanding of GBV in conflict-affected settings.

A number of individuals read the country profiles on Asia, Africa, and Europe, and many provided critical feedback on content and organization. Sandra Krause deserves special credit for commenting on all the profiles. Mary Otieno provided important insights about the overall structure of the report. Paul Ward, Sr. lent his editorial expertise to several of the profiles. The Republic of Congo profile was reviewed by Mary Otieno and Les Roberts of IRC Headquarters. Lizanne McBride of IRC Rwanda, Huy Pham of the American Refugee Committee (ARC) Headquarters, and Mary Balikingeri of the Rwanda Women's Network offered feedback for the Rwanda profile. Sierra Leone was enhanced by comments from Martha Saldinger of ARC Sierra Leone, Marnie Glaeberman, formerly with IRC's GBV program in Sierra Leone, Samantha Guy of Marie Stopes International, and the Women's Commission's Sierra Leone-based field officer Binta Mansaray. Afghanistan/Pakistan was supplemented by recommendations from Ramina Johal of the Women's Commission, as well as from Colleen McGinn, former GBV research consultant for IRC Pakistan. Burma/Thailand was thoughtfully edited by Gary Dahl of ARC Thailand, and recommendations were offered as well by Lori Bell of IRC Thailand and Huy Pham. Richard Brennan of IRC Headquarters made contributions to the East Timor profile, as did Carmen Lowry, former program manager for IRC's East Timor GBV program. Azerbaijan benefited from the critical commentary of Mominat Omarova, Vice Chairperson of the State Committee on Women's Issues, Suzanne Petroni and Cari Clark. Zeljka Mudrovcic of the United Nations Population Fund in Bosnia and Herzegovina, and Betsy Kovacs, Samantha Guy and Cari Clark provided important recommendations for Bosnia and Herzegovina.

The desk study overviews representing countries in Latin America are the result of Melinda Leonard's undaunted commitment to the challenging task of writing profiles without having conducted site visits. She was assisted in identifying GBV projects and programs by international and field-based experts, including Deborah Billings of IPAS in Mexico City, Alessandra Guedes of the International Planned Parenthood Federation in New York, Oswaldo Montoya and Patrick Welsh of the Association of Men Against Violence in Nicaragua, and Sandra Krause. Claire Morris of Marie Stopes International and Patricia Ospina Mayorga and Ana Vega of Profamilia Colombia offered helpful feedback on the Colombia profile.

Mary Murrell has extended her expertise to the review of this entire report. Her generous friendship has been as important to the editorial process as her considerable professional skill.

Bruce Ward, for reasons too innumerable to mention, is fundamental to the existence of this report.

Finally, this report would not have been possible without the generous financial assistance of PRM. Their commitment to addressing GBV issues among conflict-affected populations has significantly advanced GBV prevention and response activities in refugee and internally displaced settings. PRM's support of this global overview further illustrates their dedication to expanding the knowledge base upon which effective programming can be designed.

Executive Summary

Introduction

Throughout history, gender-based violence has been an integral component of armed conflict. In the last century, to cite a few examples, Jewish women were raped by Cossacks during the 1919 pogroms in Russia; the Japanese army sexually enslaved and raped thousands of Korean, Indonesian, Chinese, and Filipino "comfort women" during World War II; and hundreds of thousands of Bengali women were raped by Pakistani soldiers during the 1971 Bangladeshi wars of secession. This report attests to GBV against women and girls (and to a lesser extent men and boys) that has been and continues to be a feature of virtually all recently concluded and current armed conflicts.

Until the last ten years, most GBV committed during periods of armed conflict has been either condoned or ignored. This silence is in significant measure a function of deeply embedded cultural assumptions that acquiesce to the "inevitability" of violence and exploitation of women and girls. Nevertheless, recent interrelated events on the international stage have brought GBV in armed conflict, as well as in refugee, internally displaced, and post-conflict settings, into starker relief. In the broadest terms, these events include: 1) the rise of women's and human rights movements across the world, which have not only identified violence against women as a global phenomenon but have also characterized that violence as an affront to basic human rights; 2) the shift in the nature and scope of humanitarian aid afforded conflict-affected populations, including attention to the distinct protection needs of women and children and the ascendancy of reproductive health programming; 3) the increased dominance of international legal instruments and institutions in promoting and reinforcing international standards of human rights as they apply both to women and to conflict; 4) the advances in global technology as well as changes in attitudes toward war that have altered the nature of war propaganda and reporting, leading to significant international press coverage of sexual violence during the Bosnia, Rwanda, and Kosovo conflicts; and 5) a basic change in the character of war during the latter half of the past century from military engagements primarily between fighting forces to violence that targets, dislocates, or otherwise victimizes civilian populations.

The stimulus for GBV, particularly sexual crimes, committed in periods of armed conflict varies. Sexual violence can be capricious or random—the "spoils of war"—resulting from the breakdown in social and moral systems. Indeed, it is likely that this kind of "collateral" GBV is an element of all wars. In addition, sexual violence may be systematic, for the purposes of destabilizing populations and destroying bonds within communities and families; advancing ethnic cleansing; expressing hatred for the enemy; or supplying combatants with sexual services. In Bosnia, for example, public rapes of women and girls preceded the flight or expulsion of entire Muslim populations from their towns or villages, and strategies of ethnic cleansing included forced impregnation. East Timorese men were forced to rape women in the presence of the Indonesian military, and East

Timorese women were raped in the presence of family members. Some were raped because of their assumed link to the East Timorese resistance; others were forced into prostitution servicing Indonesian troops. In Rwanda, Hutu extremists encouraged mass rape and sexual mutilation of Tutsi women as an expression of contempt that sometimes included intentional HIV transmission. Under the volatile and disorganized rule of the Mujahideen, rape and sexual harassment of women in Afghanistan's capital city of Kabul were reportedly commonplace, and in the years following the Taliban takeover, ethnic minority women in the frontlines of combat were at risk of rape and abduction by all parties to the conflict. In Sierra Leone and Burma, rebel, paramilitary, and military contingents force women and girls into sexual slavery and, in some cases, marriage. Sexual crimes also occur in flight from conflict and during civilian displacement, committed by bandits, insurgency groups, military, border guards, host communities, humanitarian aid workers, security or peacekeeping forces, and fellow refugees.

Whether indiscriminate or methodical, sexual violence is only one variation of GBV that periods of armed conflict and consequent social disruption exacerbate. Other forms of violence that may increase during war and its aftermath include: early or forced marriage, especially in cultures with traditions of early marriage and dowry; female infanticide; enforced sterilization; domestic violence, which in virtually all post-conflict settings is acknowledged as a component of the "culture of violence" that ensues from war; forced or coerced prostitution or other forms of sexual exploitation, often an outcome of the disproportionate impact of war-related poverty on women and girls; and trafficking in women and girls, to which the black markets that invariably attend conflict appear to give rise. Forced conscription of boys—based on assumptions of males' responsibility to take up arms—is also a common and immeasurably devastating component of many current conflicts. All these manifestations of GBV, as well as others that may not significantly increase during conflict but are nevertheless the outcome of harmful traditional practices, such as female genital cutting and honor killing, are based on customary attitudes and behaviors that sustain and reinforce gender-based abuse and exploitation, not only in times of war but also in periods of so-called peace.

Gender-based Violence Programming

Definition of Terms

Women's rights research, advocacy, and practice have produced a dynamic and evolving discourse that frames how international humanitarian institutions and organizations have conceptualized violence against women and girls in conflict-affected settings. These conceptualizations have contributed to changes in the GBV-related idiom of the humanitarian community. One of the earliest GBV-specific projects of the United Nations High Commissioner for Refugees (UNHCR), instituted in 1993 in refugee camps in northern Kenya, was entitled the "Women Victims of Violence Project." In 1995 UNHCR published *Sexual Violence Against Refugees: Guidelines on Prevention and Response.* As with the Kenya program, its focus was primarily on sexual violence, primarily as perpetrated against women. The International Rescue Committee's (IRC) first GBV initiative, launched in refugee camps in Tanzania in 1996, was entitled the "Sexual and Gender-based Violence Program." Gender was overtly recognized as elemental to violence, even if sexual violence remained a separate manifestation that, implicit in the phraseology, was not necessarily gendered. Beginning in 2001, the Reproductive Health for Refugees Consortium (RHRC) has advocated for the inclusion of sexual violence under the umbrella term "gender-based violence" so to recognize that issues of gender underlie virtually all forms violence against women and girls that humanitarian programming seeks to address. As such, newer initiatives are more succinctly referred to as "gender-based violence programs." The centrality of gender has important theoretical and practical implications for anti-violence activities: the language itself speaks to the necessity of examining the societal and relational contexts in which violence against women and girls occurs, and therefore begs the inclusion of men, women, boys, and girls.

Gender refers to the attributes and roles differentially ascribed to males and females. These attributes and roles are socially constructed, context based, and learned through socialization. Although mutable, they are rooted in long-standing assumptions societies hold about women, men, boys, and girls. They inform relationships between males and females as well as among females and among males.

Gender-based violence is an umbrella term for any harm

that is perpetrated against a person's will; that has a negative impact on the physical or psychological health, development, and identity of the person; and that is the result of gendered power inequities that exploit distinctions between males and females, among males, and among females. Although not exclusive to women and girls, GBV principally affects them across all cultures. Violence may be physical, sexual, psychological, economic, or sociocultural. Categories of perpetrators may include family members, community members, and those acting on behalf of or in proportion to the disregard of cultural, religious, state, or intrastate institutions.

Any analysis of or attempt to reduce GBV must necessarily examine and confront the gendered foundations upon which violence occurs. It should be noted, however, that even though gender is one of the most significant factors *around the world* in the perpetuation of violence against women and girls, other essential criteria for evaluating and addressing the nature and prevalence of violence include class, race, poverty level, ethnicity, and age.

GBV and Human Rights

Focusing on the contexts in which violence occurs is crucial to reducing violence, but there remains in the international humanitarian aid community a fear of imposing "western" standards of social organization and behavior on disparate refugee, internally displaced, and post-conflict populations across the world. During research for this report, for example, many international representatives of the humanitarian aid community expressed the opinion that acts of GBV were the preserve of culture and therefore outside the scope of humanitarian intervention. This perspective may itself be paternalistic in its failure to acknowledge local communities' desire to improve the rights of its own members, but at the same time its concerns are rooted in a respect for difference that should be a feature of all humanitarian work. Nonetheless, when applied to GBV, this reluctance to intervene may reinforce behaviors that hurt and kill women and girls and, by extension, destroy families and societies.

The efforts of human rights activists (including women's rights activists) have informed deeply the work of humanitarian aid in conflict-affected populations. The premise of equal access to human rights is basic to the humanitarian agenda. Furthermore, when extended to humanitarian interventions, the human rights perspective demands that those interventions are by nature participatory—that is, they engage at every level of program assessment, design, implementation, and evaluation with the communities the programming is intended to assist. In terms of GBV programming, a human rights approach both insists that GBV is addressed within the context of humanitarian assistance and that any efforts to confront GBV are inclusive of the population served and squarely rooted in the needs identified by those most vulnerable.

Even so, there are settings around the world—by no means exclusive to conflict-affected populations—where complacency regarding certain types of GBV is the norm, both for perpetrators and victims. Men and women alike, for example, may agree that husbands are entitled to beat their wives. Perhaps even more common to conflict-affected populations, human rights are often viewed as non-essential luxuries when there is little or no access to water, food, or shelter. However, as the findings of this and other reports illustrate, those most at risk on *all counts* in refugee, internally displaced, and post-conflict settings are women and children. Their disproportionate vulnerability is informed by their subordinate status. Thus, any framework for humanitarian action must use the language and the perspective of human rights *and* gender equality if the most vulnerable are to be assisted.

Acts of GBV violate a number of principles enshrined in international and regional human rights instruments. A partial list of those principles includes the right to life, equality, security of the person, equal protection under the law, and freedom from torture and other cruel, inhumane, or degrading treatment. The Convention on the Elimination of All Forms of Discrimination Against Women (ratified by the United Nations in 1979), to which *all countries represented in this report* have acceded, commits its signatories to condemn violence against women, to create legal and social protections against violence, and not to invoke custom, tradition, or religion to avoid the obligations it outlines. The Declaration on the Elimination of Violence Against Women, adopted by the U.N. General Assembly in 1993, and the subsequent Global Platform for Action, adopted at the Beijing Fourth World Conference on Women in 1995, further elaborate the nature of GBV and reiterate state responsibility to protect women and girls.

In 1998 the International Criminal Court adopted the Rome Statute, which defines crimes against humanity to include torture, rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other comparably grave acts of sexual violence that are committed as part of a systematic attack on civilian populations. The International Criminal Tribunals for Rwanda and the former Yugoslavia have each handed down sentences that characterize sexual violence committed against women during conflict, respectively, as crimes of genocide (1998) and as crimes against humanity (2001). In 2000, the U.N. Security Council adopted Resolution 1325, which specifically "calls upon all parties to armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict."

Protecting the rights of conflict-affected populations is at the heart of the responsibilities of international humanitarian response. UNHCR's *Guidelines on the Protection of Refugee Women* (1991) recognized exposure to sexual violence as a particular vulnerability of refugee women and called upon the humanitarian community to address it within its protection mandate, and in 1995 UNHCR released its *Sexual Violence Against Refugees: Guidelines on Prevention and Response*, which more explicitly highlighted some of the major legal, medical, and psychosocial components of GBV prevention and response.

GBV and Reproductive Health

Although the *Guidelines on the Protection of Refugee Women* and the subsequent *Sexual Violence Against Refugees: Guidelines on Prevention and Response* were each important in identifying violence against women as components of conflict and displacement, these guidelines did not promote methodologies for developing specific field-based programs or protocols to tackle GBV. And although there were several model GBV programs instituted for conflict-affected populations before the mid-1990s—which addressed, for example, domestic violence among Cambodian refugees and sexual violence in Liberia and among refugees in northern Kenya—there was no attempt to standardize GBV activities until international reproductive health advocates incorporated GBV within their mandate. In 1994, the Women's Commission for Refugee Women and Children released a groundbreaking study, *Refugee Women and Reproductive Health: Reassessing Priorities*, that revealed even the most basic reproductive health services—including those to address GBV—were not available to refugee and displaced women. Following the precedent-setting 1994 International Conference on Population and Development in Cairo, and with strong support from an influential donor base, reproductive health was introduced in humanitarian settings. In expanding minimum health standards for refugees and IDPs, GBV was recognized as a major factor in women's morbidity and mortality. The significance of this change in health programming cannot be underestimated: it was through the portal of reproductive health that GBV programming was widely introduced into conflict-affected populations.

In 1995 UNHCR and the United Nations Population Fund (UNFPA) collaborated to form an Inter-Agency Working Group (IAWG) of expert international reproductive health organizations. A year later IAWG produced an inter-agency field manual, *Reproductive Health in Refugee Situations*, that includes information about the prevention and management of GBV from the emergency to stable phase of displacement. The manual was field-tested and reproduced in 1999.

RHRC has integrated GBV as a technical area within reproductive health training and services; as such, all the services advocated for and (at least theoretically) provided by the RHRC have a GBV component. In 1995, CARE took over from UNHCR its "Women Victims of Violence Project" in refugee camps in Kenya. Since then, the lead RHRC agency in addressing GBV has been IRC, which in 1996 initiated its Tanzania program and from there has established at least twelve GBV programs worldwide. RHRC's other direct service members, ARC and Marie Stopes International, have also targeted GBV in their programming. Other international organizations working in humanitarian contexts that have incorporated GBV within their programming include the International Medical Corps, OXFAM, Save the Children, Médecins Sans Frontières, and the Christian Children's Fund.

Current Standards for GBV Prevention and Response

The intersection of reproductive health and GBV allowed for a greater understanding of and greater attention to the physical and mental health impacts

of GBV, including sexually transmitted infections, reproductive tract trauma, unwanted pregnancy and complications associated with unsafe abortions, somatic complaints, depression, and suicide. However, the focal point of reproductive health resulted in GBV programming that was often based on the provision of curative services, such that other aspects of GBV programming were given short shrift in humanitarian settings. Furthermore, sexual violence was the primary element of early programming, even as other forms of GBV were being identified by service providers. In 1998, UNHCR received $1.65 million from the U.N. Foundation to strengthen its ability to address GBV in Africa. As programs multiplied and reports were published and disseminated, UNHCR and its implementing international and local NGO partners recognized that any attempts to address GBV—both in terms of prevention and response—must be the outcome of coordinated activities between the constituent community, health and social services, and the legal and security sectors. In 2001, UNHCR hosted an international conference on GBV, in which the concept of multisectoral programming was further clarified as fundamental to combating GBV. To date, this multisectoral model forms the "best practice" for prevention of and response to GBV in refugee, IDP, and post-conflict settings.

The underlying principle of the multisectoral model recognizes the rights and needs of survivors as preeminent, in terms of access to respectful and supportive services, guarantees of confidentiality and safety, and the ability to determine a course of action for addressing the GBV incident. Key characteristics of the multisectoral model include the full engagement of the refugee community, interdisciplinary and interorganizational cooperation, and collaboration and coordination among sectors. Within the heath sector, participating actors might include health facility staff, doctors, nurses, midwives, traditional birth attendants, community health workers, traditional health practitioners, health managers, administrators, and health ministry officials and staff. In the social services sector, actors might include UNHCR community services officers, community volunteers, social workers, teachers and school administrators, skills training program managers and staff, income generation and micro-credit program managers and staff, and representatives of the ministry attending to social welfare. Within the legal sector, actors might be UNHCR protection officers/assistants, judges and other officers of the court, legislators, lawyers, NGOs and legal advocacy groups, and representatives of the country's equivalent of a Ministry of Justice. The security sector might include police, peacekeeping forces, international and national military, security and field officers in UNHCR and NGOs, and representatives of the Ministry of the Interior. And of course, if existent, any multisectoral collaboration would involve close cooperation with local women's groups and representatives from the ministry responsible for addressing the needs of women and girls.

Each of these sectors is charged under the multisectoral model with basic responsibilities related to the prevention of and response to GBV. The health sector, for example, should be able to: actively screen clients for GBV in a way that is respectful and supportive; ensure same sex interviewers for survivors; respond to the immediate health and psychological needs of the survivor, and, wherever possible, provide those services free of cost. Health care providers should also be prepared to collect forensic evidence when authorized by the survivor and provide testimony in cases where a survivor chooses to pursue legal action; be aware of and refer survivors to other support services; confidentially collect, document, and analyze health data and data on the quality of services, so as to adjust services accordingly; and provide broad-based community education on the health impacts of GBV and the availability of services.

The social services sector should be able to: provide supportive and ongoing psychological assistance, in which social workers and community services workers have access to professional supervision and support; confidentially collect, document, and analyze client care data, and adjust programming accordingly; offer safe haven for victims who choose to leave an unsafe environment; provide hotlines—in settings where phones exist—to facilitate support and referral; offer income generation and training programs that allow women and girls sustained economic viability; conduct broad-based community education on the prevention of GBV and on the availability of services; and provide early childhood and adolescent education about safe touch, gender, and healthy relationships.

Members of the legal sector should work to: review and revise laws that reinforce GBV and gender discrimination; provide free or low-cost legal counseling

and representation to survivors; conduct ongoing training to members of the judiciary to apply GBV laws and carry out judicial proceedings privately, respectfully, and safely; institute provisions for monitoring court processes and collecting and analyzing data on cases; and conduct broad-based community education on the existence and content of anti-GBV laws.

Within the security sector, a zero tolerance policy should exist for all police, military, and peacekeeping staff who contribute to or commit acts of GBV, and that policy should be actively enforced by those in command. The security sector should be trained and prepared to intervene in cases of GBV in a way that acknowledges the severity of GBV and does not further victimize the survivor by: designating private meeting rooms within police stations; providing same sex police officers to work with survivors; creating specialized units to address various manifestations of GBV, such as sexual violence, domestic violence, and trafficking; offering survivors referrals for collateral assistance; conducting community policing and education programs; instituting ongoing training and supervision of police personnel; and standardizing sex-disaggregated data collection and analysis. Other security personnel should similarly be trained and equipped to intervene in cases of GBV respectfully and in such a manner that "does no harm." In demobilization and reintegration programs for former combatants, anti-GBV education should be integral, as should drug and alcohol counseling.

A critical responsibility of all the sectors is coordination, which within the U.N. refers to the systematic use of policy instruments to deliver humanitarian assistance in a cohesive and effective manner. Coordination includes strategic planning, gathering data and managing information, mobilizing resources and ensuring accountability, orchestrating a functional division of labor, negotiating and maintaining a serviceable framework of action, and providing leadership. At the more prosaic level of institutionalizing programming for GBV prevention and response, coordination includes: sharing information about GBV incident data; discussion and problem-solving among actors about prevention and response activities; and collaborative monitoring, evaluation, and ongoing program planning and development. As part of coordination, methods should exist for reporting and referrals among and between different sectors, and those methods should be continuously monitored and reviewed. Referral networks should focus on providing prompt, confidential, and appropriate services to survivors. And, perhaps most importantly, regular meetings should be convened involving representatives of the various sectors tasked with GBV responsibilities. A designated "lead agency"—which ideally would be a ministry or other national body but could also be an international institution or organization, or a local NGO or representative body invested with due authority—would be responsible for encouraging participation and facilitating meetings and other methods for coordination and information sharing among sectors.

An Overview of Findings Contained in This Report

The ideals of multisectoral programming remain just that: ideals. Although GBV prevention and response has been increasingly acclaimed as an important component of humanitarian assistance, that commitment is still not widely realized. In pockets of Bosnia and Herzegovina, such as Zenica and Gorazde, multisectoral coordination initiated by the local GBV programs has engaged the police, health services, and social workers, with apparently good outcomes in facilitating reporting and reducing GBV. More often, programs themselves have adopted an internal multisectoral expertise in order to meet the various needs of survivors, typically providing a mixture of health, psychosocial, and legal support. Most often, though, there are significant gaps in policy, programming, coordination, and protection across all sectors.

Perhaps one of the primary gaps is the lack of data on GBV. In none of the countries represented in this report were service data collected across sectors, either at the local or national level. In many countries, little or no research had been conducted on the prevalence of GBV. In some countries where prevalence research has been conducted, such as Sierra Leone, Azerbaijan, and Kosovo, the findings—though important in their own right as a way to improve awareness of the nature and scope of GBV—were not attached to programming and thus did not directly inform prevention and response activities. In several cases where data were collected by GBV programs, whether through service statistics or prevalence research, the findings resulted in sustained shifts in policy. The Republic of Congo, for example, included sexual violence response as a com-

ponent of its national health policy following data collection spearheaded by IRC and its partners, and the Ministry of Health now collects sexual violence data from hospitals and clinics where rape-related services have been instituted.

Yet another gap in addressing GBV is the tendency of donors and humanitarian institutions and organizations to focus on sexual crimes committed during conflict. Although establishing services for rape survivors is critical, addressing rape is just one component of GBV programming. In Rwanda, virtually all GBV services focus on the outcomes of genocidal rape—in terms of health provision, psychosocial support, and legal aid—even when prostitution (with related high rates of HIV) and domestic violence are believed to be endemic in the post-genocide society. This is also true of the Republic of Congo, where treating sexual violence has become standardized (at least in Congo's capital city of Brazzaville), but other forms of GBV receive virtually no attention. In few countries has programming reflected the extensive nature of GBV or begun to address its underlying causes.

Protections for survivors of all forms of GBV are weak in every country profiled in this report. This is perhaps most true of unregistered refugees in Thailand and Pakistan, where the lack of host government recognition, the culture of violence against women that supports impunity for GBV-related crimes, and the extreme discrimination against women in general conspire to promote GBV crimes. However, lack of protection is also an element among encamped and post-conflict populations. International security and peacekeeping forces are overwhelmingly male, as are national police and security forces, and very few have had training on preventing GBV or responding to GBV-related reports. UNHCR's ability to provide sustained protection for survivors is all too often only as good as a host country's commitment to addressing the issue, and UNHCR has not widely assumed the important task of advocating to national governments for improved protections in cases of GBV.

One difficulty in ensuring protections is due to variations in GBV-related policy and practice. Although codes of conduct and zero tolerance policies have been instituted for international forces in Bosnia and Herzegovia and Kosovo—particularly with regard to crimes related to prostitution and trafficking—the will to enforce those codes varies considerably. The commitment to enforcing national laws regarding GBV also varies considerably: while Colombia, for example, has model legislation, GBV is a pervasive and largely ignored problem. Very often, the judiciary is simply left out of the equation when developing training and protocols for improved response to GBV. This omission was apparent in both the Guatemalan Ministry of Public Health's research and a report by the Organization for Security and Cooperation in Europe, which revealed biases within Kosovo's judicial system that severely inhibited fair prosecution of GBV cases.

Even so, successes such as the high percentage of women recruited into the Kosovo Police Services and the trainings conducted by international personnel for East Timor's national police cadets are models for implementing ongoing protection. So are the efforts of a senior Sierra Leone police officer and a Kosovo international police officer, who established domestic violence units in their respective police headquarters; and an international police officer based in East Timor who established systems of disaggregated data collection on reported cases of violence.

Short-term funding and shifting donor priorities have also contributed to the inability of many programs to achieve the degree of expertise and conduct the level of comprehensive activities required to adequately combat GBV. To a remarkable extent in many of the post-conflict settings profiled in this report, local women's organizations have quickly regrouped or newly formed to address issues of GBV. However, because funding for conflict-affected populations is generally limited to emergency response, and because there are gaps between "emergency" relief and "development" programming, many organizations that might build on their preexisting knowledge of and commitment to GBV programming often diversify their activities and mandates to meet changing donor expectations.

Moreover, the notion of self-sustainability, which is a central requirement of many donor initiatives, is generally unrealistic as it applies to GBV programming. In post-conflict settings where national and local economies are more often too weak to support social services (and where GBV issues are marginalized in any case), it is almost a given that GBV programs will not be able to access sufficient ongoing local funding. They should not then also be expected to add

income-generation to their tasks. One particularly disturbing case in point was the hotline that was established in Gorazde, Bosnia and Herzegovina. The community considered the existence of the hotline to be an important resource for women and for the local police and social workers with whom the hotline collaborated, but lack of funding caused the hotline to be precipitously shut down. Another example is the well-regarded Women's Wellness Center in Pejë, Kosovo. Even though the center had a six-month transition period from being supported by an international NGO to establishing itself as an independent local NGO, at the end of those six months the center's director had only identified an additional six months of funding, and even that was insufficient to cover staff salaries. Overall multisectoral integration of GBV prevention and response activities should be a goal for any donor or implementing agency; however, integration requires ongoing monitoring and support from institutions and organizations—such as the Women's Wellness Center—that are specifically charged with and expert in addressing GBV. Invariably, the most successful and sustained programs are those that receive long-term technical and financial assistance from international donors committed to issues of women's rights and GBV reduction. A model example is Medica Zenica in Bosnia and Herzegovina, and its primary donor, Medica Mondiale. Kvinna till Kvinna has also been a tremendous source of funding and support to women's organizations throughout the war-affected Balkans. The U.S. Department of State's Bureau of Population, Refugees, and Migration has not only funded this report, but has in the last several years made an exemplary impact on GBV programming by supporting international research, global technical assistance, and field-based programming.

Lack of national-level strategies or policies to address GBV also contributes to the failure of broad-based programming and coordination. In part this lack of national recognition regarding GBV can be attributed to the general lack of representation of women in positions of influence. In post-conflict settings, it also speaks to the failures in international- and national-level planning to anticipate GBV as an important area for attention in any reconstruction efforts. In most of the countries represented in this report, there are no government-supported mechanisms for coordination specific to GBV. As a result, GBV programs have often developed vertically, independent of the cross-cutting sectors that could provide broad support in the prevention of and response to GBV. In many cases, GBV programs have also developed independent of other in-country international and local GBV programs. If coordination does occur, it is often from the efforts of a motivated individual or organization, often working outside a specific mandate, whose reach is limited by lack of resources and institutional support.

Because addressing the gender inequities that contribute to GBV is fundamental to addressing the perpetuation of GBV, any programming that seeks to reduce GBV must also challenge the social, cultural, and political determinants of violence. Such programming requires a long-term commitment to awareness-raising and advocacy, as well as recognition that addressing GBV includes providing women and girls access to power. Inasmuch as GBV programming should be integrated across sectors, so should efforts at gender mainstreaming. However, it is more often the case that international institutions and organizations, even if they theoretically support women's empowerment as a goal of programming, do not challenge the structures that reinforce women's subordination. To a certain extent this is exemplified in the Women's Initiatives in Bosnia, Rwanda, and Kosovo. A laudable goal of each initiative was to support the empowerment of women, but that goal often translated into small-scale income generation projects, which in some cases may have exacerbated, rather than reduced, the feminization of poverty that is often an outcome of conflict. Notably, none of the Initiatives had overt strategies for addressing GBV prevention and response as a component of women's empowerment.

With the exception of the model initiatives in Nicaragua and the White Ribbon Campaigns in the Balkans, men are essentially absent, both as targets for services and as agents for change, from GBV programming represented in this report. Although several GBV programs in Africa and the Balkans are staffed with men, and although community education does not exclude men, most often GBV-related activities focus on women and girls as potential victims and as survivors. This orientation to women and girls as service recipients justly reflects the reality of women and girls as the primary victims of GBV. However, any efforts to reduce GBV will require the significant participation of men and boys and must necessarily include activities and initiatives to examine men's participation in, and perpetuation of, violence.

Overview of Recommendations Contained in This Report

1. The donor community should examine its commitment to addressing the health and safety needs of refugee, internally displaced, and post-conflict populations; and, acknowledging the human rights violations and major impact of GBV on morbidity and mortality, pledge resources to institutionalize broad-based health and other support services to assist survivors, as well as initiatives to reduce the prevalence of GBV. Short-term self-sustainability should not be a requisite of donor support. Priority funding should be given to expert local NGOs that can assist national and local governments to institutionalize plans and protocols to address GBV.

2. National governments should review their charge of protecting refugees and internally displaced, and ensure that the same degree of protection accorded the general population also applies to refugee and IDP populations. On this basis, improvements in addressing GBV should be relevant to all those under government jurisdiction.

3. Broad-based programs to address GBV in refugee and IDP settings should be designed and implemented proactively. Protocols should exist to anticipate, identify, and prevent GBV. Multisectoral response should be integrated into refugee and IDP communities from the outset of U.N. intervention, with the full participation of refugee communities, especially those most vulnerable. Wherever possible, experts from the host community should be engaged to provide GBV training and service delivery.

4. National and local governments, in collaboration with U.N. institutions and international and local implementing partners and local women's representatives, should institutionalize coordination of multisectoral GBV prevention and response activities. Any coordinating body initially led by the U.N. or its implementing partners should have a long-term plan for transitioning to national government oversight.

5. Confidential data collection should be standardized within sectors, as should methods for data sharing across sectors. Data should be monitored, evaluated and integrated at the local and national level.

6. International peacekeeping and security forces should improve their monitoring of personnel who may directly or inadvertently contribute to coerced or forced prostitution, sexual exploitation, trafficking, and other forms of GBV, holding them to international codes of conduct and the responsibilities outlined in U.N. Security Council Resolution 1325. Females should be actively recruited to international security and peacekeeping forces.

7. Ministries responsible for internal affairs and the judiciary should require training within their respective sectors on the existence of protective laws related to GBV. Where laws offer inadequate protection, they should be revised. All actors should be held responsible for the application of those laws. Females should be actively recruited to police, military, and the judiciary. Demobilization and reintegration activities should include GBV prevention and response in their education and direct services, as well as psychological and drug abuse counseling.

8. Ministries for social welfare should ensure that GBV prevention and response is an integrated component of social welfare, including education, skills-building, and psychosocial care. Those who provide counseling to survivors should have access to ongoing supervision and support. Wherever possible, shelters and hotlines should be available. Education and social service programs should reach children and adolescents on issues of safe touch, gender, and healthy relationships.

9. Ministries of health should require that health services include protocols for addressing GBV. Standard training on all aspects of GBV treatment and response should be required for health workers, and the rights of the survivor to safety, confidentiality, and choice should be paramount in any service provision. Services for sexual assault survivors should be free of charge. Confidential data should be collected by clinics and hospitals and monitored, evaluated, and utilized at the institutional, local, and government level.

10. Widespread multi-media campaigns that utilize television, radio, and print should be used to conduct prevention campaigns and to inform survivors about the availability of health, social services, and legal aid in all refugee, IDP, and post-conflict communities.

11. Men's organizations, churches, and governments should be used to involve men and male community representatives in GBV prevention efforts. Models from Latin America, particularly the men's associations in Nicaragua that work to reduce violence against women by confronting issues of masculinity and aggression, should inform efforts to engage men in GBV prevention in other parts of the world.

Looking to the Future

UNHCR first formally introduced GBV programming into a refugee setting in 1993, and from there prevention and response activities have grown significantly. This growth is a testament to the possibility of confronting GBV. There are important newer initiatives underway that have great promise in advancing global efforts to address GBV in conflict-affected settings. Among those initiatives is a GBV assessment, design, and evaluation manual currently being developed by the RHRC according to the work of RHRC member agencies, especially RHRC's GBV Technical Advisor and its Research Officer. Another important initiative is that of the World Health Organization to standardize medical management guidelines for responding to rape, for which they have designed and are currently field testing a manual. UNHCR is also currently revising its 1995 *Sexual Violence Against Refugees: Guidelines on Prevention and Response* to reflect lessons learned about the importance of multisectoral programming. A GBV-related step-by-step guide for UNHCR protection officers is currently in draft form. The Women's Commission for Refugee Women and Children has undertaken an assessment of the implementation of UNHCR's *Guidelines on the Protection of Refugee Women* and its policy on refugee women; the assessment, to be released in 2002, makes recommendations for improving strategies to address GBV. The Center for Health and Gender Equity, a reproductive health and rights advocacy organization, has created a directory of more than 250 organizations around the world working to integrate GBV and reproductive health, and is developing a health- and rights-based framework to identify critical elements related to the design, implementation and evaluation of integrated GBV and reproductive health programs in a myriad of contexts. International Medical Corps has retained a technical advisor to assist its health programs in the integration of GBV. Save the Children is currently working on a GBV education manual for its staff. UNFPA has produced a manual for integrating GBV into reproductive health services in development contexts, of which an adaptation for refugee settings is planned. The International Planned Parenthood Federation is supporting several projects in Latin America also aimed at GBV integration and produces *Basta!*, a resource periodical based on its work.

As impressive as these initiatives are, it is the effort of the local communities represented in this report that illustrate the greatest potential for combating GBV in refugee, IDP, and post-conflict settings. As this report illustrates, repeatedly and across cultures inspiration for change is based in local women's unrelenting commitment to reducing the violence that has overwhelmed their communities and their lives.