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Addressing sexual violence in humanitarian emergencies

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Abstract
Sexual violence is a by-product of conflict commonly seen, but poorly addressed, in humanitarian emergencies. Reports reveal that extraordinary numbers of women and girls suffer physical, psychological, and social consequences of sexual violence during conflict, when fleeing conflict, and during displacement. All sectors of the humanitarian community have a role to play in the prevention of and response to sexual violence. Improvements are needed: in the short-term to meet the needs of survivors of sexual violence; in collecting data related to sexual violence in humanitarian emergencies; and, perhaps most importantly, to address the widespread tolerance for high rates of sexual violence in humanitarian settings.

Keywords: *Conflict, emergency, sexual violence, women*

Introduction

This paper reviews the current situation with regard to sexual violence in humanitarian emergencies. We provide an overview of this global health problem and describe efforts to address it through prevention and response activities. Sexual violence is but one aspect of gender-based violence,[1] an umbrella term under which reside a variety of harmful acts rooted in social roles including, but not limited to, intimate partner violence, trafficking in women and girls, and acts of sexual violence such as rape and sexual exploitation. Globally, violence perpetrated against girls and women kills more women than traffic accidents and malaria combined (Grown and Gupta 2005).

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The reality of sexual violence in humanitarian emergencies is one which requires increased examination and analysis. Rape has been associated with war throughout human history, but the community of humanitarian actors has only just begun to acknowledge its obligation to address sexual violence in an emergency response. While approaches to this issue have been proffered in guidelines since 1995, significant gaps in providing an adequate minimum response persist.

A movement to professionalize humanitarian action emerged from the conflicts in the mid 1990s (Walker and Purdin 2004). That same time period saw a parallel movement to incorporate reproductive health care into the humanitarian response, a set of activities traditionally focused on food, water, and shelter. Gender-based violence was one of the components outlined as an area of reproductive health concern. In the acute phase of an emergency, humanitarian workers are beset by competing priorities, so recommended actions to address gender-based violence were limited to the most egregious forms—acts of sexual violence.

Rules-of-war laws such as the Geneva Conventions have banned attacks on civilians, and war-related tribunals have established rape in war as a crime against humanity,[2] yet rape persists as a strategy of war and as an opportunistic offence perpetrated by persons with power in locations of insecurity. Women and girls in settings of armed conflict are subjected to extraordinary violations including rape, forced participation in the sex trade, or the requirement to exchange sex for food or security for themselves and their children.

In this paper, we focus on sexual violence against women and girls. While men and boys are sometimes subjected to sexual violence, such acts disproportionately affect women and girls. Gender-based violence, including sexual violence, is rooted in male and female gender roles that relegate women to inferior status in societies around the world. In fact, when men and boys are subjected to sexual violence the intent is gendered in nature, that is, it seeks to emasculate. In many cultures, notions of family honor are tied to a daughter's virginity and social concepts of honor may be intricately linked to the female body. Thus a single act of rape will inflict harm on the individual survivor, her family, and the community at large. A spoken or unspoken awareness of these implications often underlies the use of rape as a strategy of warfare.

Reflecting its origin in the movement to integrate reproductive health into humanitarian responses, to date programming to address gender-based violence in humanitarian settings has focused on the reproductive health consequences for survivors. Health facilities and staff serve as important entry points for survivors of sexual violence in conflict situations. However, it is necessary to recognize that addressing sexual violence requires multi-disciplinary prevention and response efforts, including care of survivors' health, psychological, social, security, and justice needs. Both the past successes and the failures of programmes addressing gender-based violence in humanitarian emergencies offer lessons to guide future prevention and response efforts.

Ample evidence exists to demonstrate that sexual violence increases in conflict situations. The reported incidence of sexual violence has been shown to be universally higher among populations affected by armed conflict than in stable non-displaced settings (Swiss and Giller 1993). While concern for sexual violence in refugee, internally displaced, and post-conflict populations has been increasing, data collection to illustrate the magnitude of the problem is fraught with challenges (Ward and Brewer 2004).

It is difficult to quantify the magnitude of the incidence of sexual violence in stable settings, and even more so in humanitarian emergencies. Many reports have shown that only a small proportion of sexual violence events are reported, either to police or to health services, whether in times of peace or war. Survivors of sexual violence often feel shame and guilt and risk negative social consequences if their plight is made public; they therefore are reluctant to reveal such occurrences.

Conducting population-based research to determine the magnitude of sexual violence in conflict settings brings additional difficulties. Sexual violence in conflict holds political significance and can bring global reproach; this risk of approbation promulgates efforts on the part of governments or other political entities to obscure and deny events of sexual violence. Research ethics preclude asking an individual if she has experienced sexual violence when appropriate services are not available, which is the norm in emergency situations. Asking such questions can put researchers at risk of physical harm, arrest, or expulsion; and answering such questions can put respondents at risk of physical harm, arrest, or social sanctions.

Despite the challenges, a number of prevalence studies have been conducted in conflict settings in the recent past, however only three are documented in the peer-reviewed literature (Swiss et al. 1998, Amowitz et al. 2002, Hynes et al. 2004). The nature of sexual violence perpetrated in conflicts can be categorized into two major groupings. First is sexual violence perpetrated as a method of warfare. Investigations of sexual violence during the wars in the former Yugoslavia describe rape as a weapon of war to terrorize and humiliate communities as well as a tool of genocide (Human Rights Watch 1995). Similar strategies, although differing in scale, have been seen in armed conflicts in Somalia, Rwanda, Sri Lanka, Eastern Democratic Republic of Congo, Sierra Leone, and in Darfur, Sudan. These actions have been specifically taken on by international tribunals adjudicating war crimes in Bosnia, Sierra Leone, Rwanda, and Sudan.

Second is the evidence of opportunistic sexual violence perpetrated within the climate of impunity present in war zones where there is a breakdown of both social and legal systems for sanctioning aberrant behaviour. These are the acts of sexual violence experienced by women and girls collecting firewood or exchanging sex for extra food. Even though not an explicit war strategy, such acts may be both systematic and on a large scale. These acts are not usually the purview of international tribunals but rather of local justice systems; systems which are, by definition, dysfunctional in settings of insecurity where impunity is the norm.

Calculations of incidence rates would be useful to guide programming, for example to calculate adequacy of service coverage and for advocacy to improve security. However, these incidence rates are not routinely available.

Methods

In this article, the authors review available data (from both published and unpublished sources) to illustrate the extent of sexual violence in humanitarian emergencies and the lack of a sufficiently robust response to the problem. The focus of the review is on material produced in the recent past, building upon McGinn's study published in 2000 (McGinn 2000). We conclude with recommendations for continuing research as well as improvements in prevention and response efforts.

Impact of sexual violence

Sexual violence associated with conflict-related humanitarian emergencies remains a persistent threat to global public health. Sexual violence impacts individuals, families, and communities. Critical to the understanding of sexual violence is recognizing that its impact on an individual survivor is profound, and that its impact extends far beyond the individual survivor into her family and community. It is the impact of sexual violence on communities that has made rape such an effective tool in warfare.

For the individual, the consequences of sexual violence are physical, psychological, and social, with acute, chronic, and even fatal implications. Reproductive health outcomes alone include: trauma to reproductive organs, including fistula; acquisition of sexually transmitted infections, including HIV; and unwanted pregnancies that can lead to unsafe abortions and other complications. Gaps in access to emergency obstetric care, which are commonplace in situations of insecurity, increase the risks associated with unwanted pregnancies. Young girl survivors of sexual violence are biologically at greater risk of acquiring infections and suffering complications of pregnancy. Reports from Rwanda, Darfur, and other settings indicate that children born of rape are at risk of neglect, abuse, malnutrition, and abandonment (Nowrojee 1996, University of Pittsburg 2005).

Psychological consequences of sexual violence include anxiety, shame, post-traumatic stress, depression, loss of sexual pleasure, fear of sex, and a loss of function in society. Sexual violence has also been known to lead to attempted suicide as well as suicide (Amowitz et al. 2002). One's sense of self is violated by any assault, and to an extreme degree by a sexual assault. Furthermore, the situation within on-going emergencies results in weakened safety and security systems for survivors and their families. The fear of retribution from perpetrators after the attack contributes to an on-going sense of fear.

Negative social outcomes for survivors can include many forms of social stigmatization, such as victim blaming, rejection by husband, family, or community, and isolation, all of which inhibit help-seeking behaviour. In addition, whole

families may suffer social ostracism by being dishonoured as the result of a daughter's rape. Sexual violence also has implications for human development, as it can affect women's productivity and their ability to care for their children and themselves (Heise et al. 1994, 1999, Morrison and Orlando 2004).

Sexual violence associated with conflict

The power dynamics before, during, and after conflicts leave women and girls at increased vulnerability to sexual abuse by soldiers and armed combatants as a direct result of the conflict. While it is common for people to encounter armed combatants during conflict, the chaos associated with conflict also brings people into contact with bandits, border guards, human traffickers, and slave traders (Nelson et al. 2004). In the locations where they seek asylum, women and girls displaced by conflict are at risk of sexual extortion by persons in authority; sexual abuse of fostered girls, sexual attack when collecting firewood or water, and transactional sex to meet survival needs (UNHCR 2001, IASC 2005). It is disconcerting to note that in their 2004 review of studies of sexual violence in post-conflict settings, Ward and Brewer found that reports of rape were significantly associated with displacement to refugee camps (Ward and Brewer 2004). During repatriation or reintegration, returnees may suffer sexual abuse as retribution or sexual extortion in order to obtain legal status (UNHCR 2001).

Survivors of the conflict in Darfur, Sudan, have been subject to strategic campaigns of rape, as well as to a systematic threat of sexual violence when collecting firewood and roots around refugee or internally displaced person[3] camps (UNFPA & UNICEF 2005). Rebel forces in Northern Uganda have abducted young girls and women into the fighting forces and exposed them and internally displaced communities to widespread sexual violence (McKay and Mazurana 2004).

The multiple wars that have swept the eastern provinces of the Democratic Republic of Congo have resulted in mass displacements and continuous sexual violence. While the actual rape incidence rates are unknown, based on hospital service statistics it is estimated that 'at least tens of thousands of rapes have taken place' (PHR 2002). In the Democratic Republic of Congo, Prince Zeid Ra'ad Zeid Al-Hussein, Permanent Representative of Jordan to the United Nations, spoke with young girls who talked of 'rape disguised as prostitution'. The girls said they were raped and given money or food afterwards to make the rape look like a consensual transaction (United Nations General Assembly 2005). An investigation by the UN in Eastern Democratic Republic of Congo confirmed that sexual contact with peacekeepers occurred with regularity, usually in exchange for food or small sums of money, and that many of these contacts involved girls under the age of 18, with some as young as 13 (UN 2005). In the Ivory Coast, it is also reported that young girls are sexually exploited by UN peacekeepers (IRIN 2005a).

A prevalence study among 288 women in East Timor in 2004 used a standardized population-based survey from *Reproductive Health in Conflict*

Consortium's Gender-based Violence Tools Manual. It was reported by 23% of the women that they had experienced sexual assault during the crisis, as compared to 10% in the post-crisis time period (Hynes et al. 2004).

In Kosovo, using the same survey instrument, researchers found that the proportion of women reporting violence by perpetrators outside of the family were highest during periods of conflict and displacement. Rates of sexual violence were 15% during the conflict and 23% at the time of displacement, while during the post-conflict period rates were significantly lower at 2% (RHRC 2005a).

In a study conducted in 2003 in Cartegna, Colombia, among a random sample of 410 women, researchers found that 8% of respondents had experienced sexual violence before the conflict-related displacement and 10% reported sexual violence while displaced (RHRC 2005b unpublished data).

As reported in a 2001 study of internally displaced women in Sierra Leone, '[b]y extrapolating the number of incidents of war-related sexual violence reported by participants in the sample [991] to the total female IDP population, PHR estimates that approximately 50,000 to 64,000 Sierra Leonean women may have suffered such human rights abuses'; and that the experience of sexual violence during the conflict period was equal to a lifetime's worth of sexual violence in the same population in non-conflict times (PHR 2002).

In a US Centers for Disease Control and Prevention study, between May and August 2000, 25% of Azerbaijani women reported experiences of forced sex. In their analysis, the researchers determined that the women at greatest risk were among Azerbaijan's internally displaced populations (Kerimova et al. 2003).

In Liberia, large numbers of women and girls survived sexual violence during the civil war, but today, internally displaced girls and women and Liberian refugees in neighbouring countries are exposed to other forms of brutal sexual abuse on a regular basis (Watchlist 2004).

Sexual violence continues to be a pervasive component of post-conflict Sierra Leone. Data from three Sexual Assault Referral Centers indicate approximately 80 new cases of sexual violence each month, reported from three centres in Freetown, Kenema and Kono, with 80% of clients under 18 years of age (IRC 2005).

Factors contributing to sexual violence in humanitarian emergencies

Displacement related to armed conflict leads to the breakdown of social networks and other forms of personal support. Dependable safeguards that are normally in place within communities to prevent sexual violence collapse. Social services, including law enforcement and legal justice, health, and education systems, weaken or fall to pieces entirely as infrastructure is destroyed and essential staff flee. Families and communities are splintered and behavioural norms can deteriorate as people focus on their own survival. The result is weakened social support structures and protection mechanisms and increased rates of sexual violence. In emergencies, single, widowed, and abandoned women, single female heads of households, and unaccompanied children, are at increased risk of sexual

violence, including sexual abuse and exploitation, due to their gender, age, and dependence on others for help and safe passage. Men's inability to resume normal cultural, social, and economic roles, or their psychological strain from the experience of a disaster, may weaken their ability to fulfil the protection responsibilities they often hold in families and communities. Underlying all these systemic breakdowns are the institutional factors that drive gender-based violence: gender inequality and discrimination, male-dominated power and control structures, and cultural and social attitudes about men and women that subjugate women even in stable times.

Addressing sexual violence through humanitarian response

In the past decade, progress has been made in addressing gender-based violence in conflict-affected settings. In 1995, UNHCR published *Sexual Violence Against Refugees: Guidelines on Prevention and Response*, the first field manual to address prevention and management of gender-based violence from the acute emergency phase to the more stable phases of displacement. This manual laid a framework for the implementation of more comprehensive services, when feasible, depending on the stability of a refugee situation.

In 1996, the Inter Agency Working Group[4] *Field Manual on Reproductive Health in Refugee Situations* provided the humanitarian community with a standardized set of actions, known as the MISP (Minimum Initial Service Package), to be implemented along with other first steps in an emergency response. Included as a health services standard in the 2004 edition of the Sphere Project *Humanitarian Charter and Minimum Standards in Disaster Response*, the MISP focuses on the prevention of and response to sexual violence, together with preventing maternal mortality and preventing HIV transmission, as priority reproductive health interventions in the acute phase of an emergency.

As has been mentioned, efforts to integrate reproductive health care, including addressing sexual violence, into humanitarian responses materialized in the mid 1990s (McGinn et al. 2004). A global evaluation of the last 10 years of reproductive health response for refugees and internally displaced persons, conducted by the Inter-agency Working Group on Reproductive Health in Refugee Situations, noted success in getting basic reproductive health components recognized as a necessity within the early days of primary health care responses in disasters (UNHCR 2004). Despite this forward movement, the evaluation concluded that gender-based violence remains severely underaddressed in these settings. The ubiquity of gender-based violence, in particular sexual violence, in humanitarian emergencies accentuates the need for its recognition as a basic part of any humanitarian response.

The physical set-up of shelters and access to essential goods play a role in women's vulnerability to sexual violence. Still, too often neglected in emergency response planning, matters such as a well-organized camp layout and inclusion of women in decision-making are concrete actions which can be instrumental in preventing on-going sexual violence. Past experience has demonstrated that

women and girls who must gain access to food and non-food items from men or from remote locations are at increased risk of sexual assault. Women and girls are often made vulnerable to sexual violence, abuse, and exploitation by overcrowded living arrangements, but also by the physical arrangement of water and sanitation facilities. Problematic situations sometimes include: communal bathing facilities with little to no privacy, forcing women and girls to bathe after dark; poorly lit facilities and pathways; inability to latch doors from the inside; and men's and women's facilities located too close together, not clearly marked, or too far from shelter structures.

The multi-sectoral model (Figure 1) of prevention and response for gender-based violence is considered 'best practice' for longer-term comprehensive services to address gender-based violence within the humanitarian field (Vann 2002, Ward 2002). Its recognition as such has enabled the international humanitarian field to generate awareness on the reality that no single sector or agency can adequately address gender-based violence prevention and response. Services to address gender-based violence must be the outcome of coordinated activities among the constituent community, health, and social services, and legal and security sectors (Ward 2002). The cross cutting nature of the multi-sectoral model of response is confounded by the reality that no single United Nations agency or other entity is specifically mandated with addressing gender-based violence. Given this variable, there is an increased importance on the need for a shared, holistic understanding among all key actors. This particularly includes all key United Nations agencies which, at any given place, might act as a lead agency for gender-based violence coordination, prevention, and response within an emergency situation.

Case study: Liberia

Liberia and its neighboring countries have been plagued with conflict since 1989. Currently there are some 365,000 internally displaced persons in Liberia along with approximately 13,000 Sierra

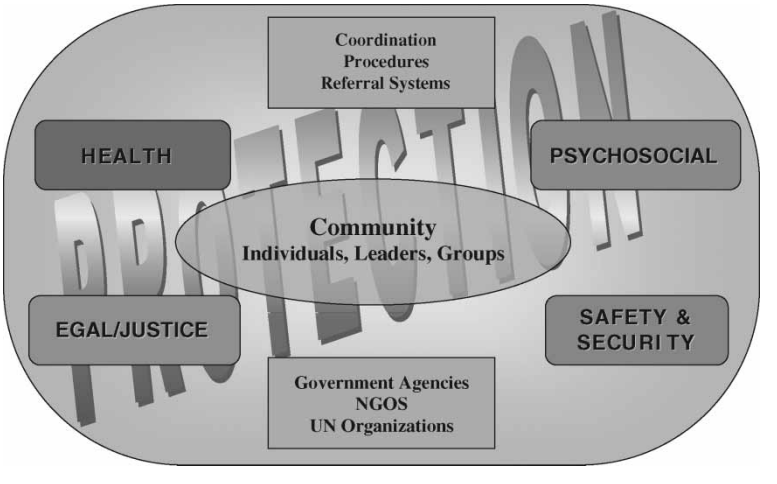

Figure 1. Graphic representation of the multi-sectoral response to gender-based violence.

Leonean and 38,000 Ivorian refugees. Sexual violence has been pervasive during periods of conflict in the region and continues to plague women and girls into the post-war period.
IRC initiated services to address gender-based violence in Liberia in 2001; since that time the programme has cared for thousands of beneficiaries. The aim of the programme is to improve the physical and psychosocial well being of women and girls by increasing community awareness about gender-based violence, providing psychosocial counselling services for survivors, facilitating survivors' re-integration into their communities, and offering relevant referral services. In addition to developing effective gender-based violence prevention and response mechanisms, the programme also supports an empowerment programme for young mothers. The programme currently operates in Bomi, Montserrado, Nimba, and Lofa Counties. During the height of the renewed fighting in 2003, the programme provided emergency response activities such as drop-in shelters and referrals to meet immediate medical, psychosocial, and protection needs of survivors and their families. As fighting subsided, the programme addressed gender-based violence in the disarmament, demobilization, and rehabilitation process. The programme continues to this day and considers among its successes a cohort of knowledgeable women demanding their right to be safe and to see justice done. Liberian women are pleased that new legislation broadening the legal definition of rape, so violations such as forced penetration with an object can be prosecuted, came into force the day after the inauguration of Ellen Sirleaf Johnson, Africa's first elected female head of state (Blunt 2006).

While the multi-sectoral model is characterized by the full engagement of the target community, interdisciplinary and interorganizational cooperation, and coordination among sectors, guidelines had not previously been developed for all the sectors that needed to be engaged in a comprehensive response to gender-based violence. Gaps in the articulation of how each sector should address prevention of, and response to, gender-based violence limited the implementation of comprehensive, well-integrated interventions focused on the protection of women and girls in emergencies. Realizing that saving lives and maximizing protection is dependent on the rapid, coordinated implementation of a minimum set of activities, the Inter-Agency Standing Committee (IASC) Task Force on Gender and Humanitarian Assistance has produced a multi-sectoral guideline to address gender-based violence with a particular focus on prevention and response to sexual violence in emergencies (IASC 2005).

The IASC guidelines (see Table I) are also intended to inform and sensitize the humanitarian community on the ubiquity of sexual violence in emergencies, and the nature of sexual violence as a significant, life threatening, health, protection, and human rights issue requiring urgent attention. The guidelines offer specific actions for incorporating prevention and response for gender-based violence into emergency preparedness, emergency response, and post-emergency planning (IASC 2005).

Table I. Example from IASC guidelines.

Health and community services	• Map current services and practices • Adapt/develop/disseminate policies and protocols • Plan and stock medical and RH supplies • Train staff in GBV health care, counselling, referral mechanisms, and rights issues • Include GBV programmes in health and community service contingency planning

The guidelines include a matrix organized by sectors, including: protection, water and sanitation, food security and nutrition, shelter and site planning and non-food items, health and community services, and education. Cross-cutting functions are also included: coordination, assessment and monitoring, protection, human resources, and Information Education and Communication (IASC 2005).

Case study: Darfur

Some three million people have been affected by the ongoing crisis in the Darfur region of Sudan. Hundreds of thousands have died, and an estimated 1.85 million have been internally displaced or have fled to neighbouring Chad (IRIN 2005b). Mass campaigns of sexual violence have been used as a strategy of genocide in the Darfur conflict, while perpetrators enjoy complete impunity. While reports suggest that a massive campaign of rape is taking place against women and girls in Darfur, consistent stories of sexual abuse, exploitation, and torture reveal that the violence has been a significant part of their lives, from initial attacks in their home villages, throughout their flight to safety, and continuing during their displacement. A qualitative study conducted by UNFPA and UNICEF illustrates that women and girls are subjected to sexual violence on a daily basis, especially in their trips to collect firewood outside of the camps where they have come seeking safety. Women and girls report that they have experienced abductions, sexual violence, and rape in front of family members (UNFPA & UNICEF 2005).

Impossible dilemmas are faced by families in relation to firewood collection in Darfur. Several reports articulate the commonly held belief that men and boys would be killed if they were the ones to leave the security of the camp and forage for the family. This leads the family to the decision to send out women and girls who are seen as risking 'only' rape.

Although humanitarian workers are striving to cope with the heavy caseloads, access to minimal services for survivors of sexual violence remains severely limited. Sexual violence is a challenging public health problem in any context, but in Darfur specific barriers prevent even a basic and immediate multi-sectoral response: impunity related to the general state of insecurity and the absence of a protection mandate for African Union (AU) peacekeepers; lack of health providers willing and competent to treat and respond to survivors; and a lack of clarity regarding reporting laws, including mandatory legal reporting of sexual violence cases before survivors could access medical care. The reporting laws have now been amended, but on-going confusion among providers and authorities continue to act as barriers to survivors in need of services.

In response, international non-governmental humanitarian organizations are using creative efforts to address the epidemic of sexual assault in Darfur. Through community based programming, including community centres, women's health services, and women outreach workers, early interventions focused on meeting survivor's immediate reproductive health and psychosocial needs. As progress has been made, organizations have been able to build the capacity of local women to provide appropriate psychosocial responses to survivors of sexual violence. Additionally, drop-in centres have been established where women and girls can share their stories and receive support and information about services, participate in skills building classes, and engage in income generating activities to promote social and psychological support. Some programmes also support community-based networks, including women's groups that encourage the local population to come up with strategies from within their own cultural experiences to address gender-based violence through community structures.

Unique collaborations, bringing together peacekeeping troops, displaced communities, UN agencies, and NGOs, are actively engaged in preventing on-going incidents of sexual violence through the use of firewood patrols in several areas of Darfur. Firewood patrols provide a level of security when girls and women leave camps in search of fuel, and they help to develop trust and coordination among communities and key actors within the insecure environment. For example, firewood patrol meetings, facilitated by humanitarian actors operating in an area of West Darfur, have brought together over 400 women and girls to discuss coordination with AU representatives. Unfortunately, the crisis in Darfur continues and, as this is being written, Kofi Annan has made a call to replace the AU force with a larger, better financed, UN force with a stronger mandate to strengthen protection and prevent ongoing killing and rape (MacAskill 2006).

Discussion

While sexual violence is only one form of violence presenting itself in humanitarian emergencies, it represents the most severe way that women and girls experience conflict differently from men and boys. Being female, with the gender differential societies place on biology, is itself a risk factor, and the platform upon which extraordinary assaults are committed in times of war. Some pose the argument that everyone has been traumatized in a conflict setting, thus, calling into question the allocation of resources and specific programme support to women and girl survivors of sexual violence. However, we must acknowledge the ever-growing body of evidence demonstrating that women and girls, by virtue of their femaleness, are subject to exceptional forms of violence requiring a unique emergency response.

The low status of women is sometimes viewed as the main issue contributing to gender-based violence in any setting, and the argument is made 'that acts of gender-based violence [are] the preserve of culture' (Ward 2002), thus, is an inappropriate area for intervention by external humanitarian actors. However, there is ample evidence, from East Timor to Sudan to West Africa, that armed conflict significantly elevates the incidence of sexual violence in every setting. The sexual violence associated with a humanitarian emergency is not simply about the current status of women within a culture, but rather it is an egregious and violent expression of the universal phenomenon of de-valuing the basic health and human rights of women and girls.

While progress has been made in placing reproductive health issues on the humanitarian agenda in conflict settings, on-going events in Northern Uganda and Darfur illustrate that the humanitarian community has yet to prioritize prevention and response to sexual violence as an area of urgent focus.

All sectors must assure that the full spectrum of services and responses necessary to comprehensively prevent and address sexual violence are put in place in humanitarian emergencies. The role of one sector, such as health, responding to the full range of health consequences to women and girls cannot be seen as competing with another sector, such as legal justice, nor are they compensatory. While each situation must be contextualized and adapted for, basic multi-sectoral responses must be in place in every emergency response. The alternative is a humanitarian community potentially complicit in on-going sexual violence, or potentially causing further harm by encouraging women and girls to seek justice before environments are safe to do so.

At the systemic level, leadership, technical assistance, and coordination among sectors must improve to facilitate collection of gender-based violence-related data and to promote evidence-based programming. At the structural level, the very need for sexual violence contingencies illustrates the presence of a more fundamental problem. It is simply *not acceptable* that an extraordinary level of sexual violence continues to be a common feature of humanitarian emergencies.

Due to its sensitive nature, sexual violence is almost universally underreported (Koss 1992, McNally et al. 1998, Ellsberg et al. 2001, Watts and Zimmerman

2002) and, while some prevalence studies have been conducted, reliable data remain difficult to come by. Yet, a consistent pattern of sexual violence in humanitarian emergencies supports the IASC guidance that the humanitarian community must assume that sexual violence is present in disaster settings (IASC 2004). Agencies cannot hesitate, cannot maintain a 'wait and see' attitude, must not mount a humanitarian response without being prepared to address sexual violence. Given the difficult nature of data collection and documentation, responses to sexual violence should not depend on studies of the magnitude of the problem; to do so would inexcusably delay services. Data collection must remain a priority, but the health and psychosocial consequences for women and girls demand an immediate response, regardless of the amount or quality of available data. Care and prevention services for sexual violence should be as readily available as measles vaccination; we have ample historical evidence of the need for these services.

Conclusion

At the same time as the IASC guidelines, designed to broaden and deepen the response to sexual violence in humanitarian emergencies, are being rolled out, a global campaign to stop rape in war is generating grass roots activism. The humanitarian community must look forward to a time in the foreseeable future when sexual violence is: (1) unquestionably addressed in the initial humanitarian response, (2) a rare event in both crisis and stable situations, and (3) receives comprehensive social and legal approbation if it does occur.

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Notes

[1] 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 and 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. Definition taken from Ward (2002).

[2] Geneva Convention relative to the Protection of Civilian Persons in Time of War. Adopted on 12 August 1949 by the Diplomatic Conference for the Establishment of International Conventions for the Protection of Victims of War, held in Geneva from 21 April to 12 August, 1949 entry into force 21 October 1950. Accessed 8 October 2005, available at http://www.unhchr.ch/html/menu3/b/92.htm

[3] A refugee is a person seeking asylum in a foreign country in order to escape persecution, while an internally displaced person (IDP) is someone who has been forced to leave their home for reasons such as natural or man-made disasters, including religious or political persecution or war, but has not crossed an international border.

[4] The Inter Agency Working Group, which includes representatives of NGOs, UN agencies, donors, and researchers, was established by the United Nations High Commission for Refugees (UNHCR) and the UNFPA in 1995 to address the lack of reproductive health services in humanitarian crises.

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