From Relief to Development: Gender-Based Violence Interventions in Conflict and Post-Conflict Contexts

Wednesday, June 4, 2008
Woodrow Wilson International Center for Scholars

Edited Transcript – Heidi Lehmann

As Geoff said, my name is Heidi Lehmann. I'm the Senior Technical Advisor for Gender-Based Violence Programming for the International Rescue Committee, and I am delighted to have the opportunity to start looking at this continuum, "From Relief-to-development: GBV Interventions in Conflict and Post-Conflict Settings." And IRC is active in programming around the world, and we certainly know the range of conflicts that we're seeing around the world and the different contexts that each of these different countries present, from Afghanistan to Ethiopia to Nepal to Sudan.

And I'm going to say a couple things about emergencies, because that is, that's what I'm here to talk about. How do you do, how do you do GBV programming in an emergency? And I'd like to frame it in terms of looking at an emergency. When we're talking about an emergency, we're talking about a situation -- I'm talking about conflict-related emergencies: a situation where there is insecurity, a situation where there is violence, a situation where there is damage to the infrastructure, where systems that had previously been operating are either seriously compromised or outrightly destroyed, okay? I'm talking about situations where we see massive movements of people, either internally displaced within a country or across borders. I'm talking about situations where massive amounts of people come together in makeshift shelter, often times, most of the time overcrowded, not a lot of access to water, food, so on and so forth. I'm talking about a situation that overwhelmingly impacts women and children, regardless of where it happens. So that's just to frame it a little bit.

So when we talk about GBV and emergencies, I think it's also important to remember that gender-based violence is not one thing, alright? It is an umbrella term that encompasses a range of abuses. And under that umbrella you have different categories: sexual violence, economic violence, physical violence, and under any one of those categories you're going to see four or more different types of violence. So when we talk about GBV, we're talking about something very, very big.

In emergency situations, the focus is typically on sexual violence, even more specifically conflict-related rape. Historically, from Kosovo to Liberia to Sudan, Nepal, sexual violence has been a part of that conflict. Over the last -- it's relatively recent though, that we've really started to talk about it and even more recently that we have started to actually respond: 1995, we see that UNHCR came out with "Sexual Violence Against Refugees." In 1999 the Reproductive Health Consortium, Reproductive Health for Refugees Consortium, came out with their guide to "Reproductive Health in Refugee Settings," in which sexual violence was a chapter in that, and more recently, we have the Inter-Agency Standing Committee Guidelines, as you can see, "For GBV Interventions in Humanitarian Settings." Again, you see, you can't really see it, it's tiny, tiny, but "focusing on prevention of, and response to sexual violence in emergencies," all right? And I think it's important to note, you know, reproductive health, reproductive health advocates have really been, historically, the voice that has pushed this issue in emergency settings.

Okay, and typically, right, when we're trying to address sexual violence in conflict, the humanitarian community's response has focused on response, alright? More specifically, it's focused on service delivery, and that takes it back to, I think, in part, the fact that reproductive health advocates are the ones that have really pushed this. So you see that the service delivery initially started through health centers, reproductive health programs, so on and so forth. And to date, I would say, I would suggest that the focus has still been on health response for survivors and what we call psycho-social support for survivors.

Prevention: it's improving, and I hope that we talk about this a little bit in the discussion, but in emergency situations, prevention is often put on the back burner for a number of reasons. One of which is the fact that, you know, sexual violence in conflict is so common that we've started to think about it as being inevitable. So people see it as, "What can we do?" There's also the issue of people say, "Well how --" for example, in Sudan, where there is, you know, lots of people continually with guns, "how do you do prevention, how do you stop this from happening in the middle of a war zone?"

Another issue is the fact that there's -- you know, this is typically not the top issue on donors' lists. When I started doing this work several years ago, an average -- you know, on average, IRC was getting between $150,000 to maybe $250,000 to implement 12-month GBV Program. So there is limited funding for this issue. That means that we have to prioritize,

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

and we are always going to prioritize in terms of service delivery that we hope has an immediate impact of saving lives, okay?

Another issue around prevention is that many, many people and humanitarian aid workers that have been doing this a long time see prevention, a major part of prevention, as changing attitudes, right? I mean, there's a reason why sexual violence continues to be part of a conflict, right? There's a reason why, you know, so many people defend the fact that a woman is raped as part of a war, why people defend the fact that a man has the right to beat his wife, and part of that is attitudes and beliefs. And folks see that, you know, addressing those attitudes and beliefs is not feasible in an emergency situation, and I've sat at the table many, many times where people say, "It's not even a priority." So prevention gets put on the back burner for those reasons.

I'm going to talk you a little bit about the International Rescue Committee's approach to gender-based violence in emergencies, and our, you know, our strategy, our overall strategy guiding our programs globally is called, "From Service Delivery to Social Change," and this has developed organically over ten years of programming, and this -- I think this title says a couple of things. First of all, it says, you know, in emergency situations we have got to act, right? And part of that action is making sure that we provide life-saving services -- because sexual violence is a life-threatening issue -- so we provide life-saving services that mitigate or reduce the consequences that survivors of conflict related rape face.

In addition to that though, we also recognize that gender-based violence, which overwhelmingly impacts women and girls, is a social problem, okay? It is a social problem, and because of that, if we are not working towards some sort of social change, right, we're going to forever be responding. So when we talk about IRC's approach to GBV, we're looking at service delivery to social change. And on average, the International Rescue Committee is in a country for ten years. So we might go in at the onset of an emergency, but we stay for many years after that.

And again, just to frame the problem -- and this was, you know, organic. We started our first GBV program in Tanzania in 1996, and about three years ago we stepped back and we said, “Okay, right, we're addressing this huge and complex issue in an extremely chaotic situation, right? We have to put some structure around it, right?” And out of that came the way that we look at the problem of gender-based violence, whether it's in a conflict situation or a post-conflict situation, and we see it as a huge and complex issue, whether it's in Nepal or Liberia

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

or Washington, D.C., and we see it as a problem that needs to be addressed by understanding how it's related to women's social and economic disadvantage and discrimination.

Now typically, when I show this slide, a hand shoots up, and some of you might be putting your hand in your pocket because it wants to shoot up. But folks say, "But you know, this only, it doesn't only affect women. What about men?" Okay? Certainly men can be victims of gender-based violence, no doubt about it. IRC's approach and IRC's programming and the statistics that we see in our programs: I would say, 95% of the clientele is women and girls, okay? So in our framework, we look at it as a problem that has to be addressed by women's social and economic disadvantage and discrimination.

What does that mean, right? That means to get to the root cause of it we have to challenge gender equality. That's fun: places like Afghanistan, Nepal, Liberia. Talking about gender is, you know -- promoting women's rights and then creating social, political and economic environments where women and girls can enjoy those rights, okay? So what we say is, "It's not enough to go in and educate about human rights. It's not enough to go in and say, 'You know, violence against women and girls -- there's health consequences,' right? We have to go the extra step and support these social and political, economic environments where women are safe and secure and can be part of rebuilding nations."

All right. So just real quickly, you know, to try to put order around the chaos we looked at our programs, and we deconstructed what our programs were doing, okay? And out of that we said, "Okay, we could see that our programs were functioning at three levels," right? The immediate level was at the community level, right, where we were in emergencies. We were doing things like providing health care services. We were doing things like getting out in the community and making sure women had the permission of the men to seek health care services, right? Often times simultaneous to that we would be working at what we call the systemic level where we were either supporting systems and strategies to monitor and respond when these acts of gender-based violence were happening or, you know, if these systems were absolutely absent, trying to put some temporary systems in place. And then we would work at the structural level, which often took the guise of preventive action, often times through advocacy for the application of guidelines, international laws, allocation of resources, those types of things.

Okay. So what does response and prevention look like in an emergency? Before I tell you, I'm going to take a drink of water so just ponder that a minute.

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

Let me start by -- and this is actually -- it's not a slide, but I was thinking about this when I was listening to Ian's presentation, and I was thinking, "You know, there are so many similarities between what we do, right? But it's often times, you know, we're in fast forward when we're doing it." So in the Central African Republic we did an assessment to look at the issue of sexual violence against women and girls there. Within two weeks we had trained a core, about three or four key health care staff, on providing treatment to survivors of sexual assault. As Ian said, you know, these health care staff have the basic medical training. Often times they have most of the supplies, and it's a matter of putting that together and often working with health care workers on their attitudes and beliefs towards survivors. So within two weeks, we had set that up. We had set up a very basic referral system, right, between health care, the health care, the health clinic and those providing basic counseling, psycho-social support. By June 2007, we were seeing 30 women and girls a day that were coming to us and saying that they had been raped as a result of the conflict. Eight months later we had provided services to 1200, right? So it's similar in that we have to set up health care services. We have to set up these psycho-social response services, extremely basic, but still getting, addressing the issue in such a way that women feel comfortable coming forward. We start to break the silence, and we certainly reduce the health consequences.

Another example is IRC's GBV program in Liberia, and when I got to Liberia in 2003, it was literally like a day after Taylor had gone on his merry way to Nigeria, and I remember UNICEF, meeting with UNICEF and saying, "You know, there is nine IBP camps, there's a about a million IDPs, there's a lot of sexual violence, and we have $25,000. What can you do?" And I said, "Well, before I answer that question, let me just go out and have a look see and see what's going on." So one of the first places I went to was the Samuel K. Doe Stadium, SKD. Anybody been there? All right, I see some nods, okay. And it was just in the paper, unfortunately. But I went to SKD, and I walked in there, and it was jam packed with IDPs, and it's a little stadium, it's a small stadium. And we started to talk to some folks there; I was with our Liberian and staff, and right off the bat, right off the bat, we identified conflict-related rape, that there were many women in there that had been raped over the last six months, over the last year. We then identified that, because all of the crowded conditions, there was a lot of what we call opportunistic sexual assault going on. We identified the fact that there was a lot of sexual exploitation around food and other things going on. We found that domestic violence, interpersonal violence between husband and wives were a problem. So then, you know, looking at -- this is where the overwhelming part of it comes in, right? And looking at the resources, we then had to decide which we prioritized.

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

So then just looking at the response -- Oops. I don't have the response up there. Don't take that to mean that there was no response.

There was a very vibrant response. So the response focused on, as I said, we started to work with health workers, even though the health care system was destroyed there was still the health workers from that system. So identifying those health workers, community-based health workers, starting to get the message out there is the very first step in letting women and girls know that there is a place to go.

Second thing is making sure that, once they know that, simultaneous to that we have to be making sure that there is a place they can go, okay? Then we trained what we call, depending on the situation, social workers, helpers -- Ian, I think you might call them first responders or first point of contact, in some situations. These are the folks that know how to validate, support and advocate in many situations for these women and girls. So the focus in Liberia was very much on response.

Prevention: we did a couple things there. We certainly advocated a lot, right? We advocated for the application of international standards so that you didn't have 40,000 people, you know, living in a place that was not designed for anybody to live in, and we also did, we also used safety audits in that stadium as well as in the nine camps that were set up throughout Liberia, trying to identify with the women, right, what were the most dangerous areas in the camp, what were making those dangerous areas, and what were their suggestions for making those areas safer. So overwhelming attention on response, working towards prevention as well.

Okay, so five years later, we're still there. We're still working on response, but the way that we do it now is very much through supporting the Ministry of Health, so we're working with the government ministries to make sure that their systems, that their policies, that their hospitals are getting to a place where they can address the problem of violence against women.

Again, the focus is still on sexual violence, but we're slowly moving towards these other types of violence. The most common type of violence -- let me ask you what do you think is the most common type of violence that IRC's GBV programs see? Domestic violence, right? Overwhelmingly, I mean, you know, about two minutes after we get into a country

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

and start to do the sexual violence programming, this problem of domestic violence emerges. And certainly after the conflict ends, you know, we see huge numbers of domestic violence. So we're working with the health care system to try and address that.

All right, let me run through some of the opportunities, challenges and lessons learned. You know, the opportunity is that we start to break the silence, you know. This violence against women and girls that happens, it doesn't start with conflict, right? It's not going to end when peace comes, but what it allows us to do is start breaking the silence that has surrounded the issues. It provides us with an opportunity to start to improve systems, influence systems that are going to protect women from a variety of abuses.

There's a few challenges to doing this work. One of them is, as I said, you know, the Liberia example: programs can be overwhelmed by the scope and scale, and this is not a priority on donors' lists, right? We've started to hear about it more in the newspaper. We've started to read editorials about it. You know, the money -- we've not put the money where our mouth is yet. When the funding is there, it's typically in 12-month cycles. That's an emergency response. So we go in, we, you know, we start to break the silence around this, you know, really sensitive issue, and then we say, "You know, our funding's done. You know, we'll get back to you."

The political will to address what is seen as a sensitive and a soft issue is lacking. I don't think that we've clued in enough to the fact that this kills people, right? And when it doesn't kill them, it seriously impairs their quality of life, and if you -- and I don't think that we've clued in to the fact that that impact goes beyond the individual. It goes to the family unit. It goes to the community. Another challenge is that humanitarian communities become stuck in this idea of emergency programming, and it is -- we get stuck on this focus of service delivery as opposed to work at the systemic and structural level that is going to move us more towards preventing or addressing the root cause of the problem. And we can even see this in other challenges. You know, folks that want to move past that emergency mentality, even the resources and guidelines, the IASC guidelines I talked about, are focused on emergency settings.

So what have we learned? As I said, GBV does not start when a conflict does, and it's not going to end when a conflict ends. I remember being out in DRC a couple of years ago, just after the peace agreement had been signed out there, and I was talking to a group of women, and I said, "You know, what do you think about the peace agreement?" And they said,

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

"Well, you know, we're waiting for it to get here." So, you know, just a reminder that this abuse continues well after any, you know, any signature on a peace agreement.

Another big lesson learned is that, you know, communities are more open to discussing sexual violence perpetrated by others that happens as part of a conflict than they are when we start talking about conflict or violence that's done by members of the community, right? As Ian said, and IRC's statistics will match that, you know, when we talk about some of these different types of violence, often times the perpetrator is known to the survivor, and when you start pushing the envelope there, you know, there is a lot of potential for backlash.

A relief-to-development approach including work at the community's systemic and structural level -- it's imperative to long-term solutions to the problem, which is why IRC has set up our framework for programming the way it does.

And the last thing is that, you know, no matter what the destruction is, or the impact of the conflict has been on the infrastructure, that before the conflict there were systems in place. They might be weak. They might have been limping along, but systems were there. And, you know, the IRC has learned to start to work with those systems, and even if they're not functioning, to have a good understanding of what those systems were because those are the systems that we're going to want to influence after the conflict ends.

Thank you.

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP