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Gender-Based Violence (GBV) in Complex Humanitarian Emergencies: Implications for
Reproductive Health of Refugees and Internally Displaced Persons (IDPs)

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Abstract

With the proliferation of intrastate conflicts in many parts of the world, particularly in developing countries, violence perpetrated against women on the basis of their gender and vulnerability has risen to global attention as a major problem with significant social, medical and public health ramifications. In conflict environments, women, and to an alarming degree, girls are consistently raped and sexually assaulted. Often, the reproductive health of victims who suffer rape and other forms of sexual assault at the hands of armed combatants tend to be significantly compromised.

The confluence of sexually transmitted diseases such as HIV and Hepatitis, among many others, is often associated with a high prevalence level of such transmissible diseases in refugee camps and among IDP populations. This fact is evident in many of recent conflicts as reports and research show.

Another troubling phenomenon is, not only do women and girls suffer gender-based violence from rogue elements such as armed militias and some government armed forces; they also suffer serious sexual abuse including rape and unwanted pregnancies from UN peacekeepers and their civilian counterparts whose duty it is to protect them.

Methodology

While gender-based violence can be the target of all demographics including men and boys, girls and women have been found to be the most vulnerable in times of conflict. The paper looks at the extent and impact of gender-based violence, during and post conflict, on women and girls with greater emphasis on the impact on their reproductive health. The paper explores this issue from conflicts from different geopolitical settings. It is a secondary research based on existing literature on conflict from both scholarly and professional sources such as books, reports and technical analysis of intergovernmental organizations (IOs) and non governmental organizations (NGOs) engaged in humanitarian intervention and human rights advocacy.

The changing nature of conflict and redefinition of violence

Warfare after the Cold War has assumed a new character. A clear departure from the conventional wisdom of war as between militaries of sovereign states, contemporary conflicts defy this Westphalian model and are increasingly becoming intranational in nature. Recent conflicts have, for the most part, been triggered by religious, ethnic, economic and political differences which are internal to populations within countries. A 2002 world health report published by the World Health Organization (WHO) notes that since World War II, there have been 190 armed conflicts “only a quarter of which have been between states.” The overwhelming two-thirds have been conflicts fought within the nation state (WHO 2002, 218).

A major characteristic of these conflicts is the emerging nature of combatants and their targets of opportunity. No longer the era of the tidy distinction between combatants on the battlefield and civilian populations, recent armed conflicts are more and more characterized by an alarming degree of violence perpetrated against civilian populations. Merson, Black and Mills (2005, 440) posit that “modern day conflicts are increasingly internal rather than between states and often have as a prime objective, alongside the quest for economic and political power, the undermining of the lives and livelihoods of civilian populations associated with opposing factions.” This is confirmed by a report by the UN Population Fund (UNFPA) which also notes that “civilians rather than the military are increasingly singled out for attack in the growing number of wars within and between nations” (UNFPA 2001, 42). Communities are targeted and marked for death and subjected to other heinous brutalities simply on the basis of their ethnic and or

religious affiliation. Women and girls are consistently tortured, raped, killed and mutilated as a way of destroying the socio-cultural fabric of an opposing ethnic group.

Even though, violence against women and girls is not a new phenomenon in conflict environments, the extent of physical and mental implications on this vulnerable group, and the intent of combatants in the perpetration of these crimes have made gender-based violence a serious emerging social issue with often very dire public health consequences for affected populations. Rapes, sexual exploitation and mutilation perpetuated women and girls during conflict cause “direct physical harm, emotional trauma, stigma, and social ostracism” (WHO 2004, 1). Smith-Sparks (2004, 1) also notes that in contemporary conflicts, rape and sexual violence against women are no longer “just a by-product of war but are used as a deliberate military strategy,” noting further that “women’s bodies have become part of the terrain of conflict.” Smith-Spark’s observation is a corroboration of a 2004 Amnesty International report “Lives Blown Apart: Crimes against Women in Times of Conflict” on the upward trajectory that gender-based violence against women has assumed in the growing number of these asymmetric warfare dotted around the world particularly in developing countries. The Amnesty International report finds that violence against women in complex humanitarian emergencies has become so pervasive that “the ‘rape victim’ has become an emblematic image of women’s experience of war” (Amnesty International 2004a, 6).

The number of women and girls who suffer violence at the hands of armed militias and conventional soldiers in places such as Rwanda, the former states of Yugoslavia, Darfur

and the Democratic Republic of Congo are assuming staggering proportions in recent past and ongoing armed conflicts. According to Schreck (2001, 162), “the widespread rape of women and forced pregnancy in Bosnia, reported extensively in the media, elicited a level of international concern about sexual and gender-based violence not previously seen.” During the Sierra Leonean war in the 1990s, 1.8 million out of the total population of 4.8 million “were displaced at some time during the conflict and of these IDPs, it is estimated that between 50,000 and 60,000 were women who were either raped or sexually abused (Save the Children 2005, 7). The concept of “collateral damage” hitherto considered as an unfortunate and untidy nature of war has given way to a calculated strategy where violence against groups such as women, and children are now a crucial strategic weapon of war. According to Merson, Black and Mills (2005, 440), about ninety percent of people impacted by contemporary armed conflicts are civilians cutting across all demographics.

Rapes and forced impregnation of women are often used as a psychological and biological tool of breaking the social and cultural cohesiveness and the “honor” of the adversary and also to destroy the cultural and ethnic fabric and integrity of an ethnic group through a strategy of ethnic cleansing. UNFPA, in a report, notes that because women are often perceived as “symbolic bearers of caste, ethnic or national identity can expose them to the risk of attack.” It further asserts that rape and sexual violence against women during conflict is primarily “intended not only as violence against women, but as an act of aggression against a nation or community” (UNFPA 2001, 43).

Research conducted by the non governmental organization, Medecins Sans Frontières on the Balkan wars in the 1990s point to the fact that in Bosnia, systematic rape was used as part of the strategy of ethnic cleansing. The main objective of forced impregnation was so that ‘women . . . could give birth to a Serbian baby’” with the avowed intention of destroying the ethnic lineage of Bosnians (Smith-Sparks 2004, 1). Such attempts at ethnic cleaning had also been recorded long before the Balkan wars of the 1990s. During the Bangladeshi struggle for independence in 1971, such tactics of war were applied to weaken “the integrity of the opposing ethnic group.” According to Gita Sahgal of Amnesty International, this was a ‘strategic attack’ used by state supported Pakistani troops to humiliate and destroy the opposing ethnic group. Here too, the strategic importance of this sexual abuse was that by raping and impregnating Bangladeshi women, wives and children, they would end up giving birth to Pakistani ‘Punjabi children.’ It is estimated that about 200,000 women were raped in the Bangladeshi struggle for autonomy (Smith-Spark 2004, 1).

Oftentimes too, sexual violence such as public rape has been used as part of terror tactics. Such violent and dehumanizing acts of atrocity are used to “terrorize a whole community and force it to flee, or it may be an expression of ethnic hatred” (Barry and Levy 2000, 190). In the ongoing genocide in Darfur in Sudan, mass rape carried out in the glaring view of an often helpless, terrorized and traumatized community are used by the pro-government Janjaweed militia to humiliate and terrorize non-Arab communities. Human Rights Watch (2005, 4) chronicles this sexual violence in Darfur with graphical precision.

According to a forty one old Fur woman who ended up getting raped for protecting her fourteen year old daughter from militant sexual predators:

I covered her with my body and prevented them from taking her. They became very angry, they lashed me and decided to have me . . . They tore my dress while I was resisting them. They took me a bit far from the group and started raping me. One would rape while two others would guard him. There were about thirty women in the same place . . . They took their turn raping me, after that they hit me hard, took me on the floor back to the crowd and threw me beside them.

Fear of such attacks has forced many women and children to flee their towns and villages resulting in “fragmentation of communities” (Smith-Sparks 2004, 2). Under such circumstances, women and young girls become even more vulnerable to rape and other sexual assault as they try to flee to safety. Human Rights Watch has extensively reported on the genocide in the Darfur region in Sudan. The human rights NGO notes “numerous incidents in all three states of Darfur, in which women and girls have been subjected to rape and other forms of sexual violence during Sudanese government attacks on villages, including multiple rapes by multiple attackers from government forces and militias” (Human Rights Watch 2005, 3). Human Rights Watch also documents that in some instances rapes and sexual assault involved girls as young as seven and eight years and that, women had to endure the double jeopardy of genital mutilation after having been raped (4).

While the immediate goal of forced sex may be the sexual gratification armed combatants derive from the sexual encounter, “its underlying purpose is frequently the expression of power and dominance over the person assaulted” (WHO 2002, 149). Human Rights Watch in its 2005 report “Sexual Violence and its Consequences among Displaced

Persons in Darfur and Chad” chronicles such psychological underpinnings of rape and gender-based violence in conflict better:

Perpetrators of rape have frequently abused the women and girls with vitriolic racial and ethnic slurs during or after the rapes, calling women “slaves,” “dirty black Nuba,” and other epithets. A Fur woman who was raped by three men during an attack on her village . . . was told by her attackers, “You Fur women of 111 [referring to the pattern of scarification popular among Fur women: three parallel lines on the upper cheek] are needed. For each “1” on your face you have a job. The first “1” is to bake kisra (a Sudanese staple food) for [Sudan President] Omar el Bashir, the second “1” is to be the slave of el Bashir, the third “1” is to do whatever el Bashir wants from you (Human Rights Watch 2005, 5).

Sexual violence against girl-combatants

Another form of exploitation of children including girls is direct recruitment to fight in militia groups during armed conflict. For instance, in a report by the Secretary-General of the UN on the war in the Democratic Republic of Congo in 2003, it was reported that “child soldiers are still present in all arm groups in DRC, in some cases representing up to 35 percent of troops and are being sent to the front lines” (Watchlist on Children and Armed Conflict 2003, 23). The fragile nature of the family structure in these hostile environments facilitates the ability of armed militias to prey on children who tend to be very vulnerable to separation from their families. Under such circumstances, children, sometimes as young as eight years, “are abducted or coerced into joining armed groups where they become spies, porters, combatants and so-called ‘wives’” (Save the Children 2005, 4). Reports from Human Rights and Refugees International conducted in 2001 also point to the fact that there were militia abductions of boys and girls from their homes, markets and roadside for conscription in the eastern DRC” (Watchlist 2003, 25). Carballo and Solby (2001, 9) also find that adult female refugee fleeing alone with their children

tend to be “easy prey for others forcing them into providing sexual favors for rations and physical protection.” In the infamous Rwandan genocide, Amnesty International (2004b, 2) observes that many Tutsi women and girls and – Hutu moderates – were either raped at roadblocks by the pro-government Interahamwe militia “or held as captives in exchange for temporary protection from Interahamwe militia and the military.” UN reports on the genocide indicates that about 250,000 Rwandan women were raped, the majority of whom were eventually executed (Amnesty International 2004b, 2).

In conflict theaters in Sierra Leone and Liberia, child-soldiers have been subjected to traumatic psychological experiences with lasting mental health ramifications. The militia groups in these armed conflicts, for instance, “used sexual violence to brutalize recruits and to break bonds between families.” While boy-recruits were ordered to rape their mothers and sisters, abducted girls also became “bush wives” or “sexual slaves” (Martin 2005, 3).

While militias and armed groups including government militaries have always targeted both boys and girls for recruitment into conflict, girls tend to be particularly very vulnerable. According to a report by Save the Children, of the approximated 300,000 children involved in today’s conflicts around the world, “up to 40 per cent (120,000) are girls” most of whom are regularly sexually violated or raped and sometimes taken as “wives” or sexual possessions (Save the Children 2005, 1). In the DRC, a 15-year old girl under an alias, Furaa, recounting the experiences of fighting for the Interahamwe militia group in Eastern DRC epitomizes the ordeal that girls are subjected to in combat:

“sometimes we carried many things – weapons, bullets, and if you had a child, you needed to carry the child as well” (Save the Children 2005, 6). In another war theater, a 16-year girl who was captured after an invasion in her village and forced into one of the armed groups in Sierra Leone told a similar story to a Save the Children field worker:

There were about ten women there, but the men there were so many, maybe 20. Everybody slept in the same room together. At first I refused to be a “wife,” but I had to agree because there was nobody to give me food except for the rebels. So I agreed to be one of their wives, but he gave me nothing. He only had sex with me. Sometimes I would join him just to get food. I was a wife for about eight months. I was not feeling well, because I had not even started my periods. I used to have pains in my abdomen (Save the Children 2005, 10).

Sexual exploitation of refugees and IDPs by peacekeepers

While, in many cases, sexual exploitation by UN peacekeepers may not necessarily be as violent as those perpetrated by combatants in armed conflicts, it is, nonetheless, a breach of the trust entrusted in these troops and, sometimes civilian personnel, to protect the lives of vulnerable populations caught in the orgy of war. Indeed, Sarah Martin of Refugees International notes that “to prey upon the very populations that you are sent to protect is one of the worst forms of violation and betrayal that there is” (BBC 2006a, 2).

Increasingly, gender-based violence against refugees and IDPs by peacekeepers is becoming an entrenched menace which threatens the very moral principle behind its conception by the United Nations. In April 2005, Jean-Marie Guéhenno, UN Under Secretary-General for Peacekeeping Operations warned: “If we fail . . . to approve decisive and visible steps to limit sexual abuse in UN peacekeeping, then

it will have serious implications for the future of peacekeeping.” To underscore the urgency of this growing violation of trust, Guéhenno further cautioned, “I do not say this lightly” (Martin 2005, Forward). This premonition is particularly significant given the fact that recommendations encapsulated in the Zeid report which spells out “policies and guidelines set by the UN Department of Peacekeeping Operations (DPKO) about sexual exploitation and abuse in missions are not always followed in the field” (Martin 2005, ii).

The Zeid report, entitled “A Comprehensive Strategy to Eliminate Future Sexual Exploitation and Abuse in United Nations Peacekeeping Operations,” recommends the establishment of on-site court martial by troop contributing countries (TCCs) to try mission personnel who violate UN zero-tolerance sexual policy in peacekeeping operations. The report also encourages the adoption of “formal memoranda of understanding in advance of deployment so that the cases of sexual exploitation and abuse are forwarded to their competent national or military authorities.” It also calls for the institutionalization of professional investigative capacity in all missions with the full support of TCCs (Martin 2005, 1).

In what has come to be known as “sex for food” and security, women in many of the ongoing conflicts are “forced to exchange sex in order to secure their and their families’ lives and livelihoods, escape to safety, and gain access to food, shelter or services” (WHO 2004, 1). Given the harsh and untenable conditions imposed on

women and girls, many of the times, the only valuable they have available to them is to sell their bodies in 'payment' for food and shelter (Holt and Hughes 2004, 1). In the Democratic Republic of Congo, allegations of sexual abuse by troops in the UN MONUC humanitarian mission have been particularly troubling. Laurie Garrett (2005, 33), in a Council on Foreign Relation report, highlights in detail the MONUC sexual scandal:

In May 2004, the credibility of UN peacekeepers came under fire when it was revealed that Moroccans and Uruguayan soldiers deployed under the UN in war-torn DRC were using their cash and food to coerce Congolese girls as young as thirteen into prostitution. This revelation opened a dreadful window onto the behavior of some of the more than 10,000 peacekeepers based in the DRC, leading to 150 investigations by the end of 2004. Charges include pedophilia, rape, coercive sex, and prostitution.

Most of the time, young girls who are abused by peacekeepers suffer multiple psychological traumas given that, often, they have been raped or sexually assaulted by armed combatants. Holt and Hughes (2004, 1), in their article, "Sex and Death in the Heart of Africa," tell of the dilemma of Faela, a 13-year-old mother of a six-month-old son whose father could be one of several militiamen who had raped and sexually abused her over a period of time. Recounting her ordeal, Faela notes, 'If I go and see the soldiers at night and sleep with them, then they sometimes gives me food, maybe a banana or a cake . . . I have to do it with them because there is nobody to care, nobody else to protect Joseph [her son] except me.' These soldiers are not militiamen; rather they are the troops from the UN mission deployed near an IDP camp in Bunia in the worn-turn Ituri province in eastern part of the country. The Bunia camp was established following an upward spiral of conflict between the Hema and Lendu ethnic groups in 2003 and was home to some 15,000 IDPs by 2004 (Holt and Hughes 2004, 2).

Symptomatic of many such conflict environments, Holt and Hughes (2004, 2) observe that “in this world of lost hope and shattered dreams, Faela’s story is a common one . . . a story of war and of soldiers, of sex and, most of all, of fear.” In this environment of hopelessness and fear, commercial sex for many women and young girls caught at the crossroads of hunger, fear and death, becomes an existential necessity. So “faced with starvation . . . Faela, along with other girls in a similar predicament, turned to the only salvation they felt that they had . . . Monuc soldiers stationed directly across from the camp” visiting ‘sometimes once a night, sometimes more’ (3).

In Liberia and Haiti, a recent investigation conducted by the BBC indicates that children in these conflicts zones have been coerced into prostitution with UNMIL and MINUSTAH peacekeeping personnel respectively (BBC 2006a, 1). BBC reported in November 2006 that a 20-year old woman had told the network that she had been forced to have sex with a World Food Programme (WFP) worker who had also sexually abused several of her peers (BBC 2006b, 1). And according to Refugees International (Martin 2005, 3), Sierra Leone was also replete with many allegations of exploitative sex particularly in 2002 “when it was alleged that members of the humanitarian community were coercing sex from female refugees in exchange for humanitarian assistance.” In Eritrea where the United Nations Mission in Ethiopia and Eritrea (UNMEE) have been deployed to patrol a buffer zone since 2000, peacekeepers have been charged with and some found guilty of several acts of gender-based violence against women and children. Refugees International, again, reports that troops from Denmark, Slovakia and Italy were expelled after investigation into separate incidents found them complicit of engaging in

sexual encounters with minors. In another incident in 2001, three Danish peacekeepers “were found guilty of having sex with a 13-year-old Eritrean girl” (Martin 2005, 5).

Indicative of this troubling phenomenon in UN peacekeeping humanitarian missions, United Nations Department of Peacekeeping Operations records indicate that “316 peacekeeping personnel in all missions have been investigated, resulting in the summary dismissal of 18 civilians, repatriation of 17 members of Formed Police Units and 144 repatriations of or rotations home on disciplinary grounds” (BBC 2006a, 2).

Impact of gender-based violence on refugee/IDP reproductive health

The health impact of war-related sexual violence on women and girls is considerable and often has devastating ramifications on both their overall wellbeing and on their reproductive health. The harsh realities of displacement have been known to exacerbate the reproductive health problems of refugees and internally displaced persons. Human Rights Watch, in its report on “Sexual Violence and its Consequences among Displaced Persons in Darfur and Chad,” observes that “during but also following an armed conflict, the confluence of displaced persons, refugees, sexual violence and HIV/AIDS is a key issue of protection” (Human Rights Watch 2005, 15).

As part of interviews conducted in Liberia to document the pervasiveness of gender-based violence in Liberia, one humanitarian aid worker told Refugees International that in some health clinics in Monrovia, “all of their female patients tested positive for at least one STI” noting also that most of the patients had been victims of rape by the militia and

rebel forces (Refugees International 2004, 1). According to Save the Children, in one of its West Africa programs alone, “32 per cent of all girls in the armed groups reported having been raped, 38 per cent were treated for sexually transmitted infections and 66 per cent were single mothers” (Save the Children 2005, 15). Unarguably, these infections do have severe consequences on the reproductive health of women and girls with both short-term and long-term ramifications. WHO notes that “in Rwanda, the HIV prevalence rate in rural areas dramatically increased from 1% before the start of the conflict in 1994 to 11% in 1997” and in another survey, “of the women who survived the genocide, 17% were found to be HIV positive” (WHO 2004, 1).

Conflict is often synonymous with the absence and or breakdown of social infrastructure including health and public health delivery systems. The lack of basic reproductive health services in such conflict environments “can lead to high mortality rates among women and children, an increase in the spread of sexually transmitted infections (STIs), including HIV/AIDS and increased morbidity related to high fertility rates and poor birth-spacing” (UNFPA 2001, 42). The high incidence of rapes and coerced sex also means that unwanted pregnancies tend to be pervasive among refugees and IDPs (iii). Amnesty International (2004c, 18) notes that “women who have become pregnant as a result of rape often suffer complications before, during and after giving birth, because of the physical injuries resulting from assault.” Fistula is one such common obstetric problem associated with rape and pregnancy.

Due to the fact that sexual relationship between vulnerable women and girls and armed combatants and soldiers are asymmetrical and lacks mutual reciprocity, sexual encounters are likely to “place them in situations of high risk of HIV” (Carballo and Solby 2001, 10).

Human Rights Watch (2005, 12) also notes that:

Women and girls who have suffered violence have a full range of health needs that must be addressed. These include treatment of injuries that may have occurred in the cause of the sexual violence, information and preventative treatment for sexually transmitted infections, (including HIV and hepatitis), information and access to services to prevent or terminate unwanted pregnancies, and counseling to address the emotional and psychological impact of sexual violence.

In conflict environments, the absence of reproductive health services such as family planning services puts women at a greater “risk of unwanted, possibly forced pregnancies leading to increased, often unsafe abortions” (UNFPA 2001, 50). According to the 2002 WHO report on health and violence, “gynaecological complications have been consistently found to be related to forced sex . . . including vaginal bleeding or infection, fibroids, decreased sexual desire genital irritation, pain during intercourse, chronic pelvic pain and urinary tract infection” (WHO 2002, 162). In a study conducted by AVEGA, an association for genocide widows, in 2000, it was discovered that out of 1125 women who survived rape during the genocide, 66.7 percent had HIV and 80.9 percent of “survivors of violence during the genocide remained traumatized in 1999,” five years after the genocide (Amnesty International 2004b, 2).

The most current of United Nation’s protocol on the recognition of sexual violence as a war crime and therefore crime against humanity is the one outlined in WHO and United Nations High Commissioner for Refugees’ *Clinical Management of Rape* protocol, which

also enjoins states to take steps to provide the needed health care to victims of rapes. It states that:

Rape in wars is internationally recognized as a war crime and a crime against humanity, but is also characterized as a form of torture and, in certain circumstances, as genocide. All individuals, including actual and potential victims of sexual violence, are entitled to the protection of, and respect for, their human rights, such as the right to life, liberty and security of the person, the right to be free from torture and inhuman, cruel or degrading treatment, and the right to health. Governments have a legal obligation to take all appropriate measures to prevent sexual violence and to ensure that quality health services equipped to respond to sexual violence are available and accessible to all” (Human Rights Watch 2005, 14)

While this protocol, unarguably, sounds very noble and must be complied with by all countries as a moral imperative, many governments in recent intrastate conflicts have been complicit in its overt violation. In the ongoing genocide in Darfur, the International Commission of Inquiry found that rape and sexual violence are consistently used by government forces and the government-backed Janjaweed militia group as a ‘deliberate strategy with the aim of terrorizing the population, ensuring control of the movement of the IDP population and perpetrating its displacement’ (Human Rights Watch 2005, 3). In Rwanda, the government military and pro-government Interahamwe militias led a mass participatory genocide that led to the death of 800,000 Tutsis and Hutu moderates and 250,000 rapes. And, of those who survived the genocide and sexual violence, “70% are estimated to have been infected with HIV,” according to a UN report (Amnesty International 2004b, 2). Under such circumstances, the last thing to be expected from a complicit government is to strengthen public health capacity to address health issues related to gender-based violence.

Due to the very mobile nature of peacekeeping, UN peacekeeping troops travel very widely within the mandated area of operation. This means that peacekeepers who are sexual predators can very easily infect many refugees and IDPs with STIs particularly HIV. As Garrett (2005, 33) asserts, “the behavior of UN peacekeepers, particularly those deployed to areas rife with HIV, threatens to spread the pandemic, undermine the credibility of the UN System, and ultimately lessen the capacity of the UN to intervene in conflict-ridden areas of the world.”

Many young girls who are raped by armed militants are often rejected by their families. The stigma and the accompanying ostracism they face from an unforgiving and unsympathetic society leave these vulnerable girls with nothing left except “survival sex.” Such social pressures often compromise their leverage on their personal dignity making them more prone to contracting sexually transmitted diseases that endangers their reproductive health and overall wellbeing (Amnesty International 2004b, 5).

Health policy requirements in complex humanitarian emergencies

Reproductive health needs of women and girls during complex humanitarian emergencies have traditionally been relegated to the background by many actors in the conflict intervention and emergency response community. The lack of attention to this area of intervention means that relevant research and information to inform policy making in critical areas such as medical needs of victims of rape and other forms of sexual abuse is often lacking. It is therefore encouraging that while a lot needs to be done in reproductive health needs of refugees and IDPs, the United Nations and other international and local

actors are now expanding their programs into this area following recent upsurge in gender-based violence against women in conflicts around the world particularly in conflicts as such as those in Rwanda, Sierra Leone, Liberia, DRC, Bosnia and Darfur. Human Rights groups have been particularly remarkable in pushing for more policy formulation that recognizes and provides for the health needs of women victimized in war. Human rights groups are making significant impact in this direction through vigorous documentation and research of gender-based violence in many of the conflicts theaters. A groundbreaking study, *“Refugee Women and Reproductive Health: Reassessing Priorities,”* conducted in 1994 by Women’s Commission for Refugee Women and Children, shed light on the lack of even the most basic form of reproductive health services for refugees and IDPs. It is this research that created the stage for more interest and donor support in reproductive health programming, including gender-based violence as an integral part of humanitarian intervention (Ward 2002, 10).

It is critical that in order to prevent and seek justice where rapes and sexual violations have occurred, women and girls be encouraged and given a space of confidence to report and talk freely about their experiences related to rape and sexual abuse. Most often, many incidents of rape have gone uninvestigated due to reluctance on the part of victims to come forward due to fear of stigma and social rejection often including close family relatives. Encouraging women to form advocacy groups as recommended by the UN Zeid Report could go a long way to create an atmosphere of increased confidence and openness. Creating such atmosphere of confidence will require that UN complaint system

in missions be “transparent, easy to access, and accountable to the local population” particularly in sexual improprieties involving UN peacekeeping troops (Martin 2005, 21).

Humanitarian agencies involved in stabilization and reconstruction in conflict zones should emphasize public health services such as family planning and other reproductive health services as integral to a holistic intervention approach. Because of the high prevalence of sexual activity associated with conflict, coerced or volunteered, women and girls are very vulnerable to sexually transmitted infections such as HIV, syphilis and Hepatitis, among others. Under such circumstances, it is necessary that health services such as post exposure prophylaxis (PEP) and HIV/AIDS voluntary counseling and testing (VCT) are made available to refugees and displaced populations in accordance with UNFPA’s Inter-Agency Standing Committee (IASC) Guidelines for HIV/AIDS Interventions in Emergency Settings and the Clinical Management of Rape Survivors. These crucial health services have been absent in many conflict intervention programs. For instance in the case of the refugee population in the Darfur and Chad, Human Rights Watch observed that, as of February 2005, only one of six agencies providing health services to these refugees and IDPs had a clearly defined protocol for rape that “included the provision of emergency contraception, comprehensive treatment of sexually transmissible disease and post-exposure prophylaxis of HIV” (Human Rights Watch 2005, 13).

In the long-term, humanitarian assistance should be expanded to include reproductive health as central to sustainable development. Given the increasing convergence of post-

conflict stabilization and reconstruction and development in contemporary humanitarianism, “assisting female survivors of violence through legal, economic, psychosocial and reproductive health services” are inextricably linked to the multifaceted nature of international development. Unarguably, a nation is only economically strong when its people are healthy, and given the fact that conflicts are often powerful vectors of STIs, failure to tackle such health emergencies in both the short and long terms has the potential to threaten the security of nations from the epidemiological perspective. In this regard, Carballo and Solby (2001, 13) argue that “for reconstruction to be possible will require that far more attention be given to the confluence of HIV/AIDS and conflict.” García-Moreno (2002, 120) also notes that sexual assault on women can have lingering sexual, physical and psychosocial repercussions that can deteriorate over time.

Pre-deployment training for UN peacekeeping troops in individual troop-contributing countries should focus substantially on discipline and importance of adhering to the peacekeeping code of conduct. Among others, the code of conduct stresses the need to “respect local customs and practices through awareness and respect for the culture, religion, traditions and gender issues” and the awareness of the human rights of women and children and a prohibition of their violation (Martin 2005, 30). Where violations occur, the mission should be furnished with the necessary investigative capacity to unearth acts of sexual abuse to recommend the necessary punishment for such violations. Recommendations outlined in the Zeid report such as the holding of on-site court martial to try violating troops as well as garnishing wages of troops whose paternity are DNA-proven when they impregnate local women and girls are all provisions that must be

forcefully pursued and enforced by UN humanitarian missions. Pre-deployment training must also encourage voluntary counseling and testing by troops in accordance with the UN regulations on “HIV Testing Policy for Uniformed Peacekeepers” as well as briefing about HIV and other STIs.

Finally, the UN’s effort at gender mainstreaming in peacekeeping mission must be taken seriously and expedited to ensure that its moral standing in such undertakings does not further deteriorate. The growing number of incidents of sexual abuse in some of these missions threatens to undo the laudable work it does in bringing peace and stability to many troubled regions of the world. It has been argued that the hyper-masculine composition of most UN peacekeeping missions encourages the commission of such sexual impropriety which in turn is encouraged by a culture of silence in the midst of such violations. Martin (2005, 5) notes that as of July 2004, women constituted only 4.4 percent of UN civilian police in peacekeeping missions and 1 percent in military personnel. The international civilian personnel composition was 27.5 percent which was a slight improvement from 24 percent in 2002.

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