CHAPTER SEVEN

WOMEN IN ARMED CONFLICTS AND WARS

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ABSTRACT

In addition to suffering inequality and gender discrimination, in armed conflicts or war women also suffer an added burden of violence arising from the conflict situation and reduced access to health and healthcare facilities, to food and to the resources needed to ensure their survival and that of their children.

In this chapter we will explain the consequences for women who find themselves in these situations, which also tend to occur in countries with endemic poverty, a history of discrimination against women, high rates of infectious diseases, serious deficiencies in health systems, systematic violence and an absence of freedom. These consequences are reflected in greater discrimination, less access to health (maternal and infant, greater incidence of HIV/AIDS, higher rates of cancer), greater liklihood of being subjected to violence (sexual violence, sexual exploitation), greater vulnerability (we will examine the situation of women in four countries), and finally we will outline the author's point of view as an aid worker.

Key words:

Maternal and infant health, mortality, vulnerability, discrimination, HIV/AIDS, sexual violence, rape as a weapon of war, sex slaves

INTRODUCTION

In armed conflicts or war, as well as the inequality and discrimination they suffer for being women, with all that that implies (inequality in access to health services, lack of maternal and infant healthcare resources, gender violence and less decision-making capacity and access to education, greater difficulty in accessing financial resources, etc.), women also suffer the discrimination derived from their situation as refugees or victims of armed violence, which makes their situation even worse.

In this chapter we will explain the consequences for women who find themselves in these situations, which tend to arise in countries whose characteristics – endemic poverty, history of discrimination against women, high rates of infectious diseases, serious deficiencies in health systems, systematic violence and lack of freedom– make them bad places in which to be a woman.

These consequences are reflected in greater vulnerability of women and are explained under the following headings, which we will develop in this article:

1) Greater discrimination

2) Less access to healthcare

   a. Maternal and infant
   b. Higher rate of HIV/AIDS
   c. Higher rates of cancer

3) Greater likelihood of being subject to violence:

   a. Rape as a weapon of war
   b. Girl soldiers and sex slaves
   c. Prostitution

4) Greater vulnerability as refugees Four countries, four examples: Somalia, Haiti, Congo and Sierra Leone.

5) Women aid workers - A personal point of view.

Women, in a humanitarian context in times of war, find themselves down the pecking order as far as rights relating to reproductive health are concerned: these types of programmes are always the last to be implemented in such situations, when they should be regarded as of the greatest urgency. The result is, as we shall see, an increase in maternal and infant mortality rates.

The World Health Organisation (WHO) has stated in numerous documents that the main cause of maternal mortality is related to maternity: on average, women in developing countries have many more pregnancies than those in developed countries, and thus have a greater risk of pregnancy-related death over the course of their lives. The risk of maternity-related death throughout life (i.e. the probability that a fifteen-year old adolescent girl will eventually die of a maternity-related cause) is 1 in 4,300 in developed countries, compared to 1 in 120 in developing countries[1].

Many women die from complications arising during or following pregnancy or childbirth. The majority of these complications appear during pregnancy; others may have been present before but become more serious with pregnancy. The main complications, causing 80% of maternal deaths, are:

- serious haemorrhaging (mainly post-delivery)
- infections (generally post-delivery)
- gestational hypertension (pre-eclampsia and eclampsia)
- obstructed labour
- unsafe abortions.

This means that every day about a thousand women die from preventable causes related to pregnancy and childbirth, 99% of them in developing countries.

This is with regard to what the World Health Organization calls "direct causes", which account for 80% of women's deaths. However, to this terrible toll of 365,000 maternity-related deaths a year, we must add those stemming from "indirect" causes, the remaining 20%: diseases that complicate pregnancy or which are aggravated by it, such as malaria, anaemia, HIV/AIDS and cardiovascular diseases[2].

Africa, where the greatest number of armed conflicts are concentrated (18, counting low- and high-intensity wars)[3], also has the greatest number of women's deaths as a consequence of HIV/AIDS, as in war situations, women are more vulnerable than men to this disease: in Africa, the proportion of women with HIV/AIDS is 60%, a percentage that increases to 74% for young women and adolescents[4].

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[1] World Health Organisation. Descriptive Note n.º 348, November 2010.
[2] *World Health Report 2005, Make Every Mother and Child Count.* Geneva, World Health Organization, 2005, p. 62.
[3] Uppsala Conflict Data Programme.
[4] In 30 years of epidemic, women and girls represent 60% of people living with HIV in Sub-Saharan Africa, and 76% of young people between 15 and 24 years of age living with HIV are women. National surveys show that young women in Eastern and Southern Africa are up to six times more likely than men to become infected, due to a combination of biological, behavioural and structural causes preventing women and girls from rejecting sexual relations or negotiating safer sex practices. *Windhoek Declaration. Women,,Girls, Gender Equality and HIV: Progress towards Universal Access.* 6-8 April 2011.

Women and girls are the main victims of war in many countries: in many armed conflicts women and girls are subjected to attacks and violence precisely because of their gender. Thus, in some wars rape has been used as a weapon and means of attack in clashes between warring factions: Sierra Leone, Rwanda, Liberia, Congo and the former Yugoslavia. In others conflicts, women, especially the youngest and even girls, have been kidnapped or recruited by force to be used as sex slaves.

In many developing countries, women are less able to access healthcare and are more vulnerable to certain types of diseases. Cancer of the uterus affects more than 1.38 million women around the world every year, and 80% of deaths from cancer are in poor countries. They are also vulnerable to cervical cancer, related to the human papilloma virus, which has a lot to do with being powerless to insist on using protection in sexual intercourse, or with situations of violence related to armed conflicts and wars.

Gender violence can occur at any stage of a woman's life cycle. Types include gender-based selective abortion, maltreatment during pregnancy, forced pregnancy resulting from rape, female infanticide, relative deficits in food and medical attention for girls, child marriage, genital mutilation, child prostitution, psychological abuse, marital rape, sexual harassment, human trafficking and the rape of elderly women.

Lastly, we end the chapter with some reflections based on my personal experience in the field as an aid worker relating to the role of women as carers or witnesses in conflict and war situations.

GREATER DISCRIMINATION

In many countries with patriarchal cultures, women are the victims when their men folk are absent. For example, women's situation in Iraq is especially difficult, as the International Committee of the Red Cross has acknowledged. According to the data presented by this organisation, there are approximately a million women in Iraq who, because of the war, have become heads of family, either because they have been widowed or because all the family's adult males are dead or have disappeared[5].

This problem is especially difficult in a society with profoundly patriarchal roots, in which it is not common for women to work outside the home and where there are no support mechanisms for these cases. These women are often forced to fall back on the family network, thus becoming a burden, since finding income to subsist is practically impossible. These female heads of families are also particularly vulnerable in a country where generalised violence persists.

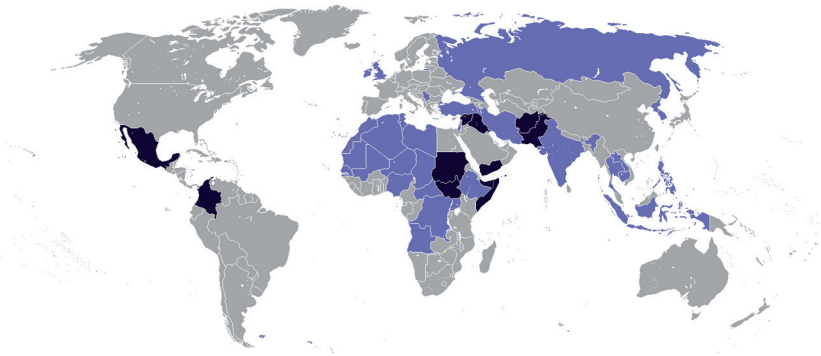
[5] *Households headed by women in Iraq: a case for action* The International Committee of the Red Cross in Iraq. August 2011

In order to survive, and this is especially dramatic if they have children or elderly parents to look after, they have to compete in a labour market in which there is no room for women. In many cases the only way out is to turn to begging.

Another problem is discrimination in access to education. If we superimpose the four world maps of poverty, armed conflicts, lack of access for women to education and violence against women, we will see that they are practically identical. In a poor country, women have less access to healthcare, less access to resources, less access to education, and a high percentage of them are victims of violence, and all these factors are exacerbated if on top of everything else the country is also immersed in conflict or war.

At the moment there are 31 ongoing conflicts, most of them in the world's poorest countries[6] and half of them are in Africa (see figure 7.1):

Figure 7-1. World map of armed conflicts



Source: Wikipedia.

LESS ACCESS TO HEALTHCARE

Women, especially in developing countries, and even more starkly in countries in conflict, have greater difficulty in accessing healthcare and are particularly vulnerable to certain diseases. For example, breast cancer, which affects 1.38 million women worldwide every year, is also the most frequent cause of death for women: half a million deaths a year. This is because it is under-diagnosed in developing countries, among other reasons.

Maternal and infant health

- It is estimated that 1,600 women die every day due to complications arising from pregnancy and childbirth, 99% of them in developing countries.

[6] Uppsala Conflict Data Programme.

- Every year approximately two million girls are at risk of female genital mutilation.
- Close to 70,000 women die each year from unsafe abortions, and many more suffer from infections and other consequences.
- Women are more likely than men to contract HIV from sexual encounters, and about 42% of all HIV-infected persons are women.
- Fifty-one percent of all pregnant women suffer from anaemia due to iron deficiency.
- In many countries in South Asia, Africa, Latin America and the Middle East, between a third and half of women are mothers before they are 20 years old.
- Cervical cancer, the commonest form of cancer in developing countries, is usually associated with the human papilloma virus.
- Domestic violence, rape and sexual abuse are important causes of disability among women[7].

The 1994 International Conference on Population and Development, held in Cairo, and the 1995 World Conference on Women, held in Beijing, extended the right to family planning to include the right to better sexual and reproductive health. Based on the World Health Organization's definition, the Cairo Programme defines reproductive health as:

> *"...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."*

More than half the world's population is under 25, and a significant number of adolescents are sexually active. From birth through childhood and adulthood, girls and women need effective services and information enabling them to lead healthy and productive lives. Boys and men also need information and services that are conducive to responsible behaviour and equal treatment of women and girls.

[7] United Nations Population Fund, UNFPA

It is estimated that some fifteen million adolescent women give birth each year, which represents as much as one fifth of all births worldwide. And every year one in every twenty adolescents contracts a sexually transmitted disease.

The experiences of women forced to flee from conflicts or disasters highlights the need to provide them with access to emergency contraception (EC), not just as a right, but also as a necessity to ensure reproductive health. In wars, armed conflicts or displacements caused by disasters or famine, being unable to access emergency contraception can be considered as being deprived of the right to reproductive health, as recognised by various international agreements and conferences, since these women may have to face unwanted pregnancies and, as a result of the situation in which they find themselves, suffer the effects of complications during pregnancy or childbirth, or even die from them.

The high rate of maternal mortality is a reality in these situations, in which giving birth, for example, involves risk or danger to health. Account must also be taken of cases of unwanted pregnancies, including those resulting from rape, which are frequent in conflict situations. In Sierra Leone, nine per cent of women displaced by the war were raped. Tanzania reported the horrifying statistic that twenty-eight percent of the female refugees of childbearing age arriving from Burundi had been raped[8].

Displaced women are also victims of another type of sexist abuse or sexual exploitation, when sex is demanded of them in exchange for security, food, family upkeep, etc.

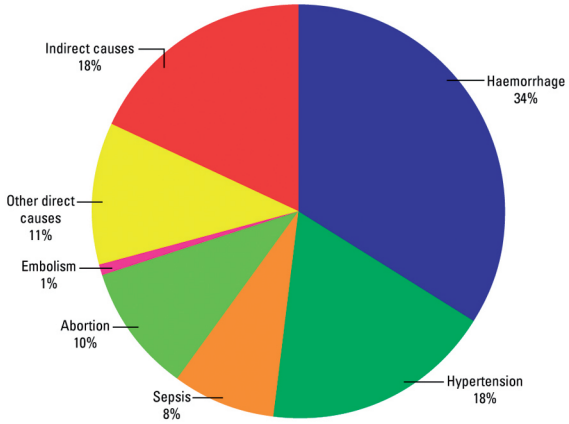
For these reasons, under the Sphere Project in 2004, the Minimum Initial Services Package (MISP) was designed, to establish the steps that need to be taken to cover reproductive health needs in the early stages of humanitarian crises, including training of personnel transferred to the area and information for female refugees and displaced persons, focusing on the most vulnerable group, adolescents, who are the main victims of sexual exploitation and violence[9] (see figure 7.2).

[8] *Emergency contraception in conflict zones* Reproductive Health Response in Conflict Consortium.
[9] http://www.sphereproject.org/

Figure 7-2. Causes of maternal mortality

Most maternal deaths are from causes that can be prevented or treated

Global distribution of causes of maternal death, 1997–2007



Source: WHO, Systematic Review of Causes of Maternal Death (preliminary data), 2010.

Source: WHO.

It can be affirmed without exaggeration that pregnancy is a serious health risk in many countries, especially in countries immersed in an armed conflict.

For example, of the ten countries in the world with the highest rates of mothers' death during labour, five are in a war or conflict situation or have recently emerged from a civil war.

- *Afghanistan (1,400 maternal deaths per 100,000 live births)*

This is the most lethal place in the world in which to give birth, out of the 164 countries studied by Save the Children[10]. Afghanistan's rugged terrain, extreme climate and lack of roads means that many women in rural areas simply cannot get to health centre, especially in winter, when floods and avalanches are common. Having very little money even for basics, with petrol a luxury, many pregnant women are forced to resort to donkeys to reach a hospital, and in many instances they end up giving birth on the way, often dying as a result of complications during labour.

The situation of armed conflict suffered by the country for decades, with many areas unsafe, militarised or home to guerrilla fighters, has further exacerbated the situation.

[10] *2011 State of the World's Mothers report*. Save the Children. 2011.

Every day in Afghanistan some fifty women die in childbirth. One in three suffers physical or sexual abuse, and women's average life expectancy is 44 years.

- *Iraq*

Although 72% of deliveries are attended by healthcare personnel, maternal mortality reached 250 per 100,000 and neonatal mortality was 60 per 1,000.

- *Haiti*

In Haiti, a country with a very high level of internal conflict and extremely high poverty figures, maternal mortality has reached 680 per 100,000 live births, having deteriorated considerably following the earthquake that devastated parts of the country.

- *Chad (1,200 maternal deaths per 100,000 live births)*

This central African country has only one midwife for every 100,000 people. A girl growing up in today's Chad is almost as likely to die in childbirth as she is to attend secondary school. Due to political instability and corruption, there has been little investment in health services. In some hospitals women find themselves obliged to give birth on an earth floor. The continuing political instability caused by the presence of various armed anti-government factions, has prevented one of the world's poorest and most corrupt countries from developing.

- *Somalia (1,200 maternal deaths per 100,000 live births)*

This country in the Horn of Africa has been devastated by civil war for the past fifteen years, health services are practically non-existent, and it suffers serious droughts and famines. One child in ten dies before the age of one. Many women have to travel through the desert by camel to reach a clinic. The famine that has afflicted the country since the summer of 2011, combined with the lawlessness of large parts of the country which are in the hands of warlords, and the total lack of security for moving around, all have a negative impact on maternal and infant health.

- *Liberia (990 maternal deaths per 100,000 live births)*

This West African country has high rates of maternal mortality. The situation has worsened with the recent influx of refugees fleeing the violence in Côte d'Ivoire (more then 100,000 people, mainly women and children), which

has overloaded the health services even more. The refugees walk for days to cross the border. Many pregnant women are obliged to give birth on the way.

- *Sierra Leone (970 maternal deaths per 100,000 live births)*

One in eight women risks dying during pregnancy or childbirth. Each year 536,000 women die, most of them from haemorrhage and infections. Some women die at home, others on their way to hospital, in taxis, on motorcycles or on foot. With access to qualified health workers, 75 percent of these women could be saved. The country's structures were seriously affected by the long years of civil war. There are areas of the country where armed groups or militias still remain, further adding to the insecurity.

Greater incidence of HIV/AIDS.

Rape, sexual abuse and the failure to respect of women's rights during many conflicts are largely responsible for the spread of certain diseases in many countries: the spread of HPV, which can lead to cancer, and of HIV/AIDS, are linked to these phenomena.

In Bosnia and Herzegovina, the Democratic Republic of the Congo, Liberia and Rwanda, rape as a weapon of war has contributed to the spread of HIV/AIDS. A study carried out among rape victims in Rwanda found that 17% of them tested positive for HIV, compared with 11% of women who had not been raped[11].

A similar study concluded that 66% of women raped in Rwanda during the civil war were seropositive.

They are also especially vulnerable to cervical cancer, which is directly related to the human papilloma virus and to HIV/AIDS. In fact 80% of women living with HIV/AIDS are in Sub-Saharan Africa, the region that concentrates the worst poverty, the least availability of healthcare resources and the largest number of armed conflicts in the world. Moreover un Africa women with HIV/AIDS outnumber men by 55% to 45%.

In Southern, Eastern and Central Africa, between 20% and 30% of pregnant women are living with HIV/AIDS, and the transmission of the infection to their children can reach as much as 40% (see figure 7.3).

[11] HALPERIN, D. "Old Ways and New Spread AIDS in Africa" *San Francisco Chronicle*, 30 Nov., p. A-31, 2000

Figure 7-3. Map showing the incidence of AIDS by continent

Source: Another World is Possible.

HIV/AIDS spreads much more rapidly within a context of poverty, social instability and weak health systems, all of which are found in the most extreme form in conflict situations. The transmission paths and mechanisms of the disease in emergencies are not the same as in stable situations, since the dynamics of the epidemic are altered by socio-economic, sexual, cultural and healthcare factors[12]. In these situations, sexual abuse and violence are decisive factors in the spread of HIV/AIDS

Rape is frequently used by military or paramilitary personnel as a means of persecuting and terrorising the population or to force them to leave certain areas. Mozambique, Rwanda, Kosovo and Sierra Leone have experienced conflicts in which sexual violence was used as a weapon of war. In the first five years of the war in Liberia, almost half of all women and girls are estimated to have suffered physical or sexual abuse[13].

In Bosnia, between 30,000 and 40,000 women were raped, and in the exodus of the Vietnamese boat people in the late seventies and early eighties, 39% of the women were thought to have been raped or kidnapped, mainly by pirates.

Refugee camps tend not to be safe places for women, because they are generally accessible to refugees, soldiers and policemen. Women and girls are in a situation of extreme vulnerability in these places, as was seen in the refugee camps in Tanzania after the Rwandan genocide. Young *Hutu men* systematically infiltrated the camps to rape women and girls, fired by a desire

[12] KHAW, Adrian J., *et. al.* "HIV risk and prevention in emergency-affected populations: A Review". *Disasters*, n.º 24 (3), 2000.
[13] BAUER J. Bauer. Report on United Nations Commission on Human Rights, 1998

to replace the Tutsis and increase the population of their own ethnic group. 80% of the 2,000 women voluntary tested for HIV were seropositive[14].

All recent research has shown that women and adolescents are at great risk than men, due to their socio-economic disadvantages, their greater exposure to violence and the fact that sex becomes a currency with which to try to improve living conditions.

- *Military and police*

The role of these groups in the spread of HIV is complex and not limited to being mere transmitters of the disease; they too are victims of it. War or conflicts put them in a position of extreme vulnerability to infection and, at the same time, make them a vector of transmission.

Studies have shown that the presence of sexually transmitted diseases among the military is between two and five times greater than among the civilian population, and the same can be said of AIDS[15].

In these conditions, the risk of HIV infection through sexual relations is especially high, since genital lesions are frequent. Uganda was the first country where the connection between the increase in the rate of seroprevalence and the military population was demonstrated statistically . The geography of the spread of AIDS closely follows the movements of the Uganda National Liberation Army after the civil war. The spread of HIV-1 in the eighties and the consequent development of AIDS from the nineties on presented an astonishingly close correlation with army recruitment and mobilisation[16].

This was a pioneering study, and its conclusions have served as a guide for controlling the spread of HIV in African countries that have suffered subsequent conflicts or civil wars.

War forces men to leave their families to join the fighting, to travel far in search of financial resources with which to support the household, or they are abducted as hostages and prisoners. In any of these cases they disappear from the family unit, which leads them to seek the company of prostitutes and frequent hostels and bars. The military and guerrilla forces involved in the African conflicts are also males of very low average age and poorly prepared, both technically and personally, to cope with the pressures of war. Sex is perceived as the only way to

[14] MUJAWAYO, E. and BLEWITT, Mary K. "Sexual violence against women: experiences from AVEGA's work in Kigali", document presented at the seminar *Silent Emergency*, London, 1999.
[15] According to a study on Angola by SANTOS-FERREIRA, M. O. "A Study of Seroprevalence of HIV-1 and HIV-2 in Six Provinces of People's Republic of Angola: Clues to the Spread of HIV Infection", *Journal of Acquired Immune Deficiency Syndromes*, n.º 3, 1990.
[16] SMALLMAN-RAYNOR, M. R. and CLIFF, A. D. "Civil war and the spread of AIDS in Central Africa", *Epidemiol. Infect.*, n.º 107, 1991.

calm anxiety and seek company. What is more, they have the financial resources to be able to buy sex.

In periods of peace, the percentage of HIV in the military population is from two to five times more than that of the civilian population, although the difference widens sharply in times of conflict. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the rate of seroprevalence among the Nigerian peacekeeping forces sent to Sierra Leone and Liberia was 11%, compared with 5% in the adult civilian population. A study carried out by the Ethiopian government among the military showed that 5.5% of those tested were seropositive. In 2000, between 60% and 70% of the military population of South Africa had HIV. In Namibia, a sample carried out by the transfusion service among 127 soldiers who had been stationed in Owambo from August 1992 to February 1993 produced an average HIV-1 prevalence of 17.2%[17].

- *The response*

Both UNHCR, with its extensive experience with refugees, and UNAIDS, with its wide knowledge of HIV, know how to provide immediate assistance in emergencies and have developed basic recommendations for tackling the prevention of HIV/AIDS infection from the first moments of the crisis. These take the form of the Minimal Initial Services Package (MISP), which contains first aid treatments relating to the transmission of the disease and the screening of blood for transfusions.

Until recently, immediate preventive care had focused on people living in the refugee camps, but there is a high percentage of displaced persons who do not go to the camps set up by the international organisations but instead seek refuge among the civilian population. In these cases, implementing the MISP is more difficult, so a number of innovative and different strategies have to be devised[18].

The risk of refugees and displaced persons contracting HIV depends on a number of factors such as:

1. The maturity of the epidemic.
2. The relative seroprevalence of HIV among the refugee and host populations.
3. The prevalence of other STDs that may facilitate transmission.
4. The degree of sexual exchange between the two communities.
5. The presence of specific risk factors such as systematic rape by military or paramilitary personnel or sex trafficking.
6. The level and quality of HIV prevention systems.

[17] WEBB, Douglas. *AIDS and the military: The case of Namibia*, report presented to the Conference on AIDS in Marrakech, 1993
[18] KHAW, Adrian J., *et. al.*, *op. cit*, pp. 190-191.

The biggest problem is that the epidemic is not simply a health matter. A multi-sector approach is required that includes education, security, establishment of community services and psychological assistance . UNAIDS and UNHCR distinguish several levels of emergency in tackling the organisation of aid and assistance in conflict situations or natural disasters. These types of events are dynamic and changing, so the agencies need to be flexible and to ensure they coordinate well with one another.

There is a series of basic strategies that can help contain the spread of HIV/AIDS infection in emergencies[19]:

- Reduce the probability of transmission of STDs including HIV.
- The most urgent actions are education and distribution of condoms, as well as treatment of the symptoms of sexually transmitted diseases.
- Ensure that there are reserves of safe blood and blood products, and always use sterilised equipment. This is a procedure of vital importance in the treatment of bleeding or open wounds.
- Facilitate access to drinking water for all members of the community, especially those with weakened immune systems. If this is not possible, methods of purifying the water must be taught.
- Maintain rigorous rules of hygiene when handling food.
- Find out who are receiving antiretroviral treatment and prepare a list of the medications needed to ensure that their treatment is not interrupted.
- Store medicines for treating infections such as pneumonia, tuberculosis and gastroenteritis.
- Avoid crowding and concentrations of people insofar as possible.

Higher rates of cancer.

Eighty percent of the 3.7 million annual deaths from cancer of all types occur in developing countries.

Breast cancer continues to be poorly understood, under-diagnosed and fatal, especially in developing countries. Researchers say that, despite more than a million official annual diagnoses, nearly half a million deaths are recorded each year. In countries with limited resources, women are diagnosed in advanced stages of the disease, and have no access to palliative treatment.

This is especially serious in conflict situations that have led to healthcare structures being destroyed or healthcare personnel being transferred to "safe" areas, leaving large areas in many countries not just without medical or specialist healthcare personnel but without medical personnel of any kind.

[19] The systematic listing comes from MAZIN, Rafael. "The basic strategies to prevent the spread of HIV/AIDS and STIs during an emergency situation". *WHO Health in Emergencies*, n.º 7, 2000.

In Rwanda, women arrive at hospitals with advanced stages of cancer after attending poorly equipped health centres. In fact it is reckoned that between 70 and 80 percent of cases are diagnosed in very advanced stages in middle and low income sectors of the population.

Although it is estimated that eight out of ten cases of cancer worldwide are diagnosed in the poorest countries, many of them immersed in or having recently emerged from armed conflicts, only five percent of overall financing for cancer goes into research, according to the Global Task Force on Expanded Access to Cancer Care and Control.

Cervical cancer is the second most frequent type of cancer affecting women worldwide: approximately half a million each year, more than half of whom eventually die of the disease.

VICTIMS OF GREATER BURDEN OF VIOLENCE

Rape as a weapon of war

In conflicts such as that of the former Yugoslavia, Congo, Sierra Leone and Liberia, women were raped as part of the combatants' war strategy. Girls are also enslaved to be used sexually by military or paramilitary groups. In the war of the former Yugoslavia alone, the Warburton Commission (1993) calculated the number of victims at 20,000, while some NGOs put the figure as high as 50,000[20].

The mass rape of the enemy population's women continues to be one of the most commonly used weapons of war. In the conflicts of the former Yugoslavia, Congo, Sierra Leone and Liberia, rape formed part of a deliberate strategy to terrorise entire communities.

Between 50,000 and 64,000 women displaced internally in Sierra Leone said they had been subjected to sexual violence by armed combatants. And half the internally displaced women who had face-to-face contact with the combatants reported having suffered sexual violence.

- 25% of Azerbaijani women interviewed in 2000 by the US Centres for Disease Control and Prevention admitted having been forced to have sexual relations.
- Internally displaced Azerbaijani populations were those at the greatest risk.
- According to a government survey carried out in 1999, 37% of prostitutes in Sierra Leone were less than 15 years old, and 80% of these were entirely without family or had been displaced by the war.

[20] *Report of the Bassiouni Commission* , presented in May 1994.

- The majority of Tutsi *women* in the Rwandan genocide of 1994 suffered some kind of gender violence, and it is estimated that between 250,000 and 500,000 of them were victims of rape.
- It is estimated that between 20,000 and 50,000 women were victims of rape during the war in Bosnia and Herzegovina at the beginning of the 1990s.
- In the wake of natural disasters, field reports on the social effects include different types of violence, as in this report of a flood in Australia:

> *"Human relations were laid bare and the strengths and weaknesses in relationships came more sharply into focus. Thus, socially isolated women became more isolated, domestic violence increased, and the core of relationships with family, friends, and spouses was exposed."*

Increased violence against women was also noted in reports from the Philippines following the eruption of Mount Pinatubo; from Central and North America after Hurricane Mitch, and from several countries following the tsunami of 2004[21].

Sexual violence related to conflicts or war has a very significant effect on the health of women and girls in these countries. According to data of the World Health Organization[22]:

- Between 7% and 36% of girls are victims of sexual abuse.
- More than 46% of young women are victims of rape.
- Between 12% and 25% of women are raped by their partners.

One of the leading causes of this violence against women in countries in conflict is to be found in the power relations between men and women, expressed in women's submission for cultural reasons or for fear of being murdered when the attacks are carried out by members of militias or armies, resulting from the lack of means of subsistence (unequal access to resources) which forces many women and girls to resort to sexual submission or selling sex to obtain food.

Women's vulnerability in armed conflicts is also related to the disintegration of families and the difficulty of accessing health services and medication.

According to a study published in the *American Journal of Public Health* in 2011, in Congo alone 1,100 women were raped every day. The results of this study focused on the period 2006-2007 and covered data on rape and sexual assaults committed against more than 400,000 women aged between 15 and 49 years. The study itself acknowledges that the figures could be worse, since

[21] Source: Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies. Inter-Agency Standing Committee, 2005
[22] World Health Organization Regional Office for Africa.

incidents of rape committed against girls under 15 or women over 49 are not documented[23].

In 2010 the UN Office for the Coordination of Humanitarian Affairs (OCHA) presented a report which documented the rape of 5,500 women in that year in the province of Kivu, and warned that this figure referred only to reported cases, so the actual figure could be even higher.

The OCHA report pointed out that 90% of rapes are committed by armed groups, both regular army forces and militias or demobilised troops. The victims are never singled out, that is to say they are always accompanied by other victims and dozens of witnesses, since in general they belong to the same community, whether a village or a tribe. The objective is, in this situation, to deliver a telling physical and psychological blow to a given group in order to make it submit to the hierarchy of a certain guerrilla group or as revenge against a rival community or government.

Fortunately, recent advances in international law have strengthened the legal instruments for combating the forms of torture used specifically against women in armed conflicts. Thus the International Criminal Tribunals for the Former Yugoslavia and Rwanda have handed down several sentences that have been of crucial importance in the struggle to bring an end to impunity for these acts. Also of crucial importance has been the Rome Statute of the International Criminal Court, which grants the Court jurisdiction in war crimes involving rape, sex slavery, forced prostitution, forced pregnancy, forced sterilisation and other forms of sexual violence committed in the context of wars, and which, according to the Statute, may also constitute crimes against humanity.

A year after peace was reached, Sierra Leone signed a "historic" agreement with the United Nations on the setting up of a special tribunal to try crimes committed during the ten years of civil war, in which some 200,000 people lost their lives and thousands were mutilated, the majority of them by the rebels of the Revolutionary United Front (RUF).

This war was notable also for violence against the female population: Amnesty International reported that rape, sex slavery and other forms of violence against women and girls were generalised practices. Practically all the women and girls who were kidnapped in their thousands by the rebel forces were raped and forced to serve as sex slaves.

Faced with this depressing panorama, UN Women proposed sixteen steps for putting an end to violence against women, as part of their Policy Agenda.

[23] PETERMAN, A.; PALERMO, T. and BREDENKAMP, C. "Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo". *American Journal of Public Health*. June 2011, vol. 101, n.º 6, pp. 1060-1067.

Compliance with these points would contribute notably towards ending this scourge.

1. Ratify international and regional treaties that protect the rights of women and girls, and ensure that national laws and services meet international human rights standards.
2. Adopt and enforce laws to end impunity, bring perpetrators of violence against women and girls to justice and provide women with reparations and remedy for the violations perpetrated against them.
3. Develop national and local action plans for ending violence against women and girls in every country that bring the government, women's and other civil society organizations, the mass media and the private sector into a coordinated, collective front against such human rights violations.
4. Make justice accessible to women and girls by providing free legal and specialized services, and increasing women in law enforcement and frontline services.
5. End impunity towards conflict-related sexual violence by prosecuting perpetrators in conflict and post-conflict contexts and fulfilling survivors' right to comprehensive reparations programmes that are non-stigmatizing and have a transformative impact on women and girls' lives.
6. Ensure universal access to critical services at a minimum, women's and girls' emergency and immediate needs should be met through free 24-hour hotlines, prompt intervention for their safety and protection, safe housing and shelter for them and their children, counselling and psycho-social support, post-rape care, and free legal aid to understand their rights and options.
7. Train providers of frontline services, especially the police, lawyers and judges, social workers and health personnel, to ensure that they follow quality standards and protocols. Services should be confidential, sensitive and convenient to women survivors.
8. Provide adequate public resources to implement existing laws and policies, recognizing the devastating costs and consequences of violence against women not only for the lives directly affected, but to society and the economy at large, and to public budgets.
9. Collect, analyze and disseminate national data on prevalence, causes and consequences of violence against women and girls, profiles of survivors and perpetrators, and progress and gaps in the implementation of national policies, plans and laws.
10. Invest in gender equality and women's empowerment to tackle the root causes of violence against women and girls. Strategic areas are girls' secondary education, advancing women's reproductive health and rights, addressing the inter-linkages of violence with HIV and AIDS, and increasing women's political and economic participation and leadership. Gender equality and ending violence against women must be placed squarely at the heart of achieving the Millennium Development Goals.

11. Enhance women's economic empowerment by ensuring women's rights to own land and property, to inheritance, equal pay for equal work, and safe and decent employment. Women's unequal economic and employment opportunities are a major factor in perpetuating their entrapment in situations of violence, exploitation and abuse.
12. Increase public awareness and social mobilization to stop violence against women and girls, and to enable women and girls subjected to violence to break the silence and seek justice and support.
13. Engage the mass media in shaping public opinion and challenging the harmful gender norms that perpetuate violence against women and girls.
14. Work for and with young people as champions of change to end violence against women, and ensure that educational systems empower girls and boys to transform and build gender relations based on harmony, mutual respect and non-violence.
15. Mobilize men and boys of all ages and walks of life to take a stand against violence against women and girls, and foster equality and gender solidarity.
16. Donate to the UN Trust Fund to End Violence against Women, the only grant-making fund in the world exclusively dedicated to channelling expertise and financial support to national, local and grass roots efforts.

Girl soldiers and sex slaves.

Studies conducted by the United Nations Children's Fund (UNICEF) showed that 75% of women and girls in Sierra Leone were victims of sexual abuse, while other calculations put the figure as high as 90%. In some cases they were forced to become the sex companion or "wife" of a single combatant, while in other cases they suffered abuse from several combatants. Apart from the brutality, and the trauma caused by the rape itself, these sex attacks also led to serious physical damage, forced pregnancies, diseases including HIV/AIDS and even death.

In this regard the Human Rights Watch presented the report *We'll kill you if you cry: Sexual violence in the Sierra Leone conflict*, which presents evidence of abuse committed against women of all ages. The report is based on hundreds of interviews with victims, witnesses and officials, and details the crimes of sexual violence committed above all by members of the rebel forces (RUF, AFRC – Armed Forces Revolutionary Council– and the West Side Boys); but also those committed by the government armed forces.

Human Rights Watch also noted the lack of assistance and rehabilitation programme for the victims of this violence.

Another particularly negative aspect is the use of child soldiers, which is even more serious for girls.

In late November 2011, Somalia and the Central African Republic became the latest countries committed to put an end to the use of child soldiers, which is considered "encouraging" by the United Nations, although in both countries the unstable situation leaves some doubt as to whether the commitment will be met. In Somalia all parties to the conflict have recruited children over the course of many years. The organisations working with children in Somalia put the number of children in the power of the various armed groups at between two and three thousand. UNICEF estimates that the number of child soldiers in the more than 30 armed conflicts going on in the world could be as high as 300,0000.

Girls, and especially orphans, are especially vulnerable, because they are often exploited sexually, raped or maltreated, or obliged to act as "wives" to other combatants, which can lead to physical and psychological trauma, unwanted pregnancies, sexually transmitted diseases (including HIV/AIDS) and social stigmatising.

Girls are used mainly by armed opposition groups, paramilitaries and militias, but also by government forces, according to UN reports. Estimates suggest that, worldwide, girls may represent between 10% and 30% of children in fighting forces.

Demobilised girls are often stigmatised and condemned to ostracism by their communities, particularly if they come back with children. Girl soldiers are exploited in the same way as boys, but gender violence is added to their exploitation.

Girls are also excluded from official demobilisation programmes, which include repatriation, resettlement or reintegration, in spite of their special problems.

For example, in Liberia some 3,000 girl soldiers were demobilised, while a further 8,000 were excluded or not registered. In the Democratic Republic of the Congo it is estimated that only 15% of the girls involved in the conflict were officially demobilised. For girls who do not go through the official programmes, there is no official support.

Military recruitment is harmful not only to the children themselves, but to society as a whole. It means years of lost schooling, which reduces societies' potential. The education system is also damaged by the destruction of schools. In 2020 the UN reported that these types of attacks were becoming a significant factor, and a growing one.

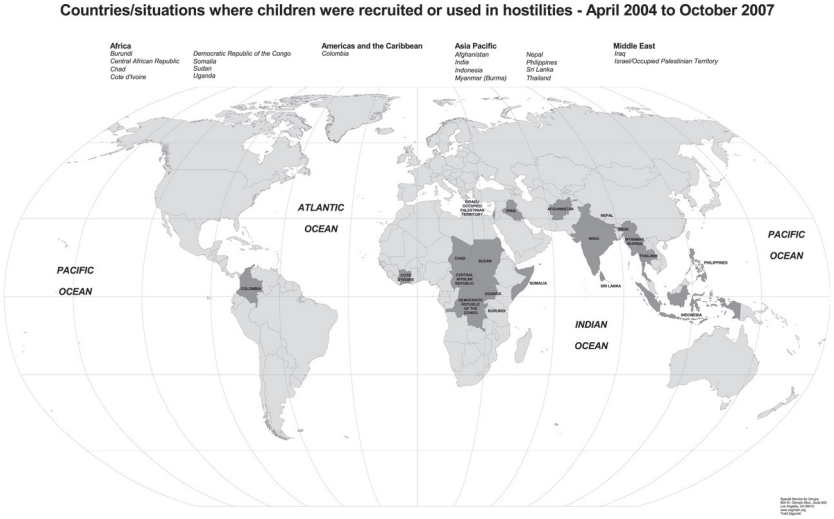
Although child soldiers have committed and continue to commit some terrible crimes in time of war, they still have the right, as the children that they are, to special protection.

There is no international consensus on the minimum legal age of criminal responsibility. The International Criminal Court, as per Article 26 of the Rome Statute, has no jurisdiction over anyone under the age of 18 - not because it believes children should be exempt from prosecution for international crimes, but because the decision on whether or not a person under the age of 18 should be prosecuted is one that belongs with the States.

What is clear is that when children have been used as instruments of brutality and barbarism, society as a whole must take part in their rehabilitation and reintegration, because it is society as a whole that is responsible.

According to Amnesty International, the following countries continue to recruit boy and girl soldiers: Afghanistan, Angola, Burundi, Cambodia, Colombia, the Philippines, Guatemala, Guinea Bissau, Honduras, Northern Ireland, Kosovo, Liberia, Mozambique, Burma, Nepal, Nicaragua, Democratic Republic of the Congo, Chechnya, El Salvador, Sierra Leone, Somalia, Sri Lanka, Sudan and Uganda (see figure 7-4).

Figure 7-4. Map of countries where child soldiers (boys and girls) are recruited



Source: Save the Children.

Prostitution

In conflict situations, sex often becomes a strategy for survival. Men abandon their families, voluntarily or under coercion, to join the army, leaving women in charge of maintaining the home. Lack of educational

preparation and financial vulnerability make women and girls easy prey to the sex trade in order to support their families.

A similar effect is seen with natural disasters, which destroy the usual means of financial and family upkeep. The cyclone that lashed the Indian region of Orissa in October 1999 destroyed the crops and led to the death of 800,000 head of cattle, similar to the damage caused by Hurricane Mitch in Honduras one year earlier. In these circumstances, the population relies on national or international aid to survive, or on such money as they can obtain in whatever way they can.

Prostitution can become a way of obtaining food or primary goods, since there are also usually long queues for aid hand-outs and many women with small children simply cannot join them.

The sex trade emerges around settlement areas of refugees or displaced persons, as demonstrated by a study of the World Health Organization (WHO). In 1999, in the east and north of Sudan, 27% of single mothers had entered sex trafficking networks in order to be able to maintain their family and children. In the camps of Tanzania, 25% of adults had had sex with a new partner since arriving there.

In the bars close to the refugee camps the sale of unprotected sex proliferates, together with consumption of alcohol and other kinds of risky practices.

The refugee camps are moreover a sort of "no-man's land" in which host countries do no feel obliged to set up AIDS control programmes. However, preventive efforts at local level have produced positive results, and could be extrapolated to conflict zones in which prostitution proliferates.

In Abidjan, Côte d'Ivoire, the prevalence of HIV among sex workers attending one clinic fell from 89% to 32% between 1991 and 1998. The use of condoms increased from 20% to 78% in the same period.

The disintegration of the community and the severing of family ties is a traumatic experience, especially for young and adolescent women who, without protection, guidance or support from adults, seek to join another social unit, and this can lead to them starting to have sexual relations at ever younger ages.

Displaced populations tend to include a proportionally very large number of solitary young people, especially women.

According to UNHCR data, about 75% of refugees worldwide are women and children, and its report for 1992 recorded an increase in the number of pregnancies among adolescents and in the number of abortions in conflict contexts.

A study carried out by a Norwegian NGO in the refugee camps of Tanzania, in 1999, found that children were starting their sexual life as early as ten years old. The most serious aspect was their sexual practices, which included unprotected sex, frequent exchange of partners and sexual relations in exchange for gifts.

GREATER VULNERABILITY AS REFUGEES. FOUR COUNTRIES, FOUR EXAMPLES

For female refugees, equal access to food and other articles distributed in the camps is of the essence. The leading cause of mortality in the refugee camps is malnutrition. The lack of food in itself causes death and contributes considerably to deaths caused by various diseases. Malnourished people are more vulnerable to disease, and recovery is impeded.

Undernourished pregnant or lactating women cannot give their children enough food to survive. Apart from that, people who lack basic necessities such as shelter, clothing and cooking utensils are more exposed to diseases.

The matter of how to distribute food and other supplies is usually decided by the international organisations and the host countries, together with the camp leaders (who are men). Generally little account is taken of the needs of women, who are the ones that have to cook and feed and clothe their families. Distribution is seldom appropriate.

Sometimes the food provided is not in accordance with the refugees' eating traditions, or it requires preparation that is difficult to carry out in the camp's facilities. Added to these problems are certain traditional practices in some refugee populations whereby men are fed first. If there is a food shortage, women and children may not get enough to eat, and be the first to suffer the consequences.

The fact that food distribution is controlled by men clearly goes against the traditional practice whereby women play the main part in food production: according to World Bank reports, in developing countries women grow 70% of the food. Although the system varies somewhat from one region to another, in developing countries women traditionally take charge of raising animals, storing food, selling and exchanging products and preparing and cooking food.

In Africa it is often the women who do all the farm work, whereas in Asia it is more usual for these tasks to be carried out jointly by both husband and wife. In Latin America, women usually take care of the crops when their husbands go to the cities in search of work to supplement their farming.

In some cases, food distributed through men has been handed to the resistance forces or sold on the black market, to the detriment of women and children. In other cases food has been used as a weapon, cutting off distribution to the civilian population. And in many other cases the men entrusted with distributing food and other articles have demanded sexual favours from the women in exchange for the food and articles given as aid.

Women refugees' access to healthcare services is important both for their own health and for the welfare of the community as a whole. It is also usually women that provide healthcare to the other family members. For this reason, the health of the other family members will depend directly on the mother's knowledge and interest in promoting a healthy environment and taking preventive measures against diseases.

Health services also play an important role in protection, identifying protection problems that arise in the refugee camps or any other place of settlement. The health personnel become aware of protection problems when women who have been sexually abused or hurt in other ways seek medical attention. Community health workers usually visit the homes of refugee communities and may, in the course of their work, become aware of specific problems, although few of them have been trained to deal with them.

Inappropriate and hard-to-reach healthcare services are further possible obstacles to women refugees' good health and that of their families. The lack of female healthcare personnel has been one of the main barriers to healthcare, especially in places where cultural values prevent a woman being seen by a man other than a close family member.

Another problem relates to the types of service offered. All too often health services today fail to take account of the specific needs of women. For example, gynaecological services are frequently inadequate, as are contraception advice services. The basic necessities are overlooked, such as suitable sanitary pads and washing facilities for menstruating women. Serious problems continue to be detected, such as infections and cervical cancer, and also harmful practices such as female genital mutilation. Advice given to both men and women on sexually transmitted diseases is generally inadequate. There are few, if any, programmes focusing on the needs of adolescent girls, despite the fact that premature marriage and pregnancy is one of the known causes of poor health.

In this section we shall look briefly at four archetypal examples, in four countries, which combine all the deplorable circumstances that women go through regarding violence, discrimination, the lack of access to healthcare and the absence of the most basic and elementary rights: Somalia, Haiti, Congo and Sierra Leone.

Somalia

The typical representative of the refugees fleeing the drought and armed conflict of Somalia and pouring into the Kenyan camp of Dadaab, considered the biggest in the world, is a young woman from the South of Somalia, aged about twenty, with three children to look after

The absence of men makes women more vulnerable. According to the NGO Care International, cases of rape –during the long journey to Dadaab– and sexual violence against refugees quadrupled compared with 2010, with 358 cases reported in the first half of 2011[24].

Women suffer violence, discrimination and illness to a much greater degree simply because they are women. A recent example: Somali refugee women and girls in Kenya are at serious risk of sexual violence, with more than 300 cases of rape so far this year in and around the refugee camps.

As well as obtaining food for their children, women in the refugee camps also face a struggle to get food for themselves and to receive sexual and reproductive care.

Care International reported in 2011 that the number of sexual assaults in Kenya's Dadaab camp, which was bursting with refugees from famine in Somalia, had shot up from the 75 cases reported between January and July 2010, to 358 in the same period of 2011.

This camp was originally built in 1991 to accommodate 90,000 refugees, but it currently houses more than 460,000. The workers and volunteers working there warn that the women and girls are more vulnerable to violence, whether in their way to the camps or inside them.

Recent arrivals living on the outskirts, where security is not assured, are even more vulnerable[25]. A survey carried out in July by the ICRC found that victims of sexual violence tend to be reluctant to report it, out of shame or fear that their families will blame them, or that their communities will consider them "not marriageable".

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[24] *Horn of Africa Drought: Reported cases of sexual violence have quadrupled among refugees*. Dadaab, Kenya, 12 July 2011.
[25] ICRC Report. July 2011

Participants in the survey identified sexual violence and rape as the main preoccupation of women and girls fleeing from Somalia. There have been reports of women and girls being raped in front of their husbands or family members by armed men.

Last year the United Nations, with the data in hand, started handing out sexual and reproductive health toolkits to rape victims through the health services in the camp. Women and girls reporting sexual violence are given psychological support, guidance, tests for HIV and other sexually transmitted diseases, pregnancy tests and treatment for any infection. In the registration centres, reference systems have been put in place for new arrivals reporting sexual violence so that they can get help from the medical centres. An added problem is that the lack of information regarding how to act following a sexual assault puts victims' health at risk of lesions, infections and unwanted pregnancies.

Women who are alone in the refugee camps find themselves in the impossible situation of not being able to feed themselves so as to prevent their children dying of hunger.

The role of women is fundamental in the fight against hunger. This is acknowledged by the FAO:

- Women produce more than half of all the world's food and invest a much larger portion of their income than men do in obtaining food for the family.
- In rural areas, women produce more than 80% of the food consumed at home. Therefore in situations such as droughts or armed conflicts in which women cannot provide food, the reduction in the supply of food to the household is dramatic, and there is not enough for the family to survive.
- In the refugee and displaced persons camps of the Horn of Africa, the groups worst affected by food shortages are women and children. In the displaced persons camps of Somalia, where there are serious difficulties in gaining access to food, most of the occupants are women and children, since the men tend to stay in their places of origin, controlled by the militias opposed to the government, for fear of being accused by the government authorities of being members of the militias. Women find themselves obliged to cover great distances alone with their children, without food, water or medicines before reaching the refugee or displaced persons camps.

The case of Haiti

Although Haiti is not at war, we should devote a few paragraphs to the country that is considered the poorest in the world, where the daily life of women is not very different from that of women in countries at war.

The difficult situation that Haitian women have lived through since the earthquake was discussed at the 54th meeting of the Commission on the Status of Women (CSW), held at the UN in March 2010. The situation for Haitian women was already difficult before the earthquake. Over a 15- year period women suffered systematic violence based on sexual abuse and systematic rape used to repress and terrorise the population. According to *The Lancet*, between 2004 and 2006 alone, nearly 35,000 women and girls suffered some form of sexual violence at the hands of the military, paramilitary and members of the FRAPH (Front for the Advancement and Progress of Haiti). Half the victims were minors.

An added problem faced by Haitian women in the context of sexual violence and discrimination is that 42% of Haitian families are headed by women.

The magnitude-7 earthquake that struck Haiti on 12 January 2010 and the aftershocks reduced the homes of more than a million people to rubble, along with the prime minister's residence and the UN building. In the space of a few hours all those buildings were turned into a 20 million m3 mountain of rubble. Two years on, the debris is still there in many parts of Haiti; impeding reconstruction, blocking drains, paths and streets; hampering necessary and urgent sanitation and drinking water projects and the development of sexual and reproductive health and maternal and childcare programmes.

This rubble is home to animals and insects and a store of dirt and faecal waste, all of which are paths of transmission for numerous diseases. And there are no doubt still thousands of dead bodies buried by it. According to some estimates, some 50,000 bodies were never recovered. Before the earthquake, only 12% of the population of Haiti had drinking water, and only 17% lived in adequate hygienic conditions, according to the Centre for Disease Control and Prevention (CDC) and the Pan American Health Organization (PAHO). As a result of the earthquake, the situation deteriorated. Many people have to drink untreated water that may be contaminated by sewage, since the drainage and water supply infrastructure was destroyed in the earthquake and, two years later, much of it has yet to be repaired.

With the devastating earthquake that destroyed the country's structures, the situation deteriorated for Haitian women, especially for the young and the pregnant. The situation as regards reproductive health in Haiti was already serious before the earthquake. The country had the highest rates of maternal mortality by far of all the countries in the region, with a maternal mortality of 670 per 100,000 births (UNFPA). At the time of the earthquake, it is estimated that there were 63,000 pregnant women in the country. Following the destruction of the health structures and the demands of the hundreds of thousands of people affected, the outlook faced by pregnant Haitian women was horrific.

The Haitian emergency is a complex one, with an interminable history of conflicts and violence, exacerbated by the consequences of the earthquake which, even now, two years on from the disaster, has improved very little.

Democratic Republic of the Congo

The Democratic Republic of the Congo has been called the worst place in the world in which to be a woman. Is this an exaggeration? According to the *American Journal of Public Health* the number of rape victims in the Democratic Republic of the Congo is equivalent to one rape every 48 hours, which means 400,000 a year.

The Democratic Republic of the Congo, a nation of 70 million people, similar in size to the whole of Europe, has suffered decades of war and internal conflict. Its forests are plagued by militias, refugees and combatants from different countries. And all have used systematic rape to destroy the cohesion of communities.

A woman in the Democratic Republic of the Congo has a 58-times bigger probability of being raped than a woman in the United States, where the annual rate is 0.5 per 1,000 women. The highest rate of rape is in the Kivo region, in the North of the country.

The results, published in the *American Journal of Public Health*, were extrapolated from a survey conducted in 2007 among 10,000 women aged between 15 and 49.

The research concluded that sexual violence extended beyond the areas of conflict in the East of the country. Sexual violence against women in the Democratic Republic of the Congo is worse than the figures considered by the United Nations, which put the number of women victims of sexual violence at 16,000: as much as 26 times worse, according to surveys and research carried out by other organisations.

The humanitarian organisation Médecins Sans Frontières (MSF) reported that more than a third of the 7,400 cases of rape attended to by its aid workers in the Bon Marché hospital in Bunia, capital of the strife-torn Congolese district of Ituri, were recorded in the past 18 months.

In Panzi hospital, in Bukavu, they have to attend to about ten women a day, many of whom need surgery to repair wounds and lesions suffered in brutal rapes.

Sierra Leone

Taking into account the abuse committed by the rebels, women have suffered, generally and systematically, rape, sex slavery and other forms of violence.

In many cases they were forced to become sex companions or wives of combatants. As well as the brutality of rape itself, and the trauma it causes, sexual assault can also lead to serious physical injuries, unwanted pregnancies, diseases and sometimes death. The rebel forces sowed terror among civilians, even, as mentioned earlier, going so far as to force men to rape the women of their own families under the threat of mutilation.

As for the girls, their experience with the rebels usually started with being raped in front of all those present. Ten-year-old girls were forced to have sex every day with anyone demanding it. So when they were freed, they presented deep traumas, and the older ones were mostly pregnant, as a result of which they were frequently rejected by their husbands.

Furthermore, and focusing on the most recent situation of women, it has to be mentioned that because of their financial dependency, they are not able to decide for themselves. They cannot attend healthcare centres to ask for family planning services, pre-natal services, care during childbirth or emergency treatment. Few women exercise their right to decide the number of children, the intervals between them or the time of birth. They have little or no ability to decide whether to have sexual relations, and the use of contraceptives is very limited.

A large proportion of deaths deriving from maternity occur in Sierra Leone and are related to the high cost of medical attention and the delays, whether in transfers to health centres or in the treatment they receive there. This situation is a consequence of, among other things, a serious lack of facilities and human resources. The number of qualified and available human resources and the amount of basic equipment are small compared with the needs of the existing health facilities, especially in rural areas.

The terrible tragedy of maternal deaths is explained in part by the high level of discrimination against women in Sierra Leone and their low social status. It is a country in which girls are obliged to marry at a very early age, excluded from schools and exposed to sexual violence. Their families, community leaders and the government attach very little importance to women's health needs. Added to these cultural reasons are structural ones. The problems facing Sierra Leone in treating newborn babies, especially premature or underweight babies, are due mainly to the lack of ambulance services and the scarcity of basic resources such as water, electricity and communications systems for medical referrals.

Women continue to suffer generalised discrimination and violence, as well as a lack of access to justice. Very little progress was made in reforming draft acts relating to marriage, inheritance and sexual offences. At the end of 2006 bills had still to been presented to Parliament for approval.

Legislation on violence in the home is still in the process of being drawn up. A provisional report on the implementation of the Convention on the Elimination of Discrimination against Women was postponed to 2007. In the informal system of justice, local chieftains and judicial officers often handed down sentences and rulings in cases that were not within their jurisdiction. The government made no significant efforts to bring an end to the practices of the local chieftains, who imposed fines on women or imprisoned them illegally, based on their interpretation of common law, in which the status of women in society is comparable to that of minors.

WOMEN AID WORKERS

In these pages we have described various situations and states of women in conflicts, always as victims or as part of a vulnerable population, but we have not touched on another particularly important aspect in discussing armed conflicts or wars in relation to women, and that is the role of women as aid workers.

Almost two decades have now passed since the Rwanda massacres (1994), and I am still astonished when I recall how little sensitivity there then was, to put it kindly, in the world of aid towards aspects such as the sexual and reproductive health of female refugees and displaced persons, or even aid workers.

I still remember the sight, through the smoke of the bonfires in those gigantic refugee camps of Goma, where hundreds of thousands of people huddled together, of the lights of the brothels where sex was practiced without any kind of precautions. I also remember the testimonies and stories of women and adolescent girls, practically children, who traded sex for food. And the frequent sexual assaults and rape of employees of the humanitarian organisations or girls by the soldiers, militia men and even occupants of the refugee camp itself.

We warned then of the need to develop HIV/AIDS prevention programmes, but we were denied financing on the pretext that priorities then lay elsewhere. Later on, time would prove us right[26]. In those years the newspapers talked above all of cholera, hunger, malnutrition of children, or the presence of perpetrators of genocide among the Rwandan refugees. Women's health, or the geometric

[26] The prevalence of HIV in persons claiming to have spent the years of conflict in refugee camps was 8.5%. Most of these people had fled the rural zones in which the prevalence of HIV before the conflict was only 1.3%. This suggests a six-fold increase in infection with HIV among the people of the refugee camps. It is likely that overcrowding, violence, rape, desperation and the need for women to sell themselves or submit sexually in order to survive contributed to producing this enormous increase in infection rates. *Global summary of the HIV/AIDS epidemic. December 1998.* UNAIDS

spread of the AIDS virus, were not considered important[27]. Conditions in the Goma refugee camp–the world's biggest, with more than 500,000 people crowded together in sub-human conditions– were so horrific that the priority was to save lives[28].

Every day we saw men going into those brothels built precariously from four planks of wood and some plastic sheeting. Every day we saw in consultation women with sexually transmitted infections or, probably, AIDS, although we did not have the equipment with which to test for it. Kigali was one of the zones with the highest rates of HIV/AIDS in Africa. Many other women arrived with signs of having been assaulted.

In Goma, among those tens of thousands of improvised homes of poles and plastic, hundreds of women went to bed each night having hardly been able to obtain any food to sustain their children. Hundreds of women, alone or at the head of a family, woke each day with a single thought in their heads: how to survive and ensure their children survived. In those circumstances, almost the only way out was to trade sex for food.

Incomprehensibly, in spite of what we were witnessing *in situ*, the United Nations organisations that were working in the Rwandan refugee camps located in the DR Congo discontinued the distribution of condoms, the only weapon we had with which to fight the spread of HIV/AIDS. The excuse was "they don't use them"[29].

[27] The world's biggest refugee camp is now just a huge rubbish dump, with skeletons of huts, plastic sheets flapping in the wind, a few corpses, wedding photographs lost in sudden flight, torn identity cards, hurriedly discarded uniforms and a military train stuck forever in no-mans land: Thursday, on the Mugunga road, 15 kilometres to the West of Goma, in the DR Congo province of North Kivu, saw the utter defeat of all that was left of the former Hutu *army* and the fearsome *Interahamwe*, the militias which for the past two years had terrorised hundreds of thousands of refugees to prevent their returning to Rwanda. The defeat of the jailers, who fled headlong with a last shield of just over 100,000 people, opened the floodgates to one of the biggest migrations in modern history. The last battle of the Rwandan genocides. Alfonso ARMADA. *El País*, 18 Nov. 1996.

[28] The flight of 500,000-800,000 Rwandan refugees into the North Kivu region of DR Congo (Zaire as it then was) in July 1994 overwhelmed the world's response capacity. During the first month after the influx, almost 50,000 refugees died, an average crude mortality rate of 20-35 per 10,000 per day. This death rate was associated with explosive epidemics of diarrhoeal disease caused by Vibrio cholerae 01 and Shigella dysenteriae type 1, 3-4 weeks after the influx of refugees, acute malnutrition rates among children under 5 years old ranged between 18 and 23%. Children with a recent history of dysentery and those in households headed by women were at higher risk of malnutrition. A well-coordinated relief programme, based on rapidly acquired health data and effective interventions, was associated with a steep decline in death rates to between 5 and 8 per 10,000 per day by the second month of the crisis. «Public health impact of Rwandan refugee crisis: what happened in Goma, Zaire, in July, 1994?». *The Lancet*Volume 345, Issue 8946, pp. 339-344, 11 February 1995

[29] *The UN humanitarian organisations have discontinued the distribution of condoms in the Rwandan refugee camps in Zaire, according to sources in the United Nations High Commission for Refugees (UNHCR).* The sources, who asked to remain anonymous, cannot

The Rwandan massacres have left many women as heads of families. Following the return of the millions of refugees, 45,000 households in Rwanda were found to be headed by children. 90% of them girls[30].

A lack of sensitivity

In those years, what little awareness there was as regards sexual and reproductive health and the problems more specific to female refugees as women –greater vulnerability, high frequency of sexual or physical abuse, worse conditions of general health, etc. – was to be found with the first women aid workers, then a minority, or fulfilling secondary roles. The surgical teams were formed mainly by men, with women doing the nursing. That's how the aid organisations were.

However, those few women were able to detect previously unknown needs, perhaps due to greater sensitivity, perhaps because they had a better understanding of the vulnerability, defencelessness and inequality of a refugee mother on her own. The role of the nurse requires a more personalised treatment of the patient, and part of a nurse's work is to listen, especially to other women, whether through affinity or sensitivity. In an emergency surgical team the surgeon does not speak to the patient, and particularly not in such circumstances.

In many cultures, moreover, it was not socially acceptable for a woman to tell a male doctor about certain problems, whereas it was acceptable to tell a woman doctor nurse.

Thus horrifying data started to be collected about the violence perpetrated against women during the Rwandan genocide, hidden beneath the mountain of corpses we saw every day on television. Rwanda was associated with "machete" in the collective imagination, that tool/weapon whose blade cut short so many lives.

But in addition to the deaths, behind those heaps of corpses there were yet more horrors: in the Rwandan genocide of 1994 it is estimated that between 250,000 and 500,000 women and girls were raped. In a study carried out by AVEGA, of women raped during the genocide, 67% of those surveyed had contracted HIV/AIDS[31]. But all these data came to light later.

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understand the decision, since the risk of the spread of AIDS in the camps is vey high. Since last September only one consignment of 1,080,000 condoms has reached the camps. "It would be a tragic paradox to save thousands of people from starvation by means of massive relief operations and not to do anything to prevent the spread of AIDS." they said. According to WHO data, before the Rwandan war, in the capital Kigali alone, between 50% and 70% of patients with venereal diseases, and 33% of pregnant women, were seropositive. Between 40% and 60% of the Rwandan army was infected with the AIDS virus. *El País*. 27 February 1995.

[30] "The World of Refugee Women at a Glance", UNHCR Report: *The Lost Girls of Sudan* (2002).

[31] Global Coalition on Women and AIDS. *Sexual violence in conflict settings and the risk of HIV/AIDS*. Global Coalition on Women and AIDS, 2004.

In those years many women aid workers suffered *shock*, depression, burn-out *syndrome* and even post-traumatic stress disorder (PTSD) after first hand encounters with victims or witnessing the horrors themselves.

In those years, little account was taken of the needs of aid workers, male or female, nor were there any mental health programmes for men or women working on humanitarian or aid projects. Aid workers were recruited from one day to the next and sent to Rwanda or to the former Yugoslavia with little more than perfunctory information on what they would find there or the work they were going to do. Needless to say, nothing specific about women.

When the first cases of stress appeared, with their consequences for the mental health of humanitarian workers of both sexes, organisations had to start taking notice of the risks that such work involves to the mental health of those doing it[32].

What about the women aid workers?

Humanitarian aid workers are exposed to many sources of stress, among them the following: the difficulties of a context of hardship and violence, contact with people's suffering, the dilemmas inherent in humanitarian work, constant self-criticism, deficient command and internal communication structures in their organisations, and high personnel turnover. This chronic exposure to stress also occurs in a context in which many of the usual psychological and affective support mechanisms such as family, partner and friends, are lacking. In many cases, and of particular importance for women, that of children.

Exhaustion or fatigue (commonly referred to as *burn-out*) is probably the commonest result of cumulative stress[33]. This type of disorder, which usually starts gradually, is characterised by the following symptoms: fatigue, emotional and physical exhaustion, difficulty sleeping, non-specific physical symptoms –such as headaches or gastrointestinal problems–, irritability, anxiety, depression, sensations of guilt and impotence, aggressiveness, apathy,

[32] "My first assignment as a volunteer was in 1994 in Burundi, a crisis symmetrical crisis to that of Rwanda. For nearly two years I was working in the Great Lakes region. I had just turned 30 and I faced some very intense medical and human situations, which has stood me in good stead, because everything I saw after that seemed less horrific Psychologists working on this have discovered a syndrome of "*aid worker* burn-out", in those involved in emergencies, which is well defined. There are some defence procedures which consist in trying to distance oneself from the source of emotion, since one is living through situations of war, post-war, meeting orphans, widows or a tragedy such as AIDS. I've been in some pretty stressful situations, but I took *breaks*, I tried to create a distance. I've known people who, being of a more sensitive nature, have broken down and had to leave a project because they were about to go crazy." Miguel Ángel Ramón TOUS, doctor. He worked with Doctors of the World in the Great Lakes region. Testimony posted on the Doctors of the World website: www.doctorsoftheworld.org

[33] SALAMA, P. (1999), "The Psychological Health of Relief Workers: Some Practical Suggestions". In *Relief and Rehabilitation Network Newsletter*, n.º 9, ODI, London

cynicism, substance abuse, difficulty communicating and distancing from the situations and beneficiary population[34].

Women aid workers are also more vulnerable if they do not have adequate sexual and reproductive health resources available and on top of that must live with the risk of being assaulted, raped or abducted.

Women aid workers also have to cope with a certain male-chauvinistic paternalism, perhaps not deliberate and to some extent understandable, when carrying out their work in "hot" zones. Casting my mind back, I still recall with a certain trepidation when, as president of Doctors of the World, in the heat of the war of the former Yugoslavia, I had to sit down and negotiate around a table with four huge Croatian militia commanders who were armed to the teeth, and I as the only woman, unarmed, for them to allow us access to the people who were in need of medical attention.

At that time there were very few women involved in aid work from positions of responsibility and with the power to make decisions. Florence Nightingale was apparently long forgotten[35], but we women had to continue breaking glass ceilings, as in every activity and at every stage of our lives. The first Doctors of the World aid worker to die in the field, when I was chairing the organisation, was indeed a woman, Mercedes Navarro: administrator of the Doctors of the World project in Mostar. She was assassinated by a man who burst into the office of Doctors of the World in May 1995 brandishing a machine gun[36].

[34] STEARNS, S. D. (1993). "Psychological Distress and Relief Work: Who Help the Helpers?". In *Refugee Programme News*, n.º 15, September.

[35] Florence Nightingale rose to fame for nursing the sick and wounded during the Crimean War (1854–56). After the war, she might have taken a high-profile post as a hospital matron and superintendent of nurse training. Instead, she retired from public life to use her influence to campaign and promote educational schemes. Her impact was probably greater for choosing to influence policy rather than exercising power. Florence Nightingale wrote 200 books, reports and pamphlets after the Crimean War, which had a profound effect on army health, welfare in India, civil hospitals, medical statistics and nursing. Her greatest educational contributions were in the establishment of new institutions for the training of army doctors and hospital nurses, but some of her lesser-known educational schemes are illuminating. *Prospects. Quarterly Review of Comparative Education* (Paris. UNESCO: International Bureau of Education, vol. XXVIII, n.º 1, March 1998, pp. 173-189.

[36] "Spanish aid worker assassinated in Mostar. Spanish aid worker Mercedes Navarro Rodríguez, age 37, coordinator for Doctors of the World in Mostar, was killed yesterday, and her compatriot psychiatrist Alberto Fernández Liria, age 40, a member of the same non-governmental organisation, was seriously wounded when they were machine-gunned in their office in the capital of Herzegovina by an individual who then committed suicide. This is the first death of a Spanish aid worker in the former Yugoslavia. Navarro had been in Bosnia only since 27 April. The incident happened mid-afternoon, when a resident of the street in which Doctors of the World has its office charged into the building with a machine gun and opened fire. Mercedes Navarro died instantly, and Fernández was hit in the leg. He was operated on in a hospital in the West of Mostar, where his condition was described as serious." *El País*, 30 May 1995.

Since then, other women have died or been abducted while working on emergency or development projects. Blanca Thiebaut and Montserrat Serra, abducted in October last year in Kenya while working for Médecins sans Frontières, and Ainhoa Fernández, abducted in Tindouf, also last October, together with two colleagues. Before that, another aid worker with Doctors of the World, nurse Flors Sirera, was murdered in Rwanda in 1997, together with two colleagues –a logistician and a doctor– while working on a project designed to help the population returning from the Hutu *refugee camps*.

At this stage of history women have now occupied posts at every level of aid work, and even on the scale of victims of war-related violence. In fact, as in many other professions, we are now a majority: according to data of the Spanish International Co-operation Agency in 2009, 70% of aid workers were women. However, 70% of the management positions in the organisations for which these women work are occupied by men. Given this situation it is not surprising that even today it is difficult to get the people in charge of some NGOs to understand not just the needs of women refugees or aid recipients but those of the women who are going to work on the ground.

We will keep trying.

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