Susan Forbes Martin
John Tirman
Editors

Women, Migration, and Conflict

Breaking a Deadly Cycle

Springer

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ISBN 978-90-481-2824-2 e-ISBN 978-90-481-2825-9
DOI 10.1007/978-90-481-2825-9
Springer Dordrecht Heidelberg London New York

Library of Congress Control Number: 2009930473

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Printed on acid-free paper

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Preface

An estimated 32 million people worldwide are displaced mainly by conflict, and some 75% of those are women and children (UNHCR, June 2008).[1] During the time away from their homes and communities – often many years – women and their children are subjected to a horrifying array of misfortune, including privations of every kind, sexual assaults, disease, imprisonment, unwanted pregnancies, severe psychological trauma, and upon return or resettlement, social opprobrium and isolation.

These consequences, among others, are poorly addressed by the international community. Few agencies are equipped to handle the multifaceted needs and problems of women displaced by war, and even the legal protections are not in place. Women are caught in a nether world of inadequate attention, resources, and protections. They are victims of the worse kinds of predation, virtually without a voice or standing. Many women in these situations have shown remarkable ingenuity, strength, and courage in devising strategies to cope, to earn money, to educate their children, to return to their homes, and so on, but their experiences are typically a constant struggle for security, for resources, and indeed for hope.

Only recently has field research even attempted to describe and analyze these predicaments, and fewer still prescribe solutions. This volume brings the recent and authoritative field research to the fore to analyze the most pressing dimensions of the problems and to prescribe actions for the international community that are both timely and feasible. The volume adds a uniquely in-depth treatment – scholarly and practical – to the literature.

These contributions are designed to be intellectually rigorous and useful because they were commissioned to be such by the Women, Peace, and Security Committee of the United Nations Population Fund (UNFPA). Sahir Abdul-Hadi, Technical Adviser at UNFPA, requested the MIT Center for International Studies and the Inter-University Committee on International Migration,[2] which MIT hosts, to convene scholars who had undertaken field research in vital areas of concern with respect to women, migration, and conflict. The topics we agreed to explore, among many possibilities, included livelihoods, sexual violence, reproductive health, legal status, shelter, mental health, and HIV/AIDS. With Ms. Abdul-Hadi, I worked within the community of scholars of the Inter-University Committee's network to recruit what became a remarkable group of top scholars, all of whom have extensive experience

with field research and consultancies to international organizations, aid agencies, and NGOs.

To head the intellectual effort I asked the distinguished scholar and practitioner, Susan Forbes Martin, to undertake the strategy paper and worked with her to organize the project generally. We convened the group at MIT in February 2007 with Ms. Abdul-Hadi and several of her colleagues and proceeded with the writing of the papers, which were designed to integrate state-of-the-art knowledge about each of these topics, drawing on the authors' own experience and research as well. The initial phase of the project concluded with a workshop for UNFPA field staff and other partners in Tunisia in June 2007, at which the scholars presented and interacted with the UNFPA cohort (UNFPA, 2007).[3]

As was discussed at that conference and by Ms. Abdul-Hadi in her contribution to this volume, the U.N. is now undertaking a broad revision of policy and practice to include women as both stakeholders and decision makers. It is enabled by the historic Security Council Resolution 1325, which "requires the inclusion of gendered perspectives and training in peacekeeping," said Sanam Anderlini, a consultant to the project, at the Tunisian meeting. "Woman and girls must be protected from sexual and gender-based violence in conflict," she added, and UNFPA's core missions – relating to reproductive health, HIV/AIDS prevention, women's empowerment and protection, et cetera – were both braced by 1325 and apply to the situations of women displaced by conflict. In this light, the areas covered in this volume are central to UNFPA's responsibilities as well as a growing interest in the U.N. community more broadly.

In conflict studies, this bundle of issues is also gaining, gradually, more attention. Until recently, "gender and conflict" scarcely registered in international relations theory and has been injected only recently in a kind of intellectual insurgency that comes from several directions – feminism, post-colonial studies, critical theory, development studies, and the human security paradigm. All of these discourses attempt to refocus attention on the interactions of communities, organizations, individuals, *and* states. Many gender-and-conflict analyses have nonetheless emerged from intellectual efforts outside the academy, such as the World Bank's studies that have focused on women's roles in war, as peacemakers, and in post-conflict reconstruction (Tsjeard et al., 2005; Anderlini, 2007; Moser and Clark, 2001).[4] More traditional approaches to security studies have a growing recognition that gender violence and forced displacement are weapons of war, intentional and effective in gaining and holding territory, terrorizing populations, and feeding nationalistic ideologies. But this recognition has not translated into a body of research that provides much policy guidance.

Migration scholars have been far quicker to a gender analysis, likely because the central role of women in all forms of migration has long been obvious, and perhaps because of the likelihood of more women scholars in fields like anthropology and sociology which have been a primary lens on migration. Initially, as with migration theory generally, the gender analysis framed women's roles in decisions to migrate, labor migration, and the like (Pedraza, 1991).[5] Forced migration came into sharper focus after the Cold War in part due to an upsurge in civil wars – some of them

involving large population displacements and gruesome sexual violence. This naturally led to the policy communities asking questions about the roles of women (Indra, 1999). Feminist and critical theory informs this research as well,[6] but on the whole the interest tends to reside in field-based research, practice, and policy, and is significantly lodged in development studies, anthropology, and independent research centers. Among the many contributions of the emerging discourse has been to see these issues as involving *gender*, not women only, but men and women (Pessar and Mahler, 2003; *International Migration Review,* 2002).

Like few other issues, forced migration studies have benefitted from the active intellectual interest of international organizations such as the World Bank and the U.N., which have helped to shape the underpinnings of this growing field. The Bank, as a primary actor in development, and the U.N., with principal responsibility for refugees and conflict, are highly motivated to understand more fully the precise scope of the problems, their dynamic interactions, and the impacts of interventions. The keen interest in "best practices" research is itself driven in part by a sharply critical literature on multilateral interventions that took the international community to task for sporadic commitment, ideological agendas, and inappropriate interactions with the people in greatest need, among other sins (Duffield, 2001; Terry, 2002). It is noteworthy, then, that many of these agencies have responded by demanding of themselves better interventions – more informed, more sensitive, more durable, and more comprehensive. That they attempt to do so while operating in situations of flux – sudden and massive movements of people, as from and within Iraq in 2004–2007 – and often in tandem with feckless governments, is all the more remarkable.

The Iraq case illustrates the enormous barriers practitioners face. Most reliable estimates calculate the number of war refugees (mostly in Lebanon, Syria, and Jordan) at 2 million, and internally displaced at 2.7 million. The refugees are not in camps and are difficult to reach to provide services. The internally displaced people (IDP) are particularly at risk, given the levels of violence and the deterioration of social services and health conditions. The United States alone will spend $1 trillion on operations in Iraq, and others will add many tens or hundreds of billions of dollars more. Yet, as a 2008 assessment by the Brookings Institution holds, humanitarian assistance for IDPs and refugees is only a small fraction of the need estimated by responsible agencies; the insecurity in Iraq prevents many agencies, public and private, from operating there; and armed militias were likely to assume responsibilities for social services. This means that other ethnic or sectarian groups could be excluded altogether from health care, education, emergency food assistance, resettlement, et cetera, and women's abilities to earn a living may be further impeded by social disintegration or religious extremism. The known situation for women and children generally, but particularly for the displaced, is reported to be dire: there are 1–2 million widows, many in extreme poverty; fewer than 30% of children are in school; and 10% of displaced have either suffered rape or witnessed a family member being raped (Ferris, 2008; Kami, 2008).[7]

These kinds of statistics, among others, are sobering in themselves but particularly so given the attention Iraq is getting. Chronic or acute crises of war and

displacement in central Africa, Southeast Asia, and elsewhere far from the view of the major powers receive even less attention, and thus the challenges for women and children displaced in the many conflicts besetting these regions are daunting.

Each chapter in this volume is cognizant of these problems, of course, but what is striking about what each addresses is the sheer effort underway in most of these situations to find solutions. This problem-solving approach informs the volume as well, both descriptively and analytically. While not every aspect of the multitude of challenges facing women in these situations is addressed in this volume, we did select what we believe to be the most urgent, those with the broadest impact, and those with relevance to UNFPA's mission. Assessing these efforts in a systematic way, we hope, will be of direct utility to policy makers at all levels, practitioners in the field, and other stakeholders.

The arguments forwarded in the following chapters apply in many instances more widely than the focus on women, migration, and conflict. The analysis obviously has broader gender applicability, but it also informs the needs of victims of natural disasters, the needs of women and children in conflict who have not been displaced, the response to social disintegration wrought by disease, and the need for new institutional sensitivities – such as legal protections – for categories of people affected by the "new wars" and vicissitudes of globalization.

It goes without saying that the responsibility for dealing with these many issues is not the U.N.'s alone. States involved in the conflicts, the major donor countries, regional organizations, multilateral security organizations, the large NGO humanitarian groups, the news media, and others are all by necessity players in any set of solutions. It is, in this light, all the more to UNFPA's credit for taking on this task of action research – further developing the best knowledge on this range of issues, bringing the knowledge to the people and organizations that deal with the issues in the field, and prompting our political and policy leaders to do better. That, in my view, is what social scientists should be doing and public servants should be seeking from them – an optimally creative and productive partnership, which, in our case, we hope and trust will provide actual results on the ground the world over.

Notes

1. The number could be higher. Current estimates hold that there are 11 million refugees worldwide, and 26 million conflict-induced internally displaced persons. These are within the U.N. High Commission for Refugees' purview – i.e., "people of concern" for whom the agency is responsible. Of populations that have been surveyed, half are women and 40% are children under 18, it is likely there is some overlap of girls under 18 and women. (UNHCR, June 2008).
2. The Inter-University Committee on International Migration includes MIT, Harvard University, Tufts University, Boston University, Brandeis University, and Wellesley College. Jennifer Leaning, one of the volume contributors, is a member of the committee which is chaired by Professor Reed Ueda and Professor Anna Hardman of Tufts, both of whom were helpful in this project, as was former chair Sharon Stanton Russell at MIT.
3. A good summary of this workshop was published by UNFPA, (UNFPA, 2007).
4. See for example (Tsjeard et al., 2005), which has a good bibliography. See also (Anderlini, 2007; Moser and Clark, 2001).

5. (Pedraza, 1991) is representative in this regard.
6. See (Pessar and Mahler, 2003) and the exceptionally helpful special edition on gender and migration in (International Migration Review, 2002).
7. On widows, see (Kami, 2008).

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Acknowledgments

We wish to thank our scholar/practitioners, of course, for their outstanding contributions to this project. Special thanks are due to Sahir Abdul-Hadi of UNFPA, who initiated this work, and Sanam Naraghi Anderlini, a research affiliate of the Center for International Studies, who worked with UNFPA and MIT to ensure the quality and success of the project. Several members of the Inter-University Committee on International Migration were helpful at several stages, especially Anna Hardman, Jennifer Leaning, Sharon Stanton Russell, and Reed Ueda.

I particularly thank Susan Forbes Martin, whose scholarship and leadership on this and many other projects have been exemplary. We thank the John D. and Catherine T. MacArthur Foundation for supporting this project, providing funds to enable us to transform the papers prepared for the conference in Tunisia into the chapters of this volume. A particular thank you goes to Jill Floyd at Georgetown University for her excellent editorial assistance. We are also grateful to Springer and especially Bernadette Deelen, for their support, confidence, and patience.

Cambridge, MA, USA John Tirman

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Acronyms

ADIMI	Association of Maya Ixil Women-New Dawn
AFRC	Armed Forces Revolutionary Council
AMIS	African Union Mission in Sudan
ART	Anti-retroviral therapy
CINEP	Center for Investigation and Popular Education
CPR	Contraceptive prevalence rate
ECHO	European Community Humanitarian Office
ECTF	European Community Task Force
GVB	Gender based violence
IASFM	International Association for the Study of Forced Migration
IAWG	Inter-agency Working Group (on Reproductive Health in Crisis Settings)
ICPD	International Conference on Population and Development
ICRC	International Committee of the Red Cross
ICTR	International Criminal Tribunals for Rwanda
ICTY	International Criminal Tribunals for the former Yugoslavia
IDP	Internally Displaced People/Person
IDU	Injection drug use
IEC	Information/education/communication
IHL	International Humanitarian Law
IRC	International Rescue Committee
IUD	Intrauterine device
LRC	Lord's Resistance Army
MFIs	Micro-finance institutions
MIP	Men Involved in Peace-building
MISP	Minimum Initial Services Package
MSF	Medecins Sans Frontieres
MSMs	Men who have sex with men
NGO	Non Governmental Organization
OAU	Organization of African Unity
PEP	Post-exposure prophylaxis
PHR	Physicians for Human Rights

PID	Pelvic inflammatory disease
PTSD	Post Traumatic Stress Disorder
RAISE	Reproductive Health Access, Information and Services in Emergencies
RH	Reproductive health
RHRC	Reproductive Health Response in Conflict
RUF	Revolutionary United Front
SARC	Sexual Assault Referral Centers
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TRC	Truth and Reconciliation Commission
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNAMID	United Nations-African Union Mission in Darfur
UNDP	United Nations Development Program
UNESCO	United Nations' Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WRI	Women's Rights International

Introduction

Susan F. Martin

Overview

By most estimates, 70–75% of the refugees and displaced persons uprooted by conflict are women and their dependent children (Martin 2004). Children account for about half of all refugees, with adult women often outnumbering adult men. This picture varies, however, by countries of origin and refuge. It is particularly true when persons are internally displaced or flee conflict in one developing country and take refuge in another, usually neighbouring country. It is also true of the victims of human trafficking. This distribution does not generally hold for asylum-seekers who seek admission to more developed countries in North America, Europe and Oceania. A higher proportion of male applicants can be found making their way to these more distant places.

Women who have been forced to flee from conflict present many challenges to the international community. Foremost are their special needs for legal and physical protection. Civilians are increasingly the targets of attacks in civil conflicts, with rape and sexual violence now a recognized war crime. Rape and sexual assault also occurs during flight at the hands of border guards, government and rebel military units, bandits and others. Women's safety may be no more ensured once in refugee and displaced persons camps. For example, refugee and displaced women have faced serious threat of rape when they pick firewood, often the only source of heating and cooking fuel. Refugee women have been forced to provide sexual favours in exchange for obtaining food rations for themselves and their families. In some cases, only male heads of households receive documentation of their status, leaving their spouses vulnerable to harassment each time they leave their homes.

As discussed by Martin and Callaway (Women, Conflict and Trafficking: Towards a Stronger Normative Framework for Protection), human traffickers prey on the physical and financial insecurity of those affected by conflict, deceiving or

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_1, © Springer Science+Business Media B.V. 2009

coercing them into sexual or labour exploitation. Decker et al. (Forced Prostitution and Trafficking for Sexual Exploitation among Women and Girls in Situations of Migration and Conflict: Review and Recommendations for Reproductive Health Care Personnel) conclude, "Migration and conflict confer unique vulnerabilities for trafficking and forced prostitution." They identify a number of factors, including conflict-induced poverty, changes in familial structures, and displacement itself.

Conflict precipitates direct forms of trafficking. Refugee and displaced children who are abducted or forcibly recruited as soldiers, for example, are also victims of trafficking, as are those who are coerced into forced labour or prostitution. A sudden increase in trafficking for sexual exploitation often occurs when peacekeeping forces are deployed in conflict zones. While one of the responsibilities of these troops may be to protect civilians, their use of brothels may contribute to both internal and international trafficking.

Such problems do not necessarily stop when the women return home. The conflict may still be continuing and, even if a peace agreement has been signed, political instability, the continued presence of landmines and the destruction of the economy and infrastructure make conditions dangerous for women and their families. Yet, refugee and displaced women are also an important resource for the development of post-conflict countries. They have often learned skills in refugee or displaced persons camps that are in short supply in their home communities. For example, many refugee health services train refugee women as community health and outreach workers and traditional birth attendants.

Some refugees are unable to return or to remain in countries of first asylum. Similarly, some internally displaced persons may find it impossible to remain where they initially take refuge and unable to return to their home communities. They may be candidates for resettlement to another country. Resettlement is generally considered to be the least desirable solution for refugees, and especially internally displaced persons, because it moves them far from their own countries and cultures. In many situations, however, resettlement is the best solution for the individuals and groups involved, particularly when needed to provide protection or durable solutions for refugees. Among potential candidates for resettlement are women at risk, particularly those who have experienced sexual violence and have been shunned as a result by families and members of their community.

Security Council Resolution 1325 on Women, Peace and Security recognized these special challenges facing women refugees and displaced persons in conflict settings. A principal aim of the resolution was to increase the protection of women in armed conflict, particularly in the prevention of and response to gender-based violence and sexual abuse. More specifically, as related to refugees and displaced persons, the resolution calls on all parties to the conflict to respect fully international law applicable to the rights and protection of women and girls as civilians, citing in particular the 1951 Refugee Convention (Security Council Resolution 1325, #9). It also calls on "all actors involved, when negotiating and implementing peace agreements, to adopt a gender perspective, including inter alia: (a) the special needs of women and girls during repatriation and resettlement and for rehabilitation, reintegration and post-conflict reconstruction…." (Security Council Resolution 1325, #8). Further, the resolution "calls upon all parties to armed conflict to respect the

civilian and humanitarian character of refugee camps and settlements, and to take into account the particular needs of women and girls, including in their design. . .” (Security Council Resolution 1325, #12).

This introduction begins with a broad discussion of the legal status of women forced to migrate because of or in the context of conflict, detailing three categories of forced migrants of concern to the international community: refugees, internally displaced persons and trafficking victims. It continues with a discussion of the life cycle of forced migration, to review the phases of potential intervention. It then discusses concerns and issues arising in the sectors of particular relevance to women displaced by conflict, summarizing some of the major points raised in the more detailed chapters to follow. This section focuses on livelihoods, health and reproductive health, sexual violence, mental health, trauma and resiliency, and shelter/settlement. Next comes a discussion of the role of the United Nations Population Fund (UNFPA) in addressing the challenges faced by refugee and displaced women in conflict settings. As described by John Tirman in the Preface, the chapters in this book were originally developed to advise UNFPA on how to ensure better implementation of Security Council Resolution 1325 as it relates to women displaced by conflict. It concludes with a brief introduction to the recommendations that emanate from the project.

Legal Norms Regarding Forced Migrants

As discussed more fully in Audrey Macklin’s chapter (Legal Aspects of Conflict-Induced Migration by Women), three principal groups of forced migrants have different, though overlapping, statuses based on existing international legal and normative frameworks – refugees, internally displaced persons and victims of human trafficking. Refugees have a special status in international law. A refugee is defined by the 1951 UN Convention Relating to the Status of Refugees as “a person who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.” (UN Convention Relating to the Status of Refugees). Refugee status has been applied more broadly, however, to include others persons who are outside their country of origin because of armed conflict, generalized violence, foreign aggression or other circumstances which have seriously disturbed public order, and who, therefore, require international protection. It should be noted that the status of Palestinian refugees is governed by a different set of UN provisions. The UN Relief and Works Administration for Palestine Refugees in the Near East (UNRWA) offers the following operational definition: “persons whose normal place of residence was Palestine between June 1946 and May 1948, who lost both their homes and means of livelihood as a result of the 1948 Arab-Israeli conflict.” The definition includes descendents. Unlike other refugees, the Palestinians retain their refugee status even if they take on the citizenship of another country.

There is no convention for internally displaced persons (IDPs) that is comparable to the Refugee Convention. Instead, the Guiding Principles on Internal Displacement, adopted by the United Nations to help inform States of the rights of the internally displaced and the obligations of States towards them, builds on existing international human rights and humanitarian instruments and, by analogy, refugee law. Internally displaced persons are described as "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border" (Guiding Principles on Internal Displacement).

As Macklin discusses, there are similarities and differences in the legal status of refugees and internally displaced persons:

> In the context of conflict induced migration, the trauma, experiences, and needs of IDPs may render them indistinguishable from refugees. However, two important differences warrant emphasis: First, the IDP definition encompasses a broader range of causal factors (e.g. development or disaster-induced displacement) than does the UN refugee definition (which is limited to persecution on grounds of race, religion, nationality, membership in a particular social group or political opinion). Secondly, the fact that IDPs have not crossed a border means that as citizens, they are legally entitled to the protection of their state of citizenship.

As she also discusses, the institutional arrangements for addressing the needs of refugees and IDPs have been quite distinct. The UN High Commissioner for Refugees has a clear and long-standing mandate to protect and assist refugees, deriving from its 1950 Statute and the 1951 UN Convention and its 1967 Protocol. By contrast, the international community's institutional arrangements for responding to situations of internal displacement are much newer and less well tested. At present, responses for humanitarian emergencies in general and internal displacement in particular are spread across a number of UN agencies – known as the collaborative approach. In 2005, the Emergency Relief Coordinator/Under-Secretary General for Humanitarian Affairs established a cluster system to define responsibilities under the collaborative approach. The UNHCR was assigned responsibility for coordinating efforts to ensure the protection of IDPs as well as the sectors of emergency shelter and camp management. UNFPA's role in the clusters is discussed in greater detail below.

As discussed above, trafficking in persons often accompanies and contributes to conflict. Human trafficking is defined in the Protocol to the UN Convention on Organized Crime as: "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" (Protocol To Prevent, Suppress And Punish Trafficking In Persons, Especially Women And Children, Supplementing The United Nations Convention Against Transnational Organized Crime). Trafficking victims may have been forced or deceived into moving within their own countries or across international borders for the purposes of

exploiting their labour. Those who are trafficked internationally may also qualify as refugees if they have a well-founded fear of persecution by the traffickers if their home government is unable or unwilling to provide protection against such retaliation. Similarly, internal trafficking victims may fit the description of internally displaced persons found in the Guiding Principles. As Martin and Callaway discuss in their chapter (Women, Conflict and Trafficking: Towards a Stronger Normative Framework for Protection), using a combination of international instruments may help to provide additional protection to women and girls who are trafficked in conflict.

The Life Cycle of Forced Migration

Forced migration is a process that begins before the movements themselves and, for the fortunate, ends with reintegration into one's home community or integration into a new one. In most conflict-related forced migration situations, there are early warning signs that people will be uprooted. Over time, the potential to withstand the trauma of conflict declines until little choice remains but to move to greater safety. Often, violence is not the only precipitator of migration. Loss of livelihoods, hunger, illness, forcible recruitment into military operations, and similar events are the proximate causes of flight. The decision to flee may be an individualized one; in many cases, it is made en masse as the conditions deteriorate for all or armed elements drive members of the community from their homes. Despite the early warning signs of forced migration, the international community is often surprised by the size and rapidity of movements. Translating early warnings into accurate projections of flight remains a challenge for policy makers and practitioners concerned with displacement.

Projecting the potential scale of forced migration is made all the more difficult because the timing, form and destination of flight vary considerably from case to case and family to family. Economics can have a powerful effect on the decision-making. Families with few resources may not have the wherewithal to leave at all or they may move only miles from their homes. Those with some resources may be able to flee to an urban area within their own country or cross into a neighboring country, while those who have still greater resources often have greater options and migrate to more developed countries. Theories as to the causes of migration posit that households make decisions on migration to hedge their bets against uncertainty. Some members of the household will stay behind to watch their property and try to maintain their crops and livestock, with others going into camps and still others seeking safety in more distant locations. Members of an extended family may pool their resources to send the most vulnerable and/or the most able away – the vulnerable to be protected and the able to find livelihoods in order to send money home to support the other members. In cases of forced recruitment, the vulnerable (those who are most likely to be recruited) and the able (those with the strength and resources to make them attractive subjects of recruitment) may be one and the same. Under these

scenarios, it is not surprising that asylum seekers in developed countries are more likely to be male and that a disproportionate number of women-headed households may be found in camp settings in developing countries. Moreover, women often report having had little opportunity to participate in the decisions about when and where to flee, moving when patriarchs within the family or community determine that they must relocate.

Following flight can be shorter or longer periods of displacement. Some well-publicized conflicts have come to an end quickly, leaving people displaced for relatively short periods. The majority of refugees and displaced persons, however, are in protracted situations. UNHCR estimates that "the average duration of major refugee situations, protracted or not, has increased: from 9 years in 1993 to 17 years in 2003" (Executive Committee of the UNHCR, 2004). Similar trends affect internally displaced persons. This means that many women and girls have grown up knowing no life other than one of uprootedness and displacement.

As can be seen in these figures, solutions to forced migration are elusive for many refugees and displaced persons. There are three classical solutions to these situations. The best solution is return in safety and dignity, preferably following resolution of the conflicts that forced the displacement to take place. Return is the preferred solution because it restores individuals and families to their lost communities and countries. All too often, though, return occurs under less desirable circumstances, before a full resolution of the conflict takes place. Even after the major fighting has ceased, there may be pockets of insecurity where violence remains. Landmines may not yet have been cleared. Infrastructure may not have been restored, and livelihoods may be lacking in areas destroyed by years of conflict. The rush to return may be self-selection – for example, to return in time for elections, or to ensure that property can be recovered before others claim it, or to find family members lost during flight. In many cases, the decision to return is highly restricted by the policies of the host country, which may determine that camps will close or aid will be cut off by a certain date. For many refugees, the life cycle of displacement continues in a different form after repatriation. They may be unwilling or unable to return to their home villages, particularly if insecurity and economic problems persist, and find themselves relocating to urban areas. At this point, their need for assistance and protection may resemble that of internally displaced persons.

When return is not an option, the second most desirable solution is integration into a new location in the host country (in the case of refugees) or the home country (in the case of internally displaced persons). Generally, local integration enables uprooted populations to remain in a familiar environment. Often, they have taken refuge in places with similar language and customs. Although integration was common in early periods, particularly in Africa, it is increasingly difficult to achieve today. Most host countries (and communities in case of internally displaced) see the forced migrants as burdens, not opportunities. Often, the numbers of persons concerned far exceed the capacity of the hosts to absorb the newcomers into their communities without substantial international assistance. Believing that aid is more likely to be forthcoming if refugees and displaced persons remain in camps, the host governments are unwilling to risk integration. Reluctance to integrate may also be

related to political aims. Integration may be seen as tantamount to recognition that the conflict will not end in a manner favorable to return. Particularly in the case of ethnic cleansing, governments may be unwilling to reify the results of the expulsions by offering permanent settlement in new locations.

Third country resettlement is the least used solution to displacement. Bringing refugees and displaced persons to distant lands which may have distinctly different economies, cultures and political systems is a difficult and expensive undertaking for all parties, including the forced migrants who must go through a second uprooting. Yet, in many cases, it is the only solution available for persons who would otherwise be at risk or who have no other options. Some resettlement programs give priority for women who have experienced rape or are at risk of sexual violence. These programs are small in number and sometimes have unintended consequences when they are the only route to resettlement. The author has witnessed situations in which women have separated from their families, thereby placing themselves in harm's way, because of their desperate wish to provide a better life for themselves and their children.

Identifying a solution is only the penultimate end of the life cycle of displacement. Full (re)integration takes much longer than the process of return or resettlement. While a refugee may cease to have formal legal status as such upon repatriation or resettlement, her needs as a refugee do not abruptly end. Access to shelter, livelihoods and services may be constrained by the prior experience of exile, and special security and protection needs may continue. Similarly, the end of internal displacement is a gradual process. Over time, if successful return or resettlement takes place, the refugee or displaced person's needs and opportunities should begin to resemble that of other residents and they cease to be of concern as a former forced migrant. This is not to say that they will not have significant needs for assistance and protection, but that these would be addressed through mainstream programs, rather than special initiatives related to displacement.

Sectoral Concerns and Issues

Using the life cycle view of migration, this book focuses on the key sectoral areas that arise in conflict situations affecting women.

Livelihoods

As Dale Buscher (Women, Work, and War) explains, "A livelihood is comprised of the capabilities, assets and activities required to live."[1] Conflict and displacement disrupt livelihoods. During conflict, households are often unable to continue their regular activities, whether in farming, trades, businesses, professions, or other sectors. Families may exhaust the coping strategies that allow them to continue to live at home, having sold their livestock and other belongings and borrowed to

the limit of their credit. This loss of the capacity for self-support often precipitates displacement, which further disrupts access to livelihoods, particularly if refugees and displaced persons have no access to land, employment or markets in which they can sell their products. Survival may then lead to longer-term dependency on humanitarian assistance or, if that assistance is not available, a range of negative coping strategies, including "illegal collection of natural resources such as firewood, the theft of crops and livestock, transactional sex, buying and selling arms and drugs, prostitution, and illegal employment outside of camps. (Buscher, 2007, p. 4)." Return home or integration in a new location may not mean that refugees and displaced persons regain their livelihoods. Damage to the economy, landmines, loss of infrastructure and continuing instability and insecurity may well render it difficult for them to find means of livelihood.

Limited access to livelihoods also creates vulnerability to trafficking, not only of refugees and displaced persons but others as well. The promises of traffickers about improved economic opportunities elsewhere are more believable and enticing in the absence of opportunities at home. In turn, trafficking victims experience further loss of traditional livelihoods, when they are coerced or deceived into exploitative activities. If they are able to leave the traffickers, the capacity to regain non-exploitative livelihoods may well be restricted, particularly if they face ostracism or discrimination at home or in a new location because of the activities (often sexual) in which they were forced to engage while trafficked.

Loss of livelihoods is gendered in its causes, forms and consequences. As Buscher explains, "men and women have different resources available to them in crisis situations, and will turn to different strategies for survival." (Buscher 2007) A livelihood is sustainable if it can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation.

Programs to promote livelihoods for refugee and displaced women must be carefully designed to ensure sustainability. Herein lies a dilemma: mainstreaming women into many livelihood programs faces barriers resulting from cultural norms about appropriate female activities as well as skills or educational deficits that may impede the ability of women to compete for slots; separating women into "culturally appropriate" activities may result in unsustainable livelihoods producing marginal income. Often, "culturally appropriate" translates into handicrafts, sewing or other projects that cannot produce sufficient income to support families. Women generally have to engage in multiple activities related to child, household and outside income-generating responsibilities. Diversification of livelihoods is often needed to minimize risk and allow women to engage in these multiple areas. As Buscher notes, "Most economically successful displaced women engage in multiple activities: gardening/crop production, raising animals, tailoring, petty trade, collecting firewood and wild fruits for selling, etc."

Similarly, programs designed to promote livelihoods must be multi-faceted. Buscher states, "A successful program is one that takes into account a myriad of issues – physical location, availability of natural resources and raw materials, access to markets, including transport, the condition of infrastructure, market demand, and

the impacts of cultural gender practices that either pose barriers to, or provide opportunities for, displaced women's livelihood strategies." They must overcome such barriers as lack of security for participants and inadequate services to help participants fulfill their childcare responsibilities. Addressing the livelihood needs of refugee and displaced men as well as residents of poor neighboring communities may be essential to preserving the security of the women involved in the livelihood activities.

Health and Reproductive Health

The health problems refugee and displaced women and children face are similar to those of other women and children in developing countries, but many of them are compounded by the experience of forced migration. A principal contributor to heightened mortality in humanitarian emergencies is malnutrition. Malnourished people are more susceptible to disease and are more difficult to cure of illnesses. Malnourished women who are pregnant or lactating are unable to provide sufficient nutrients to their children to enable them to survive. In addition to food problems, poor sanitation and contaminated water supplies contribute to high death rates in many refugee situations. Women who are forced to move can suffer from physical disabilities resulting from conflict and flight. They may be the victims of mine explosions, for example. Loss of limbs is not uncommon both in flight and during stays in camps.

Once the emergency phase is over, a leading cause of death among refugee and displaced women of childbearing age are complications from pregnancies. Lack of training of midwives and traditional birth attendants (TBA), septic abortions, unsanitary conditions during birth, septic instruments, poor lighting during deliveries, and frequency of pregnancies all lead to difficulties. Health complications also arise from female genital cutting, a practice in some parts of Africa that carries over into refugee and displaced persons camps. Problems include: infections due to instruments that are not sterile, damage to adjacent organs, obstructed menstrual flow, painful intercourse, severe blood loss and obstetric complications.

As Decker et al. (Forced Prostitution and Trafficking for Sexual Exploitation among Women and Girls in Situations of Migration and Conflict: Review and Recommendations for Reproductive Health Care Workers) explain, "Victims of trafficking and forced prostitution are likely to suffer serious and complex reproductive and sexual health consequences as a result of their experiences of sexual violence, unsafe sex, and behaviors that may facilitate transmission of sexually transmitted infections." Exposure to HIV/AIDS is a particular problem for women affected by conflict and displacement. Raj et al. (Women, Migration, Conflict and Risk for HIV) conclude, "Migration alone is not a risk factor for HIV, but the context in which migrants often live, i.e., poverty, discrimination, exploitation, and family/relationship/community instability, does increase risk for HIV." In their chapter in this volume, they further argue that forced migrants may be more vulnerable than

either voluntary migrants or resident populations. Rape as an instrument of conflict, destruction of health infrastructure, survival sex and sexual trafficking, high rates of intimate partner violence in conflict settings, and other similar factors contribute to the heightened vulnerability.

In contrast to other sectors, refugees and displaced persons sometimes are advantaged relative to their neighboring populations in access to health care services. Special programs may be implemented in camps and settlements; expatriate physicians and nurses offer their services. Prior to recent years, however, health services for refugees and displaced persons too often overlooked female-specific needs. As McGinn (Barriers to Reproductive Health and Access to Other Medical Services in Situations of Conflict and Migration) explains, "Reproductive health is a relative newcomer to humanitarian response, an important consideration in the discussion of barriers to care." An assessment of UNHCR's Guidelines on the Protection of Refugee Women concluded that the international community "have made important strides in providing reproductive health services. In contrast to a decade ago, when such services were rare, they are presently an integral part of health care delivery programs in some places" (Women's Commission, 2002a, p. 30).

Representatives of UN agencies, nongovernmental organizations (NGOs) and governments formed the Inter-agency Working Group on Refugee Reproductive Health (IAWG). The IAWG produced a field manual that outlined a "Minimum Initial Service Package" (MISP) "designed to prevent and manage the consequences of sexual violence, reduce HIV transmission, prevent excess neonatal and maternal morbidity and mortality and plan for the provision of comprehensive reproductive health services" (IAWG 1999:12). Several NGOs also came together as the Reproductive Health for Refugees Consortium to offer actual services for refugee and displaced women and girls.

Safe motherhood is an essential component of the MISP. In the acute stage of a humanitarian emergency, neonatal and maternal morbidity and mortality can be reduced by providing clean delivery kits to promote clean home deliveries, providing midwife delivery kits to facilitate clean and safe deliveries in health facilities, and initiating the establishment of a referral system to manage obstetric emergencies. Once conditions have become more stable, comprehensive services for antenatal, delivery and postpartum care should be established. Also needing attention are post-abortion complications for those suffering the complications of spontaneous and unsafe abortion. To the extent possible, the needs of both the refugee and displaced and the local population should be addressed. This is particularly important because most refugees and internally displaced persons are in countries with high maternal and infant mortality rates.

Family planning services are a second priority in reproductive health services. From the beginning of an emergency, relief organizations should be able to respond to the need for contraception, particularly the distribution of condoms. Providing a full range of family planning services may require more stable conditions. A range of contraceptives should be provided, as well as assessment of needs, counseling and information about methods, and follow-up care to ensure continuity of services. Providers must have the technical skills to offer the methods safely, and they must have an adequate logistics system to ensure continuity of supplies.

Prevention and treatment of sexually transmitted diseases (STDs) is particularly important in humanitarian emergencies involving mass movements of people. As the field manual explains: "Women and children are frequently coerced into having sex to obtain basic needs, such as shelter, security, food and money." Steps should be taken at the beginning of the emergency to limit the spread of STDs. Once the situation stabilizes, comprehensive prevention, treatment and care programs should be established based on systematic assessments of the infrastructure of the health services available to refugees, collection of baseline data on prevalence and patterns of transmission, and interviews with key informants on target groups for intervention, acceptability of preventive measures, and other information necessary to design effective programs (UNHCR, WHO, UNAID 1995).

Experts emphasize that mandatory testing programs should not be implemented because they would violate the rights of refugees and displaced persons. Moreover, mandatory testing could put refugees in danger of *refoulement*. Voluntary counseling and testing (VCT) programs do have a role if basic protections of rights are in place, including provisions for informed consent, pre- and post-test counseling, confidentiality, a method to confirm findings and sufficient resources to train counselors and testers and carry out the programs (Women's Commission 2002b).

Particular attention needs to be given to the reproductive health needs of adolescents. A UNHCR/Women's Commission report describes the specific needs of younger refugees: early and unwanted pregnancy; complications of pregnancy and delivery; maternal mortality; STIs, including HIV/AIDS; unsafe abortions; rape, forced marriage, sexual enslavement and other forms of sexual violence; and genital mutilation (UNHCR and Women's Commission for Refugee Women and Children, 2002). The field manual on reproductive health emphasizes that services for this population should be "user-friendly;" have competent staff who are friendly, welcoming, and non-judgmental; promote trust and confidentiality; be free or low cost; be easily accessible; have flexible hours; be located in attractive facilities; and offer same-gender providers (UNFPA, p. 91).

Decker et al. discuss the need for reproductive health programs in conflict to also be aware of the special risks faced by women and girls who have been trafficked. Effective implementation of the MISP may help identify women and girls who are of particular risk during the emergency phase. During protracted emergencies and in the context of post-conflict return and reintegration, special attention should be given to victims of trafficking and forced prostitution to ensure that they receive the services needed to address reproductive health problems that are likely to have arisen.

McGinn recognizes the improvements that have been made in the delivery of reproductive health services in conflict situations, but argues that there are still important barriers to care. She identifies the limited scope and quality of available reproductive health services as the principal barrier to greater access. Reproductive health services are new to many humanitarian organizations, limiting their capacity to provide effective programs. Variable demand for the services is a further barrier. Many displaced women had little access to reproductive health care prior to the conflict, reducing their demand for these services after displacement. Finally, funding

is an issue; as McGinn notes, "Inadequate funding, however common a complaint, is nevertheless a real barrier to adequate service delivery."

In their chapter, Raj et al. recommend changes in policy and practice to address the heightened vulnerability of displaced women and girls to HIV/AIDs exposure. They emphasize that "gendered considerations related to sexual assault, sex trade/survival, and family and marital relationships/dynamics (including child/forced marriage, partner violence) must be included, with an eye toward the differential gendered aspects of risk by age." They conclude with a call for better systems of surveillance and research that will increase understanding of the complex interplay of gender, conflict and migration as risk factors for HIV/AIDS.

Mental Health, Trauma and Resiliency

Forced migration often involves trauma, dislocations and abrupt changes in life. At a minimum, refugee and displaced women may face emotional problems and difficulties in adjustment resulting from loss of family and community support. More serious mental health problems may arise from torture and sexual abuse prior or after flight. Depression and post-traumatic stress disorder sometimes follow such experiences although these diagnoses affect a small, though highly vulnerable, minority of refugees and displaced persons.

As Elżbieta Goździak emphasizes in her chapter (Culturally Competent Responses to the Effects of Armed Conflict on the Well-Being of Refugee Women), the majority of forced migrants are highly resilient in dealing with trauma. Yet, we know far less about the bases of resilience than we do about the causes of harm. Quoting Goździak, "While we have a moral obligation to support those who suffer and study risk factors, we also need to understand protective factors in order to maintain the resilience and well-being of those affected by war and prevent possible delayed onset of disabilities stemming from exposure to armed conflict as well as mitigate the effects of post-conflict experiences on the well-being of refugee women and girls."

Approaches to trauma related to conflict vary greatly. Purely medical models stressing clinical depression and PTSD are more often found in developed countries with the resources to provide a full array of psychiatric services. More prevalent in developing country settings are psycho-social service programs for refugees and displaced persons that provide a broader range of interventions and emphasize psycho-social well-being over psychological pathology. Rather than focusing only on individuals, these programs assume that "the needs of individuals are generally appropriately conceptualized within the context of a family or household which, in turn, is located within an 'affected community'" (Psychosocial Working Group, 2003). They also emphasize the interplay of human capacity, social ecology, and culture and values that affect the ability of refugees and displaced persons to respond to the challenges they face. Psycho-social interventions may range from play, sports and other recreational groups for traumatized children to income generation activities for traumatized women to programs which address human rights abuses

against refugees and displaced persons. The aims are to address stressors that negatively effect mental health to the degree possible, and to strengthen the capacity of refugees to cope with the traumas and stressors when prevention fails.

As Goździak points out, there has been little evaluation of the effectiveness of the psychosocial programming approach. Even less studied have been more indigenous coping strategies that may arise spontaneously in the context of conflict and displacement. Traditional healers as well as religion and spirituality play important roles in many societies in helping people to cope with trauma. Processes developed to obtain justice for victims may also increase psycho-social well-being. Truth and reconciliation commissions, for example, provide a cathartic environment for victims of trauma to discuss their experiences while taking action to prevent future abuses.

Gender and Sexual Based Violence

Despite growing international recognition that gender and sexual based violence is a war crime, it continues to be used as a weapon of war. Refugee and displaced women and trafficking victims are particularly vulnerable to such violence. Violence occurs at all stages of displacement. During flight, refugee and displaced women and girls have been victimized by pirates, border guards, army and resistance units, male refugees, and others with whom they come in contact. When women are separated from husbands and brothers in the chaos of flight or they are widowed during war, they are especially susceptible to physical abuse and rape. Violence against women and children does not necessarily abate when refugee and displaced women reach the supposed safety of an asylum country or displaced persons camp. Perpetrators of violence against refugee and displaced women and children include not only military personnel from the host and home countries and resistance forces but male refugees and humanitarian aid personnel as well. The abuse may be as flagrant as outright rape and abduction or as subtle as an offer of protection, documents or assistance in exchange for sexual favors.

Many factors contribute to the vulnerability of refugee and displaced women and girls to sexual violence and exploitation. Exploitation certainly is related to the absence of alternatives for refugees and displaced persons. When a group is totally dependent on others for economic survival, members of the group are inherently vulnerable to such exploitation. In many camps, the physical facilities increase the likelihood of protection problems. Camps are often overcrowded. Unrelated families may be required to share a communal living space. Poor design of camps also contributes to protection problems for women. Camps tend to be poorly lit, if at all. Among common problems, communal latrines may be at some distance from the living quarters, thereby increasing the potential for attacks on women, especially at night. Collection of firewood remains one of the most dangerous occupations for refugee and displaced women and girls, who must often venture far from camps to find the fuel source, thereby becoming vulnerable to attacks by persons set to prey on them.

Traditional mechanisms for protection of the vulnerable may be lost when refugees and displaced persons are forced to live in camps. In particular, the communal support systems for protection of widows, single women and unaccompanied minors are often no longer present. Spouse and child abuse and abandonment are problems encountered by women and children in refugee and displaced persons situations. Heightened levels of domestic violence are not infrequent where refugees have lived for extended periods of time in the artificial environment of a refugee camp. Psychological strains for husbands and adolescent boys unable to assume normal cultural, social and economic roles can result in aggressive behavior towards wives, children and sisters. The enforced idleness, boredom and despair that permeate many refugee and displaced persons camps are natural breeding grounds for such violence.

As discussed above, human traffickers often prey on refugee and displaced women and children. The trafficking is itself a form of violence, rendering victims vulnerable to rape and other sexual abuse. While women and girls (and some boys and men) are often trafficked directly into sexually abusive and exploitative labor, including prostitution and pornography, those trafficked for other forms of labor exploitation are sexually abused as a bi-product of the slave-like conditions in which they find themselves. This is particularly true of women and girls forced into domestic service as well as those forcibly recruited into military operations.

A final significant impediment to protection of refugee and displaced women and children is the general insecurity that places humanitarian operations at risk. In modern conflict, civilians have become the targets of armed attack, not just the innocent victims of war. Also targeted are the humanitarian actors that seek to assist and protect civilians. Insecurity is by far the biggest impediment to securing the rights of refugee and displaced women and children, particularly when the displaced are still within their own countries or they remain under the control of military forces in a country of refuge[2]. Insecure conditions impede access to vulnerable populations for delivery of aid, create protection problems for aid workers as well as their clients, and make it impossible to monitor and evaluate the effectiveness of aid operations. Because of attacks on humanitarian aid operations and their consequences, forced migrants too often end up "out of sight and out of mind" of the very humanitarian system that is designed to assist and protect them.

Leaning et al. (Sexual Violence During War and Forced Migration) argue that responses to SGBV must be multi-faceted. They recommend a three pronged approach, addressing opportunities for violence, vulnerability of displaced populations, and the impunity that allows perpetrators to continue their violence. Constraining opportunities for violence requires preventative approaches. These include diplomatic techniques of political and economic pressure, either unilateral or collective, and armed military intervention to stop the violence. According to Leaning and Bartels, neither has been shown to be particularly effective in protecting women from violence, particularly in the absence of political will to intervene and apply the necessary diplomatic pressure.

Reducing vulnerability involves prevention and, when prevention fails, intervention to help the victims. The presence of humanitarian personnel can provide a form of prevention, though in many conflicts, the humanitarian workers themselves become targets of armed elements. Practical steps to reduce violence include better camp design, firewood alternatives or patrols to lessen risk, and livelihood initiatives to reduce the vulnerability of women and girls to sexual exploitation.

To be effective, preventative initiatives must focus on both women and men. Men are the principal perpetrators of violence against women. Without their cooperation, efforts to reduce the vulnerability of women will be unlikely to succeed. As discussed above, camp life, in particular, erodes the traditional roles and responsibilities of men and adolescent boys and creates an environment conducive to violence. Although there is no excuse for taking out frustrations in violence against women, tackling the causes of violence requires attention to these situations.

Curbing impunity involves bringing perpetrators to justice. As Leaning et al. describe, "Intervention measures designed to curb impunity rely on the main tactic of documentation and reporting, with the dual purposes (not always in tandem or coordination) of compelling some form of response from the international community or supplying evidence for possible indictment and trial."

Programs to address SGBV have grown along with the recognition of the vulnerability of forced migrants to such abuse. SGBV programs generally advocate a multi-sectoral approach that takes into account prevention of abuses, the physical and psychological ramifications of violence, the potential need of the victim for a safe haven, the longer-term economic needs of vulnerable populations, the legal rights of victims, training of police and security personnel, and other similar issues. Strategies include health services to address the often serious physical problems arising from violence; psycho-social, indigenous healing or religious programs to help survivors cope with the trauma of violence; community awareness building activities that reach out to men as well as women to discuss the prevalence and reasons for sexual and gender based violence; social forums for women to discuss issues affecting their lives; and training for staff of service providers in the camps to alert them to issues surrounding sexual and gender based violence.

Shelter and Settlement

As discussed in greater detail in Zetter and Boano (Gendering Space for Forcibly Displaced Women and Children: Concepts, Policies and Guidelines), shelter is a principal need of women displaced by conflict. Unlike settled populations affected by conflict, refugees and displaced persons arrive in camps or urban areas without ready access to housing. Zetter and Boana argue persuasively that shelter carries multi-faceted meanings in addition to the actual structures that provide housing, representing a "complex set of social, cultural, domestic and personal needs represented by the variety of ways in which space is identified ordered and used." As a sector, shelter is highly gendered in concept and implementation. Again, quoting

Zetter and Boana, "gendered boundaries of housing in most societies constitute an environment in which women lay claim to the house as their domain, as a locus of social and economic rights and obligations, and a space for social relations and identity." Often, the impetus to provide shelter quickly in an emergency leaves women out of decision-making on the form and nature of the housing that will be built. Since most refugees and displaced persons remain uprooted for protracted periods, the decisions taken early in the crisis have long-term ramifications.

A gendered approach to shelter and settlement require "first, governance structures and processes which embrace the roles and resources and the participation and empowerment of women; second, their practical contribution at all stages of intervention – principles for design and layout at different spatial scales, the production and construction of space and place both in displaced and return settings, land rights (especially in repatriation or resettlement)." Shelter must protect individuals from the elements and "provide space to live and store belongings, privacy and emotional security." (UNHCR, 2007, p. 144) Decisions about shelter and camp location and layout, more generally, greatly affect the physical security of refugee and displaced women, as discussed above. Where shelter is located also affects access to services and to livelihoods. Women headed households are often particularly disadvantaged if refugees and displaced persons are expected to build their own shelter and women do not have the strength, tools or resources to accomplish the task. Often, they find themselves on the periphery of camps, unable to claim and hold onto the best land. In the context of solutions to displacement, issues of land and property ownership, restitution and compensation also affect women's security and livelihoods. When women are legally barred from owning or inheriting property, the harm to women-headed households may be particularly severe.

While much of the focus on refugee and displaced persons is on camp populations, a large proportion of forced migrants are self-settled in rural and urban areas. Although precise statistics are not available, some experts estimate that a majority of refugees and displaced persons live outside of camp settings. Citing a growing body of research on urban displaced, Zetter and Boana state, these self-settled populations "endure a high degree of marginality, severe impoverishment, degraded housing conditions and limited access to social and community infrastructure such as schools and medical assistance."

UNFPA's Role

The Programme of Action adopted by the International Conference on Population and Development (ICPD) in 1994 "placed women's rights, empowerment and health at the centre of development efforts." (UNFPA, August 2006, para. 6). UNFPA submitted to its Executive Board a three year plan to ensure the effective integration of ICPD concerns into humanitarian and recovery planning and programming. Its two principal roles are "(a) building knowledge and commitment; and (b) strengthening capacities for effective programming" (Ibid., para 10). The strategy is both

inward looking, to build UNFPA's own capacities to respond to humanitarian emergencies, and outward looking, "to support capacity development at the national level and within the global humanitarian community" (Ibid., para 12). In effect, the internal capacity building aims to bring awareness and expertise in responding to humanitarian crises to an agency that is primarily development-oriented. The external focus brings awareness and expertise on women's issues – particularly sexual violence, reproductive health and women's empowerment – to humanitarian agencies.

In building knowledge of and commitment to the importance of gender and reproductive health issues in crisis and transition situations, UNFPA has led the development of guidelines and training programmes in the areas of reproductive health, HIV/AIDS and emergencies, and sexual and gender-based violence. UNFPA has taken on responsibility for gender mainstreaming for the InterAgency Standing Committee, and as part of the Cluster Approach to humanitarian response, seeking to ensure that gender issues are considered effectively by all of the clusters. UNFPA worked with the Office for the Coordination of Humanitarian Assistance (OCHA) to develop a handbook on gender mainstreaming in humanitarian response. Yet, by UNFPA's assessment, "despite progress in establishing norms and standards, reproductive health, gender and data issues are not adequately understood; are not integrated into humanitarian operations; and are neglected in many countries in planning for recovery" (Ibid., para 14). As part of its future efforts to build knowledge and commitment, UNFPA plans to expand the evidence base, particularly of effective reproductive health and gender-related interventions in humanitarian and transition situations. It also intends to intensify its advocacy to sensitize partners as to the issues affecting women and girls; map, develop and share tools and resources; expand partnerships for knowledge sharing and research; and improve monitoring and evaluation systems (Ibid., para 15–21).

UNFPA's "Policies and Procedures Manual, Policy for UNFPA Support to Emergency Preparedness, Humanitarian Response and Transition/Recovery" spells out the specific operational activities undertaken by the agency in these situations. They are organized around the phases of emergency preparedness, acute emergency response, chronic humanitarian situations, and transition and recovery. The core activities fall into three areas: sexual and reproductive health, population and development, and gender.

UNFPA generally works with partners in undertaking its work in humanitarian emergencies. With regard to women forced to migrate in response to conflict, UNFPA collaborates with the UN High Commissioner for Refugees (UNHCR). The Memorandum of Understanding (MOU) governing this cooperation was signed in 1995. The stated aim is to "support the promotion of a holistic approach to women's health over their life-spans and the concept of reproductive health as a human right." The MOU recognizes UNFPA's special mandate to address population issues and reproductive health (RH), and UNHCR's special mandate to provide international protection and assistance to asylum seekers, refugees, returnees and, when requested, to other groups of internally displaced persons (hereinafter referred to as "persons of concern to UNHCR").

The MOU gives UNFPA responsibilities to provide technical assistance and support in the assessment, monitoring and evaluation of RH needs and services; provide appropriate equipment, supplies, drugs and contraceptives consistent with UNFPA policies and consonant with UNFPA programme in the particular country; provide technical assistance in the development and production of appropriate education materials related to RH information and services; provide technical assistance for the training of personnel for service delivery and related Minimal Initial Service Package (MISP) activities; and provide through UNFPA country support teams, and at the request of UNHCR; technical assistance for the improvement of statistical information on persons of concern to UNHCR. UNHCR commits to provide logistical support to RH needs assessments, monitoring and evaluation missions, provide RH information and services, inform UNFPA on the situation of persons of its concern to facilitate provision of RH information and services, and to seek technical guidance from UNFPA on RH activities. Together, they would develop strategies and programmes of advocacy for RH information and services and to combat sexual violence, with particular attention to adolescents and young people. They would also undertake joint assessment, monitoring and evaluation missions, develop field manuals, facilitate coordination and develop strategies to ensure the integration of RH information and services into the relevant programmes of other organizations.

Conclusions

As the chapters in this book indicate, much progress has been made in addressing the specific needs of women who have been forced to migrate as refugees, internally displaced persons or trafficking victims in the context of conflict. As discussed in Sahir Abdul-Hadi's chapter, the perspectives of UNFPA and other field representatives proved critical in refining the findings of these chapters and developing a set of recommendations for further action. Abdul-Hadi discusses the importance of improving security for the displaced and humanitarian actors, addressing barriers to access, improving data, and focusing on long-term sustainability. She outlines practical innovations, ranging from women's centers to initiatives to involve men in the protection of women displaced by conflict.

Drawing from the more specific recommendations presented herein, a strategy to consolidate gains made in addressing the needs of displaced women and further improve their lives would include the following elements:

1. *Address the full life cycle of forced migration, from early warning through flight and short- and long-term displacement to (re)integration.* In framing a "women, migration and conflict" strategy, the international community should keep in mind that there are significant, and in some cases, differing needs for protection and assistance at each stage of the displacement life cycle. As many more resources and political attention tends to be focused on the emergency stage and, in some cases, the recovery stage, development agencies, such as UNFPA,

can play a particularly important role in raising the visibility of the needs of refugee and displaced women in protracted conflict situations.

2. *Focus on all forms of conflict-induced migration, including refugee movements, internal displacement and trafficking in persons.* Migration as a result of conflict takes many different forms. Millions of women cross international borders, becoming refugees in a neighboring or distant country. Even larger numbers are internally displaced, seeking safety in other parts of their own country. An unknown but believed to be large number of women and girls face the prospect of being trafficked, finding themselves in a highly exploitable situation as conflict and/or displacement affects their livelihoods and security. A comprehensive approach to women, conflict and migration must recognize the complexity of these migration patterns.
3. *Address the reproductive health needs of women forced to migrate because of or in response to conflict.* There has been much progress during the past decade in developing and delivering appropriate reproductive health programs for refugees and displaced persons. As stated in the MOU with UNHCR, UNFPA has a special role in supporting "the promotion of a holistic approach to women's health over their life-spans and the concept of reproductive health as a human right." This role should be extended to all women uprooted by conflict, including refugees, internally displaced persons and trafficking victims. A comprehensive program would provide technical assistance and support in the assessment, monitoring and evaluation of reproductive health needs and services; provide appropriate equipment, supplies, drugs and contraceptives; and provide assistance in development and production of appropriate education materials and training of personnel for service delivery and related MISP activities. A key focus of attention should be national Ministries of Health and local public health systems, which need to provide sustained attention to the reproductive health needs of refugee, displaced and trafficked women.
4. *Address the causes and consequences of sexual and gender based violence against women forced to migrate because of or in response to conflict.* Such initiatives should take a multi-sectoral approach to prevent and respond appropriately to abuses against women, including provision of accessible and confidential services to survivors of rape and sexual assault. Programming should focus not only on the women who are victims of sexual and gender based violence but also on men whose actions may serve to protect or abuse women in these situations. These programs should recognize the inherent connections between services to reduce and respond to violence and those that focus on livelihoods for both women and men.
5. *Expand availability of culturally appropriate services that focus on the physical and mental well-being of women forced to migrate because of or in response to conflict.* Such services must recognize the resilience of women displaced by conflict, building on their own capabilities and resources. Traditional healing practices, religion and spirituality, truth and reconciliation initiatives and other non-medical approaches can play an important role in helping forced migrants

to cope with the traumas of displacement. Multi-sectoral approaches that address the causes of continuing vulnerabilities, including livelihood programs, should be seen as an integral part of psycho-social initiatives.

6. *Expand initiatives to empower women forced to migrate because of or in response to conflict, particularly through livelihood programs.* Creative interventions are needed to increase the access of refugees, displaced persons and trafficking victims to the means by which they can support themselves and their families. These initiatives should be aimed at both women and men. Developing more comprehensive approaches require pilot-testing innovative programs, providing technical assistance to program implementers, and advocating the value of promoting livelihoods.
7. *Engage in active advocacy in support of shelter and settlement policies that promote the safety, security and access to livelihoods, education and services of women and girls forced to migrate because of or in response to conflict.* As discussed above, decisions about shelter, camp design and policies regarding spontaneously settled forced migrants have profound consequences for the lives and safety of women. Advocates for gender mainstreaming should include attention to the consequences of shelter and settlement practices.
8. *Improve the collection of sex and age disaggregated data on forced migrants.* Although improvements have been made in collecting disaggregated data, there continue to be major gaps in data collection, particularly regarding internally displaced persons, trafficking victims, and urban refugees and displaced persons. As recommended in "Policies and Procedures Manual, Policy for UNFPA Support to Emergency Preparedness, Humanitarian Response and Transition/Recovery," there is need for regular surveys/censuses of refugees and internally displaced, regular monitoring of mortality and reproductive health needs, incorporation of demographic data into education programs, support to identify adolescent concerns, interests and ideas in protracted situations of forced migration. Also needed are "studies/analyses of population, migration and poverty issues and factors affecting re-integration of returnees, with particular focus on adolescents and youth in transition and recovery situations."
9. *Consult with the refugee, displaced and trafficked women prior to implementation of policies and programs.* As described by Buscher regarding livelihood programs but more generally applicable, "Program design must be flexible and responsive to local needs and conditions as well as to the unique culture, skills, and capacities of the target population. Consulting with the entire affected population is vital as is the collection of age- and sex-disaggregated data to analyze impact. Intended clients must be consulted before any decisions are made about project design and type of intervention. Target populations must be involved with the planning, management, monitoring, and evaluation of each project using a livelihoods approach."
10. *Educate refugee, displaced and trafficked women about their rights under international and domestic law.* As described by Macklin, the capacity of women "to advocate on their own behalf and to engage in formulating and

implementing strategies for self-protection and survival can only be enhanced with knowledge." There is great need, however, for education campaigns and training programs to raise awareness and consciousness of rights and entitlements.

Notes

1. Referencing Chambers, Robert, Conway, Gordon, *Sustainable rural livelihoods — practical concepts for the 21st century,* IDS Discussion Paper 296, Brighton, 1991.
2. This conclusion is based largely on the author's participation in a three-year collaborative project on barriers to effective assistance and protection for forced migrants. The study team conducted field visits in Burundi, Sri Lanka, Colombia, East Timor and Georgia. Consistently, the case studies revealed insecurity to be the principal barrier to assistance and protection, particularly when humanitarian aid operations were the target of military activities. Preliminary findings were presented at the biannual meeting of the International Association for the Study of Forced Migration, Chiang Mai, Thailand, 2003.

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Legal Aspects of Conflict-Induced Migration by Women

Audrey Macklin

Introduction

People migrate to avoid anticipated conflict, to flee ongoing conflict, and to escape the consequences of past conflict. The capacity to migrate and the migratory experience itself are inflected by gender. The purpose of this paper is to survey how international legal norms and institutions frame and respond to conflict-induced migration, with particular attention to the impact of gender on access to legal status and protection (Martin 2003).

In conflict situations, women and girls tend to be less mobile then their male cohorts. Constraints may include responsibility for children, elderly or disabled kin, as well as safety, cultural and financial obstacles to travel without male accompaniment. The majority of the world's forcibly displaced populations do not traverse state borders, and the majority of this population is also female.

If a woman flees ongoing or impending conflict but remains within the geopolitical borders of a state, her migration is described as internal displacement, and she is labeled an internally displaced person (IDP). If she crosses an international border into a neighboring country that is a party to the 1951 UN Convention Relating to the Status of Refugees and/or the 1967 Protocol, she may qualify as a refugee. Other regional instruments may also offer similar protection. More rarely, she may journey further afield, even to one of the industrialized states of the global North. Depending on how she travels, she may be categorized as a resettled refugee, an asylum-seeker, or a smuggled or trafficked person. The first two categories come within the refugee regime or related national schemes conferring complementary protection, while the protocol to the International Convention Against Transnational Organized Crime governs trafficking and smuggling.

Finally, in any situation where a person crosses an international border and does not secure a legal status, she is potentially subject to domestic law regarding the treatment and expulsion of non-status (illegal) migrants. Apart from refugee protection and the prohibition on the return of persons to face a substantial risk

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_2, © Springer Science+Business Media B.V. 2009

of torture (Convention Against Torture, Article 8), international law imposes few restraints on the right of states to expel non-citizens.

The nexus between armed conflict and violations of women and girls' human rights is addressed by UN Security Council Resolution 1325. The Resolution exhorts Member states, parties to armed conflict, military and civilian personnel of peacekeeping missions, and other actors to attend to the specific vulnerabilities and needs of women and girls in armed conflict, and to incorporate a gender perspective (and more women) into all phases of activity, including training, programming and field operations. Importantly, Article 1 of Resolution 1325 also "urges Member States to ensure increased representation of women at all decision-making levels in national, regional and international institutes and mechanisms for the prevention, management and resolution of conflict." Other provisions emphasize the importance of "involving women in all peacekeeping and peacebuilding measures" (Article 6) and the need for "measures that support local women's peace initiatives and indigenous processes for conflict resolution, and that involve women in all of the implementation of the peace agreements" (Article 8(b)). This twin emphases on substantive protection of women and girls' human rights *and* the procedural imperative of including women in decision-making and governance at all stages and levels is mirrored in various initiatives specific to women and conflict-induced migration.

The gender-specific social, economic, familial, sexual, physical and medical impacts associated with conflict-induced migration are documented in detail in other reports commissioned by the UNFPA for this research review. A recent United Nations High Commissioner for Refugees (UNHCR) report usefully summarizes the major risks and vulnerabilities to women and girls through the lens of human rights protection:

(a) there are birth registration or documentation problems, resulting in a lack of legal identity, which can mean women and girls in particular are vulnerable, for instance, to exclusion from access to resources, to trafficking, to statelessness and/or are unable to pass on nationality to their children;
(b) there is a lack of age and sex disaggregated data, which prevents adequate identification of groups with specific protection needs;
(c) camp management, community and leadership structures are insufficiently inclusive of women and gender power relations are unequal;
(d) there are food and other shortages, resulting in women's and girls' exposure to prostitution, sexual harassment and trafficking, malnutrition, increased drop-out from schools for girls, and child labor;
(e) health services, including female-to-female services, are not sufficiently accessible, especially bearing in mind that women's sexual and reproductive roles place them at particular risk during pregnancy and giving birth, and that they are disproportionately vulnerable to HIV/AIDS;
(f) functioning justice systems are not in place or, where they are, traditional harmful practices, domestic violence and other crimes are not adequately addressed; and

(g) return and reintegration are hampered, for instance, by discriminatory property and inheritance laws. (ExCom 2006a)

This paper focuses on the legal frameworks related to migration, and the extent to which they address (in theory and in practice) these impacts. It is important to acknowledge that while armed conflict and displacement trigger a range of human-rights violations by hostile forces, women displaced by conflict are also at heightened risk of domestic violence, coerced sex, harmful cultural practices, unequal access to resources and social exclusion from members of their own families and communities. Conflict and displacement do not create the structural inequality that underwrites systemic violations of women's human rights, although both phenomena can and do exacerbate the manifestations of that inequality.

Internal Displacement

Normative Framework

The UN *Guiding Principles on Internal Displacement* (hereafter *IDP Guiding Principles*) define its subject matter as

> persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised State border. (IDP Guiding Principles, Introduction).

In brief, internally displaced persons (IDPs) are forced migrants within state borders. IDPs may remain in their state of nationality for a variety of reasons: They may wish to stay as close to their homes as possible, they may have kin or friends within the state who can provide assistance (often precarious), they may lack the resources to reach an international border, or neighboring states may physically prevent their departure by obstructing entry to the adjacent state. Although international actors acknowledge the right to exit one's country and to seek and enjoy asylum, efforts are sometimes made to discourage flight by offering some form of international protection (in so-called safe havens or other designated areas) within the territory of the state. The success of these initiatives is notoriously uneven and they remain controversial.

The term IDP is descriptive. It does not designate a status recognized in international law, and does not confer specific or unique rights. (In contrast, refugee status entails a legal right against *refoulement*.) In the context of conflict induced migration, the trauma, experiences, and needs of IDPs may render them indistinguishable from refugees. However, two important differences warrant emphasis: First, the IDP definition encompasses a broader range of causal factors (e.g. development or disaster-induced displacement) than does the UN refugee definition (which is limited to persecution on grounds of race, religion, nationality, membership in a

particular social group or political opinion). Secondly, the fact that IDPs have not crossed a border means that as citizens, they are legally entitled to the protection of their state of citizenship. At the same time, their own state may directly or indirectly create the conditions leading to displacement, and then attempt to shield itself from external intervention or criticism of its failure to protect by invoking the principle of state sovereignty. Francis Deng and Roberta Cohen provide a pithy rejoinder to this disingenuous assertion of state sovereignty through the concept of "sovereignty as responsibility": "The concept of sovereignty cannot be dissociated from responsibility: a state should not be able to claim the prerogatives of sovereignty unless it carries out its internationally recognized responsibilities to its citizens" (Cohen and Deng, 1998, 276-7).

The IDP Guiding Principles are known as "soft law" because they do not in themselves create binding legal obligation on states. In spite or because of that fact, the IDP Guiding Principles have attracted broad support and endorsement since their formulation. The IDP Guiding Principles set out standards relating to protection of IDPs and the provision of humanitarian assistance. To the extent that humanitarian assistance may be a material means of fulfilling protection objectives, protection and humanitarian assistance may overlap in operational terms. Nevertheless, a recent study argues for the importance of attending to the "group-based protection needs of IDPs, as a separate issue from the material needs of IDPs (which may or may not vary significantly from those of non-displaced populations)" (Collinson 2004: 26). This comment reminds us that just as IDPs and refugees are similar in certain respects and distinguishable in others, so too are IDPs and non-displaced civilians and, for that matter, male and female IDPs.

Some of the *IDP Guiding Principles* simply reiterate existing norms of international human rights and international humanitarian law, or restate them in terms directly applicable to the IDP context. Other provisions of the Guiding Principles adapt by analogy from the UN Refugee Convention and regional refugee instruments. Finally, the Guiding Principles also draw from other sources of "soft law", which often offer greater precision and detail than broadly worded norms contained in international treaties and conventions. As the annotations indicate, the content of the Guiding Principles is informed by, or is consistent with, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the 1993 UN Declaration on the Elimination of Violence Against Women, the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, the Statutes of the War Crimes Tribunals for the Former Yugoslavia and Rwanda and the Rome Statute for the International Criminal Court.

A thorough analysis of the IDP Guiding Principles lies beyond the scope of this paper (see Kalin 1999). The following protection-related provisions are highlighted because of their centrality and/or because of their particular salience for women displaced by conflict:

- Preclusion or minimization of displacement through compliance with international human rights and international humanitarian law (Principle 5)
- Right against arbitrary displacement (Principle 6)

- Equality and non-discrimination between IDPs and non-displaced people in the enjoyment of international and domestic rights and freedoms (Principle 1; Principle 22)
- Equality and non-discrimination among IDPs in the application of the Guiding Principles; equality not violated by differential protection and assistance to vulnerable groups (including pregnant women, mothers with young children, female heads of household) (Principle 4)
- Right to dignity and physical, mental and moral integrity, including protection against gender-based violence, forced prostitution, indecent assault, slavery, sale into marriage, acts of violence intended to spread terror (Principle 11)
- Right to respect for family life, including entitlement of displaced family members to remain together (even in internment camps), and facilitation of reunification of separated families (Principle 17)
- Entitlement to necessary medical care and attention "to the fullest extent practicable and with the least possible delay," without distinction on grounds other than medical grounds; access to psychological and social services (Principle 19.1)
- Special attention to the health needs of women, including "access to female health care providers and services [and] reproductive health care, and appropriate counseling for victims of sexual and other abuses" (Principle 19.2), and to the prevention of communicable diseases, including AIDS (Principle 19.3)
- Equal right of women and men to obtain new or replacement identity documents from authorities, without the imposition of "unreasonable conditions, such as requiring the return to one's area of habitual residence" (Principle 20)
- Special efforts to enable women and girls to exercise their right to educational and training programmes and facilities as soon as conditions permit (Principle 23)
- Right to an adequate standard of living (Principle 18.1); right to seek freely opportunities for employment and to participate in economic activities (Principle 22.1(b))

The IDP Guiding Principles encapsulate two important human rights dimensions of internal displacement: First, forcible displacement itself (where arbitrary and/or of undue duration) is a violation of human rights and secondly, displacement precipitates and or exacerbates the violation of many fundamental human rights and provisions of international humanitarian law.

As this abbreviated sampling above suggests, the IDP Guiding Principles are sensitive to many of the gender-specific dimensions of internal displacement, including sexual and gender-based violence (SGBV), sexual, reproductive and mental health risks, food insecurity, access to education and livelihood, non-recognition of women's independent legal personality, etc. Admittedly, some of the provisions that explicitly address gender are framed in hortatory rather than mandatory terms, but it seems reasonable to suppose that the main obstacles to implementation have less to do with the precise wording of the IDP Guiding Principles than with inadequate resources, the exigencies of crisis management, and perhaps political will (Bagshaw and Paul, 2004).

In addition to articulating and defending the specificity of internally displaced women's protection needs, the *IDP Guiding Principles* also encourage authorities to recognize and respect women's agency. For example, Principle 3(d) advises authorities to involve women in the planning and implementation of relocation, and Principle 18.3 similarly instructs authorities to make "special efforts" to ensure women's participation in the planning and distribution of food, shelter, clothing and medicine distribution. Involving women in these activities may, among other things, lead to greater attention to the impact of relocation processes and camp design on women's security.[1] Women's participation in the latter activities would also be instrumental in ensuring non-discriminatory distribution practices, and in diminishing the risk that male relief workers and/or male IDPs will abuse their privileged access to basic supplies to sexually exploit female IDPs.

Institutional Framework

Although primary responsibility for IDPs resides with their states of nationality, the unwillingness or inability of these states to respond effectively to the challenges of internal displacement necessitate an international response. Owing in part to the fact that IDPs are not the subject of a negotiated international agreement, IDPs are rather like institutional orphans. No single agency is dedicated to their protection and assistance. Since the early 1990s, various United Nations agencies, regional governmental agencies, the International Committee of the Red Cross (ICRC) and a host of domestic, regional and international non-governmental organizations have collaborated in addressing the humanitarian and protection needs of IDPs. This collaborative response has sometimes been criticized as inadequate, ad hoc, unaccountable, and opaque. Rather than review its evolution through the years, I will briefly describe the current set of institutional arrangements (Feller 2006; McNamara 2006; Morris 2006).

The United Nations' senior humanitarian official, the Emergency Relief Coordinator, bears overall responsibility for co-ordinating protection and humanitarian assistance in complex emergencies through the Office for the Coordination of Humanitarian Affairs (OCHA). The Internal Displacement Division (IDD) is an inter-agency entity housed within OCHA which is tasked with providing support and technical advice on the collaborative response to the Emergency Relief Coordinator. The coordinating function is executed through the Inter-Agency Standing Committee (IASC). Members of the IASC are drawn from key humanitarian actors, and include representatives from UN Agencies (including UNFPA) and international non governmental organizations (INGOs). The role of the International Committee of the Red Cross (ICRC) is especially significant in the context of armed conflict because its mandate is guided by international humanitarian law, which specifically focuses on the laws of war in relation to civilians and combatants. The IASC also has a Sub-Working Group on Gender (Gender SWG).[2] In addition to UN representatives (including UNFPA), the Gender SWG also includes representatives from the International Committee of the Red Cross (ICRC), OXFAM, and the

Women's Commission on Refugee Women and Children. In 1999, the IASC issued a "Policy Statement for the Integration of a Gender Perspective in Humanitarian Assistance," and in 2005 produced the "Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focus on Prevention of and Response to Sexual Violence in Emergencies."

Reform of the entire humanitarian response system in 2005 resulted in the introduction of a "cluster approach." The IASC has identified nine sectors or areas of concern and created working groups for each cluster. Each working group is tasked with designating a lead agency for that cluster, developing a list of roles and responsibilities associated with the cluster and member agencies, and surveying existing gaps and capacities.[3] The UNHCR is the cluster lead for protection, emergency shelter, and camp co-ordination and management, which is consistent with the UNHCR's historical engagement in extending its "good offices" to a segment of the world's IDP population. The new cluster approach is being rolled out in emerging sites of complex emergencies and natural disasters.

The UNFPA played a leadership role in developing the Guidelines on Gender-Based Violence Interventions as well as the Gender Task Force's recent Gender Handbook on Humanitarian Action. These documents set out background information and key actions regarding gender-specific dimensions for most of the nine clusters at different stages of a humanitarian emergency, thereby enabling the mainstreaming of gender issues within each sector. Humanitarian actors are optimistic about the potential of the cluster approach to provide greater effectiveness and accountability in protection and assistance.

While the UNHCR is the lead agency in the protection cluster, OCHA has also created an inter-agency protection capacity project (ProCap), and a gender capacity (GenCap) project. ProCap's objective is to respond to urgent requirements for "rapid deployment of experienced protection staff to support the UN protection response for IDPs and other vulnerable groups in emergencies and complex crises" (Providing Capacity to do Protection, 2006, 14).[4] GenCap will adapt this model by employing senior gender advisors and maintaining a roster of gender officers for rapid field deployment in order to ensure mainstreaming of gender issues in all aspects of the humanitarian response.

The practical merits and deficiencies of the cluster approach and of GenCap in addressing the specific needs of women and girls cannot properly be assessed without a fine-grained analysis of the internal dynamics between the many actors involved. Such an analysis lies beyond the scope of this paper.

National Responses

Implementation of the IDP Guiding Principles requires support, or at least non-interference, by the state. With respect to women's human rights, achievement of protection goals before, during and post-conflict necessitates a domestic legal framework capable of responding to gender-based violence, affirming women's independent legal identity, and a property regime that enables women to control property on equal terms with men.

Since 2000, over a dozen states have developed policies or laws that reflect or implement aspects of the *IDP Guiding Principles*, including at least some gender-related provisions.[5] Progress in narrowing the gap between principle and practice remains a persistent problem, owing to the non-neutrality of the state vis a vis different classes of IDPs, direct or indirect responsibility for human rights and humanitarian law violations, resource limitations, and the pervasive, systemic inequality of women. The following recent examples are no more than random illustrations.

In 2002, Sri Lanka adopted a National Framework for Relief, Rehabilitation and Reconciliation that incorporated the Guiding Principles as official policy for conflict-affected IDPs. According to one commentator, however,

> as conflict resumes, political calculations are again taking precedence over humanitarian considerations. Displaced tsunami survivors have been more successful in accessing resources. Houses, albeit of poor quality, were built in record time and compensation payments made. Conflict-affected IDPs were upset by the differential treatment, especially as their monthly food rations were less than those given to tsunami survivors. UNHCR officials are aware of discrepancy of provisions but there is little they can do (Bannerjee 2006).

National legal systems regarding property ownership, inheritance and transfer play a crucial role in the ability of widowed women to thrive upon return or resettlement, as this African example indicates:

> . . .restrictions on women′s ability to own, acquire and manage property must be overcome. Widowed women are particularly vulnerable because in a number of countries they are unable to inherit land or property from either their husbands or their parents. This was a significant problem in Rwanda for the many displaced widows seeking to return home after the genocide. Recently in Liberia, and at the urging of local women′s groups, national law has been amended to allow women married under customary law to inherit their husband′s property. However, efforts are needed to ensure that IDP women are aware of these rights. Due to low literacy, in particular among women, creative dissemination techniques are needed (Mooney 2004).

In 2004, the Colombian Constitutional Court ruled that state authorities violated the constitutional rights of IDPs: "through action or omission by the authorities in providing displaced populations with optimum and effective protections, thousands of people suffer multiple and continuous violations of their human rights" (quoted in Cepeda-Espinoza, 2006, 22). The Court drew particular attention to the high proportion of vulnerable social groups (including female heads of household and pregnant women) among the IDPs.

In Darfur, the protection mandate of international actors is hampered by the antagonistic stance of the government of Sudan. While rape by militia is recognized as chronic and widespread,

> [o]ne disappointing characteristic of the protection response in Darfur has been the limited emphasis on understanding and supporting community self-protection strategies. One example of working with communities has been the arrangement of patrols to protect women from sexual violence and abduction by militia while searching for firewood around camps. Humanitarian agencies have collaborated with [African Union Mission in Sudan] to organise weekly or bi-weekly firewood patrols from the major camps. For the individuals

> involved, these patrols had a significant protective effect, but they were only carried out in a limited number of camps and were not consistently undertaken.
>
> Another attempt to reduce the risk of sexual violence women face has been the provision of fuel-efficient stoves. Fashioned from clay and water, these stoves cut down on firewood usage by up to 40%, thereby reducing the frequency with which women have to travel outside the relative safety of camps in search of fuel. Although such stoves had been introduced with great success elsewhere in Sudan and in northern Kenya, humanitarian organisations spent over a year debating whether they would be appropriate in Darfur on the grounds that women who supported themselves by selling firewood would lose income – arguably a secondary consideration set against the risk of rape, and one that could have been addressed through complementary income generation. When the concept was finally adopted, further time was lost selecting the stove model (Pantuliano and O'Callaghan, 2006, 11).
>
> Large INGOs with experience in protection undertake a range of stand-alone protection activities, including women and child protection programming and access to justice projects. Many have also mainstreamed protection approaches across their relief activities. Working on protection has resulted in antagonistic relations with the Sudanese authorities, and as a result many other agencies have limited their engagement in protection to less contentious programming, such as the provision of fuel efficient stoves (Pantuliano and O'Callaghan, 2006, 8).

The vulnerability of women to members of their own community, especially when they appear to challenge conventional gender hierarchies, is revealed in the following observation:

> Humanitarian actors have established or strengthened women's committees which are consulted in relation to issues regarding food distribution and sexual violence.
> Humanitarian agencies in Darfur are also implementing programmes aimed at building the knowledge and capacity of national organisations to undertake work in support of human rights and international law. One concern in this regard is that international organisations do not have the capacity to protect local organisations from the heightened threats they face as a result of their increased involvement in protection work (Pantuliano and O'Callaghan, 2006, 13).

UNFPA's leadership role in responding to sexual and gender-based violence in Darfur posed serious challenges for the agency, including capacity and resources to attend to both the health and legal dimensions of sexual and gender based violence. Success in suspending a Sudanese legal requirement of reporting sexual violence to local police as a pre-requisite to medical treatment, and the successful conviction of an army officer for rape, can be counted as important achievements.

Refugees

The contemporary refugee regime began in Europe, and was formulated by and for Europeans displaced by World War II and the descent of the Iron Curtain. The singular, distinctive right that attaches to the declaration of refugee status is *non-refoulement*, or non-return to the country of nationality. The 1951 UN Convention Relating to the Status of Refugees formally expanded in geographical, temporal scope with the 1967 Protocol on the Status of Refugees, but the legal definition of the refugee remains essentially unchanged. A refugee is a person who:

> owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country.

Refugees must be outside their country of citizenship, must fear a harm that constitutes persecution, and the persecution must have a nexus to one of the five grounds. The 1984 OAS *Cartagena Declaration* and the 1969 OAU (now AU) *Refugee Convention* broaden the scope of refugee protection, de-emphasize the individualized requirement of persecution, and encompass reasons for flight that affect populations as a whole, such as "generalized violence," "massive violation of human rights," and events "seriously disturbing public order."

The mandate of the United Nations High Commissioner for Refugees (UNHCR) is "to safeguard the rights and well-being of refugees. UNHCR strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another state, and to return home voluntarily." To that end, the UNHCR engages in protection and humanitarian assistance, works with states that host asylum seekers and refugees, and seeks durable solutions to refugees' displacement, whether by return, local integration in the country of first asylum, or resettlement in a third country.

In addition to serving those who meet the legal definition of a refugee, the UNHCR also responds to situations of mass influx by designating groups as "prima-facie refugees" without performing individualized assessments. The UNHCR also lends its "good offices" to assisting some IDPs and stateless people. To the extent that the mandate of the UNHCR and the ICRC overlap, the division of labour tends to favour the UNHCR in the refugee domain, unless host governments actively impede UN agencies from operating in the field (Aeschlimann 2005; Krill 2001).

Factoring Gender into the Refugee Regime

Gender emerged on the international refugee agenda in the mid-1980s, and attention at the international, regional and domestic level has manifested in a number of initiatives since then. Indeed, during a period that witnessed states (especially in the Global North) expending increasing resources on non-entrée mechanisms to deter and deflect asylum-seekers, the generally favourable response (in principle) to recognizing gender-related persecution stands out as a rare counter-trend, thanks in large measure to feminist advocacy, scholarly research, and networking inside and outside governmental institutions (Macklin 1995; Macklin 1998; Crawley 2001; Spijkerboer 2000).

The Definition of a Refugee

Reference to sex or gender is notably absent from the refugee definition's grounds of persecution, leading some to insist that the existing definition must be amended to add sex or gender to the list. This argument has not prevailed internationally or domestically for a variety of reasons, not least of which is that the prospect of

inviting states to open up the refugee definition for revision in a climate of resistance (if not open hostility) to refugees risks the outcome of a more restrictive, retrograde definition.

Instead, the UNHCR and various states have adopted guidelines that advance a gender-sensitive interpretation of the existing refugee definition, and counsel decision-makers on procedural issues that relate to creating a safe and supportive environment within which a refugee claimant can disclose her narrative in furtherance of making a proper determination of refugee status. This approach has been refined over the years through the individual initiatives of states, non-governmental organizations (NGOs), regional organizations and the UNHCR (Center for Refugee and Gender Studies, Guidelines; Crawley and Lester 2004). Each set of guidelines draws inspiration from existing refugee jurisprudence in non-gender contexts, developments in women's human rights, and from cross-jurisdictional precedents. The outcomes reflect an ongoing process of iteration, mutual feedback, and transnational networking across jurisdictions and subject areas.

Broadly speaking, the substantive analysis contained in most gender guidelines addresses three elements of the refugee definition: the agent of persecution, the form of persecution and the reasons for persecution. Drawing on feminist critique of the public/private distinction as well as developments in refugee jurisprudence (Ward 1993), gender guidelines emphasize that the agent of persecution may be the state, or a non-state actor (spouse, relative, employer, insurgent group) in circumstances where the state is unable or unwilling to provide protection. In addition to forms of physical and psychological suffering commonly inflicted on both sexes, persecution includes rape, domestic violence, female genital mutilation, dowry-related violence and trafficking. Although refugee law distinguishes between prosecution and persecution, the enforcement of certain laws (e.g. forced abortion) may be inherently persecutory, even if in furtherance of a legitimate state objective (cf. population control). The same applies to laws imposing a penalty that is seriously disproportionate to its objective (e.g. stoning for adultery). The cumulative effect of persistent, chronic, discrimination that imposes consequences "of a substantially prejudicial nature on the person concerned" may also constitute persecution. Similarly, a pattern of state denial of protection to women abused by non-state actors could also contribute to a finding of persecution (UNHCR 2002, para. 14).

While the form of persecution may be uniquely or mainly inflicted on women, the reasons may be unrelated to gender. For example, racialized women may be subject to sexual violence or reproductive control to terrorize, punish or annihilate a given racial/ethnic/cultural group. In such cases, persecution may be gendered in form, but on account of race or nationality. A union organizer may be raped (while her male colleague is tortured some other way) on account of real or imputed political opinion.

Women who resist the strictures placed on them by theocratic regimes in the name of religion may face persecution on account of their political opinion (feminism) or religion (non-conformity to the dominant interpretation of religious requirements). In certain cases, the reason for persecution and/or the absence of state protection is the devalued status of the female claimant as a woman. Domestic

violence and female genital mutilation are two frequently cited examples. Defining and circumscribing "particular social group" in refugee law has proven controversial, but tribunals and courts in various jurisdictions have nonetheless accepted that women (or some subset thereof) may constitute a particular social group because sex is an innate or unchangeable characteristic, and women are socially subordinate to men.

As the foregoing examples illustrate, the grounds of persecution may overlap, and the same facts may yield multiple (though complementary) legal conclusions regarding the nexus between persecution and the listed grounds. Some states, courts and the UNHCR have explicitly confirmed that gays, lesbians, bi-sexuals and other sexual minorities may also constitute particular social groups.

On the procedural side, gender guidelines offer practical advice on how to promote an adjudicatory environment that is non-intimidating, accessible, culturally sensitive, confidential, and female-only (on request or automatically). Gender guidelines may also caution decision-makers about inappropriate reliance on demeanour and the possible dearth of documentary evidence. The UNHCR guidelines advise that female asylum seekers should be interviewed separately and in the absence of male kin in order to protect women's opportunity to present their own case. They also recommend that psycho-social counseling and other support be available where necessary.

Fewer than half of asylum-seekers are women. Taking as given the estimates that women comprise more than half of the world's refugees, this suggests that asylum is less accessible for women than men. Since countries in the global North (including Australia) expend enormous resources on deterring the arrival of asylum-seekers, thereby rendering the journey expensive, dangerous and difficult, it is unsurprising that proportionally fewer women are in a position to reach countries of asylum. The success of gender guidelines in encouraging greater recognition of gender-related persecution must be balanced against the fact that fewer women than ever are able to access countries of asylum to advance those refugee claims.

Protection Issues for Refugee Women in Countries of Asylum

The practical problems confronting refugee women in countries of first asylum are broadly comparable to those of internally displaced women. Some potential differences in the circumstances of refugees versus IDPs that may be attributable to border crossing include the following:

- Lack of identity documents may complicate recognition of citizenship status of children born to women outside the country of nationality
- Family reunification in refugee situations is complicated by the fact that family members are separated by a border; the ICRC has particular expertise and capacity in tracing missing persons and reuniting family separated by conflict
- Refugees may be more likely to converge in camp settings, while a greater proportion of IDPs may be dispersed (residing with relatives) or in hiding (from fear)

- IDPs may be closer to the arena of conflict, and therefore women, girls and boys may be more likely to be subject to abduction/forced recruitment
- Government forces and opposing militia may be especially hostile to the presence of humanitarian actors in IDP situations, and obstruct delivery of assistance and protection
- IDPs may be more vulnerable to ongoing coercion in relation to their mobility, meaning that they may be repeatedly displaced or forcibly immobilized.

Because no one situation of displacement is identical to another, generalizations about the material impact of border crossing on women should be made advisedly.

Like OCHA, the UNHCR has formulated policies, guidelines and manuals about mainstreaming gender into all aspects and phases of refugee protection and assistance, including participation in decision-making about protection and assistance. Recent documents indicate a shift in tone, from the idea that forcibly displaced women and girls are inherently vulnerable, to an approach that focuses on identifying and disaggregating the specific types of harms and risks to which women, girls, men and boys are vulnerable. One might describe this as a transition from asking the question "what is the impact of displacement on women and girls?" to asking instead "how does the impact of displacement vary in relation to gender?"

The latest UNHCR initiative concerning to gender and conflict-induced migration is the ExCom Conclusion on Women and Girls at Risk (hereafter "ExCom Conclusion"). The preamble to the ExCom Conclusion observes that women and girls are more likely to encounter certain kinds of protection problems, and less likely than men or boys to be able to exercise their rights. This gendered discrepancy is meant to explain why the ExCom Conclusion advocates taking "specific action in favour of women and girls [to ensure that] they can enjoy protection and assistance on an equal basis with men and boys." The identification of a particular woman or girl as "at risk" appears to be the precondition to an "urgent protection intervention", and presupposes that not all women and girls should be characterized as "at risk" on account of being female.

The ExCom Conclusion begins by identifying general and specific risk factors in the protection environment that, alone or in combination, place individual women or girls "at risk." The ExCom Conclusion also notes how risk can be compounded over time and space, suggesting that "if women and girls have been subjected, for instance, to SGBV in the area of origin or during flight, this may leave them at heightened risk in the place of displacement."(ExCom Conclusion, para. (d)). Women and girls in urban versus camp settings may both face risks of SGBV, but they deal with different constraints on movement and access to assistance from international actors.

The ExCom Conclusion lists a number of preventive strategies for the UNHCR, other international governmental organzations (IGOs) and NGOs to use in identifying, assessing and monitoring risk factors at all stages of displacement. The last section of the ExCom Conclusion articulates immediate, medium and long-term intervention responses to deal with individual cases of at-risk women and girls.

These include safe houses for women victimized by domestic and sexual violence within refugee camps, relocation to other sites of refugee protection, resettlement, access to legal, psycho-social and economic assistance, and deployment of mobile courts to facilitate access to justice.

Repatriation and Resettlement of Refugee Women

Repatriation of refugee women raises similar issues to the reintegration of IDP women in their regions of origin. Gender-specific legal barriers include restrictions on women claiming, inheriting or acquiring title to property. Stigmatization of widows and women who were (or were presumed to have been) prostituted or sexually violated also impedes return and reintegration. Resettlement to a third country (United States, Canada, Australia, Norway, Sweden, Great Britain etc.) benefits few refugees, and proportionally fewer women than men. The ExCom Conclusion's encouragement of resettlement for women at risk must be read in light of this background constraint, which is unlikely to change significantly in the foreseeable future.

A major limitation of both the IDP and the refugee regimes is the institutional presumption among key international governmental organizations (and their funders) that displacement ought to be and therefore will be temporary. Investment in programmes and strategies for the management of indefinite or permanent displacement is difficult to reconcile with this presumption, even though experience shows that many situations of displacement go unresolved for years, even decades.

Trafficking

The international legal approach to trafficking is framed within a criminal law perspective that makes states not individuals – the primary victim. This creates a misalignment between the implicit or explicit human rights framework informing the approach to trafficking in IDP and refugee discourse, and international law governing trafficking. This incongruity is especially visible in respect of persons trafficked across borders. The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (Trafficking Protocol), supplements the UN Convention Against Transnational Organized Crime. Trafficking in persons is defined as follows:

(a) "Trafficking in persons" shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs;

(b) The consent of a victim of trafficking in persons to the intended exploitation set forth in subparagraph (a) of this article shall be irrelevant where any of the means set forth in subparagraph (a) have been used;
(c) The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered "trafficking in persons" even if this does not involve any of the means set forth in subparagraph (a) of this article;
(d) "Child" shall mean any person under eighteen years of age.

The Trafficking Protocol is situated in an international instrument devoted to combatting transnational crime. In this context, the illicit movement of contraband arms, drugs, and people across borders is understood as a criminal activity orchestrated by transnational organized crime to the detriment of individual states. Although trafficking does not require that the person concerned cross an international border, the transnational focus of the UN Convention orients attention toward unauthorized movement across borders, and the consequential "assault" this inflicts on state sovereignty.

Trafficking and Conflict-Induced Migration

Trafficking and forced migration converge in at least two ways: First, women and girls who are displaced by conflict may be targeted by traffickers. Trafficking may be for the purposes of sexual exploitation by international peacekeepers, forcible recruitment into militia, forced "marriage" to combatants, or non-sexualized exploitative labour. This linkage between displacement and trafficking is widely recognized in the literature and addressed in various UN documents, including the IDP Guiding Principles and the UNHCR ExCom Conclusion on Women and Girls at Risk. It should be noted, however, that sex trafficking attracts attention that is probably disproportionate in relation to trafficking for other forms of exploitation. Nevertheless, even where women and girls are trafficked for non-sexual forms of labour exploitation, their subjugation places them at risk of sexual, emotional and physical abuse and the various consequential harms to physical and mental health.

Secondly, trafficking itself may be understood as a form of [indirect] conflict-induced migration (Martin 2006). For example, a woman who has not fled ongoing or impending conflict may nonetheless experience economic, personal and/or sexual harms that make her especially vulnerable to traffickers. If she is trafficked within the borders of her country, one may describe her as an IDP. If trafficked outside her country she may, subject to meeting various other criteria, come within the definition of a refugee.

There are, in theory, few obstacles to treating internally trafficked persons as IDPs for purposes of bringing them within the ambit of the IDP Guiding Principles. The situation of transnationally trafficked women is less clear (Demir 2003). A few successful asylum claims have been made by trafficked women in Australia (VXAJ, 2006), Canada (CRDD T98-06186, 1999), and the United States (JM, 1996), other cases in these same jurisdictions (*Lleshanaku* 2004) and in the UK (VD, 2004)

and elsewhere, the narrowness of the refugee definition makes it an awkward vehicle for redressing the harms to trafficked women. Moreover, the refugee definition directs attention solely at future persecution in the country of nationality, whereas the harms of trafficking are arguably inflicted in the country into which the woman is trafficked (and where she would make her asylum claim) as much as in the country of origin. While advocates tactically and creatively deploy the refugee regime to protect trafficked women, it is a strategy dictated by the absence of viable remedial alternatives.

The Trafficking Protocol recognizes persons who are trafficked as "victims", but does not recognize the harms inflicted on them as human rights violations. While the Protocol encourages states to undertake programs and actions to prevent trafficking and to treat trafficked persons as victims rather than criminals, it does not entitle trafficked persons to a remedy. These protection gaps reflect the fact that the Trafficking Protocol supplements an instrument that formally regards them as contraband commodities. The Trafficking Protocol encourages states to extend various forms of medical, psychological and social assistance to trafficking victims. It recommends that repatriation of trafficked persons to their countries of nationality or residence "preferably be voluntary." It also invites states to consider legislation that would permit trafficking victims to remain in the country temporarily or permanently, with due regard to "humanitarian and compassionate factors" (Article 7). None of these provisions is mandatory. In particular, the discretion reserved to states on the matter of deportation of trafficked persons (unlike refugees, who possess a right of *non-refoulement*) is attributable to states' experience with the UN Refugee Convention. States are now resolute in their refusal to relinquish sovereign authority to expel non-citizens, especially those who enter or remain without legal authorization (which is typically the case with trafficked persons). In short, the Trafficking Protocol confers no rights on trafficked persons. States can and do deport trafficked women back to places where the women were so desperate to leave, or their families were so destitute, or child welfare institutions so inadequate, that they more or less knowingly put them(selves) in the hands of traffickers. In these situations, deported women and girls stand a high risk of being re-trafficked, either because they cannot thrive in their country of origin, or because those who trafficked them initially will apprehend them again.

While one may criticize the Trafficking Protocol for making the welfare of trafficked persons a matter of state discretion, it is important to note that some states have followed the Trafficking Protocol's recommendation regarding temporary protection. The United States offers a temporary visa to trafficked women, although it is contingent on women agreeing to cooperate in prosecutions of traffickers. Provisions for granting temporary resident permits to trafficked persons also exist in Canada and many EU states (Citizenship and Immigration Canada 2006; Schlapkohl 2006: 71–80).

The Council of Europe Convention on Action Against Trafficking in Human Beings (hereafter "Trafficking Convention") goes further by securing trafficked persons short-term residence permits without conditions attached:

> Each Party shall provide in its internal law a recovery and reflection period of at least 30 days, when there are reasonable grounds to believe that the person concerned is a victim. Such a period shall be sufficient for the person concerned to recover and escape the influence of traffickers and/or to take an informed decision on cooperating with the competent authorities. During this period it shall not be possible to enforce any expulsion order against him or her. (Article 13).

The Trafficking Convention also requires the issuance of renewable resident permits to trafficked children when it is in the best interests of the child, and to adults where:

(a) the competent authority considers that their stay is necessary owing to their personal situation;
(b) the competent authority considers that their stay is necessary for the purpose of their co-operation with the competent authorities in investigation or criminal proceedings. (Article 14)

These latter provisions effectively implement the same discretionary principles as exist in the Trafficking Protocol. The Council of Europe Trafficking Convention will come into force when ratified by ten Member States. Thus far, only Austria, Moldova and Romania have ratified but over thirty states have signed the Convention.

The phenomena of trafficking, smuggling and irregular migration more generally must be understood against a landscape where the opportunities for lawful migration and asylum anywhere, but especially to prosperous and stable states of the global North, are extremely restricted. The options for women to relocate as autonomous, permanent immigrants are even more limited. The vast majority of women's migration is structured around the performance of gendered work namely sex, child/elder care, or household labor, even where the women in question possess education, skills, and experience in other occupations. Spousal migration (including so-called mail-order marriages), domestic work, and sex work each involve performance of one or more aspects of "women's work." In short, the migration of women is often dependent on a man and/or temporary. The resort to trafficking, smuggling and clandestine entry is largely a response to the absence of alternatives. The preponderance of gendered forms of labour reflects the global demand for (low cost) gender work in receiving countries. Without defending the exploitation involved in trafficking (which also often accompanies other types of irregular migration), it remains the case that combating irregular migration in the absence of viable alternatives in the country of origin deprives women of the only exit route that exists for them.

Conclusion and Recommendations

A survey of the many guidelines, handbooks, resolutions, toolkits, conclusions, and manuals produced by various United Nations bodies confirms an awareness of the protection issues specific to women and girls displaced by conflict, and an intention

to operationalize the norms at all levels, especially in the field. Persistent challenges to effective implementation remain. This paper does not presume to resolve this gap between theory and practice. Rather, I offer three recommendations that build on the distinctive role the UNFPA plays in advancing the protection of women and girls displaced by conflict.

Chronic Displacement

The main UN bodies that address displacement (UNHCR and OCHA) operate from the institutionalized premise that displacement ought to be temporary. This norm constrains the capacity of these bodies to adopt strategies that accommodate the ineluctable fact that many situations of displacement are long-term, if not permanent. However, the UNFPA operates in many different contexts (e.g. development as well as emergencies) and with different populations (displaced and non-displaced). It is not organized around a narrature model of catastrophe, followed by temporary disruption, culminating in restoration of the *status quo ante*. As such, its programming need not reflect the same assumptions and priorities as other actors. Therefore, the UNFPA may be well positioned to implement strategies in the health, livelihood and shelter domains that recognize the potential permanence of the temporary, and which (where appropriate) traverse the divide between displaced women and girls and non-displaced women and girls in surrounding communities who may be similarly situated with respect to the risks and needs addressed by UNFPA activities.

Trafficking as a Protection Issue

As noted earlier, trafficking is formulated as a "crime control" problem in the Trafficking Protocol to the UN Convention on Transnational Organized Crime. Although many commentators inside and outside the United Nations acknowledge the human rights dimensions of trafficking, no body has made the protection of the human rights of trafficked persons a central tenet of an agenda for action. The expertise and experience of UNFPA with respect to SGBV and reproductive health place it in a unique position to advance a protection agenda for internally trafficked women and girls within the IDP framework, and to promote the human rights of trafficked women and girls more generally. The Report of the Special Rapporteur on Violence Against Women on trafficking provides a useful starting point for developing a human rights framework for action (Coomaraswamy 2000).

Legal Literacy

Every day, refugee and internally displaced women demonstrate their resilience and resourcefulness in the face of relentless hardship. They also reflect on their situation and, given an opportunity, speak out. A remarkable video posted to YouTube

in 2008, depicts a committee of Darfuri women in a Chad refugee camp who gathered to produce a list of grievances grounded in their specific experience as female refugees. Their action was sparked by an incident of horrific and organized violence against seven girls and women in the camp, ranging in age from ages thirteen to thirty. These girls and women were accused of prostitution, and some of the men decided to "restore morality" by making an example of them. One night, the girls and women were rounded up, bound, and severely beaten and abused within earshot of camp residents. In the wake of this attack, a committee of women gathered together to publicize the ways in which their lives as Darfuri women had been worsened by the refugee camp experience. At risk to their own safety, they demanded recognition and respect for their humanity, their dignity and their rights. The result was the Farchana Manifesto (http://www.youtube.com/watch?v=-DfeOTR_lZE). The following is transcribed from the translation of the Arabic text, as narrated in the video:

A Declaration Written by the Women of Farchana Refugee Camp: We the women have many concerns about deprivation of our liberties and denial of our freedom of expression. Here, we relate them to you, one by one:

1. Limited Freedom of Expression. We are denied freedom of expression. Women have no voice.
2. Limited Right to Work. It is forbidden for women to better their living conditions. If a woman works, she must still see to all her responsibilities such as caring for the sick, household management, and caring for the children. The husband's role is non-existent. And a woman is not married needs to go to work to bring food for herself and her children, but has no right to do so.
3. Inequality Between Wives. There is a lack of equality between wives, if a man has multiple wives. This in an injustice.
4. Lack of Property Rights. Women cannot freely decide how to manage their own property, such as money, gold, domestic objects and cattle.
5. Restricted Movement. There are restrictions on external communications, for example, visiting neighbours, family friends and especially long distance. If a woman is allowed to travel long distance, she will not receive any money, and will have to make do.
6. Limited Access to Education. Access to education is restricted for girls, especially university.
7. Discouragement of Girls. Girls are discouraged from attending school.
8. Mothers Blamed. When a girl becomes pregnant, her mother must take responsibility and is held accountable. This can bring negative reactions from her husband, and can lead to divorce.
9. Physically Gruelling Labour. Hard labour is done by women: Gathering fireword, collecting grass for cattle, shelter construction. All physically grueling work is the responsibility of women.
10. Lack of Trust. A woman cannot leave her home without her husband's approval or knowledge. Otherwise, she will immediately be accused of having left in order to prostitute herself. Even worse, when she is out gathering firewood, she

may be caught and raped When she comes home, men blame her for the rape, accusing her of “asking for it”.

11. Lack of Worth. A woman has no value except for sexual pleasure. Men want to have many children, but do not think of their children.
12. Forced Child Marriage. After five or six years of school, girls are forced to marry. Then they must stay at home without higher education, work, or freedom.
13. Agencies not Listening. Even during aid agency meetings, women’s voices are not taken seriously. Only the men are being heard.
14. No Recourse for Grievances. The space or organization that will take into account their concerns does not exist.

We thank you, and hope that women’s liberties and worth become important matters in this world, on this day June 10, 2008.

The general concerns raised in the Farchana Manifesto are surely not unique to this group of refugee women. The UNFPA’s activities bring them into regular, close contact with women under the aegis of providing services that are perceived as more or less apolitical. This opens up an opportunity for the UNFPA to be an organization that listens and that takes women’s concerns into account. The UNFPA can be an important ally for change, an ally that displaced women seek, need and deserve.

Notes

1. The location of latrines, and the means of gathering firewood are two commonly cited illustrations of camp design issues that affect women’s security.
2. Formerly the IASC Task Force on Gender and Humanitarian Assistance.
3. The clusters and lead agencies for conflict-induced IDPs are as follows: Logistics (WFP), Emergency telecommunications (OCHA, UNICEF, WFP), Camp co-ordination and management (UNHCR), Emergency Shelter (UNHCR), Health (WHO), Nutrition (UNICEF), Water, sanitation and hygiene (UNICEF), Early Recovery (UNDP), Protection (UNHCR).
4. According to the IASC website, the Guidelines “specifically details minimum interventions for prevention and response to sexual violence to be undertaken in the early stages of an emergency”, while the Gender Handbook “is a sector-by-sector guide on how to ensure gender equality programming in humanitarian situations. It provides practical tips on how to mainstream gender and checklists to measure the progress in meeting the needs and ensuring the equal participation of women, girls, boys and men in all aspects of humanitarian response.” The Guidelines and the Handbook are meant to support and complement one another.
5. States and regional organizations that have adopted or indicated an intention to adopt laws or policies reflecting the Guiding Principles include Angola, Burundi, Liberia, Sierra Leone, Nigeria, Uganda, Great Lakes Region, India, Nepal, Philippines, Sri Lanka, Colombia, Peru, Azerbaijan, Bosnia-Herzegovina, Georgia, Serbia-Montenegro, Russia, Turkey, the African Union, the Inter-governmental Authority on Development in the Horn of Africa, the Organization of American States, the Organization for Security and Cooperation in Europe. Brookings Institution, n.d.).

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Women, Conflict and Trafficking: Towards a Stronger Normative Framework for Protection

Susan Martin and Amber Callaway

Introduction

Human trafficking for forced labor and sexual exploitation is one of the fastest growing areas of international criminal activity and one that is of increasing concern to the international community. Human trafficking is the recruitment, transportation, harboring, or receipt of people for the purpose of exploitation. That exploitation takes many varied forms, but in all cases it leads to forced labor or sexual exploitation for profit or benefit of another. Armed conflict is inextricably linked to trafficking. War and instability cause a breakdown in law and order, a deterioration of institutional and social protection mechanisms, increased poverty, deprivation, and dislocation of the civilian population – creating an environment in which trafficking flourishes. Traffickers take advantage of the opportunity to exploit the vulnerable. They prey on those who are forcibly displaced or compelled to migrate in search of safety and stability, both internally and across borders, and they forcibly abduct those who lack adequate protection.

Women are particularly vulnerable to trafficking during conflict. While all people suffer from the devastation that accompanies war, violence against women, particularly on account of their gender, has reached epidemic proportions in many conflicts around the world. Women and girls are far more vulnerable to gender-based persecution, discrimination, oppression, and forced sexual slavery. The abuse they experience during conflict is often associated with their status in society. Trafficking of women during conflict is based on similar factors and conditions that characterize trafficking in general, which are exacerbated during conflict. Pre-war gender inequalities, a lack of status and inadequate livelihood opportunities leave many women at an increased risk of trafficking during conflict situations. Armed conflict also leads to specific forms of war-related trafficking such as military abduction and enslavement for sexual servitude or forced labor.

Women who become refugees or internally displaced persons (IDPs) as a result of conflict face an extremely high risk – especially in camp situations. Displacement

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_3, © Springer Science+Business Media B.V. 2009

strips away economic opportunities, terminates dependable employment and educational opportunities, induces extreme forms of isolation and poverty, and destroys social structures. As the men go off to fight, many displaced women struggle to survive with inadequate shelter, little or no access to food or basic healthcare, and no protection. They are cramped together in makeshift dwellings, often in unhygienic conditions, leaving them disoriented and less able to resist exploitation as they desperately search for a means of survival. Traffickers take advantage of their desperation either by forcibly abducting them or luring them away with false promises of a better life somewhere else. They are subsequently trafficked for forced labor or sexual exploitation.

This chapter examines the complex interconnections between trafficking of women and armed conflict. It is based on Martin's field work and an analysis of reports by international governmental and non-governmental organizations, newspaper articles, and academic publications. After a brief review of the literature and discussion of the various ways in which trafficking intersects with conflict, the chapter provides a detailed analysis of the legal and normative frameworks that have been adopted to combat trafficking of women, particularly during conflict. We argue that using a combination of international instruments creates a stronger framework for protecting and assisting these women than any of the instruments do on their own. While norms by themselves will not prevent trafficking or protect victims, they can serve as a basis for advocating implementation of policies and programs to achieve these goals. In emphasizing the importance of developing a strong normative framework to address trafficking in conflict, the chapter follows Martha Finnemore's framework for understanding the interplay between international norms and state behavior: "State interests are defined in the context of internationally held norms and understandings about what is good and appropriate. That normative context influences the behavior of decisionmakers and of mass publics who may choose and constrain those decisionmakers (Finnemore, 1996)."

Literature Review

Although the issue of trafficking in persons has garnered considerable attention during the past decade, a recent review of the literature found that

> there is little systematic and reliable data on the scale of the phenomenon; limited understanding of the characteristics of victims (including the ability to differentiate between the special needs of adult and child victims, girls and boys, women and men), their life experiences, and their trafficking trajectories; poor understanding of the *modus operandi* of traffickers and their networks; and lack of evaluation research on the effectiveness of governmental anti-trafficking policies and the efficacy of rescue and restore programs, among other gaps in the current state of knowledge about human trafficking (Goździak and Bump, 2008).

Goździak and Bump's analysis of journal articles and reports found that most were analyses of trafficking for sexual exploitation, with only a few articles focusing on trafficking for labor exploitation or domestic servitude (Goździak and Bump, 2008).

The literature on trafficking of persons in conflict and crisis settings is particularly sparse. Few articles in scholarly journals focus explicitly on these issues. Most case studies focus on relatively stable countries with relatively easy access by researchers. Even those books and journal articles presenting case studies of trafficking in countries with conflict often devote little or no attention to the role that the conflict may be playing in relationship to trafficking, focusing instead on economic and social factors (see, for example, Hennink and Simkhada, 2004, on sex trafficking in Nepal and Ali, A., 2005 on South Asia). A notable exception is Friman and Reich (2007) on the Balkans. Richer in their treatment of trafficking, conflict and displacement are reports issued by human rights groups and relief agencies that work in such settings (see, for example, Amnesty International, 2004; Human Rights Watch, 1997, 2002; Women's Commission on Refugee Women and Children, 2005, 2006a, b, 2007; GTZ, 2004; Lough and Denholm, 2005). With press reports of the increase in trafficking associated with military and peacekeeping operations, attention has also been paid in the literature to these issues (see, for example, Allred, 2006; Crook, 2005; Hughes et al., 2007). The connections between trafficking and child soldiers have also received increased attention, including in the context of refugees and displaced persons (see, for example, Ford Institute 2008). A further area of research focuses on the interconnections between asylum and trafficking (see Koser 2000; Women's Commission 2006, 2007). In all, however, trafficking in persons in the context of conflict is an under-researched area.

Forms of Trafficking in Conflict

Abduction by Armed Forces for Sexual Enslavement and Forced Marriage

During times of conflict, women and girls are especially vulnerable to trafficking by armed forces. Many of these women are held for sexual enslavement or enforced military prostitution. In some cases, women are abducted and given as "wives" to reward fighters. They may be captured for a variety of reasons, but sexual violence is almost always a part of their exploitation. Abduction for sexual enslavement by government and rebel groups has been documented in many past and current conflicts, including: Angola, the war in the Former Republic of Yugoslavia, Sierra Leone, Liberia, Uganda, Indonesia Rwanda, and the Democratic Republic of Congo (DRC).

In the camps straddling the Thai-Cambodian border in the 1980s, for example, women and girls were routinely trafficked by insurgent groups to be servants, "wives" and porters.[1] During the Indonesian occupation of East Timor, Indonesian army officials and militias abducted women and sent them to camps in West Timor, where they were "married" to Indonesian soldiers (Rehn and Sirleaf, 2002). During the 1994 Rwandan genocide, "ceiling women" were kept in the space between rafters and the roof while their captors were away, and were brought down for sexual and domestic servitude upon their captors return (Human Rights Watch, 1996).

In Afghanistan, more than 20 years of civil war has resulted in chronic insecurity, massive displacement, and poverty borne of conflict and drought, making

women extremely vulnerable to trafficking. Both Taliban and rebel fighters sexually assaulted, abducted, and forcibly married women during the conflict (Save the Children, 2003). According to the International Organization for Migration (2003), women and girls continue to be abducted for forced marriages in many Afghan provinces, particularly in rural areas that have been severely affected by drought, and among displaced populations. Women and girls are either snatched while walking outside, or forced from their homes by armed groups.

During the 10-year civil war in Sierra Leone, women were trafficked into refugee camps and used as sex slaves for the camp managers (United Nations, 2002). A report by Physicians for Human Rights (2002) found that one third of the women reporting sexual violence during the war had been abducted and 15% were subject to sexual slavery. The report also found that 94% of displaced households surveyed in Sierra Leone experienced sexual assaults, including rape, torture, and sexual slavery.

Similarly, the abduction of women and girls for sexual slavery and forced "marriage" has been particularly pervasive during the war in northern Uganda, where the Lord's Resistance Army (LRA) has abducted thousands of women and girls and used them as domestic slaves and assigned them as "wives" to the LRA commanders.

In Burma, where the military regime routinely abducts, rapes, and abuses women, victims often face rejection by their families and attempt to flee to Thailand, where they are not recognized as refugees and therefore denied protection, humanitarian aid and counseling. Once in Thailand, these women are vulnerable to further trafficking and exploitation (Shan Human Rights Foundation, 2002). As noted by the Women's Commission for Refugee Women and Children (2006a) Thai immigration officials are participating in this exploitation by actively trafficking women in Mae Sot, a town located on the northwestern border with Burma. A senior UN official interviewed by the Women's Commission reported that immigration officials sometimes force women, some of whom have been previously trafficked and are fleeing in search of safety, to have sex with them. Afterwards, they sell the women to work as sex slaves in the karaoke bars.

Forced Labor

The exploitation of women's labor is also an important factor in sustaining war economies. Apart from being sexual slaves, women are forced to do domestic work, collect firewood, cultivate crops, and demine contaminated areas. They are forced to work in mines or drug plantations in order to sustain war economies and prolong conflict.

In the DRC, women and children are commandeered as slave workers, porters and guards in mines and plantations (United Nations, 2002). They are forced to live as slave laborers in the forest with the rebels or with local men who control and benefit from the mines and plantations. During the conflicts in Angola and Sierra Leone women and children were not only trafficked as sex slaves, but also as day laborers and domestic servants. They were abducted and forced to carry supplies, such

as ammunition, looted goods, and messages between work gangs or among fighting forces (Coalition to End the Use of Child Soldiers, 2001). Reports from Sierra Leone also indicate that some women and girls were forced to become combatants for the rebels – a common phenomenon in many contemporary conflicts around the world. In Colombia, women (and men) are forced by guerrillas or the paramilitary forces to work on drug crops (GTZ, 2004).

Trafficking of Displaced Populations

Mass displacement of the population and a loss of livelihood opportunities create a potential supply of trafficking victims. While men usually go off to fight in war, women and children are left behind unarmed and unprotected. Often times they languish in displacement camps with inadequate shelter, little or no access to food or basic healthcare and no protection. They are cramped together in makeshift dwellings, often in unhygienic conditions, leaving them disoriented and less able to resist exploitation as they desperately search for a means of survival. Sometimes these women are kidnapped outright in one country and taken forcibly to another. In other cases, traffickers entice victims to migrate voluntarily with false promises of stability, access to safety zones, or good paying jobs in foreign countries as au pairs, models, dancers, domestic workers, etc. After providing transportation and false travel documents to get victims to their destinations, they subsequently charge exorbitant fees for those services, creating lifetime debt bondage. An absence of law and order leaves borders uncontrolled – creating an opportunity for recruiters and armed forces to traffic vulnerable women and girls with little consequence.

Post-Conflict Trafficking

Unfortunately, trafficking of women for sexual exploitation and forced labor does not stop when the conflict ends. In fact, post-conflict regions offer ideal conditions for traffickers, as they are frequently characterized by the absence of law and order, political instability, increased criminal activity and dysfunctional law enforcement institutions. This highly volatile environment, coupled with social disintegration, destruction of livelihoods and a lack of economic activities following a war, particularly for women, offer a large collection of highly vulnerable people who are struggling to reconstruct their lives. Former militia, ex-combatants, or war lords may turn to trafficking in human beings as a way to replace revenue losses caused by the cessation of the war (GTZ, 2004). Additionally, demobilization programs force ex-combatants to turn in their weapons, causing an income loss in small arms trafficking which may be filled with trafficking in women and children.

At the same time, post-conflict countries generally do not have the government systems in place to combat trafficking. Establishing the rule of law through functioning policing and judicial systems often takes time, particularly if trained personnel are not available. For example, newly appointed government officials in Serbia, following the fall of the Milosevic government, identified trafficking as one of their

most serious problems, but they had neither the resources nor the expertise to prevent trafficking. Nor did Serbia have a legal code that would permit prosecution of traffickers. Police did not understand the problem, and in many cases, received bribes from the traffickers. In the prior regime, informants stated, trafficking was not only tolerated but encouraged because it was a source of revenue for the government. Moreover, with all of Serbia's other problems, officials stated, combating trafficking was a low priority.[2]

A sudden increase in trafficking for sexual exploitation often occurs when foreign or international peacekeeping or civilian forces are deployed to a war zone. Foreign soldiers bring money and time to post-conflict settings where both are regarded as priceless commodities. With an increase in demand for sexual services comes an increase in supply. The arrival of peace support missions often directly coincides with an increase in local sex markets around military and peacekeeping camps. Traffickers and local authorities in post-conflict regions are quick to enter and benefit from the emerging market, which represents an economic opportunity in a situation where few other opportunities to earn an income exist.

The deployment of peacekeeping forces to Sierra Leone, Kosovo, Eritrea, and Bosnia, for example, created huge local sex markets (GTZ, 2004). In Bosnia and Herzegovina an explosive growth in "sex slaves" was fueled by the arrival of tens of thousands of predominately male NATO and UN personnel in the wake of the signing of the Dayton Peace Accords by Bosnia, Croatia, and Yugoslavia in 1995. The United Nations High Commission for Refugees (UNHCR) estimated that 30% of those visiting brothels in Bosnia were UN personnel, NATO peacekeepers or aid workers. Other research estimates that since 1995, 70% of traffickers' income in Bosnia came directly from peacekeepers (Refugees International, 2004). In the Democratic Republic of Congo, the international media reported allegations of a soldier-run prostitution ring involving girls as young as 15 in the South Kivu area (IDMC, n.d.). In Mozambique, following the signing of the peace treaty in 1992, soldiers of the United Nations Operation in Mozambique (ONUMOZ) reportedly recruited girls as young as 12 into prostitution.

Legal Protection of Trafficked Persons

Despite notable progress by the international community to protect victims of trafficking, current international instruments are insufficient on their own to protect and assist women who have been trafficked during conflict. Taken together, however, the instruments provide for a more holistic and integrated approach to protecting and assisting the women who fall victim to this exploitative criminal activity than any do on their own, as each instrument has strengths and weaknesses that are balanced by the other.

International Anti-Trafficking Law

Human trafficking is now considered the third largest source of profits for organized crime, behind only drugs and guns, generating billions of dollars annually.

Recognizing the growth of trafficking operations, the UN General Assembly adopted the Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children (Trafficking Protocol) in November 2000 (UN Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children, adopted by UN General Assembly, November 15, 2000 [hereinafter Trafficking Protocol]). The Trafficking Protocol requires international cooperation in combating and preventing trafficking in persons with special attention to women and children. It lays out the first internationally recognized definition of trafficking as:

> the recruitment, transportation, transfer, harboring, or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, or deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall including, at a minimum, the exploitation or the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs (Trafficking Protocol, art. 3(a).

As binding international law ratified by more than 90 countries, the Trafficking Protocol requires states to take specific actions to prevent trafficking and prosecute traffickers. The Trafficking Protocol contains provisions related to the protection of trafficking victims, but the language is fairly weak in assigning responsibilities to governments. The Protocol states, for example, that governments "shall endeavor to provide for the physical safety of victims of trafficking in persons while they are within its territory (Trafficking Protocol, art. 6)." The Protocol also requires a state party to protect the confidentiality of trafficking victims "in appropriate cases and to the extent possible under its domestic laws (Trafficking Protocol, art 6)."

Additionally, the Protocol encourages but does not require state parties to adopt provisions to help trafficking victims to recover: "Each State Party shall consider implementing measures to provide for the physical, psychological and social recovery of victims of trafficking in persons (Trafficking Protocol, art 6)." Among the areas to be considered are: appropriate housing; counseling and information; medical, psychological and material assistance; and employment, educational and training opportunities. For victims that are trafficked across an international border, the Protocol also encourages states to "consider adopting legislative or other appropriate measures that permit victims of trafficking in persons to remain in its territory, temporarily or permanently, in appropriate cases (Trafficking Protocol, art 7)." Also in the case of transnational trafficking, the Protocol includes specific provisions regarding return and reintegration of trafficking victims to their home countries. By contrast, it includes no provisions related to the return or reintegration of internal trafficking victims to their home communities. This is particularly important for women who are abducted by armed groups during internal conflicts – which make up the majority of contemporary warfare – because they are typically trafficked internally.

However, the Trafficking Protocol does require states to facilitate the safe return of their trafficked nationals and residents (Trafficking Protocol, art 8), and it requires the country that is returning a trafficked person to do so with full regard for

the victim's safety and the status of legal proceedings related to the trafficking (Trafficking Protocol, art 8). The Protocol also mandates that governments provide and strengthen training for law enforcement and immigration officials in the prevention of trafficking in persons with special consideration to human rights and gender specific issues (Trafficking Protocol, art 10). Furthermore, the Trafficking Protocol contains a savings clause that notes "nothing in this Protocol shall affect the rights, obligations and responsibilities of States and individuals under international law, including international humanitarian law and international human rights law and, in particular, where applicable, the 1951 Convention and the1967 Protocol Relating to the Status of Refugee and the principle of non-refoulement as contained therein" (Trafficking Protocol, art 14).

International Refugee Law

Today, primary responsibility for refugee protection and assistance rests with the UNHCR. Refugees, as defined by the 1951 Convention relating to the Status of Refugees and its 1967 Protocol, are persons outside their own country who are unwilling or unable to return because of a well-founded fear of persecution on account of race, religion, nationality, political opinion or membership in a particular social group (United Nations Convention Relating to the Status of Refugees, 189 UN Treaty Series 137 (opened for signature July 28, 1951); United Nations Protocol Relating to the Status of Refugees, 606 UN Treaty Series 267 (opened for signature January 31, 1967) [hereinafter Refugee Convention]). The Refugee Convention prohibits the expulsion or return of refugees to a country where their lives or freedom would be threatened because of a well-founded fear of persecution the basis of the five criteria mentioned above – a principle known as *non-refoulement*. The Refugee Convention is legally binding. It has been ratified by 147 states party to either or both the Convention and the Protocol as of September 2007 (UNHCR, 2007).

In 2006, the UNHCR published guidelines on the application of the Refugee Convention to people who have been trafficked. The Guidelines note that UNHCR's involvement in the issue of trafficking is essentially two-fold. First, UNHCR "has a responsibility to ensure that refugees, asylum-seekers, IDPs, stateless persons, and other persons of concern do not fall victim to trafficking." Secondly, UNHCR "has a responsibility to ensure that individuals who have been trafficked and who fear being subjected to persecution upon a return to their country of origin, or individuals who fear being trafficked, whose claim to international protection falls within the refugee definition contained in the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees are recognized as refugees and afforded the corresponding international protection."

While the guidelines in no way suggest that all victims of trafficking are entitled to refugee status, they demonstrate how some trafficked persons may have entitlements under the Refugee Convention. For example, they state that some acts – which are inherent to the trafficking experience – "constitute serious violations of human rights which will generally amount to persecution." These include: abduction,

incarceration, rape, sexual enslavement, enforced prostitution, forced labor, removal of organs, physical beatings, starvation, and the deprivation of medical treatment. The guidelines also state that "the mere existence of a law prohibiting trafficking in persons will not of itself be sufficient to exclude the possibility of persecution. If a law exists but is not effectively implemented, or if administrative mechanisms are in place to provide protection and assistance to victims, but the individual concerned is unable to gain access to such mechanism, the State may be deemed unable to extend protection to the victims, or potential victim, of trafficking."

The guidelines include provisions related to the possible persecution upon the return of trafficking victims to the territory from which they have fled or from which they have been trafficked. For example, they state that reprisals and/or possible re-trafficking could amount to persecution depending on whether or not the acts feared involve serious human rights violations. In addition, the guidelines recognize that victims may fear ostracism, discrimination, or punishment by their family and/or the local community which could give rise to a well-founded fear of persecution, particularly if aggravated by the trauma suffered during, and as a result of, the trafficking process. Notably, the guidelines note that even if the ostracism does not rise to the level of persecution, "such rejection by, and isolation from, social support networks may in fact heighten the risk of being re-trafficked or of being exposed to retaliation, which could give rise to a well-founded fear of persecution."

The UNHCR guidelines represent a useful addition to our understanding of the Convention regime, but they are not legally binding and they do not purport to amend the Refugee Convention – states remain only bound by the 1951 Refugee Convention and its 1967 Protocol. Even in cases where trafficked persons can be entitled to refugee status, the Refugee Convention only protects refugees fleeing very specific kinds of persecution, leaving those fleeing civil wars, ethnic conflicts, and generalized violence – which make up the majority of refugees and a substantial number of trafficked persons – inadequately protected (Loescher, 1996). Although some regional laws have been adopted to address this deficiency, such as the Convention Governing Specific Aspects of Refugee Problems in Africa and the Cartagena Declaration on Refugees in Latin America, protection of refugees fleeing for grounds other than persecution need to be formalized in both national and regional law in order to provide adequate protection.

Protection of Internally Displaced Persons

Not all persons forced to leave their homes as a result of armed conflict actually cross an international border and thus become refugees under international law. People who flee for similar reasons as refugees but remain within the borders of their own country are known as internally displaced persons (IDPs). Worldwide there are an estimated 26 million IDPs (IDMC, 2008). Although IDPs now outnumber refugees by two to one, their plight has received far less international attention. This is largely due to complex legal and political challenges related to state sovereignty. Although it is clear under international law that states themselves carry the primary

responsibility to protect their own citizens, the governments of many countries that experience internal displacement are either actively involved in the persecution of IDPs or are unable or unwilling to protect them.

In 1998 the UN Secretary-General's Special Representative on Internal Displaced Persons developed the *Guiding Principles on Internal Displacement* (Guiding Principles). Although not legally binding, the Guiding Principles provide a critical framework for defining and promoting IDP protection. They do not create rights per se, but they restate and compile existing international human rights and humanitarian law relevant to the internally displaced. They also attempt to clarify gray areas and gaps in international instruments with regard to issues of particular relevance to the internally displaced (Martin et al., 2005).

Under the Guiding Principles, IDPs are defined as:

> persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized stated border.

The Guiding Principles identify the rights and guarantees relevant to the protection of IDPs in all phases of displacement. They provide protection against arbitrary displacement, offer a basis for protection and assistance during displacement, and set forth guarantees for safe return, resettlement and reintegration. They also establish the right of IDPs to request and receive protection from national authorities, and the duty of these authorities to provide protection (Guiding Principles on Internal Displacement, principle 3). Vulnerable populations, such as expectant mothers, mothers with young children, and female headed households are entitled to protection required by their condition and to treatment that accounts for the needs (Guiding Principles on Internal Displacement, principle 4).

The Guiding Principles specify the rights of IDPs to be protected against various human rights violations, including genocide, summary execution and forced disappearances (Guiding Principles on Internal Displacement, principle 10). They specifically call for protection of IDPs from many forms of trafficking, including: acts of gender-specific violence, forced prostitution, and indecent assault (Guiding Principles on Internal Displacement, principle 11). They also call for the protection of IDPs against slavery or any contemporary form of slavery, such as sale into marriage, sexual exploitation and forced child labor (Guiding Principles on Internal Displacement, principle 11).

The Guiding Principles specify that internally displaced persons have "the right to be protected against forcible return or resettlement in any place where their life, safety, liberty and/or health would be at risk" (Guiding Principles on Internal Displacement, principle 15). This would benefit victims who have been internally displaced as a result of being trafficked who may be returned to their home communities without an adequate assessment of the risks they may face.

The Guiding Principles also stipulate that "internally displaced persons who have returned to their homes or places of habitual residence or who have resettled in

another part of the country shall not be discriminated against as a result of their having been displaced. They shall have the right to participate fully and equally in public affairs at all levels and have equal access to public services" (Guiding Principles on Internal Displacement, principle 29). This provision is particularly important for internally displaced trafficked victims that suffer from social stigmas after being forced into prostitution.

International Humanitarian Law

International humanitarian law, which comes into force during international and non-international armed conflict, regulates the conduct of hostilities and protects civilians who are not taking part in hostilities. This area of law is particularly relevant to the protection of women and girls during armed conflict. The principle instruments of humanitarian law are the four Geneva Conventions of 1949 and their Additional Protocols. The protections and guarantees set out in these instruments are granted to all without discrimination, but women also benefit from special provisions that offer them additional protection.

For example, the Fourth Geneva Convention states that "women must be especially protected against any attack on their honour, in particular against rape, enforced prostitution, or any other form of indecent assault" (Geneva Convention IV, art 27). The Additional Protocols prohibit "violence to the life, health or physical or mental well-being of persons. . .in particular humiliating and degrading treatment, enforced prostitution and any form of indecent assault or threats thereof" (Geneva Convention, Additional Protocol I, art. 75). They also prohibit "slavery and the slave trade in all their forms" (Geneva Convention, Additional Protocol II, art 4(2). Additional protection is provided to pregnant women and mothers of young children (Geneva Convention IV, art. 8, 20, 21). They are afforded special treatment in relation to medical care (Geneva Convention IV, art. 50 and 91; Protocol I, art. 70), physical safety (Geneva Convention IV, art. 14, 17, 18, 20, and 21), and release, repatriation and accommodation in neutral countries.

The protections afforded by international humanitarian law are applicable in situations amounting to "armed conflict." However, the protections do not apply "in situations of internal disturbances and tensions, such as riots, isolated and sporadic acts of violence and other acts of similar nature" (Geneva Convention IV, art. 132; Protocol I, art. 76). Additionally, Protocol II, which applies to internal armed conflicts, provides fewer protections than the Geneva Conventions provide to those affected by inter-state conflicts (United Nations, 2002). Most conflicts that occur in the world today are non-international in nature which leaves many civilians without full protection under international humanitarian law.

Some additional protections are provided to civilians affected by non-international armed conflict through Common Article 3, which is common to all four Geneva Conventions. Although more applicable to contemporary armed conflict, Common Article 3 is not explicit in granting special protection for women against gender- based crimes. Human rights norms, which complements the protection

provided to women during times of armed conflict, are particularly significant in the context of non-international armed conflicts where the protection provided by conventional international humanitarian law is more limited (United Nations, 2002).

International Criminal Law

International criminal law also has increasing significance in relation to crimes against women and girls during armed conflict, in particular crimes of sexual violence. The Rome Statute constituting the International Criminal Court (ICC) was adopted at a diplomatic conference in Rome on 17 July 1998 and it entered into force on 1 July 2002. It is an international treaty binding only on those states which formally express their consent to be bound by its provisions. The ICC has the power to exercise jurisdiction over the major international crimes: genocide, crimes against humanity, and war crimes. One of the most important and highly praised aspects of the Statute is that it covers internal armed conflicts, as well as international conflicts.

The court does not have universal jurisdiction. Rather, its jurisdiction can be triggered in three different ways: by a state party, by the Security Council, or by the prosecutor of the Court (after receiving authorization from the Pre-Trail Chamber). Furthermore, the court's jurisdiction is limited by events that have occurred since the Statue came into force on July 1, 2002 (Rome Statute of the International Criminal Court; herinafter Rome Statute). The fundamental principle under which the ICC operates is one of "complementarity" to national criminal jurisdictions. The ICC may exercise jurisdiction only when certain criteria are satisfied, meaning that national courts have the primary responsibility for the prosecution of international crimes. Thus, Article 17 limits the ICC's jurisdiction in favor of national judicial systems, "reflecting the concerns of States over national sovereignty and the potentially intrusive power of an international institution" (Holmes, 2002).

The Rome Statute codifies gender-related crimes within the definition of war crimes to include rape, sexual slavery, enforced prostitution, forced pregnancy, and enforced sterilization (Rome Statute, art. 8 (xxii)(b)). The range of gender-specific crimes are also extended within the definition of crimes against humanity to include "rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity," provided that these crimes are "committed as part of a wide-spread or systematic attack directed against any civilian population, with knowledge of the attack" (Rome Statute, art 7(g). The Rome Statute further defines enslavement as "the exercise of any or all of the powers attaching to the right of ownership over a person and includes the exercise of such power in the course of trafficking in persons, in particular women and children" (Rome Statute, art 3 (2)(c)).

The Rome Statute is an important step in providing adequate protection to women during armed conflict from trafficking and sexual abuse. However, to date, the ICC has only opened up investigations in four situations – northern Uganda, Central Africa Republic, Democratic Republic of Congo, and Darfur – all of which have

been highly controversial. It has issued public arrest warrants for 12 people, 6 of which remain free. In northern Uganda, the ICC issued arrest warrants for 5 top rebel leaders – two of which have died since the indictments – for crimes against humanity which fall under Article 7 of the Rome Statute, including murder, sexual slavery, imprisonment, rape and mutilation. The ICC referral has raised fundamental questions about whether ICC involvement is the appropriate response, given the fact that peace has not been reached in northern Uganda. Many people believe that the simultaneous pursuit of peace and justice is only delaying a resolution of the conflict.

Conclusion

Taken together, the Trafficking Protocol, international refugee law, the Guiding Principles, international humanitarian law and international criminal law provide a good normative framework for protecting women who have been trafficked during conflict but they still lack strong legal enforcement measures. Although legally binding, the language in the Trafficking Protocol is weak in assigning responsibilities for the protection of trafficking victims to governments. International refugee law is also legally binding, but does not protect those who do not cross an international border in search of safety or those fleeing civil wars, ethnic conflicts, and generalized violence. The UNHCR guidelines on the application of the Refugee Convention to people who have been trafficked provide a useful interpretive legal guidance, but are not legally binding.

The Guiding Principles fill many of the gaps in setting out a legal framework for addressing the protection of victims who are trafficked internally, but they are not legally binding except to the extent that the Principles are based on existing international law. International humanitarian law is also very useful in addressing the protection needs of women during conflict, but offers fewer protections for women during internal armed conflict than to those affected by inter-state conflicts. Finally, the codification of gender-related crimes within the definition of war crimes and crimes against humanity marks an important step in protecting women against trafficking for sexual slavery during conflict. However, the ICC is controversial in nature and has only issued arrest warrants for high profile perpetrators of the most serious crimes. Although important, this is unlikely to deter the foot soldiers and criminal enterprises from continuing their abuse and exploitation of women during conflict.

Constraints of sovereignty undoubtedly make it difficult to enforce compliance with any of the international norms that have been adopted to protect women from becoming trafficking victims during conflict. To return to Finnemore (1996), states must be "socialized to accept new norms, values and perceptions of interest by international organizations." Understanding the interconnections between human trafficking and conflict is a first step towards developing a more comprehensive approach to combating the problem and providing more effective protection to the victims.

Notes

1. Based on interviews that Martin conducted in the camps in 1986
2. Interviews conducted by Martin in Belgrade, June 3–5, 2001. For more analysis of trafficking in Serbia, see "Philip Martin, Susan Martin and Patrick Weil, Managing Migration: The Promise of Cooperation, Lanham, MD: Lexington Books, 2006."

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Forced Prostitution and Trafficking for Sexual Exploitation Among Women and Girls in Situations of Migration and Conflict: Review and Recommendations for Reproductive Health Care Personnel

Michele R. Decker, Siân Oram, Jhumka Gupta, and Jay G. Silverman

Introduction

The potential for sexual and gender-based violence against women in situations of migration and conflict is widely recognized (UNHCR, 2003; Wakabi, 2008; Longombe et al., 2008; Hynes and Cardozo, 2000; Al Gasseer et al., 2004; Cottingham et al., 2008). While individual- and gang-perpetrated rape has been the focus of much of the limited literature to date, the scope of sexual and gender-based violence, both overall and within situations of migration and conflict, is far wider, and includes trafficking for the purpose of sexual exploitation and forced prostitution.

Migration and conflict pose unique risks for sexual and gender-based violence (Rehn and Johnson Sirleaf, 2002; Hynes, 2004), and particularly for trafficking for sexual exploitation and forced prostitution (UNHCR, 2003). Accordingly, recent efforts to describe, prevent and respond to such violence have articulated a broad definition of sexual and gender-based violence which includes both trafficking for sexual exploitation and forced prostitution; both are included as critical issues within the UNHCR's "Guidelines to Prevent and Respond to Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons" (UNHCR, 2003). Notably, while these under-studied forms of sexual and gender-based violence share many vulnerabilities and consequences with the atrocities of mass rape and singular instances of sexual violence, they are simultaneously distinct in many ways, and thus require specific attention regarding prevention and intervention within the context of conflict and migration.

The current report is designed to (1) define trafficking for sexual exploitation and forced prostitution, including the scope, perpetrators and reproductive health impact of such violence; (2) provide an overview of the state of knowledge regarding mechanisms by which migration and conflict may confer particular risk for sex trafficking and forced prostitution; and (3) provide recommendations for how field-

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_4, © Springer Science+Business Media B.V. 2009

based reproductive healthcare professionals can best prevent and respond to these forms of gender-based violence.

Definition, Scope, Perpetrators, and Reproductive Health Consequences of Trafficking for Sexual Exploitation and Forced Prostitution

Trafficking for Sexual Exploitation

The United Nations defines trafficking as "...the recruitment, transportation, transfer, harboring, or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, or deception...for the purpose of exploitation [including]...prostitution or other forms of sexual exploitation..." (United Nations, 2000). Women and girls are at particular risk of trafficking for the purposes of sexual exploitation, forced prostitution and sexual slavery. Statistics on human trafficking are difficult to approximate with any accuracy, but frequently cited is the estimate that 600,000–800,000 people are trafficked across international borders annually, of which women and girls comprise 80% (US Department of State, 2008). Added to this estimate should be the many thousands who are trafficked domestically within national borders, for instance from rural to urban areas. (US Department of State, 2008). The limited research to date concerning trafficking suggests that false promises of improved economic opportunities or marriage on the part of traffickers, as well as abduction by force or use of drugs (Hennink and Simkhada, 2004; Silverman et al., 2007b) are common tactics used to traffic girls and young women. Economic, social, and political breakdown in situations of conflict and migration are thought to render women and girls particularly vulnerable to trafficking and sexual exploitation based on the economic and physical desperation common to such contexts (Leiter et al., 2006; Singh et al., 2005; Huda, 2006).

Forced Prostitution

Forced prostitution, which includes coercive transactional sex, may occur in situations of migration and conflict. In these contexts, women and girls may be forced or coerced to trade sex for basic resources and services, including food for themselves and their children, security, documentation, relief goods, access to education, and border crossings (Johnsson, 1989; Swiss et al., 1998; Chonghaile, 2002; Hankins et al., 2002; Rehn and Johnson Sirleaf, 2002; Fagen, 2003; UNHCR, 2003; Larsen et al., 2004). A recent population-based survey conducted in northern Uganda and Southern Sudan found that just over 8% of Sudanese refugees had experienced forced prostitution/sexual slavery, compared to 1.4% of Sudanese nationals (Karunakara et al., 2004). Notably, 43% reported that they had witnessed forced prostitution scenarios, underscoring the widespread nature of such sexual exploitation among refugee populations (Karunakara et al., 2004). Forced

prostitution among women and girls affected by migration and conflict has been documented in numerous African contexts including Uganda, Liberia, Sudan, Sierra Leone, Guinea (Swiss et al., 1998; Chonghaile, 2002; Fagen, 2003; Karunakara et al., 2004; Amowitz et al., 2002).

Perpetrators of Trafficking and Forced Prostitution

Sexual violence in migration and conflict settings is often considered primarily a tactic of war, mostly perpetrated by combatants and opposing forces. However, recent reports of sexual violence perpetrated by aid workers and peace-keepers (Save the Children, 2008; Martin et al., 2005, Hynes and Cardozo, 2000), the very individuals charged with protecting victims, have highlighted the wide range of potential sexual violence perpetrators in these settings.

Individuals in positions of institutional, economic, or social power, including teachers, humanitarian aid workers responsible for rationing food and other scare/critical resources, peacekeepers and other military personnel (e.g., soldiers/officials at checkpoints or border crossings) are the major perpetrators of forced or coerced transactional sex (Johnsson, 1989; Rehn et al., 2002; UNHCR, 2003; Larsen et al., 2004; Ondeko and Purdin, 2004). The economic and social power imbalance between military and peacekeeping troops and the impoverished communities in which they serve creates an atmosphere within which troops can easily sexually exploit women and girls; where individuals and families have little or no means for obtaining necessary resources, military and peacekeeping troops are able to demand sex in exchange for the provision of food, other forms of aid, or cash. Demonstrating the exploitation of these power dynamics are statements from international aid workers indicating their sexual access to women and girls in refugee settings, e.g., “Not one of these men even needs to think about rape. . .any one can have any one of these girls for a little piece of food” (Fagen, 2003, p. 80). Trafficking for sexual exploitation is, likewise, often perpetrated by those in positions of economic or social power over women and girls, including peace-keepers and aid workers. For example, evidence of sexual exploitation and trafficking of Burmese migrant women by both Thai immigration officials and police officers (Leiter et al., 2006) highlights the similar vulnerability of migrant women to individuals in positions of institutional power. Climates of chaos and disorder may limit the capacity for effective supervision and management of military and humanitarian workforce, thus facilitating exploitation and providing ample cover for trafficking operations.

The trafficking of women and girls in the form of abduction and sexual enslavement by military and/or rebel groups has also been well-documented (Chunghee, 1996) and is reported to have continued in more recent conflicts across numerous countries including Angola, the former Yugoslavia, Sierra Leone, Liberia, the Democratic Republic of Congo, Indonesia, Colombia, Burma, Afghanistan and Sudan (Physicians for Human Rights, 2000; Beyrer, 2001; Nikolic-Ristanovic,

2003; Amnesty International, 2004; Wolte, 2004). Once forcibly abducted, women and girls may be kept for sexual and domestic slavery, and be kept as a “wife” for military personnel (Wolte, 2004; Bastick et al., 2007). Women and girls may also be raped with the goal of forcing pregnancy as a strategy to dilute an enemy’s identity, In Sierra Leone alone, for instance, close to one-third of all women reporting war-related sexual violence victimization were abducted and 15% reported sexual enslavement (Physicians for Human Rights, 2000).

Importantly, evidence from non-conflict settings suggest that perpetration of sex trafficking also extends to individuals with a pre-existing relationship to victims, such as co-workers and family friends (Hennink and Simkhada, 2004; Silverman et al., 2007). Notably, the little research available on perpetrators of sex trafficking indicates that both men and women may be perpetrators (Silverman et al., 2006). While trafficker gender has not been studied specifically within the context of migration and conflict situations, it warrants unique consideration relative to other forms of sexual violence as women may be well-positioned to perpetrate trafficking for sexual exploitation for a variety of reasons. Concerns for pre-marital virginity in many cultures can create climates in which women and girls may be discouraged from interacting with older adolescent or adult men (Abraham, 1999; Almeida et al., 1999). Such socially-sanctioned efforts to preserve a woman’s purity often lead to female-only social networks that are inaccessible to adult males; these norms likely afford female traffickers greater access to young women and girls than male trafficking agents. The trafficking of young women and girls by females may also be facilitated by social norms that emphasize the unconditional acceptance of hospitality being offered by others, particularly that offered by women (Almeida et al., 1999). Through exploiting such norms, women traffickers may be well-positioned to insist that their “gestures of hospitality” (e.g., drugged food or invitation to the trafficker’s home) be accepted. Thus, it is important to note that while females are unlikely to be direct perpetrators of forced prostitution, they can play an active role in the trafficking process. Women should therefore not be overlooked as potential threats to the security of women and girls both in general and within the contexts of conflict and migration.

Specific Vulnerabilities to Trafficking for Sexual Exploitation and Forced Prostitution in Migration and Conflict Settings

Among those most vulnerable to trafficking for sexual exploitation or forced prostitution are women or girls who are young, temporarily or permanently unaccompanied or separated from their families, and/or female heads of families (Johnsson, 1989; Fagen, 2003; UNHCR, 2003). Some reports have indicated that girls ages 13–18 are most at risk for forced prostitution (Chonghaile, 2002), although prepubescent girls should not be considered invulnerable to such sexual exploitation. Women and girls with mental and/or physical disabilities may be particularly vulnerable to trafficking and forced prostitution (UNHCR, 2003). All of these

vulnerabilities may be exacerbated by situation of migration and conflict (Wolte, 2004). Prior experience of gender-based violence also appears to increase vulnerability to trafficking and forced prostitution: studies have found that experiencing violence from intimate partners and/or other family members appears to increase vulnerability to trafficking (Silverman et al., 2006, Zimmerman et al., 2008), and previous victimization by sexual violence may increase risk through social isolation and economic vulnerability. Notably, situations of ongoing forced prostitution can lead to increased isolation (Murray, 2000), which can compound vulnerability of women and girls to further exploitation. Moreover, women and girls with mental and/or physical disabilities may be particularly vulnerable (UNHCR, 2003). All of these vulnerabilities may be exacerbated by situation of migration and conflict (Wolte, 2004).

Migration and conflict confer unique vulnerabilities for trafficking and forced prostitution. A recent study examined the explicit connection between armed conflicts, post-conflict situations and trafficking, based on analysis of reports by international governmental and non-governmental organizations (NGOs), media articles, existing academic publications, and key informant interviews with leading NGOs in this field (Wolte, 2004). This comprehensive review identified the following factors as increasing risk for trafficking and forced prostitution among women and girls during and after periods of conflict and migration: (1) gender-specific vulnerability within migration and conflict situations (2) sexual assault, military abduction, and sexual enslavement-related vulnerabilities (3) political instability, and (4) absence of gender-related concerns in post-conflict rebuilding agendas.

Gender-Specific Vulnerability Within Migration and Conflict Situations

Poverty

While increased poverty is commonplace during and after periods of crisis, the gendered distribution and impact of scarce resources, economic opportunity, and displacement can lead to heightened risk for trafficking and forced prostitution amongst women and girls (Wolte, 2004). Insufficient food resources and inequitable distribution of goods are often cited as major contributing factors to women and girls' vulnerability in these settings. The gendered power-imbalance favoring men coupled with the grave lack of basic resources may leave women and girls with few alternatives to the coercive exchange of sex for vital resources. Gender-specific vulnerability in the context of poverty may also manifest itself more directly, for example women may be unable to receive necessary relief goods and cash support where men are exclusively recognized as heads of households (MacDonald, 2005).

Poverty may also increase women and girls' willingness to accept "risky" job propositions (i.e., propositions that involve extensive or unescorted travel, offers that appear "too good to be true" (Hennink and Simkhada, 2004; Silverman et al., 2007); thereby raising susceptibility to trafficking and sexual exploitation. Similarly, as has

been recently documented in Iraq, extreme poverty propagated by civil unrest may encourage parents to more readily accept lucrative job offers for their daughters (Wolte, 2004). An Iraqi NGO, the Organization for Women's Freedom, estimates that approximately 3,500 women were missing in 2006 following the US-led invasion of Iraq in 2003; the NGO remains concerned that many of these women and girls were ultimately trafficked into sex work and may have been deceived into leaving the country by the false promise of earning money to support their families (IRIN, 2006). Traffickers exploit the economic desperation of families, offering the prospect of domestic work for daughters in richer nations within the Middle East, advance payment, and assurance of their daughters return in a year's time: trafficked survivors however report forced prostitution, virginity sales, and physical abuse (IRIN, 2006). Under conditions of migration and conflict, extended family members are often required to accept responsibility for unmarried or widowed women; such unmarried female family members are often associated with high expenses (e.g. related to bridal provision of dowry) and as such may be especially susceptible to exploitation and deceptive offers of prosperous employment based on their relatives' inability or unwillingness to accept such additional financial responsibilities (Silverman et al., 2007).

Changes to Familial Structure

Within conflict settings, women are far more likely to be widowed than men, particularly very young women (Hynes, 2004; Wolte, 2004), due in part to the larger numbers of male soldiers who die in combat (Hynes, 2004). In Rwanda, for example, some 58,000 households were reportedly headed by minor girls post-conflict (Save the Children, 2002). Sudden loss of income typically accompanies the death of a male spouse, exacerbating financial burdens due to post-conflict economic inflation following war and related crises as well as reduced opportunities for employment; in such situations, the vulnerability of young women and girls to sexual exploitation can be increased (Wolte, 2004). For example, Human Rights Watch reported that a group of mothers who migrated in search of work in order to support their children following the conflict in Bosnia and Herzegovina were trafficked en-route (Human Rights Watch, 2002). Additionally, prevailing gender roles in post-conflict settings may leave women vulnerable to forced prostitution within their own communities: if women are prevented from remarrying after widowhood or leaving their home without a male escort (even in situations where they are seeking employment) (Hynes, 2004), they are left with few economic options with which to secure their and their children's basic needs. (Hynes, 2004; UN Division for the Advancement of Women, 2001)

Beyond the consequences of widowhood, the collapse of social and familial structures following armed conflict or humanitarian crises can render women and girls, particularly younger girls, vulnerable to exploitation. The lack of support and supervision by family members resulting from absence, illness and death appears to contribute to vulnerability to trafficking and sexual exploitation. A recent study of how context affects the risk of trafficking in South Asia found that one in seven

trafficked women and girls reported the death or illness of a family member (including husbands) as a factor directly leading to their vulnerability to exploitation (Silverman et al., 2007).

War and disaster-related poverty may also prompt the enrollment of orphaned girls, as well as those whose families are unable to provide for them, into orphanages. Anecdotal evidence suggests that orphanages may not provide a sufficiently safe sanctuary for at-risk girls (Manohar, 2002). In a case reported in *Time* (Bennett, 2006), a nurse who was working at an orphanage in Iraq attempted to adopt one of her charges, only to then sell her into sexual slavery.

Displacement

Globally, women and children make up 80% of refugee and internally displaced populations, thus constituting the critical majority of these groups (UNHCR, 2003). Women who are refugees or otherwise internally displaced face extreme danger of being trafficked or sexually exploited. Refugee camps may serve as a concentrated source of women and girls for trafficking gangs, who may form alliances with corrupt officials within refugee camps in order to abduct women and girls (Wolte, 2004). For example, some thirty five female Bhutanese refugees were reported to have been trafficked from a Nepalese refugee camp into sexual exploitation, facilitated by the cooperation of camp personnel (Wolte, 2004; Human Rights Watch, 2003). Fear and uncertainty following conflict and migration may increase the vulnerability of women and girls to intimidation and deception, which may subsequently heighten their susceptibility to sexual exploitation (Leiter et al., 2006). Moreover, the context of mass migration may serve as a cover for traffickers (Hughes et al., 2000). Reflecting these issues is the emergence of extensive international concern regarding the plight of the estimated 35,000 children orphaned by the 2004 South and Southeast Asian Tsunami, including their vulnerability to trafficking and sexual exploitation (Huda, 2006).

Sexual Assault, Military Abduction, and Sexual Enslavement-Related Vulnerabilities

The potential for extreme sexual brutality, military abduction and sexual enslavement of women and girls within conflict-affected areas has been well-documented (Bastick et al., 2007). Among the myriad of health and social consequences of such victimization may be additional vulnerability to sex trafficking and forced prostitution even after the conflict has ceased and they have returned to their communities. Victims of such violence are often subject to extreme stigma upon their return to their home community (Longombe et al., 2008); community members may view them as being “tainted” by the enemy party, especially if the victims were forcibly married or impregnated (Human Rights Watch, 2002; Wolte, 2004). Individual and gang-perpetrated sexual assault within conflict settings are often characterized as involving extreme force and brutality (Longombe et al., 2008); both the violent victimization and the numerous health consequences (e.g., fistula and extensive

gynecologic injury) result in extreme stigma and isolation for victims (Longombe et al., 2008). This lack of acceptance from family and close community members may exacerbate isolation, placing these women and girls at increased risk of trafficking and prostitution-related revictimization (Wolte, 2004): economic desperation coupled with limited social support may render these women and girls more vulnerable to trafficking agents and their offers of economic opportunity and to situations of forced prostitution Similarly, formerly kidnapped women and girls may choose to not return to their families, believing that they will bring shame upon their families. In the absence of social and economic support, these women and girls may be highly vulnerable to sexual exploitation through trafficking and forced prostitution.

Vulnerability Due to Political Factors

Political Instability

The context of chaos and instability in armed conflicts and other humanitarian crises that may result in large-scale migration can foster a climate conducive to sexual exploitation. With an attenuated or non-functioning police force and situations of near lawlessness, criminal activities such as sex trafficking may be more able to gain and maintain a stronghold (Wolte, 2004). In Iraq, gang-based activities are reportedly growing at an alarming rate, in part due a lack of law and order capacity (Bennett, 2006). This situation is reported to have been aggravated further by bureaucratic action to freeze the assets of local NGOs that may have provided refuge to at-risk girls (Bennett, 2006). In the aftermath of such instability, former militia and ex-combatants may turn to trafficking activities in order to replace income lost due to lack of post-conflict employment (Wolte, 2004).

Neighboring Country Policies

Displaced women and girls also face a risk of being trafficked due to the policies of neighboring nations which surround regions of migration or conflict. For example, some 200,000 women and girls have fled North Korea to northeast China to seek protection from political persecution (Hughes, 2005). China, however, does not accept these refugees, thus forcing these women to seek refuge illegally. Traffickers within China may take advantage of the illegal status of these political refugees, and sell them into sexual slavery using threats of exposure to Chinese authorities to ensure the compliance of victims (Hughes, 2005).

Absence of Gender-Related Concerns in Post-Conflict Rebuilding Agendas

It has been noted by many international NGOs and aid agencies that the unique needs of women and girls are often not addressed or incorporated into post-conflict planning as nations move to reconstruction and reconciliation (Rehn and

Johnson Sirleaf, 2002; Wolte, 2004; Amnesty International, 2005; PROWID, 1998). This lack of attention to women's needs during the post-conflict process may, in part, be attributable to the lack of female actors and participants in these processes and within the responsible organizations. Historically, women have not been invited to participate in reconstruction policy development efforts (Wolte, 2004; Amnesty International, 2005), thus greatly reducing the likelihood of consideration of gendered issues such as sex trafficking and other forms of sexual exploitation. Governments may also prioritize establishing overall security within a country to the exclusion of security issues such as gender-based violence that are specific to large but likely marginalized populations. It may also be considered unpatriotic to discuss or prioritize stigmatized issues such as sexual and gender-based violence during a time when a nation is trying to focus on positive aspects of the society and attract external investment.

Reproductive and Sexual Health Consequences of Trafficking for Sexual Exploitation and Forced Prostitution

Victims of trafficking and forced prostitution are likely to suffer serious and complex reproductive and sexual health consequences as a result of their experiences of sexual violence, unsafe sex, and behaviors that may facilitate transmission of sexually transmitted infections. In a setting of conflict and forced migration factors such as poverty, the breakdown of social support, the disruption of services, and endemic violence both exacerbate these health consequences and make their resolution more challenging.

Direct and Indirect Effects of Sexual Violence

Sexual violence contributes to reproductive and sexual ill-health in a number of ways. The risk of infection with STIs and HIV may be increased due to blood contact and trauma to the vagina, anus or urethra, which can facilitate transmission of infection (Campbell 2002, Kalichman and Simbayi 2004). Infection risk is particularly heightened amongst very young girls, as biological factors related to immaturity of the reproductive tract increase vulnerability to tears and ulceration (Sarkar et al., 2005). The immunosuppressive effects of stress, depression, and trauma subsequent to sexual violence may also increase the risk of sexually transmitted infection following exposure (Campbell, 2002). In situations of conflict and forced migration the immunosuppressive effect of sexual violence may exacerbate that caused by extreme stress and poor environmental conditions following displacement.

Actual or threatened violence, physical or sexual, also reduces the ability of women to control risk within a sexual encounter. Women experiencing violence

may be forced to accept high numbers of sexual partners, and will have little control of the choice of sexual partner and limited capacity to negotiate condom use (Murray 2000; Larsen et al., 2004, Kalichman and Simbayi, 2004). This is likely to be particularly true in the context of forced migration and conflict; the situation is typically one of disempowerment for women and girls, and their extreme vulnerability and dependency on others for the means of survival is likely to compound the lack of power women and girls have in situations of sexual exploitation. To ensure compliance with their demands, abusers may also threaten a woman's family and children. In situations of forced migration and conflict, where women and girls may be exposed to mass violence and feel in constant danger from sexual abuse and harm, threats of violence all likely to be all the more meaningful.

Sexually Transmitted Infections and HIV/AIDS

In addition to the role of violence in increasing the risk of infection with HIV and STIs, women and girls trafficked or forced into prostitution will be at increased risk of infection when they have limited knowledge of protective contraceptive methods, or are unable to access or afford contraceptives. These issues are of particular concern within settings of conflict and forced migration due to the disruption or lack of health service infrastructure. Additionally, several studies have shown that women working in prostitution are often offered and paid more for unprotected intercourse (Wojcicki and Malala, 2001; Rosenthal and Oanha, 2006; Choi and Holroyd, 2007): where women are forced to trade sex for basic commodities, the incentive to insist on condom use is likely to be reduced even further.

Women trafficked or forced into sexual exploitation are thus at elevated risk of contracting HIV and other sexually transmitted infections. This issue is particularly pertinent in settings of conflict and forced migration, which have been characterized as posing a serious threat to the individual risk of infection and the spread of infection within specific settings (Hankins et al., 2002; Anema et al., 2008). Prevalence of infection and the spectrum of sexually transmitted infections will, in part, reflect local epidemiology. Studies with trafficked women have found, for instance, high levels of HIV infection in South East Asia (Sarkar et al., 2008; Silverman et al., 2006; Silverman et al., 2007a; Tsutsumi et al., 2008), but levels are likely to be lower in low prevalence regions. Trafficked children exposed to HIV may be at elevated risk of infection relative to trafficked adults, due to greater biological vulnerability, poorer knowledge of HIV/AIDS risk and appropriate protection methods, and inability to negotiate safe sexual practices (Silverman et al., 2006).

Reproductive Ill Health

A range of gynecological problems, developing as a result of sexually transmitted infections and sexual violence, have been reported in the trafficking literature. Common gynecological complaints amongst women trafficked or forced into sexual

exploitation are likely to include vaginal discharge, heavy bleeding and bleeding during sexual intercourse, pelvic pain, and pain during urination and sexual intercourse (Zimmerman et al., 2003; Cwikel et al., 2004; Zimmerman et al., 2008). Under circumstances of extreme sexual violence women may suffer serious long term damage to the reproductive tract, including vesico-vaginal and rectal fistula. Traumatic fistula cases are typically observed in conflict and post-conflict countries in which sexual violence has been used as a weapon of war, and occurs due to the tearing of the vaginal tissues as a result of violent sexual assault. The physical consequences include urinary and/or fecal incontinence, which have devastating social consequences; women suffering traumatic fistula are often shunned by their families and communities, compounding the already considerable stigma endured as a victim of sexual assault. (UNFPA Traumatic fistula information sheet accessed September 2008).

Unwanted Pregnancy and Pregnancy Loss

Women trafficked or otherwise forced into sexual exploitation may conceive unwanted pregnancies as a result of limited access to contraceptives or inability to negotiate their use. This problem may be intensified in conflict settings in which forced pregnancy is being used as a weapon of war. Women may therefore request, or have already undergone, abortion. Where women have been forced to seek unsafe abortion during exploitation they are vulnerable to a number of complications, including sepsis, hemorrhage, trauma of the reproductive system and abdomen, infection, pelvic inflammatory disease (PID) and infertility.

Experiencing trafficking or forced prostitution may also increase the risk of miscarriage. Studies have shown that the risk of miscarriage is elevated where women experience physical or sexual violence, certain sexually transmitted infections, and poor general health and nutritional status (Morland et al., 2008; Garcia-Enguidanos et al., 2002; Wynn and Wynn, 1993; Yong and Wang, 2005); the effect of risk factors for miscarriage are likely to be particularly salient where women are sexually exploited in conditions of forced migration and conflict. The psychological consequences of unwanted pregnancy and pregnancy loss are likely to be substantial.

Mental Health

The emotional and mental health effects of sexual exploitation are severe; these range from chronic anxiety, sleep disturbances, and depression to post-traumatic stress disorder, dissociation and suicidal ideation (Zimmerman et al., 2003; Cwikel et al., 2004; Zimmerman et al., 2008; Tsutsumi et al., 2008). Experiences of sexual exploitation are likely to compound the "baseline" traumatic effects of situations of forced migration and conflict.

The Role of Reproductive Health Care Providers in Preventing and Responding to Trafficking and Forced Prostitution

Reproductive health care providers have an important role to play in both the prevention and response to trafficking and other sexual exploitation. This role encompasses putting measures in place to reduce the risk of sexual exploitation, screening to identify women who are at risk of, or experiencing, such abuse, and meeting the needs of women who have survived this exploitation.

The factors governing the vulnerability of women and girls to trafficking and sexual exploitation, the resources available to the health care provider, and, therefore, the role of the health care provider in responding to trafficking and forced prostitution, will be affected by the stage of the conflict. Although varying ways of categorizing a conflict have been put forward, here we have considered the phases of a conflict as emergency, post-emergency, stabilization, and settlement and repatriation.

Measures to Reduce the Risk of Sexual Exploitation

Emergency Phase

Integrating Gender Concerns into Camp Structures

The integration of gender concerns when planning camp structures can help to reduce the vulnerability of women and girls to abduction, sexual violence, and sexual exploitation. The United Nations Development Program (UNDP) manual on Gender Approaches in Post-Conflict Situations offers strategies and tools for field staff to facilitate the incorporation of a gender-informed perspective in the planning and implementation of post-conflict programs and policy. The following recommendations are adapted from the UNDP manual, tailored specifically to the post-conflict needs of women and girls regarding sex trafficking and forced prostitution.

- In organizing refugee or IDP camp structures, include female participants and ensure consideration of security priorities for women and girls.
- Register men and women separately for camps to facilitate disclosure by refugees and displaced persons of related concerns (i.e. trauma from sexual slavery) or protections they are seeking from sexual exploitation.
- Ensure that latrines and showers for men and women are located in separate locations.
- Ensure women's latrines and showers are not located in such a way that individuals must travel through or to isolated or unlit areas of the camp.
- Educate camp security staff on the unacceptability of sexual exploitation and trafficking, and externally monitor security, particularly at the perimeter of the camp, to detect acts of exploitation.

Support and Use of Informal Women's Groups Within the Community

Informal groups of women in social leadership positions within the community can provide a critical source of infrastructure and support for prevention and victim assistance regarding sex trafficking and forced prostitution. Such informal networks of women should be identified by field staff and approached to serve the following functions:

- Provision of a network for communication about risks related to sexual exploitation and trafficking (e.g., identification of risky area or individuals, discussion of potential for exploitation related to food distribution systems)
- Provision of a culturally relevant structure for supporting individuals following exploitation
- Development and reinforcement of preventative actions and mechanisms related to sex trafficking and forced prostitution, particularly community surveillance efforts to:
  - Ensure that no girl children are unattended, particularly in food lines
  - Identify girls that are physically or socially isolated for whatever reasons and, therefore, at risk
  - Identify and promptly report young women and girls who suddenly disappear as potential trafficking victims

Training for Aid Workers on Sexual Exploitation

Training for all aid workers in situations of conflict and forced migration on the scope and nature of trafficking and forced prostitution is critical. At all levels of management, protocols should be in place to discourage involvement in sex trafficking and forced prostitution, with credible investigation and penalty procedures in place for workers who engage in such exploitation.

Moreover, aid workers should be trained on how to identify situations of potential trafficking and forced prostitution so as to prepare them to play their critical role in prevention (e.g., ensuring that no girl children are left unattended in food lines and elsewhere in the camp, reporting observed acts of trafficking recruitment or approaches for exploitation). Such training should occur both prior to deployment and on-site as community norms and patterns for vulnerability to trafficking and forced prostitution become known (e.g., location, time of day). It is critical to maintain confidentiality regarding individual cases of trafficking and forced prostitution; this confidential atmosphere is necessary to facilitate the victim's disclosure of experiences of trafficking and forced prostitution. Thus, no details regarding specific instances of trafficking or forced prostitution should be shared for the purpose of training and increasing surveillance. Warning signs, recruitment locations, and other relevant factors should always be presented as patterns, never as isolated instances, in order to protect victims from the possibilities of stigma and retribution.

Stabilization/Repatriation

In the stabilization and repatriation phases, the need for prevention is two-fold: personnel should aim firstly to prevent the initial trafficking and sexual exploitation of women and girls, and secondly to prevent the re-trafficking and repeat sexual exploitation of women and girls. Various recommended actions in addressing these goals have been outlined elsewhere for a variety of actors; the role of the reproductive health practitioner in preventing trafficking and re-trafficking in this setting lie in awareness-raising and in collaboratively developing reintegration and rehabilitation programs.

As outlined in Section "Specific Vulnerabilities to Trafficking for Sexual Exploitation and Forced Prostitution in Migration and Conflict Settings", women and girls may still be vulnerable to both cross-border and internal sexual exploitation in the post-conflict phases of stabilization and repatriation. Risk may be exacerbated where the injury or loss of a family member to conflict increases economic hardship and the need for women and girls to provide financial support to their family. Bleak in-country economic opportunities and the breakdown of social networks may increase uncritical acceptance of job offers and migratory projects, particularly where women and girls are keen to leave their county or community because their return was not voluntary. In the stabilization and repatriation phases, awareness raising efforts should build on those undertaken in the conflict and post-conflict phases. Maintaining awareness amongst at-risk women and girls is vital, but continuing efforts must also be made to educate the community and aid workers in the region.

The reintegration of women and girls who have been trafficked or otherwise forced into prostitution aims to restore physical, psychological, social and economic well-being and reduce the risk of re-trafficking or a return to situation of sexual exploitation. Women and girls who have been previously trafficked are frequently re-trafficked within the first two years of exiting the situation of exploitation (Jobe A., 2008). Post-trafficking, women and girls are likely to face limited economic opportunities and suffer ongoing mental health problems, and both of these factors may be exacerbated by stigmatization from their family and community due to having been in a situation of sexual exploitation. In a post-conflict setting the risk of re-trafficking is likely to be even higher: stigmatization and isolation may be worsened by poor social cohesion and strained community relationships, health services may not yet rebuilt, and economic opportunities are likely to be scarce.

In order to reintegrate into their communities and be rehabilitated from the trauma and abuse they have endured, women and girls who have suffered sexual exploitation are likely to require support in finding safe housing and jobs or vocational training opportunities, and will have ongoing physical and psychological health needs. Clearly, the ability of health care providers to work collaboratively to develop reintegration and rehabilitation programs for women who have experienced sexual exploitation will be extremely limited in resource constrained settings. However, health care practitioners should work creatively to utilize whatever resources are available to them:

- Identify organizations that have been set up for this/similar purpose. Where no specific organizations have been developed, programs set up to help victims of torture or sexual violence may be able to offer some support.
- Work with women's networks and other community groups to address issues stigma around experiences of sexual exploitation.
- Facilitate group support programs, which may be able to provide psychological and social support to women and girls who have experienced sexual exploitation.

Identifying Women and Girls Who Are at Risk of, or Experiencing, Sexual Exploitation

Screening can help to identify women who are at risk of, are experiencing, or have previously been in a situation of trafficking and sexual exploitation. Screening is thus a critical tool in both the prevention of sexual exploitation and the protection of those who have experienced it.

Emergency and Post-Emergency Settings: Basics of Identification and Prevention

The UNHCR guidelines for Preventing and Responding to Sexual and Gender-based Violence (2003) offer well-constructed and effective recommendations for the identification and support of victims of all forms of gender-based violence, including sex trafficking and sexual exploitation in the forms of forced prostitution. The following strategies can be adopted to identify and support victims of such exploitation, as well as prevent victimization among women and girls considered at high-risk based on the factors reviewed previously. The following recommendations have been adapted from the UNHCR guidelines and are tailored to sexual exploitation in the forms of forced prostitution and trafficking, and the roles of reproductive and sexual health field staff. Thus, they are designed to supplement the existing UNHCR material. Through consideration of these action steps, reproductive and sexual health care field staff will be better able to utilize their unique position to not only identify and support victims, but also to contribute to infrastructure to prevent these crimes.

- Field staff should become informed about the refugee and/or local culture, gender relations, and the most appropriate and relevant language for describing situations of prostitution and sex trafficking. Attention to the language used to discuss incidents of forced prostitution and sex trafficking recruitment is critical in enabling field staff to identify and discuss such instances with those in their care and the broader community.
- Field staff should engage with female local opinion leaders or elders to identify ways in which sexual exploitation and forced prostitution have traditionally been prevented and how such methods are compromised under current conditions.

- Field staff should, with these same individuals, identify areas within the community that are most likely to leave women and girls vulnerable to recruitment for trafficking or exposed to sexual exploitation (e.g., food distribution points, border crossings, areas where women and girls might frequent alone).
- Field staff should, with these same individuals, identify potential perpetrators who are most likely to recruit women and girls for trafficking or expose them to sexual exploitation.
- Field staff should support and facilitate the development of surveillance programs (to be carried out by members of the community) to monitor identified areas and potential perpetrators. Surveillance programs should also engage in the monitoring and collective supervision of young and unattended girls who may be most vulnerable.

Integrating Screening and Support with Standard Reproductive Health Care

To prevent and address sexual exploitation within emergency settings, the UNHCR has urged that women have ready access to both female safety advocates (professional or lay) and reproductive health facilities that are operated by female medical staff and gynecologists (UNHCR, 2003). These requirements warrant particular attention in the prevention and treatment of women exploited by forced prostitution and trafficking. Screening for potential, present or previous experience of sexual exploitation should begin in, and continue beyond, the emergency phase of the conflict.

In order to facilitate screening staff must create an environment in which women and girls feel that they can confidentially report their experiences. Ensuring confidentiality is critical not only for building trust with women and girls who have been sexually exploited, but also for ensuring their safety. Accordingly, staff must provide women and girls with assurance that their disclosures will not result in retribution. A number of steps are considered critical for creating this environment, although clearly in a resource-constrained environment the capacity of health practitioners to meet all of these steps can be compromised.

- Development of culturally appropriate methods of asking questions regarding exposure to exploitation and trafficking attempts (see the following section for details)
- Communication in a discreet, compassionate, and validating manner (i.e. assurance that that staff believe the client's story)
- Respecting choices and dignity. Medical services should be provided on the basis of informed consent only.
- Provision of private physical space (if possible) for discussion of these topics
- Provision of same-gender interviewers, interpreters, and clinicians
- Safeguarding recorded information. Recorded information should be kept securely in locked files, and information should be shared with relevant agencies only with the specific and informed consent of the victim.

Screening in the Context of Standard Reproductive Health Care

The following screening techniques are recommended specifically for soliciting disclosures of perceived risk or actual experiences of sex trafficking recruitment and forced prostitution. Such screening is recommended for several purposes, including identification of women and girls at risk, provision of appropriate services for victims, raising awareness of the issue among at-risk women and girls as a prevention strategy, and monitoring trends in these forms of sexual exploitation. Thus, in addition to facilitating the identification of victims, screening should also be viewed as a critical tool for raising awareness among women and girls regarding how sex trafficking and sexual exploitation may take place. Standard screening can also convey the message that trafficking and sexual exploitation are not considered acceptable to all women and girls within the community, and that assistance and emotional support are available for individuals victimized via these experiences.

Staff should ask screening questions in *normalizing, non-stigmatizing manner* to avoid creating perceptions among those screened that they are being judged or blamed.

Examples:

- Many girls and women are offered food, rations, or safety in exchange for sex or sexual favors, so we ask all women if they have ever been asked to provide sex or sexual favors in any of these circumstances
- Many times, girls and women are offered jobs outside of the camp/away from their community, such as domestic work or cooking. Has anyone approached you with a job offer like this?

Screening should take place in a *private setting* if at all possible in order to facilitate confidentiality and comfort. Because of the stigma often associated with trafficking for sexual exploitation and forced prostitution, and feelings of shame and/or self-blame among victims, safety and confidentiality are of utmost importance.

Ongoing Screening and Support

As with many forms of gender-based violence, women and girls may not feel comfortable disclosing their experiences the first time they are screened. In light of the stigma and shame experienced by women recruited for sex trafficking or victimized by sexual exploitation, it is critical to develop a trusting relationship and provide continued screening and support at each subsequent visit in order to best support potential victims.

Meeting the Needs of Women and Girls Who Have Experienced Sexual Exploitation

The needs of trafficked and sexually exploited women and girls can be thought of in three phases. Within each phase the reproductive health care provider plays a

critical role. In the first phase – *crisis intervention* – urgent medical needs should be addressed. Other aspects of need should also be attended to, including personal security, housing, food, documentation. Further medical needs should be met in the second – *post-crisis* – stage: reproductive and sexual health problems are the medical needs most commonly requiring attention, but physical and mental health needs must also be addressed. In the *long term,* care is likely to focus on the recognition of enduring mental health issues but there may also be long-term reproductive and sexual health needs, particularly if the victim has been infected with HIV (Zimmerman et al., 2003). The capacity of health care providers to comprehensively meet the reproductive and sexual health needs of trafficked and sexually exploited women and girls is dependent on the stage of the conflict and the state of the health sector, but reproductive care providers should be aware that they may face any of these phases of need at any stage of a conflict.

Meeting Needs in Emergency and Post Emergency Phases

In emergency and post-emergency stages of conflict women are vulnerable to recruitment into, and may already be in a situation of, sexual exploitation due to trafficking or forced prostitution. Identification of women in situations of sexual exploitation through the screening mechanisms outlined in Section "Identifying Women and Girls Who Are at Risk of, or Experiencing, Sexual Exploitation" may facilitate the woman's exit from exploitation and the initiation of care.

In emergency settings reproductive health care providers should ensure that the Minimum Initial Services Package (MISP) – a set of priority activities that aim to prevent and respond to sexual violence, reduce HIV transmission and plan for comprehensive reproductive health (RH) services – are implemented. Health care providers implementing the MISP standards should be able to provide a basic response to sexual exploitation and violence, including emergency contraception, preventive treatment for STIs, post-exposure prophylaxis for prevention of transmission of HIV, and tetanus and hepatitis B vaccinations and wound care (Women's Commission for Refugee Women and Children, 2008).

As the conflict situation moves into the post-emergency phase additional reproductive and sexual health services should be added to these minimum standards in order to more comprehensively meet the needs of trafficked and sexually exploited persons.

Additional services may include:

- Provision of contraception
- Provision of antenatal and postnatal care, and midwife training
- Screening and treatment of STIs
- Care, treatment and support for those infected with HIV/AIDS
- Expansion of medical, psychological and legal care for women and girls who have experienced sexual violence, including those who have been sexually exploited in trafficking or forced prostitution.
  (Women's Commission for Refugee Women and Children, 2008)

Meeting Needs during Stabilization, Settlement, and Repatriation

In situations of stabilization and settlement/repatriation, reproductive health care providers are likely to face multiple challenges: women may be returning from situations of sexual exploitation either overseas or in-country, may continue to be trapped in a situation of sexual exploitation, and remain vulnerable to both recruitment into sexual exploitation and re-trafficking. Women and girls who have received assistance to return to their communities may have had some prior access to medical treatment: the health care provider should conduct a full medical assessment in order to determine what further care and support is needed. Depending on the type of assistance received and the nature of the reproductive and sexual health problems sustained in the trafficking situation, further treatment may be needed and existing treatment may have to continue.

In the post-conflict environment, the aim of reproductive health care providers should be to work towards the *reintegration* of women and girls who have been sexually exploited through trafficking and forced prostitution. The restoration of physical, sexual, reproductive, and mental health is an important part of the reintegration process, and is typically a key priority of women and girls exiting situations of sexual exploitation. Reintegration should be a period in which health problems are attended to, but *new concerns* can also arise during this period. (Zimmerman, 2003). Women and girls who have been trafficked or otherwise sexually exploited are likely to feel isolated and alienated from their families and communities, and may suffer extreme stigmatization at the hands of their family and community. This may be the case particularly where the woman has been infected with HIV as a result of sexual exploitation; women infected with HIV should be offered specific psychological assistance. Further problems may arise with respect to the accessibility, affordability and quality of health services; this is problematic during the reintegration of many trafficked and exploited women and girls but will be a particular problem in the context of conflict and post-conflict settings. Economic opportunities are likely to be limited; women and girls may return from the situation of exploitation without money or prospects of employment, preventing access to health services. Access to HIV treatment may be particularly difficult due to the often prohibitive cost and poor availability.

Trauma Informed Care

As discussed in Section "Reproductive and Sexual Health Consequences of Trafficking for Sexual Exploitation and Forced Prostitution", trafficking and sexual exploitation often result in sexual and reproductive ill-health. In a post-conflict setting, health care providers may already have protocols in place to address these reproductive and sexual health needs – including HIV/AIDS and STI diagnosis and treatment, unwanted pregnancy, and gynecological morbidity. However, when working with trafficked and sexually exploited women and girls, these protocols should be modified according to the principles of trauma-informed care. Women and girls who have been exploited through trafficking or forced prostitution are likely to

present with high levels of trauma due to the physical, sexual, and psychological abuse suffered, and trauma and its symptoms may continue to be experienced for an extended period following exit from exploitation.

Trauma-informed care is based on the recognition of the devastating impact that violence has on a person's life and behaviour, and the integration of this understanding into clinical practice. The *key features of a trauma-informed approach* are that the practitioner:

- **A**cknowledges the effects of violence –the health care provider should integrate discussions of abuse with other elements of the clinical encounter, and should be aware of the need for physical and psychological care.
- **B**uilds a safe space – services must be confidential and private, whilst providers must earn trust through non-judgemental supportive attitudes and signalling their belief in the patient's story (see Section "Identifying Women and Girls Who Are at Risk of, or Experiencing, Sexual Exploitation").
- **C**onnects with other resources- the provider must network with other resources in preparing to treat the patient. The broader process of reintegration also requires shelter assistance/other accommodation, psychological counselling, social and legal counselling, grants and other financial assistance, schooling and vocational training. Health care providers must work to be part of the reintegration *process* by coordinating and cooperating with other agencies and organizations to provide care and support to trafficked and sexually exploited women and girls (Zimmerman et al., 2007).

Conclusion

Women and girls in situations of conflict and forced migration are at heightened risk of trafficking for sexual exploitation and forced prostitution. Increasing understanding of these forms of sexual violence and specific factors that place women and girls at risk for victimization in these situations, as well as appropriately altering and expanding the role and practice of reproductive health field staff as described in this report, may both greatly reduce these gender-based crimes and human rights violations and vastly improve the care provided to the often-overlooked victims of sexual exploitation.

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Women, Work, and War

Dale Buscher

Introduction

This chapter focuses on the livelihoods of women displaced by conflict, including those who have sought refuge outside their countries and those displaced within their own countries. The chapter presents the challenges, needs, and opportunities as well as some creative interventions and knowledge gaps that exist in current thinking and practice. The chapter concludes with recommendations for the humanitarian assistance community. Livelihood interventions in the context of displacement are still in their infancy. Little is known about their longer-term impacts, and there has, historically, been little focus on sustainability. This chapter aims to enhance understanding of the issue in order to improve both livelihood policy and practice.

A livelihood is comprised of the capabilities, assets and activities required to live. A livelihood is sustainable if it can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation (Chambers and Conway, 1991). Essentially, livelihoods refer to the means used to maintain and sustain life (De Vriese, 2006).

The lack or disruption of livelihoods, which are vital to existence and sustenance, can both lead to conflict and be a result of conflict. Livelihood failure can contribute to the emergence of conflict by weakening the social fabric of a society, pushing people to resort to violence to obtain needed resources, and increasing individuals' vulnerability to those with an interest in promoting conflict for political or economic gain. At the same time, conflict is a major threat to livelihoods as conflict restricts or blocks access to physical, natural, human, financial, social and/or political assets (United States Agency for International Development [USAID], 2005, pp. 2–3). In Darfur, for example, the systematic destruction of livelihoods has probably contributed as much if not more to the increase in displacement among conflict-affected populations than the effects of direct attacks on communities (Young et al., 2005). The conflict is devastating livelihoods in a number of ways; the violence stops people from moving freely leaving market places empty thereby bringing trade to a

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_5, © Springer Science+Business Media B.V. 2009

standstill. Crops do not get cultivated; animals do not get herded; people can not collect firewood; and remittances are neither sent nor received (ibid).

Numerous examples in recent years demonstrate that the lack of livelihoods or competition over resources can be root causes of conflict. Examples include the lack of renewable resources and increasingly scarce agricultural land in Rwanda and the availability of valuable resources such as gold and diamonds in Sierra Leone, the Democratic Republic of Congo and Angola over which conflicts were instigated and fueled. Many conflicts are, in fact, directly caused by competition for essential livelihood resources. These resources are seldom in the hands or control of women, yet women often suffer most from the resulting conflicts and subsequent displacement.

Conflict often leads to displacement. Displacement, however, can also be a result of violations of or the denial of rights for which migration is often a strategy to reduce risk. For example, when rape is used as a weapon of war in conflict settings women may flee to reduce their risk of violation. Displacement then can also signify resilience – moving to protect oneself, one's family, and, at times, one's assets.

Experiences of conflict and displacement are gendered (that is, they affect women, men, girls and boys differently) both in terms of participation and impact. Civil conflicts are generally fought by bands of armed young men who have few options or opportunities. Young males, with limited economic prospects and emasculated by societies in which traditional male breadwinner roles are often no longer available to them, are ready recruits for militias and warlords. These very militias are themselves often fighting and seeking control over vital livelihood resources – land, minerals, wealth. Conflict and resulting displacement affect men and women, as well as boys and girls, differently. Young women and girls are generally the first to be forced out of school when the livelihoods of families require that they help out at home – carrying water, chopping wood, tilling soil, or caring for young or elderly family members. Conflict and displacement interfere with what young men have been culturally conditioned to expect as men; young women, on the other hand, most often have had their expectations of a better life stymied earlier, even before the eruption of conflict. Men and young men often join fighting forces leaving women to care for families or to flee unaccompanied by male protectors to safer regions or countries.

A gender perspective acknowledges diverse social, economic, and political gender inequalities persist both within and across countries of origin and destination. Gendered inequities and social exclusion can impel women to migrate in search of food, resources, security, and opportunities, while simultaneously making them vulnerable to a range of abuses and exploitation in the migratory process (United Nations, 2005, p. 1). Structural and cultural gender inequalities in both countries of origin and destination also significantly impact the range of livelihood options and strategies available to women during displacement. Women, for example, are generally not poor through some inherent fault of their own, but rather because international, national, community and familial power relations are skewed against them at every turn.

As livelihoods are vital for daily sustenance and emotional well-being and provide the foundation for hopeful futures, it is important to support refugee livelihoods throughout all phases of displacement, from the onset of crisis through the phase

when durable solutions are found. Applying a livelihoods approach from the beginning of displacement can help refugee households preserve the assets they may have. Livelihood interventions should be designed and implemented to strengthen women's and men's productive capacity early on, when it matters most, and to promote longer-term self-reliance (Inter-Agency Standing Committee [IASC], 2006). While host governments often place restrictions on refugees' rights and, hence, their ability to pursue livelihoods, it must be advocated that Article 17 of the Refugee Convention promotes, in principle, that refugees have the right to engage in wage-earning employment and to maintain a livelihood standard comparable to those residing in the host community (McMaster, 2006, p. 140).

Impact of Conflict and Displacement on Women's Livelihoods

During conflict, livelihoods are disrupted. Access to agricultural and grazing land becomes restricted, as may access to water and natural resources; markets become inaccessible; labor opportunities constrict and labor markets collapse. During conflict, long-distance control of assets becomes difficult, and rural-urban exchanges of food, building materials, and information are often blocked. Additionally, banking systems and government services can be disrupted and even cease to function. Moreover, vital infrastructure is often severely damaged or destroyed.

In disasters, people's ability to sell assets of all kinds can be an important coping mechanism (Lautze, 1997). Homes, furnishings, jewelry, and other assets may be sold to acquire cash for basic survival needs or to pay costs associated with fleeing the conflict. Many assets, though, are lost before or during flight, and the displaced find various obstacles to creating new livelihoods once in exile (Horst, 2006, p. 13). Lost assets, such as livestock, may require people to engage in new or different livelihood activities from those they historically practiced. In fact, one of the most marked effects of forced displacement is the need to shift or diversify livelihoods (Jacobsen, 2002, p. 11). Displaced households respond to these major changes by using both short-term coping strategies (such as changes in consumption, household composition and location) as well as long-term adaptations, including extensive shifts in the nature of livelihood strategies (Stites et al., 2005). In general, refugees take initiatives to improve their livelihoods that are flexible and spread risks. A common strategy for reducing risks and accessing opportunities is to move to towns rather than stay in assigned camps.

The disruption of community and social structures resulting from dislocation tends to affect women more than men, as women usually rely and depend on community and other social networks for emotional and practical support – such as childcare support, for example. As Srilakshmi Gururaja states in her article on the gender dimensions of displacement, "When displacement occurs, far more damage results than simply the destruction of goods and property. People's lives and their social fabric are left in tatters; new, often unfamiliar, living environments affect the social roles and responsibilities of men and women; former support structures break down; and families may face poverty for the first time" (Gururaja, 2000).

Displacement has different consequences for women than men across a range of both urban and rural contexts; men and women have different resources available to them in crisis situations, and will turn to different strategies for survival. Conflict, for example, often produces a dramatic increase in the number of female heads of household. Crises also usually multiply the care burdens of women, while discrimination based on gender can exacerbate women's unequal access to productive resources – as credit, relief commodities, seeds, tools and productive land become ever scarcer (United Nations Population Fund [UNFPA], 2006, p. 76).

When designing income generation activities targeting women, it is vital to pay attention to the overwhelming family and household responsibilities they already shoulder. Women in refugee camps, for example, generally continue to be productive members of their families, responsible for such domestic activities as food, water and firewood collection, preparation of meals, and other household chores. By contrast, men often find that they cannot fulfill their traditional productive roles in agriculture or other income-generating labor. These changes in gender roles result in changes in power dynamics between men and women and husbands and wives, which can play out in a variety of ways, including increases in domestic violence.

When villages are displaced, women are often forced out of land-based work and pushed into menial and marginalized labor as, for example, maids, servants, and prostitutes – all highly unorganized and often socially humiliating roles. Women may not have equal access to services and assistance, and they may not have equal voice in decisions regarding their future and that of their family. On the other hand, displacement may provide entry for women into extra-household arenas previously unknown or inaccessible to them – in leadership positions on camp committees, as non-governmental organization (NGO) staff, and as project and training participants.

Refugees may receive care and maintenance assistance while displaced in camps without opportunities to work or access training or income generation activities – relying on food rations that are often inadequate to meet even their basic nutritional needs. In such situations, humanitarian aid becomes a component of a refugee's livelihood strategy (De Vriese, 2006, p. 13) as the aid is sold, bartered, traded, and supplemented by other meager income generation sources. The impacts of limited opportunity to develop and practice skills and engage in economically productive activities are far-reaching and include idleness, despondency, dependency, and the erosion of existing skills.

Negative Coping Strategies

Negative coping strategies become more frequent when few other options are available. People in desperate need will turn to a wide range of means to access resources necessary for survival. Women, in particular, will resort to negative economic coping activities as they more often shoulder the responsibility for and care of children. Negative economic coping strategies include the illegal collection of natural resources such as firewood, the theft of crops and livestock, transactional sex,

buying and selling arms and drugs, prostitution, and illegal employment outside camps. Cracking down on illicit activities and negative economic strategies without offering viable alternatives can undermine people's means of survival – regardless of how detrimental these activities may be in the longer term.

A lack of access to a means of livelihood also creates conditions for gender-based violence, including prostitution and forced or early marriage. In fact, one of the most frequent means for refugees to survive in protracted situations is through exploitative sexual relationships, either commercial prostitution (Conway, 2003) or transactional relationships in which a girl or woman receives goods and gifts from a regular sexual partner (Dick, 2002). Entering into a partnership with men thus becomes a livelihood strategy for women (Gale, 2006, p. 76). These "partnerships" are generally a response to poverty, reflect an absence of alternative income generation options (Kaiser, 2001) and are relationships in which women and girls have little or no bargaining power, placing them at risk of abuse, HIV transmission, and unwanted pregnancies.

Child labor may also be a livelihood strategy for families with few options. Many parents are obliged to make their children work so that they can assist in meeting basic family needs. In Pakistan, for example, refugee families in urban areas sent their children, often young and unaccompanied, out to collect garbage, placing them at risk for abuse and exploitation. In other situations, displaced children beg in the streets or work as domestic laborers for local households in order to contribute to their families' income. In extremely difficult circumstances, parents have, as an economic coping strategy, "sold" or married off young children, particularly girls, placing them at heightened risk of child prostitution, trafficking, and HIV/AIDS. Parents' negative coping strategies may, therefore, have a severe impact on child protection.

Other negative strategies include leaving camps to work illegally, placing refugees at risk of arrest, detention, and deportation. In Thailand, it is estimated that 40% of refugees leave the camps along the Burma border without permission to work as day laborers in construction and agriculture (Women's Commission for Refugee Women and Children, 2006, p. 4). Every day refugees taking this risk are arrested and deported. Families also sell or barter a portion of their food ration to obtain other desired food and non-food items. In fact, research has found that most refugees in camps obtain some income by selling food rations (often the only source of cash income) or with "piecework" on local farms or in households when the opportunity arose (Jacobsen, 2002, p. 11).

Challenges

A significant challenge to the design and implementation of effective livelihood programs is the collective mindset within the humanitarian community that often views displacement as a short-term, emergency phenomenon. Yet, recent statistics indicate that the majority of refugees are now displaced on average for 17 years, (United Nations High Commissioner for Refugees, 2002) and that the longer the

refugee camps persist, the fewer aid resources there are to be found, and the greater economic insecurity (Jacobsen et al. 2006, p. 23). And yet, historically, humanitarian livelihood interventions have been piecemeal, serving only a small segment of the displaced population, and more focused on keeping people busy, that is, psycho-social in nature, rather than aimed at generating sustainable income. In such instances, livelihood interventions inevitably fail. Livelihood approaches are, by necessity, complex, contextual, and resource intensive. As Machtelt De Vriese notes in an article written for the United Nations High Commissioner for Refugees (UNHCR) on refugee livelihoods, “A livelihood approach cannot be planned based on providing the minimum level of support for the shortest possible time but will in the first instance rather require maximum assistance over the longer-term” (De Vriese, 2006, p. 35)

A further challenge to the design and implementation of effective livelihood programs is the predominant needs-based framework most humanitarian organizations operate from. When provision is based on need, people will present themselves as needy (De Vriese, 2006, p. 13). When generating income means corresponding reductions in rations, those displaced will either be reluctant to engage in productive economic activities and/or under-report income received from such activities. Despite the best of intentions, productivity is often penalized.

Livelihood projects that specifically target displaced women often perpetuate, however inadvertently, a commonly held assumption that women’s livelihoods stand secondary to those of men. Any income earned, no matter how minuscule, is often presupposed to be only a helpful supplemental to a larger household economy headed by a male breadwinner. In contexts of displacement, however, women’s economic activities are often the primary source of family income; livelihood programs must recognize the primary importance of women’s income and implement programs that provide the levels of income required to care for children, often unemployed or disabled spouses, and, at times, aging parents and other extended–family members.

Host country policies and institutions, both formal and informal, are powerful forces that either help or hinder access to assets. These include systems of governance, gender roles, and ownership systems (USAID, 2005, p. 3). Livelihood opportunities can be enhanced or limited by factors in local, national, and international legal and policy environments. Refugees, for example, cannot establish or maintain their livelihoods when they cannot exercise the rights to which they are entitled under international human rights, humanitarian, and/or refugee law. Often refugees suffer from the absence of civil, social, and economic rights, including freedom of movement and residence, and the right to engage in wage labor and self-employment (Jacobsen, 2002, p. 26). Access to land, the right to use land, and gendered cultural practices concerning the inheritance of land are key inhibiting or enabling factors to be taken into account when developing plans for livelihood projects in rural communities. When governments restrict rights, it is often due to a lack of vision about how refugees could become an asset to the host country. This failure to look for more creative and positive approaches represents an extraordinary waste of resources (Jacobsen, 2002, p. 70).

In situations where refugees live in camps for decades, they are often not able to transfer agricultural or pastoral skills on to their children (Horst, 2006, p. 13). As the length of displacement extends with no solutions in sight, lives remain in limbo, hope is lost, and despondency develops, representing lost opportunities, years in exile squandered, leaving those displaced unprepared for the eventual rebuilding of their lives, communities, and countries.

Even if refugees are allowed to work, refugee camps are often located in ecologically marginal areas without adequate access to water, grazing, and crop land. Refugees are often placed in environments where they lack access to land and natural resources. Livelihood strategies employed in rural areas under normal circumstances often comprise many non-agricultural activities; it is therefore important to realize that supporting rural refugee livelihoods is not identical to supporting subsistence farming. Further, while women often form the backbone of a rural economy, they generally lack adequate access to land, capital, and credit, as the provision of resources is often limited to the male partner. When agricultural activities are promoted, however, the plots of land provided are often too small or of limited fertility to achieve the objective of self-sufficiency, and the training and extension services provided are generally inadequate. Families cannot be expected to be fully self-sufficient on the basis of crop production alone. Nor can it be assumed that every refugee wants to be a farmer; different solutions must be identified and tailored for different interest groups. In fact, in camps the most common economic activity is petty trade and the availability of humanitarian aid and related inputs is a significant factor in the economy of refugee camps (Jacobsen, 2005b, p. 34).

Many refugee households use camps as a part of a broad strategy of survival, in which the workers live outside in order to farm or find employment and the non-workers (elderly, mothers, and children) live in the camp where they have access to assistance (Jacobsen, 2005, p. 7). This diversity of location provides refugee families with at least at minimal level of food security, through rations provided in the camp, while one or more family members, often the husband/father, migrate to the urban area to work in the informal economy, the income from which supplements the humanitarian assistance provided in the camp. Often refugee populations swell during food distribution times as refugees living and working outside the camp return for their rations. This supposed "misuse" of assistance must be understood as a livelihood strategy rather than merely a means of taking advantage of the system.

Refugees with professional skills and higher education are more likely to move to urban areas and bypass camps altogether (Jacobsen, 2005, p. 30). Insufficient attention, though, has been given to urban refugee and IDP (internally displaced persons) livelihoods. Urban settings present both specific opportunities and unique constraints for refugees and IDPs seeking to improve their economic situation. Urban refugees face similar challenges as the urban poor – slums, unemployment, and crime, plus the additional challenges of xenophobia and an insecure legal status which make them more vulnerable to exploitation and marginalization. In urban areas, the displaced generally lack family and community networks, which often serve as economic safety nets for the urban poor. Further, urban refugees have often moved without permission to do so, making their status in town illegal. Having no

documentation or permit to allow them to stay in cities, refugees are vulnerable to police abuse and exploitation by landlords and employers. Women are particularly susceptible. As a result, most refugees in urban areas face alarming levels of poverty (Horst, 2006, p. 14). Despite the risks and hardships in urban settings, many refugees prefer life in the cities to life in the camps. As a Congolese refugee in Nairobi said, "In this country you chose between relative security and hopelessness [in the camp] or insecurity and possibility [in the city]" (Campbell et al., 2006, p. 95).

In many urban areas, refugees are not allowed to work and can only secure an income through illegal employment in the informal sector of the economy (Sperl, 2001, p. 3). In such situations, refugees are under-paid, economically exploited, and/or work in so-called "three 'D' jobs" – dirty, disgusting and dangerous. In urban areas where work is possible, women often find it easier to earn a living than men, as they have the possibility of working in the domestic sector, restaurants, and hotels. While many urban refugees are dependent on small business to make a living they can face many barriers, their start-up costs are often higher – and the start-up phase longer – than for locals. For example, in Dar es Salaam, landlords require twelve months rent paid upfront (Willems, 2003, p. 102). In addition, refugees' diplomas and certificates may not be recognized in the host country, thereby impeding access to local labor markets. Access to job markets is further limited by poor economic conditions, language differences, lack of marketable skills, lack of tools or start-up capital, and xenophobia towards refugees (De Vriese, 2006, p. 10). Urban refugees often face greater protection risks (than those in camps), and receive less support, and sometimes none at all, in terms of shelter, health care, and education. Four of the main economic obstacles facing urban refugees are housing, documentation, xenophobia, and access to financial services (Jacobsen, 2005, p. 44).

Income generation projects seldom take into account women's existing workloads. The Beijing Platform of Action stresses the fact that migration and mobility, and consequent changes in family structures, have placed additional burdens on women, especially those who provide for several dependents (UN Division for the Advancement of Women, 2003, p. 2). Women often have multiple roles, which means that their workloads are already heavy, rendering them "time-poor" and often unable to engage in much-needed leisure and/or educational activities. Further, skills training programs, rather than offering new opportunities, often reinforce current gender roles and women's marginalized status. Training programs are often removed from everyday life of refugee women, irrelevant to their daily needs, and most often focused on skills that are not marketable. Skills training programs for displaced women seldom, in fact, take into consideration or match local market needs. The rule for designing and implementing these interventions should be simple – no market demand, no training (Anselme, Avery, Sesnan and Wood, 2004, p. 33).

Vocational training programs must be oriented toward the local labor market of the host country or towards employment opportunities in the country of origin in the case of impending repatriation (De Vriese, 2006, p. 21). These programs must recognize and build on women's existing skills, including non-monetized skills. When planning income generation activities for women, it is necessary to assess skills and life experience gained through non-monetized activities (child-rearing, household

maintenance, sustaining their families) and how these can be built upon for livelihood programs (IASC, 2006, p. 79). It is also important to recognize the impact women's reproductive lives and childcare needs have on their livelihood strategies and their ability to participate in skills training programs.

Low levels of education and training among many displaced women often limit choices and alternative livelihood occupations. Numeracy and literacy rates among displaced women are often low and lower than those of the men, as women and girls usually spend more time doing domestic work, such as gathering food, fuel, and water instead of going to school or earning an income. Women are, therefore, more often relegated to employment in the informal sector.

Given differences in opportunities, skill sets, and current workloads, more attention needs to be given to supporting men's livelihoods and ensuring that the income they generate does, in fact, benefit the entire family. Men must be supported to carry part of the family's economic burden during displacement ideally in concert with expanding opportunities for their wives and partners. Women's status and clout within the household improve when they participate as partners, rather than as sole providers or as non-participants, in their households' economic security.

There are many additional challenges to refugee livelihoods. Refugees have almost no access to credit – they cannot open bank accounts or get loans; such access is even more difficult for refugee women. Access to markets is also often problematic as is a lack of demand for goods the displaced are selling. In addition, when cash grants and micro-credit loans are provided, they are often not used for their intended purpose and instead go towards daily household consumption and survival needs.

Refugees are often viewed as a homogenous group and livelihood interventions seldom cater to the unique needs of the many subgroups and diverse individuals within the population. The displaced are expected to "fit into" the programs offered rather than tailoring the programs "to fit" the refugees. Additionally, when livelihood projects are supported, financial and technical supports are often withdrawn too early or too suddenly, negatively impacting longer-term sustainability.

Violence, too, creates additional challenges to refugee livelihoods. Violence is a reality both in and around many refugee and IDP camps and women and girls are at particular risk when they go outside the camps to collect firewood, water, and other scarce resources. Insecurity can prohibit the practice of any income generation activities that require movement outside of camps, as in the case of Darfur, where IDPs are unable to tend crops and graze livestock due to risk of attack by the janjaweed. Current and future shifts in the security environments in the regions of displacement also severely impact the sustainability of any livelihood approach.

The majority of livelihood interventions are, in fact, not sustainable and they seldom, if ever, prepare the displaced for emerging markets – where there may be new opportunities, especially for women, as new markets are often not yet monopolized by a specific gender. In addition to preparing the displaced for emerging market opportunities, there is a clear need to prepare them for vocational adjustment – a strategy for learning and applying new ways to build household income (Hill et al., 2006, p. 41). In Colombia, for example, most of the displaced originate from rural

areas but flee to urban centers where agrarian skill sets are not easily transferable and they must, therefore, learn new trades and skills to compete in the urban market.

Needs

One of the most important advocacy initiatives on the part of donor countries and humanitarian agencies is to move host governments towards a more rights-positive position that would allow refugees to be economically active (Jacobsen, 2005, p. 69). Without the right to work and freedom of movement to access raw materials, markets, and employment options, livelihood programs have very limited potential for success; creating an environment where the displaced are able to engage in economic activities will be far more beneficial than any livelihood programs implemented by the humanitarian community.

It is crucial to ensure refugee participation and incorporate refugee input in livelihood program design and implementation. Displaced women must be consulted on their livelihood strategies, needs, and barriers to opportunities. Women's entrepreneurial development involves supporting women to overcome barriers to starting and running a business, which can result from their social and economic standing relative to men (International Labour Organization [ILO], 2005, p. 6). Economic mapping exercises need to examine what businesses women are engaged in, what skills they have, what obstacles they face, and what market opportunities exist for business start-ups and growth (ILO, 2005, p. 7). Understanding and promoting sustainable livelihoods also involves recognizing and supporting women's roles in agriculture, animal husbandry, commerce, and in the distribution and consumption of food within the household and community. Despite decades of evidence of women's contributions to food production globally, development and humanitarian agencies still tend to focus their investment in crops and production systems managed by men (El-Bushra, 2000, p. 5).

Displaced women often respond to situations of deprivation in amazing ways; what emerges is a picture of resilience, resourcefulness, ingenuity, and flexibility of response (Golooba-Mutebi, 2004, p. 7). To provide options for women and reduce risks of exploitation, the range of economic coping strategies developed and adopted by refugee women need to be identified, built upon and assessed for their potential growth and scale up. The "gender mainstreaming" of livelihood interventions requires both promoting equal access to opportunity for both displaced men and women but often also necessitates targeted interventions focusing on displaced women as a means of compensating for inherent inequality and existing unequal access.

As asymmetrical relations of power and access to resources privilege men, it is necessary to design livelihood interventions that specifically target and provide opportunities for women. However, when women's initiatives are supported, parallel equivalent initiatives must exist for the men; excluding them risks undermining the success of projects focused on women. Eliciting and engaging the support of men

and boys is crucial so that the male members of the displaced community understand the benefits and are supportive of women's livelihood projects and activities.

Livelihoods are influenced by a range of economic, political, social, and environmental factors. It is essential to apply a comprehensive, holistic approach to the design and implementation of refugee livelihood programs, in particular, those targeting women. A successful program is one that takes into account a myriad of issues – physical location, availability of natural resources and raw materials, access to markets, including transport, the condition of infrastructure, market demand, and the impacts of cultural gender practices that either pose barriers to, or provide opportunities for, displaced women's livelihood strategies.

Known barriers to women's livelihoods are security and childcare responsibilities. To address these concerns, there is a need to look at where women's livelihood projects are implemented and whether such sites, and travel to them, heighten women's vulnerability to exploitation. Women's Centers are often safe spaces for women to congregate and may provide an option for the implementation of some livelihood projects. Caution must be taken, though, in ensuring that the projects are not merely psycho-social in nature (as many knitting and beadwork projects are) but actually provide sustainable income. Home-based cottage industry and backyard garden projects may also provide income, although often meager, while allowing women to stay at home and care for young children.

The existence of social capital is a vital aspect of a successful livelihood strategy, and the importance of social networks for gaining access to other forms of capital is widely acknowledged (Horst, 2006, p. 11). Existing social networks are essential for the livelihoods of refugees in camps and gender can create differential access to such networks. Women's groups can, for example, play an important role in livelihoods, as in the case of establishing and participating in informal savings and lending systems, the membership of which are often composed of friends, relatives and neighbors. Solid post-primary educational and training programs must be a matter of priority for the building of social capital and agency, especially for women, who have often had fewer opportunities. Such programs are often the only way to enable female refugees to maximize their potential so they can compete adequately in the labor market, build a more secure future wherever they may go, and compensate for the disadvantages their status usually entails (Sperl, 2001, p. 35). Finally, there is a need to pay much closer attention to livelihoods after return, and to recognize that even if repatriation is the end of one cycle, it is also usually the beginning of a new cycle, which can challenge and expose some returnees to new or persistent vulnerabilities (Stigter, 2006, p. 111).

Opportunities

The economic empowerment of refugee and IDP women is one of the most effective strategies for enhancing their protection. By providing a source of income and increasing access to, and control over, resources such as land, women are able to obtain more control of their lives. Economic empowerment has been shown

to impact positively on the involvement of women in household and community decision-making processes and to improve their negotiating position (ILO, 2005, p. 7). Economic options also reduce women's vulnerability to exploitation and, as such, serve as a protective tool in the fight against gender-based violence and HIV/AIDS.

To maximize impact and enhance economic opportunities, it is important to use a gender-sensitive approach to livelihood programming, which entails an understanding of the different skill sets, needs, vulnerabilities, and responsibilities of affected women and men, girls and boys. A gender-sensitive approach creates space to challenge gender inequality in access to and control of resources, (UNFPA, 2006, p. 76) affirms women's role as economic agents and promotes equal access to productive resources.

The changes in gender roles that often accompany displacement opens up options that may have been previously unavailable to women. Situations of displacement can provide an opportunity for re-negotiating gender relations. Displaced women tend to take on more and different roles as providers and protectors of families, to draw confidence and determination from these experiences, and to develop their political consciousness and agency (El-Bushra, 2000, p. 5). Women assume an increasingly important position as contributors to the household cash income (Golooba-Mutebi, 2004, p. 11). In post-tsunami Sri Lanka, for example, the deprivations and cash needs of displaced families compelled women to enter the labor market which rendered *purdah* (exclusion from public space) an untenable practice. Women became more visible as they had to move around the camp to attend to daily household chores. Women also became casual farm workers and breadwinners while men had limited opportunities for employment in the host areas. Women's entry into the labor market and interactions with other women and men gave them new experiences that impacted their consciousness and made them more aware of the post-displacement changes in their lives and status as women (Zackariya and Shanmugaratnam, 2002, p. 3).

Flight can offer refugees an opportunity to escape exploitation, discrimination, and persecution. The breakdown of society can also afford an opportunity to rebuild anew on a foundation of equality and respect for human rights (UNFPA, 2006, p. 57). New tensions can emerge, however, if men are unemployed or under-employed and women are the main breadwinners. High unemployment, stress, and frustration among male refugees can, for example, lead to increases in alcohol consumption and domestic violence (UNFPA, 2006, p. 61).

The gendered division of labor in contexts of displacement often means women assume the primary role of breadwinner (De Vriese, 2006, p. 22). It is significant that women, more than men, regard their earnings as family income and give priority to the needs of care of their family over their own material and nutritional needs. As such, they tend to spend the majority of their wages on food and their children. Women's economic empowerment, therefore, tends to benefit the entire family – improving health and nutritional status as well as educational attainment.

Displaced women may also be more likely to access local labor markets – especially in urban areas. In Kampala, for example, urban refugee women were found to be particularly successful at integrating into the local economy and sustaining their

own livelihoods. Many were found to be resourceful and entrepreneurial – selling charcoal, home-made clothes, hairdressing and growing vegetables (Macchiavello, 2004). The examination of Congolese livelihoods in Nairobi clearly revealed that they, too, were an asset, not a burden, to the city and its residents (Campbell, 2006, p. 104) and brought in new skills, such as the Congolese style of hair-braiding and unique, hand-sewn Congolese dresses, both of which proved to be highly desired by local residents.

The displaced are generally extremely resilient in finding means of care for themselves and their children. As such, refugees and other displaced should be helped to assist themselves and promoted as agents of development in the regions that host them (Horst, 2006, p. 6). Humanitarian assistance should focus on promoting refugees' own positive and independent livelihood-strengthening strategies which requires identifying people's areas of resilience and strength, and helping them maximize these qualities (De Vriese, 2006, p. 26).

Household economic strategies are the ways in which households deploy assets and use their capabilities in order to meet their objectives. These strategies are generally based on past experience – those ways the household has historically survived, which may or may not be relevant in their current context of displacement. The most effective responses should build on appropriate existing strategies and work towards creating new opportunities that enable refugees to channel their own energies towards solutions (De Vriese, 2006, p. 11). People look for opportunities to improve their lives. Similarly, refugees are not idle people, but people willing to work to rebuild their lives if given a chance. UNHCR's agricultural program in Côte d'Ivoire, for example, focused on assisting an activity which local people were already undertaking and supporting solutions found by refugees themselves rather than designing new ones for them (Kuhlman, 2002, p. 41). A necessary starting point is to identify the essential components that made up the livelihoods of a particular group during a "normal" (i.e., non-conflict) time (USAID, 2005, p. 9) and assessing how these components can be re-introduced, adapted and enhanced during displacement.

Mutual aid through inter-household economic and social support as well as other assistance has been critical to refugees' ability to cope with limited income-earning opportunities. Mutual assistance consists of the exchange of a variety of goods and services with both kin and non-kin. For example, people without food borrow from those who have. Mutual assistance is the refugees' emergency coping mechanism and an important feature of their livelihood strategies (Golooba-Mutebi, 2004, p. 17). As such, the identification and strengthening of existing mutual assistance schemes and the development of new ones can provide opportunities for enhancing livelihood strategies, especially amongst the most vulnerable and needy.

It is also necessary to look at the living conditions of host communities and their relationship with the refugees/IDPs. Providing livelihood support to host populations as well as the displaced population can help mitigate tensions between the displaced and local communities. Additionally, refugees can enrich local communities socially, culturally, and economically – markets can be increased with new products introduced by the refugees and new services provided that benefit both the refugees and the host community. Developing livelihood interventions that facilitate

the economic development of the region hosting the displaced not only mitigates xenophobia and discrimination between host and displaced communities but assists in work with host governments on promoting the realization of refugee rights – namely, freedom of movement and the right to work.

Financial remittances to displaced families and communities from relatives and family members living elsewhere create additional opportunities for building economic security. While some $90 billion is estimated to be remitted each year, (United Nations Division for the Advancement of Women, 2005, p. 20) it is unknown how much of this actually reaches or targets the displaced. The proportion of refugees in first asylum countries that receive remittances is estimated to be small (Jacobsen, 2005, p. 61). Remittances, though, may have a far greater positive impact on communities in developing countries than previously acknowledged. Additionally, there are advantages to the "people-to-people" aspect of remittances. While overseas development assistance generally goes to governments, which make decisions about its use, remittances go to families, including many women-headed households, who use the funds in the manner they believe best meets their needs. As such, remittances that do reach the displaced, and displaced women in particular, could have a significant impact on their well-being and that of their families. Often, though, to ensure that remittances are not squandered on consumer goods, recipients may need assistance on financial management and investment of their remitted resources including in micro-finance and savings programs. Financial literacy training for senders and recipients of remittances can help increase the pay-off from these resources, particularly in educating migrants and refugees about the best ways to transfer and invest the money. It is also worth noting that remittances can inhibit migration by providing people with the financial resources to stay where they are.

Finally, there are emerging opportunities for partnership with the private sector in the design, implementation and funding of livelihood interventions. Refugee camps, for example, often provide a contained, relatively educated, employment-seeking population that could be easily employed in the out-sourcing of piecemeal work from nearby factories. Partnerships with Microsoft have resulted in computer training courses in some refugee camps while a partnership between UNHCR and Nike has resulted in increased educational opportunities for girls in the Dadaab camps in Kenya. These partnerships can also address difficulties with market access through, for example, the export of refugee products to regional and even global markets. Partnerships with the private sector, while a relatively recent phenomenon, are beginning to play an ever-increasing role in humanitarian assistance work and can be tapped into to expand refugees' economic opportunities.

Creative Interventions

Program design must be flexible and responsive to local needs and conditions as well as to the unique culture, skills, and capacities of the target population. Consulting with the entire affected population is vital as is the collection of age- and sex-disaggregated data to analyze impact. Intended clients must be consulted before

any decisions are made about project design and type of intervention. Target populations must be involved with the planning, management, monitoring, and evaluation of each project using a livelihoods approach.

Most economically successful displaced women engage in multiple activities: gardening/crop production, raising animals, tailoring, petty trade, collecting firewood and wild fruits for selling, etc. Diversifying activities serves to minimize risks. Rural people, for example, adopt multiple livelihood strategies to diversify their income generation activities. Diversification lessens their dependence on an often unreliable agrarian resource base (Golooba-Mutebi, 2004, p. 6). A household with well-diversified assets and livelihood activities can better cope with shocks and stresses than one with a more limited asset base and few livelihood resources (De Satgé et al., 2002). In some situations, refugees also diversified their locations. Liberian and Sierra Leonean refugees in Guinea, for example, strategized their settlement to diversify their resources. They placed some household members in camps to access resources there and other members in urban areas where a different set of resources could be targeted (Levron, 2006, p. 10). Livelihood diversification becomes key; people adopt multiple and varied livelihood strategies, including opportunity-seeking migration (USAID, 2005, p. 10).

Micro-finance, especially when coupled with business training, mentoring, and savings, can be an effective livelihood intervention when implemented by an organization with the requisite expertise. Micro-credit loans targeting Mauritanian refugees in northern Senegal, for example, enabled women to engage in non-traditional activities and many family benefits were reported, including that children were well-fed and in good health (Stone, 2005, p. 31). Other micro-finance programs serving refugees and IDPs include referral to micro-finance institutions (MFIs) or banks in regions of origin following return based on good credit histories during displacement. It must be noted, however, that micro-finance programs are often not appropriate interventions to serve the poorest of the poor but that they can be effective interventions targeting the economically viable poor and can be particularly effective when targeting women. Poor women, even more than poor men, often rely exclusively on microfinance institutions for financial services as they lack access to larger, commercial credit facilities. Therefore, the availability and sustainability of microfinance institutions are key for the empowerment of displaced women.

Micro-finance programs have been particularly effective in post-conflict situations when the formerly displaced are returning to previous domiciles and are often re-building their lives from scratch. The aim of microfinance programs, however, must be on assisting the poorest clients move into the mainstream of commercial credit and savings rather than on continually targeting the same people in what can become a subsidized cycle of debt, one that does not enable them to move up economically.

The establishment of women's cooperatives – such as chicken hatcheries and fish farms; engaging women in non-traditional activities – such as road construction in Afghanistan; and intensive business skills development programs to help women succeed in starting or growing small businesses, have also proven to be successful interventions when appropriately designed and implemented. Perhaps one

of the most successful interventions has been the practice of subsidiarity, that is, not doing for people what they can do for themselves. Subsidiarity requires the harvesting and development of local talent whereby nongovernmental organizations recruit and invest considerable resources in training refugees to manage and implement their own programs. This practice opens up opportunities for women in areas such as teaching, health care, community mobilization, administration and program management.

Relief substitution, that is, utilizing the beneficiary population to produce humanitarian assistance items locally rather than importing items into refugee camps, can also expand economic opportunities. In the Burmese border camps in Thailand, for example, refugee women weave the traditional sarongs for periodic camp-wide distribution. Previously, the sarongs were purchase at Thai markets outside the camps. Now, they are purchased directly from the refugee women weaving them thereby providing a source of income, further developing the in-camp cash economy, and keeping alive a traditional cultural practice.

What is known about livelihood interventions targeting displaced women is that the interventions must be based on client participation, must include in-depth market assessments, should build on existing skills, including non-monetized skills, and that interventions must be specifically tailored to individuals and groups instead of the female population *en masse.*Interventions must match local market needs, create real opportunities without flooding the markets and driving down prices, and should, whenever possible, prepare women to work in non-traditional gender trades and professions – where their access to higher levels of income is greater. Furthermore, livelihood interventions must treat women's income as primary, rather than secondary, as it is women's income that most often leads to better health and education for their children.

Knowledge Gaps

Significant knowledge gaps remain in terms of understanding women's livelihoods during displacement. Little is known about women's current economic coping strategies and without this understanding, it is impossible to build on these strategies and bring them to scale. Understanding current refugee livelihood strategies is vital to designing and improving interventions. Little, too, is known about creating women's social capital and agency, and the programs that have been effective in doing so. And yet, building social capital and agency are essential components of effective, sustainable livelihood interventions.

Little is also known about the impact of women's livelihoods on men. Does it impact men's financial earnings or how such earnings are used? How are power relations impacted both positively and negatively by women becoming viable economic agents? How are economic resources shared and spending decisions made?

Further, there is a lack of knowledge about the longer term impact of current livelihood interventions. Few longitudinal studies on impact have been undertaken. Without these, the collective wisdom on appropriate interventions is not enhanced

and it is not known if programs are doing more harm than good in the longer term. Monitoring, evaluation, and impact assessment remain weak throughout the livelihoods sector – particularly in the context of displacement where situations are less stable than in more traditional development contexts. How do the programs impact women's mobility, for example, and their access to information? What has been the impact on household food security? Has women's participation in income generation impacted their role in decision-making and control over assets as well as control over their own body and sexuality? Has access to quality health services and education for themselves and their children improved?

The longer-term impact of preparing women for non-traditional gendered professions and trades is also a knowledge gap. Do these women revert to previous roles upon return to home communities? Do such professions place them at increased protection risks? And what are the ramifications for their daughters' and sons' career and livelihood choices?

Additionally, as mentioned previously, there is little information about the scope and role of remittances in refugee and IDP situations. With a better understanding of the scale and use of remittances, more effective interventions capitalizing on this potential investment could be designed and the impact of the remittances enhanced to promote the protection, participation, and enjoyment of rights of displaced women.

Recommendations

The design and implementation of livelihood interventions must be undertaken by staff with the requisite knowledge and experience. Economic interventions necessitate understanding complex operating environments and changing markets. As such, to ensure success, the management of these interventions can no longer be assigned to generalists and junior program staff.

The most effective interventions will be those that are based on the direct participation of displaced women themselves in the program design, implementation, and evaluation. The participation of women in project design will help ensure that the intervention is not further burdening women's workload but is rather creating realistic opportunities for them.

Effective livelihood interventions must start with baseline data on economic coping strategies and available skill sets coupled with market assessments on local labor needs and absorption capacity. Situation analysis should be conducted to assess obstacles and opportunities for livelihood interventions including market access, available infrastructure and natural resources, access to raw materials including land and water, transportation and storage capacity, and local and regional market demand.

Displacement often changes gender roles and traditional gender responsibilities. As such, it provides an opportunity to expand the economic choices available to women. Livelihood interventions should capitalize on these opportunities and

provide access to women in traditionally male-gendered professions as these professions generally carry more status and higher earning potential.

Comprehensive livelihood approaches are needed that recognize displaced women as a heterogeneous population with diverse needs. Comprehensive approaches offer participants the opportunity to "graduate" up from project to project. For example, women may first participate in a vocational skills training program followed by an apprenticeship placement with a business which provides them with the opportunity to hone and further develop their acquired skills. The apprenticeship can be followed by an in-kind or cash start-up grant which can, when the small income generation project is functional, be scaled up through a micro-credit loan.

Periodic monitoring and evaluations must be built into project design and should include client participation and satisfaction with the service provided. Longer-term impact assessments need to be written into project design and methodology and must include both qualitative and quantitative indicators. Impact indicators should measure changes in gender roles, the creation of new opportunities for women, and the impact of women's earning on household nutrition, health and education.

Notes

1. Informal, small scale, savings and lending groups

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Women, Migration, Conflict and Risk for HIV

Anita Raj, Jhumka Gupta, and Jay G. Silverman

Introduction

Women now constitute the majority of those living with HIV/AIDS globally, even if only by a small margin (UNAIDS, 2007). While the lower status of women has been recognized as increasing their HIV risk, issues of migration and conflict combined with this lower status are believed to propel women's risk for infection further, particularly in high infection areas such as Sub-Saharan Africa. Recommendations to address women's risk for HIV in the context of migration and conflict are needed. However, such recommendations must be built upon our understanding of the global HIV epidemic among women as well as the needs of women facing conflict and migration. Thus, this chapter begins with an overview of HIV among women across world regions, considering how women's lower social status is increasing their HIV risk in nations characterized by high (≥2%) and lower (<2%) HIV prevalence. Second, mechanisms by which migration can heighten women's risk for HIV are discussed, particularly focusing on forced migration, a common result of conflict. Although forced migration is not always linked to an increase in HIV incidence, it is commonly associated with behaviors and contexts that increase the likelihood of HIV infection among women migrating to higher HIV prevalence areas. Finally, taking into consideration the ways in which forced migration appears to increase women's HIV risk, recommendations are offered in the areas of reproductive and sexual health practice, policy, and research/surveillance.

Overview of the Global HIV Epidemic Among Women: The Most Marginalized are at Greatest Risk

Current UNAIDS estimates indicate that approximately 33.2 million people in the world are living with HIV, with 7% of these individuals having become infected in

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_6, © Springer Science+Business Media B.V. 2009

the past year. Across regions and nations, rates of HIV, mechanisms of transmission, and populations most heavily affected vary; nonetheless, at a global level, women, particularly lower income and disenfranchised young women, disproportionately carry the burden of HIV. An overview of the HIV epidemic across international regions is presented to provide insight into how marginalization of women based on age, access to education and employment, social and economic reliance on male partners, and gender-based violence against women contribute to risk. Data presented are from the UNAIDS 2007 Report (UNAIDS, 2007); these data are offered in the order of regions with the greatest to the smallest numbers living with HIV.

Sub-Saharan Africa

While the AIDS pandemic is now a global health concern affecting all continents, Sub-Saharan Africa remains disproportionately affected. Although Sub-Saharan Africa comprises 10% of the world population, the region accounts for 68% of the world's adult HIV cases and 90% of HIV cases in children. While HIV rates in Sub-Saharan Africa appear to have stabilized, with some nations (e.g., Kenya and Zimbabwe) actually reporting a decline in infection, these rates remain at a substantial level for most Sub-Saharan African countries, with adult (aged 15–49 years) HIV prevalence ranging from 5 to 32% across these nations; this is a notable contrast with the global adult HIV prevalence rate of 0.8%. While rates and populations affected in this region vary by nation, overall women, particularly young women, bear the brunt of the Sub-Saharan HIV epidemic. More than half (61%) of HIV/AIDS cases in the region are among women aged 15 years and older. Increased biological risk compared to males has been identified as a reason for increased risk for young women. However, compounding this biological risk are consequences of women's low status compared to men, which also contribute to women's increased risk for HIV. Women experience: (1) lower educational access and occupational opportunity increasing women's financial reliance on men, (2) patriarchal relationship dynamics which can include older and more sexually experienced male partners, (3) social acceptability and practice of sexual violence, and (4) masculine gender norms which support and reinforce men's promiscuity and non-monogamy in intimate and marital relationships.

East, South and Southeast Asia

While Sub-Saharan Africa, particularly the Southern most nations of the region, remains at the heart of the HIV pandemic among women, the growing epidemic among women in Asia also warrants serious consideration. Current estimates indicate that an estimated 4.9 million people in Asia are living with HIV, with about half (51%) of these residing in India. This is in part attributable to the large population of the country; the proportion of adult Indians infected is about 0.36%. Proportions of the Asian population infected with HIV are greatest in Cambodia and Thailand, although rates of infection are declining in these nations. HIV prevalence is increasing in China, Indonesia and Vietnam, while other regions in Asia have

not yet hit epidemic proportions with HIV. Across Asia, the primary risks for HIV among women are attached to sex work (including sex trafficking and sex tourism), and being a partner to someone engaging in sex work or injection drug use (IDU). Additionally, there are signs that the epidemic could hit Bangladesh and Pakistan via injection drug use and sex trade involvement; currently Pakistan, in particular, has minimal prevention efforts in place to address the potential epidemic that could occur. For these emerging epidemics, again women's risk will predominantly be attached to sex work or their involvement with an "at risk" male partner. Hence, as with Africa, women's lower status, as demonstrated by educational and economic disenfranchisement as well as reliance on male partners, contributes to their risk for HIV.

Eastern Europe and Central Asia

The AIDS Pandemic within Eastern Europe and Central Asia has been growing rapidly, experiencing a 150% increase within the past six years. The epidemic has historically been limited primarily to only two nations, the Ukraine, which continues to experience growth in its HIV rate, and the Russian Federation, which has the largest number of HIV/AIDS cases in all of Europe. However, Kazakhstan, Tajikistan, and Uzbekistan also now report epidemic levels of HIV. Historically, the region primarily saw transmission among young injection drug users (IDUs), a population often already on the margins of society. Young men in prisons, treatment centers, and homeless facilities dominate the epidemic; however, more recently, increased rates of HIV have been seen among those involved with sex work and those engaging in injection drug use, as well as those partnered with injection drug users. Again, young and lower income women are bearing the burden of the women's epidemic.

Oceania

The HIV epidemic in Oceania is largely centered in Papua New Guinea, which accounts for 70% of the HIV cases in the region. Papua New Guinea is experiencing a notable HIV incidence rate of 1.3%, which continues to rise steadily. Pervasive negative attitudes toward women and women's right to sexual autonomy, as characterized by high rates of sexual violence and paid sex, have been linked to the disproportionate rates of HIV among young women in Papua. While much of the remaining 30% of HIV cases in the region are located in Australia, Australia's older HIV epidemic differs starkly from Papua's. The Australian epidemic is largely attached to men, specifically men who have sex with men (MSMs) and IDUs. Infected women are more typically IDUs or partners of IDUs. Notably, evidence also indicates that indigenous people are more likely than non-indigenous people to be infected; this disproportionate rate of infection may be tied to higher rates of IDU among indigenous peoples in Australia. While New Zealand has a substantially lower rate of HIV, the faces of the epidemic are similar to that seen in Australia.

The Caribbean

Much of the Caribbean has been heavily affected by the HIV epidemic. AIDS is currently the leading cause of death among 25–44 year olds in the region. Adult HIV rates in Haiti are at 2% and rates have passed 1% in many other countries. Heterosexual infection is the primary means of infection in the region, and as seen in other regions of the world where the epidemic is centered on heterosexual transmission, younger women are at the highest risk of infection, being 2–6 times more likely to become infected than same age young men. Notably, the risk profiles of Caribbean females most likely to be infected are similar to the profiles seen in many Sub-Saharan African nations. In both regions, cultural norms related to relationships characterized by older men and young girls, with sexual exchange for favors and gifts, has been identified as a concern increasing risk for HIV among young women.

Latin America

The largest Latin American nations are also those with the largest HIV epidemics. Brazil is home to one-third of the HIV cases in the region, though countries like Argentina and Uruguay are now experiencing high rates of HIV transmission as well. Within Central America, the proportion infected is greater for smaller and poorer countries, specifically Belize and Honduras; unfortunately, these nations also have few resources with which to address the epidemic, both in terms of prevention and treatment. Transmission in the region is largely due to injection drug use, but a reasonable proportion of MSMs are infected. The epidemic has only more recently begun to affect women; those most at risk are partners of men who use injection drugs or have sex with men. Taboos against MSM behavior result in many men leading “double lives”, in which they have a steady relationship with women but on the side and without her knowledge have sex with other male partners. Higher rates of HIV among MSMs in the region are resulting in male infection and then transmission to female partners. However in more heavily affected nations in the region, such as Honduras where AIDS is the leading cause of death for women, sex work is also placing women at increased risk for HIV.

North America and Western Europe

These nations, some of the wealthiest in the world, have relatively low HIV prevalence with which to contend, while simultaneously having greater resources with which to support HIV prevention and treatment efforts. The United States has the worst epidemic in these regions, with a 0.4% HIV prevalence rate nationally. As with many of the other nations in North America and Western Europe, the largest proportion of those infected are MSM. Although women are the minority of those infected, among women, those who are younger, racial/ethnic minority, and lower income are at disproportionate risk for contracting HIV. Studies from the region also

document that lower income and minority women, due to marginalization and lack of economic opportunity, may be more likely to use drugs and/or have partners who use drugs, are at greater risk to become involved with sex work, and are at increased risk for sexual victimization, all factors which contribute to risk for HIV/STI. Hence, these findings document that while there is overall low risk in the Western world, women at risk are those that are experiencing the greatest social vulnerabilities.

The Middle East and North Africa

With the exception of the Sudan, HIV prevalence rates in these nations are less than .1%; the Sudan's HIV prevalence rate is 1.6%. The majority of those with HIV were infected via heterosexual activity. However, IDU-related HIV infection is a growing concern, particularly in The Islamic Republic of Iran and the Libyan Arab Jamahirya; these nations are also seeing high rates of HIV among their prisoners, many of whom are drug users. Information on potential risk for MSMs is minimal due to strong taboos against such behavior. Sex work has been an identified concern, as well, particularly in Algeria, Morocco and Sudan, which has identified high HIV rates among female sex workers. Overall, these findings indicate that primary risks for women in the region are attached to their male partner's risky activities; women's lack of control over sex and condom use, particularly in their marital relationships, combined with male partners' risky sexual behaviors exacerbate this risk.

Summary

A review of the HIV epidemics across regions and nations documents that in high prevalence regions, women are more likely than men to be HIV infected, while in low prevalence regions men are more likely than women to be HIV infected. Patterns across global regions suggest that men's risk behaviors (e.g., injection drug use, same sex behavior), more than women's, escalate the epidemic in low HIV rate regions; this is attributable to the fact that shared needles and anal sex are more commonly reported by men and are riskier activities than penile-vaginal sex. However, penile-vaginal sex is a more pervasive activity; hence, in the presence of higher rates of HIV, penile-vaginal sex becomes the dominant means of transmission. In this context, rates for women increase because women are biologically more susceptible than men to HIV via penile-vaginal sex; this heightened biological risk is enhanced by the often lower social status of women which impedes women's access to HIV prevention education and inhibits their ability to request that their male partners use a condom.

Of note is the fact that, regardless of HIV risk levels, the most marginalized women are the first affected and remain at greatest risk for becoming infected as an epidemic escalates. Across regions, marginalized women are those who are lower income, less educated and younger; in wealthier nations, these also include racial/ethnic minority women (e.g., Blacks and Latinos in the US, indigenous peoples in Canada and Australia). Higher rates of drug use, sex trade involvement, and

victimization from gender-based violence are seen for these marginalized women and appear to be the primary reasons for their increased risk for HIV. Hence, while lower status of women contributes to HIV risk, those women most marginalized due to sociostructural factors (e.g., class, race, income) are also the most vulnerable to infection.

Migration and Women's Risk for HIV

In the current climate of globalization and global industrialization, mass migration movements are further contributing to the marginalization of certain groups and their increased risk for HIV. Migration is simply the movement of persons or communities from one country or locale to another. Primarily, migration is occurring due to diminished economic opportunities in regions of origin, resulting in large rural to urban migration as well as migration from developing to industrialized nations. United Nations′ Educational, Scientific and Cultural Organization (UNESCO, 2002) reports that 1 out of every 35 individuals in the world is a migrant; in 2002, there were 175 million international migrants, which is approximately 3% of world's population. Migration has become increasingly feminized in the past decade, and women now comprise half of all migrants (UNESCO/UNAIDS, 2004).

Migration alone is not a risk factor for HIV, but the context in which migrants often live, i.e., poverty, discrimination, exploitation, and family/relationship/ community instability, does increase risk for HIV. According to UNESCO (2002), migration is linked to HIV in a number of ways: (1) Migrants are commonly denied health services and prevention education opportunities, as non-citizens in their places of residence; this may be particularly problematic for those HIV-positive migrants who migrated for access to HIV/AIDS care. (2) The legal restrictions typically placed on migrants, particularly undocumented migrants, result in their maintenance as a hidden and thus hard-to-reach population. And (3) migrants often are racial/ethnic or religious minorities in their places of residence, subjecting them to compounded discrimination; female migrants and those with HIV are further stigmatized and disenfranchised. Extensive evidence from Africa, the Caribbean, and Asia does indicate that migrants are at increased risk for HIV (e.g., Brewers et al., 1998; Foreit et al., 2001; Lurie et al., 2003; Poudel et al., 2006; UNDP, 2004; Zuma et al., 2003). However, some conflicting evidence also exists indicating that migrants are at no greater risk for HIV than natives (Mundandi et al., 2006; Singh et al., 2004). In some cases, returning migrants actually have had lower HIV incidence than the population that remained in the migrants' regions of origin (UNHCR, 2006). The differences in patterns of migration and the spread of the epidemic likely explain these differences in risk for migrants. Forced migration, a consequence of conflict, disaster, or development projects in a region, likely heighten risk in these contexts, as the option of returning home is often impossible for this group. Hence, there may be no way to avoid the diminished access to services, legal restrictions and discrimination these migrants, a predominantly female population, are forced to endure (UNHCR, 2006).

Forced Migration and Marginalized Women

Forced Migration is defined by the International Association for the Study of Forced Migration (IASFM) as the displacement of people due to conflicts, natural or environmental disasters, chemical or nuclear disasters, famine, or development projects. Forced migration can result in relocation across international or regional lines, but it can mean internal displacement as well. Such migration occurs despite the migrants' lack of desire to leave their place of residence and involves destabilization and loss of resources in almost all cases. The most vulnerable to such destabilization and further loss are the marginalized – the young, the poor, the minority and the female – the same groups at increased risk for HIV.

According to Forced Migration On-Line (2006), a resource dedicated to understanding human displacement, there are three types of forced migration: 1. *Conflict-Induced Displacement*, which occurs when people are forced to leave their homes due to armed conflict including civil war, generalized community violence, or persecution related to their ancestry, race/ethnicity, religion, political opinion, or social group; 2. *Development-Induced Displacement*, which occurs when people are forced to relocate as a result of governmental policies and projects, such as large-scale infrastructure projects including dams and roads; urban clearance initiatives; mining and deforestation; and the introduction of conservation parks/reserves and biosphere projects; and 3. *Disaster-Induced Displacement* which occurs when people are displaced "as a result of natural disasters (floods, volcanoes, landslides, earthquakes), environmental change (deforestation, desertification, land degradation, global warming) and human-made disasters (industrial accidents, radioactivity)." These types of displacements result in millions of forced migrants globally each year, with 75–80% of these being women and children (UNHCR, 2006). Forced migrants can be refugees, asylum seekers, internally displaced persons (IDPs), development displacees, environmental and disaster displacees, smuggled persons, and trafficked persons; each of these groups is identified as a vulnerable populations and is predominantly female. While scholars have discussed how the context surrounding each of these types of forced migration can contribute to women's vulnerability to HIV infection, this chapter will primarily focus on HIV vulnerability in relation to conflict-induced displacement. Additionally, as these types of forced migration are not necessarily mutually exclusive, discussion will also include other types of forced migration where relevant and appropriate.

Forced Migration and Higher Rates of HIV

Mass migration is commonly understood to be a key factor in the global spread of infectious diseases (Minas, 2001; Smith, 2002). While movement or exchange of individuals between high infection centers and low infection centers facilitates contact for communicable diseases to be transmitted to new populations, migration's primary effect on HIV rates occurs through increasing the rate of high risk sexual

behaviors (Coffee et al., 2007). Conflict, residential instability and poverty, the primary causes of forced migration, have also been linked to poor health outcomes including HIV (Murray et al., 2002; Richard et al., 1999; Noji, 1997; Connolly and Heymann, 2002; Levy and Sidel, 1997; Leaning et al., 1999; Spiegel et al., 2004a, b). However, more recent evidence suggests that increased HIV rates are not always the consequence of forced migration. Understanding when and why HIV risks increase in this context is vitally important to create programs to address these risks better. Unfortunately, inadequate data impede this process.

Epidemiological evidence linking forced migration and increased risk for HIV infection is minimal, and that which exists is largely subject to research biases (Hynes et al., 2002; Jacobsen and Landau, 2003; Salama and Dondero, 2001; Spiegel et al., 2004a, b, 2001). Such biases exist because it is difficult to capture accurate prevalence and incidence data in contexts of crisis. Roberts (2004) notes that rapid population movement affects both assessment of infection and determination of denominators; lack of baseline or comparable data also affect ability to compare numbers assessed from "norms." Hence, those migrants obtaining access to testing may be a select group and not necessarily indicative of the total refugee group in a region. Further HIV mortality data may not be identified as such, when opportunistic infections (e.g., TB or pneumonia) rather than HIV are identified as the cause of death. Also surveillance data even in optimal circumstances may simply not capture migrant or immigrant status or related factors, inhibiting our ability to assess infection rates (Roberts, 2004; Salama and Dondero, 2001; CDC, 2006). Thus making the data unreliable for epidemiologic surveillance purposes.

Nonetheless, despite these methodological concerns, existing data indicate that forced migrants within certain regions may be more vulnerable to HIV acquisition than both voluntary migrants and native residents, as reflected in one of the few pieces of work examining the link between forced migration, conflict, and HIV related vulnerability (Agadjanian, 2005). In this Angola-based work, forced migrants were found to be more likely to engage in casual sexual relationships than native residents (Agadjanian, 2005). Other work indicates that immigrants, migrants and refugees from certain regions have high rates of HIV or other STIs, and in some cases higher rates than those in their region of origin or those in the surrounding area. Studies of pregnant women and antenatal clinic attendees in Africa and Asia found that refugee women reported higher STD rates than that seen in their countries of origin (e.g., Cossa et al., 1994; King et al., 1990; IRC, 1999; Mayaud et al., 1997; Ministry of Health, Sudan, 1995). Studies of migrants and refugees from Africa and Haiti reported higher rates of HIV than those seen in their countries/regions of destination (Bouree et al., 1995; Nunn et al., 1995; Rey et al., 1995; Rey et al., 1996). Unfortunately, these studies did not have data to indicate whether infection was happening in refugee/relocation sites or had occurred prior to migration.

Historically, it was suspected that high conflict and forced migration, were linked to increased HIV infection at relocation, as a consequence of reduced capacity to screen blood and blood products, use of non-sterile medical equipment, reduced HIV/STI testing and treatment, and halting of HIV/AIDS prevention programs.

However, more recent evidence indicates that this is not always the case (Mock et al., 2004; Spiegel, 2002; Spiegel and Qassim, 2003; Spiegel and Nankoe, 2004). Increased isolation, high death rates, and low sexual activity due to sex segregation or depression/trauma may impede sexual practices that place people at risk for HIV (Mock et al., 2004). Additionally, when high conflict nations have lower HIV prevalence than surrounding nations, people with lower mobility remain within the lower prevalence high conflict regions. This may provide relatively lower HIV exposure to these low mobility groups. Such cases have been documented in the high conflict regions of Angola, Sierra Leone and Southern Sudan (De Jong and Spiegel, 2003; Kaiser et al., 2003; Van Rensburg et al., 1995). Of concern, however, is that the more mobile refugees from such regions will become infected upon relocation to the surrounding more stabilized nations characterized by higher rates of HIV (Spiegel and Qassim, 2003). As these HIV-infected displaced individuals return to their regions of origin and engage in sex with new partners, they take the epidemic with them. Higher rates of HIV in Rwanda and Angola have been attributed to rural Rwandan refugees in Tanzania and Zaire, as well as Angolan refugees residing in Zambia and Namibia, who brought the virus back to their countries of origin (Schreck, 2000; Spiegel and Qassim, 2003).

Further affecting risk in the conflict context is higher HIV rates surrounding war zones due to military presence. The military, a population with higher HIV/STI rates and riskier sex practices than the general population, may be heightening risk for infection among locally displaced women. There is evidence that refugee sites closer to war zones have higher HIV incidence than those farther from the war (Santos-Ferreira et al., 1990; McGinn et al., 2001); it is believed that the military presence in part explains the increased rates of HIV. Such patterns can result in the rapid increase of HIV prevalence among a population with previous low exposure, especially as those who became infected return to their low-prevalence nations of origin, post-conflict (McGinn et al., 2001).

Forced Migration, Conflict, and Women's Risk for HIV

Despite global discussion regarding the importance of conflict, migration, and gender in shaping the global HIV/AIDS pandemic, very few studies have specifically examined how women's vulnerability to HIV may be exacerbated within the context of conflict-induced forced migration. Nonetheless, existing research does demonstrate that forced migration inevitably results in disenfranchisement regardless of what causes relocation (UNESCO/UNAIDS, 2006). There are always financial costs to relocation (e.g., paying to relocate, loss of resources such as land or housing in areas of origin), and there are often legal or linguistic barriers to social and employment opportunities upon relocation. Many forced migrants report taboos on sexuality, lack of condom use, and poor health care habits even in their countries of origin, exacerbating their risk for HIV after migration (UNESCO/UNAIDS, 2006),

and one recent study found that forced migrant women in Angola, relative to voluntary migrants in the region, felt at greater risk for HIV but less able to speak with partners or peers about this risk (Agadjanian et al., 2005). Forced migration often results in poverty, poor access to health care, poor nutrition, lack of education, and political, economic, and social discrimination, all factors that increase risk for HIV/AIDS (Roberts, 2004). Any society in which such drastic change has taken place will experience an erosion of civil expectations and social cohesion, resulting in increased high risk behaviors as well (Rhodes and Simic, 2005). The prejudice and stigma associated with HIV/AIDS can also become particularly virulent when combined with stigma directed at displaced persons (Salama and Dondero, 2001; Decossas et al., 1995).

Reviews conducted by Forced Migration On-Line (2006) and Humanitarian Practice Network (2002), in addition to the published literature, document the following reasons for increased infection attached to women's disenfranchisement and forced migration.

Lack of Health Infrastructure

In situations of conflict, chaos, migration and resettlement, a stable health infrastructure is difficult to maintain. The ability to maintain blood supplies that have been screened for blood borne disease, including HIV, is more difficult, increasing the likelihood of infection via transfusions. Provision of HIV education and condoms is difficult, particularly if linguistic barriers prohibit any education from occurring. HIV counseling and testing may not be possible if testing kits and trained counselors are unavailable. All of these health infrastructure factors maintain increased risk in resettlement and migratory environments. Furthermore, medical facilities that serve forced migrants are also likely to suffer from shortcomings. For instance, work in conflict-affected Northern Uganda documented a shortage of HIV services, including prevention of maternal to child transmission (PMTCT), within districts containing camps for IDPs (Chamla et al., 2007). Furthermore, as refugee camps may be primarily staffed by male aid workers, forced migrant women may be less comfortable to discuss personal health needs, such as sexual health issues, thus leaving women vulnerable to HIV due to lack of knowledge, barrier-based protection, testing, and possibly treatment.

Use of Rape as a Weapon of War

There has been extensive documentation of both military (including foreign militaries and paramilitary groups) and civilians using rape as a weapon in war (Donovan, 2002; Amnesty International, 2004; Roberts, 2004). In the context of high HIV rates, such sexual violence substantially increases the likelihood of women becoming infected. Sexual assault not only increases women's risk of

contracting HIV due to forced, unprotected sex, but such violent sex also confers HIV risk due to lacerations and other injuries within the female genital tract. Forced migrant women may be particularly vulnerable to being victimized by war-related rape and sexual assault. In multiple global settings that have grappled with widespread political turmoil (e.g. Darfur), women were often present in the villages during attacks while men were in neighboring towns as laborers. As women fled their villages to escape from the attacks, they were often chased and raped at security checkpoints, roadblocks, and elsewhere during their escape attempts (Amnesty International, 2004). Such experiences of sexual assault likely renders these women to face stigma from their communities, as they may be viewed as "tainted" by the enemies. Victimization from sexual assault, coupled with ostracization from their social circles likely bestows feelings of isolation among victims, leaving women and girls highly vulnerable to future sexual violence. Unfortunately, rape and sexual assault perpetrated against women have also been documented in refugee camps and settlements housing IDPs (Amnesty International, 2004; Kerimova et al., 2003). High and increasing HIV rates among women in refugee camps and regions plagued by war have been attributed to such assaults (Save the Children, 2001; Smith, 2002; Holmes, 2001; Roberts, 2004; Green, 2003).

Survival Sex and Sex Trafficking

In the context of crisis and economic loss, circumstances common to forced migration, women may sell sex as a means of survival. This may be particularly true within the context of forced migration. In times of violent conflict, mortality disproportionately affects men (Murray et al., 2002), thus leaving women as single heads of household. With the sudden loss of income in an already depressed economic climate, women and girls may have very few alternatives, other than survival sex, to obtain money, food, and other necessities. Documentation of women turning to survival sex in the context of migration has been observed cross-nationally (Renaud, 2001; Lawday and Webb, 2002). In part, this can also be the context of smuggled or trafficked migrant women being forced into sex work. Like other forms of sexual violence (e.g. rape and sexual assault), sex trafficking, which is a form of gender-based forced migration in it of itself, is also believed to be rampant during times of conflict. While the documentation of HIV among sex trafficking victims is scarce, recent data from South Asia suggest that the prevalence of HIV among sex trafficked women and girls is as high as 38% (Silverman et al., 2007a). Likely mechanisms underlying such elevated rates include inability to demand condom use during forced, unprotected sex, and being forced to carry out sex work within a controlling environment characterized by debt bondage (Silverman et al., 2007a). The interplay of sex trafficking, forced migration, conflict, and gender are believed to create such a dire situation regarding HIV that sex trafficking has recently been specifically highlighted as an important factor in fuelling Nepal's dual epidemic of political conflict and HIV (Singh et al., 2005).

Social Norms and Regulations Related to Sex are Lost in Situations of Chaos

Forced migration is highly destabilizing, as family and community members are lost or killed in the migration process. Such destabilization breaks down family, social, and/or cultural norms that regulate safe and healthy sexual activity. Normal development of sexual relationships and activity in such contexts is highly impeded. People in this context may turn to multiple others for sex as a means of obtaining comfort in a time of crisis, increasing risk for HIV exposure. Safe sex practices are also likely to be abandoned in such situations, especially involving women, as condom use is much more prevalent in MSMs than in heterosexual intercourse (UNHCR, 2006). In the context of violence, sexual violence may also feel "normal" to young men, again increasing HIV risk (Smith, 2002; Roberts, 2004). Finally, younger people may be exposed to sexual activity at too early of an age due to lack of sexual privacy and pervasiveness of sexual assaults; such early exposure may incite them to begin sexual activity at too young an age.

High Rates of Intimate Partner Violence in Conflict-Affected Settings

Cross-national studies demonstrate that women experiencing violence from intimate partners are at increased risk for HIV due to abusive partners' higher likelihood of engaging in risky sexual behaviors, including multiple partnering and use of sex workers (Dunkle et al., 2007; Silverman et al., 2007b; Raj et al., 2006). As described above, the context of forced migration often results in greater availability of sex trade for men; it has also been hypothesized that men's victimization from political conflict, and their subsequent forced migration, increases male likelihood to perpetrate violence against their female intimate partners (Krug et al., 2002). Understanding and considering partner violence as an HIV risk factor for female forced migrants is clearly needed, but limited work has been undertaken to examine this issue.

Growing work documents a strong association between men's exposure to political conflict and their perpetration of both sexual and physical violence against female partners (Gupta et al., 2008). Consistent with these findings, extremely high rates of intimate partner violence have been documented in refugee camps and settings in multiple global contexts (HRW, 2003; Khawaja and Hammoury, 2008; Amnesty International, 2004). Such intimate partner violence perpetration among these men may be more likely due to stronger perceptions of the acceptability or normative nature of such violence, the negative mental health sequelae associated with these men's exposure to violent atrocities, and greater desire and entitlement to control female partners when these men become otherwise disempowered by society (Krug et al., 2002; Gupta et al., 2008). Policies that register refugee families using the male head of household's name are also likely to render forced migrant

women vulnerable to violence and dependency on male partners, as food and other goods are often distributed to family heads (HRW, 2003), thus fostering a situation of greater male power.

Military Members, Including Peace Keepers, Increase STI/HIV Risk

Extensive evidence has documented heavy and high risk sexual activity among military members and their promotion of sexual activity, both consensual and non-consensual, with vulnerable local and refugee populations (McGinn et al., 2001 Van Landingham et al., 1993). Current indications are that HIV rates among the military are higher than those seen in the general population (McGinn et al., 2001; Elbe, 2003), in some cases 2–5 times higher (Webb, 2002), and condom use is not typical of many soldiers regardless of their HIV serostatus (Van Landingham et al., 1993; Roberts, 2004). Further, youth, lengthy periods away from steady partners, military values that promote risky behaviors, and better pay than local residents increases local demand for sex work (UNAIDS, 1998; McGinn et al., 2001; Zwi and Cabral, 1991); simultaneously, the vulnerability of displaced young women increase their turning to sex trade with the military as a means of survival. Reports have also documented the abduction of vulnerable women and girls by military groups; these women and girls are then used as sex slaves (Amnesty, 2004). Taken together, the military presence poses great risk to HIV for female refugees and forced migrants (Smallman-Raynor and Cliff, 1991; Hankins et al., 2002; Elbe, 2003).

Review Summary

HIV is a global pandemic disproportionately affecting young, poor, women of color in regions and neighborhoods burdened by poverty and violence. While increased biological risk for HIV from penile-vaginal sex is in part an explanation of why these women are at increased risk, their reduced social status attached to gender, age, race/ethnicity, class, and place of origin further contribute to this risk. For many of these women, their vulnerability is further compounded by forced migration and loss of infrastructure in their places of origin. In this context, women's risk for HIV increases due to lack of health infrastructure in which to receive HIV education, condoms, testing or treatment; heightened risk for sexual assault from residents and the military; increased reliance on sex work as a means of survival and economic security; greater casual sex with multiple partners in a context of chaos and unstable family structures; heightened risk for intimate partner violence and related partner HIV risk attached to the political victimization and disempowerment these male partners have faced, and greater exposure to HIV due to military presence or relocation to higher epidemic regions. Research documenting higher rates of HIV among migrant, refugee and IDP women support these findings (e.g., Brewers et al., 1998;

Ministry of Health Sudan, 1995; UNDP, 2004; Zuma et al., 2003). These findings have implications for HIV program, policy, surveillance and research.

Implications for Reproductive and Sexual Health Practice and Policy

In response to increasing concern regarding the sexual health of women and girls who are forced to undergo conflict-induced migration, several guidelines and manuals have been put forth by international agencies. These include the UNHCR publications entitled, "Reproductive Health in Refugee Situations: An Inter-Agency Field Manual" (1999) and "HIV/AIDS, Conflict, and Forced Migration" (Roberts, 2004), as well as the World Health Organization's Inter-Agency Standing Committee's Guidelines for HIV/AIDS Interventions in Emergency Settings (2003a), and the Reproductive Health Response in Conflict Consortium's Guidelines for the Care of Sexually Transmitted Infections in Conflict Affected Settings (2004). These resources provide important guidelines and recommendations for addressing HIV and other STIs in refugee populations. In this section, we have adapted these guidelines to integrate gendered aspects of conflict-induced forced migration (e.g. vulnerability to sexual assault) and their intersection with HIV risk.

Practice Implications

A. Prior to undertaking new initiatives related to HIV prevention with forced migrants, a situational analysis must be conducted to help plan appropriate and comprehensive HIV prevention and treatment-related services. The situational analysis should assess: (1) the prevalence of STI and HIV in the host and home country (or region/area) and (2) the cultural and religious beliefs, attitudes, and practices concerning sexuality, reproductive health, STI/HIV prevention. Gendered considerations related to sexual assault, sex trade/survival, and family and marital relationships/dynamics (including child/forced marriage, partner violence) must be included, with an eye toward the differential gendered aspects of risk by age.

B. Any health care practice efforts undertaken or maintained must implement the practice of universal/standard precautions in health-care settings, to prevent transmission of HIV and other pathogens from patient-to-patient, health worker to patient, and patient to health worker. In stressful work settings, such as refugee camps, standard precautions may not be rigidly followed. For instance, within such crisis-oriented environments, health workers may be more likely to "cut corners" in sterilization techniques; they may also be more likely to experience work-related accidents such as needle-stick injuries. Thus, health care workers should all be trained on standard precautions. All patients must be informed of the precautions necessary for clinical setting and what currently is being undertaken in their care.

Communication surrounding the handling of body fluids can help reduce additional feelings of stigmatization within refugee camp settings, particularly for women.

C. High-quality condoms should be made accessible to both refugee communities as well as host populations, as contact is likely to occur between the two. In conjunction with distribution of condoms, promotional campaigns should target men, as men may be less likely to use condoms with female partners due to perceptions of diminished pleasure with sexual intercourse and/or attitudes favoring traditional masculine attitudes and norms. In times surrounding conflict, such attitudes may grow even more rigid than at baseline.

D. STI/HIV and reproductive health care must be delivered to women in a trauma sensitive and safe manner. Exposure to sexual violence and other trauma may result in heightened reluctance of women and girls to see male clinicians, particularly if a physical or gynecological exam is required. Simultaneously, such violence can result in increased risk for severe urogynecological injuries (Longombe et al., 2008), requiring greater need for gynecologic care. Female health providers must be made available and trained to support care of these women and girls with consideration of the often co-morbid mental health trauma that accompanies such assault-related injuries.

E. STI diagnosis and care are key to reducing vulnerability to HIV; hence, effective and proper STI case management is needed to ensure identified infections are handled appropriately. This involves the following: (1) training health care providers in diagnosis and follow-up, (2) providing guidelines for case management, (3) consistent availability of appropriate drugs and condoms, and (4) monitoring. For women and girls, it may also be necessary to ensure that adequate numbers of female health provider staff are available. Furthermore, due to limitations with clinical etiological diagnosis and feasibility constraints for using laboratory diagnosis in low resource settings, a *syndromic* approach to STI diagnosis is recommended. This approach was first put forth by WHO during the 1970s, and is currently considered the most feasible approach to STI management in conflict-affected areas. Syndromic diagnosis involves the identification of a consistent and easily recognizable group of symptoms and signs, followed by appropriate treatment and follow-up. (See WHO, 1999, 2003b for details.)

F. STI management must be sensitive to the vulnerabilities attached to partner disclosure and notification, among victims of sexual assault and other violence. While ideally, partner identification, notification and treatment are key to assisting in the management of STIs, such efforts must consider the vulnerabilities of women infected by abusive partners, sexual assault perpetrators, and those in positions of authority (e.g., police, military). Required partner notification may not be optimal in such circumstances. Broad testing and treatment should be considered in situations where such infections have been identified.

G. Comprehensive HIV/AIDS care and support services must be made available in sites known to have large proportions of migrant populations; these services must include HIV/STI prevention education; HIV and STI counseling, testing and quality drug treatment; and support and linkage to long-term care for those infected. For women and girls, these services should be integrated into comprehensive sexual

and reproductive health care, which should also include safe motherhood and emergency obstetric care services as well as family planning including provision of free condoms. This provision should occur in refugee and resettlement sites as well as migrant worksites and villages.

H. Comprehensive HIV/AIDS services must be created in ways that do not support the ostracizing and stigmatization of those infected with HIV nor those identified as victims of gender-based violence. To ensure the confidentiality of women and girls presenting for such care, the services must be integrated into more socially acceptable existing services, such as reproductive health care services, as described above. Similarly, health agents providing home-based care pertaining to HAART should also perform other health-related duties (e.g. general nutritional counseling) to minimize community members' association of certain personnel with HIV/AIDS.

I. Services must be broadened to address issues of gender-based violence including partner violence and sexual assault, these must include prevention/education as well as support services for victims. Additionally, educational services must be made available to potential perpetrators as well as potential victims; potential perpetrators can include but are not limited to site residents, local military including peace keepers, and health care providers. Given the substantial rates of violence experienced by forced migrant and refugee women, programs and services for victims must be maintained. These should include support, counseling and shelter; longer-term as well as short term shelter should be maintained when possible.

J. Programs for women involved or vulnerable to involvement with sex trade must also be maintained. These programs should include HIV prevention, testing, and education, as well as free condoms, to support women and girls involved with sex exchange. Simultaneously, primary and secondary education, as well as job skills training, should be provided to support women's economic empowerment. Many migrant women who have not had access to education or training may engage in sex trade in the absence of other job options, however, many become involved in sex work because of overall low economic opportunity for both men and women, regardless of skills and training. Improved identification of perpetrators of sexual exploitation must also be integrated, in order to prevent forced migrant women's further exposure to sexual assault and HIV/STIs.

Policy Implications

All policies supporting migrant women must consider their special needs as migrants and their rights as humans. Existing international doctrines related to refugee rights, human rights and humanitarianism must guide government policies related to migrants. These existing doctrines include (a) the Convention on the Status of Refugees (1951) and its Protocol (1967), (b) the Universal Declaration of Human Rights (1948), and (c) the four Geneva Conventions (1949) and their two Additional Protocols (1977). While these international policy documents declare that migrants and those living with HIV have a right to health services on a par with nationals

and non-HIV infected individuals, national policies and practices do not always support these rights. National policies that are anti-migrant or anti-immigrant must be reviewed and reconsidered (e.g., limiting job opportunities or welfare access based on citizenship, birthplace, or linguistic fluency). Additionally, policies should be implemented to guarantee provision of health care and education for migrants, including documented and undocumented migrants, as well as trafficked and smuggled individuals; policies supporting family reunification among migrants should also be implemented as an important mechanism of potential HIV prevention.

Policies specific to the rights and health of those living with HIV are also needed. One easily observable indicator of high-level commitment within organizations is the existence of formal HIV/AIDS policy statements. The United Nations has taken a lead on such policies. In 1988, a memorandum was issued by the Office of the United Nations High Commissioner for Refugees (UNHCR), "Policy and Guidelines regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS)." This memorandum stated that refugee and resettlement programs must provide care and support for those who are HIV-infected, regardless of when infection occurred. In June 2001, a statement of commitment was also adopted at the U.N. General Assembly Special Session on HIV/AIDS. This document specifically highlights HIV/AIDS in conflict-affected regions and pledges (a) to include HIV/AIDS education, care and treatment into programs or actions responding to emergency situations, (b) to train emergency personnel to deliver quality HIV education, care and treatment; and (c) to address the spread of HIV among military (including peacekeepers) by training them in HIV prevention, with special consideration of issues related to gender-based violence and sex trade. In 2006, the UN met again to discuss AIDS related topics, reaffirming the goals of the 2001 statement and adding a particular concern for gender inequality, resolving to focus on the increasing proportion of female AIDS sufferers (UN General Assembly/UNAIDS, 2006) Unfortunately, as with human rights policies, national governments do not always adhere to these international doctrines. Nonetheless, governments HIV/AIDS policy statements are increasingly more common, giving greater opportunity for advocates to push for development of more egalitarian and respectful HIV/AIDS policies across nations.

Implications for Surveillance and Research

One of the greatest concerns related to increased risk for HIV among migrant women is the lack of data to guide and explain how risks are occurring. Many nations lack national surveillance efforts, and those that have them often lack questions on immigrant/migrant status, including time in current residence and location of origin. Inclusion of such data in national surveillance efforts will give important insight into differences between migrant and non-migrant communities within the nation; it will also serve as a comparison for local surveillance efforts with special populations, including forced migrants. Surveillance of migrant populations is

needed at refugee sites, resettlement locations, and migrant worksites and villages; such surveillance should include both HIV and STI assessments. Special efforts must be made to ensure that women and girls who are refugees or otherwise displaced from conflict-induced migration are included in such systems, both those within and outside of camps. Such surveillance should not only include biological outcomes, but also social contextual factors (e.g. violence, condom use, transactional sex, stigma). In addition to individual-level surveillance, efforts should also be made to capture program and risk indicators at the levels of health center and community level, as well as to capture demographic and migration patterns locally and regionally. With higher quality HIV/STI surveillance data mapped against community/health center indicators and global migration patterns, we will be better able to understand the complexity of how migration is linked with the HIV pandemic and what can be done better to reduce HIV transmission attached to migration. However, in addition to surveillance work, social and behavioral research is needed to identify risk factors linked to higher and lower rates of HIV and STIs among migrants compared with residents locally and in places of origin, with the goal of creating better programs to address the epidemic. Finally, with development and refinement of HIV programs and policies tailored to and targeting migrant women and girls, there will be a need to evaluate these programs and policies to determine and recommend best practices in future.

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Barriers to Reproductive Health and Access to Other Medical Services in Situations of Conflict and Migration

Therese McGinn

Introduction

People living in situations of conflict and forced migration do not receive the health care they need and want, and to which they have a right. There are many factors contributing to this lack of adequate care. The purpose of this paper is to examine these factors, using reproductive health care as the lens through which barriers to providing and using health care are reviewed.

The definition of reproductive health articulated at the International Conference on Population and Development (ICPD) in Cairo in 1994 and adopted by the World Health Organization is widely accepted for its encompassing vision. The definition states:

> Reproductive health is 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 are 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 (United Nations, 1994; World Health Organization, 2004).

The ICPD Programme of Action continues:

> In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (United Nations, 1994).

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_7, © Springer Science+Business Media B.V. 2009

The barriers to reproductive health care in conflict include and often exceed barriers to other components of health services, such as preventive and curative care for children and management of infectious diseases for populations in general. This holds true for both provision and utilization of such care: reproductive health often faces greater obstacles to both supply and demand than do than other categories of care. Reviewing barriers to reproductive health care in conflict situations, therefore, allows a thorough examination of barriers to health care more generally.

Background to the Field of Reproductive Health in Conflict

Reproductive health is a relative newcomer to humanitarian response, an important consideration in the discussion of barriers to care. Traditionally, the focus of international and local relief agencies' response to complex emergencies has been the provision of adequate food, water and shelter and basic health care to reduce mortality through control of infectious diseases. Attention to reproductive health is frequently dated from the mid-1990s when, indeed, concerted interest was initiated and then maintained. However, in the 1970s and 1980s, some organizations provided reproductive health services, carried out research and formulated guidelines in response to specific needs they identified among refugee and displaced persons or others exposed to violence. For example, Lao and Hmong refugees (Chongvatana and Lavely, 1984) and Khmer refugees (Lenart and St. Clair, 1991) in Thailand in the late 1970s were offered family planning services. Research studies included a comparison of fertility levels among different groups of Hmong refugees in Thailand in 1979–1980 (Holck and Cates, 1982); an assessment of pregnancy outcomes in Chile during the civil unrest of the mid-1980s (Zapata, 1992); and the prevalence of sexually transmitted infections among pregnant Vietnamese refugees in Hong Kong in 1989 (King et al., 1990). In 1991, the United Nations High Commissioner for Refugees (UNHCR) developed the first set of guidelines recognizing that refugee women and girls faced particular protection concerns (UNHCR, 1991). While reproductive health was not specifically the focus of this document, it encouraged provision of family planning services; pregnancy, delivery and gynecological care; counseling for rape survivors; and management of sexually transmitted infections as part of a comprehensive response to the needs of refugee women and girls.

In the mid-1990s, a series of global events occurred which focused attention on reproductive health needs of war-affected populations. First, a *Lancet* editorial entitled, "Reproductive freedom for refugees," (1993) noted that, "It is *not* offering choices [to refugees] that is reprehensible." Second, a 1994 study carried out by the Women's Commission for Refugee Women and Children showed that reproductive health services were virtually absent in the eight refugee and internally displaced persons (IDP) field sites the researchers visited, except for some antenatal and basic delivery care, even though some of the populations had been displaced for long periods (Wulf, 1994). Next, both the 1994 International Conference on Population and

Development in Cairo and the 1995 Fourth World Conference on Women in Beijing highlighted the reproductive health needs of displaced populations, and of displaced women specifically (United Nations, 1994; United Nations, 1995). Finally, the scope of the atrocities, particularly sexual violence, during the conflicts in the former Yugoslavia and in Rwanda in the mid-1990s, covered extensively in the world's popular media, forced attention to reproductive health issues.

Following the sobering realization of the absence of reproductive health services to those in conflict settings, humanitarian and development agencies mobilized to address the gap. Early in 1995, five international NGOs – CARE, International Rescue Committee, JSI Research and Training Institute, Marie Stopes International and the Women's Commission for Refugee Women and Children – formed the Reproductive Health Response in Conflict (RHRC) Consortium to promote sustained access to comprehensive, high-quality reproductive health care in emergencies and to advocate for policies that support the reproductive health of people affected by armed conflict. Also in 1995, UNHCR and the United Nations Population Fund (UNFPA) agreed to collaborate to address the needs of displaced populations for reproductive health information and services. One form of this collaboration was their decision to co-host a series of consultative meetings on reproductive health in conflict settings; as a result, the *ad hoc* Inter-agency Working Group on Reproductive Health in Crisis Settings (IAWG) was formed in 1995 with membership from United Nations, multi- and bilateral, non-governmental, university and donor organizations.

IAWG served, and continues to serve, as a mechanism for agencies to discuss concerns in the field of reproductive health in conflict, determine priorities and collaborate to address them. A major initiative taken by IAWG was the development of a technical manual entitled *Reproductive health in refugee situations: An inter-agency field manual* (UNHCR, 1999). The manual, endorsed by thirty-three UN, non-governmental organization (NGO), university and government bodies, was published in 1999 after two years of field testing in seventeen countries (Schreck, 2000). It is intended as a tool to encourage organizations to initiate reproductive health programming and to guide program managers in developing, implementing and evaluating interventions in the field.

Consistent with the ICPD definition of reproductive health care, the *IAWG Field Manual* describes fundamental principles for reproductive health programs in crises and contains programming guidance for both the emergency and stabilization phases. (UNHCR, 1999) For the early stages of an emergency, IAWG defined the Minimum Initial Services Package (MISP), a series of actions to be taken in all new humanitarian situations without a population-specific needs assessment. The objectives of the MISP are to identify an organization to coordinate the reproductive health response; prevent and manage the consequences of sexual violence; reduce HIV transmission by enforcing standard precautions and making condoms available; prevent excess maternal and neonatal mortality by providing clean delivery kits for use by pregnant women, providing midwifery kits to health facilities and establishing referral systems for obstetric emergencies; and

plan for the provision of comprehensive reproductive health care after the emergency phase. Programming guidance for comprehensive care is also fully described in the *IAWG Field Manual*, with comprehensive care defined to comprise safe motherhood; sexual and gender-based violence; sexually transmitted infections including HIV/AIDS; and family planning. The manual also addresses the reproductive health of young adults and surveillance and monitoring appropriate to these settings.

The rapid development, publication and wide dissemination of the *IAWG Field Manual* is an early example of the intense and collaborative nature of the young field of reproductive health in conflict. In the almost fifteen years since the field was established, additional technical manuals were developed, both by individual agencies and groups of partners, on safe motherhood, family planning, STIs/HIV/AIDS and gender-based violence (examples include: Holmes/IRC, 2003; IASC, 2005; RHRC Consortium, 2004a, b); advocacy for favorable policy change was carried out in UN, donor and NGO fora; three professional conferences were held, sponsored in 2000 and 2003 by the RHRC Consortium and in 2008 by the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative and the Consortium (RHRC Consortium, 2000; RHRC Consortium, 2003; RAISE Initiative and RHRC Consortium, 2008a); research studies were carried out and journal articles published; and a standard for reproductive health was included in the 2004 revision of the *Sphere Charter and Minimum Standards in Disaster Response* (2004) – all indications of the maturation and professionalization of a field which did not exist prior to 1995. Most importantly, humanitarian agencies, supported by dedicated funding and the newly available policy and technical guidance, began to shift policies and field procedures to deliver reproductive health services to people in conflict settings.

The Reality: Barriers Block Delivery and Use of Reproductive Health Care

Three overviews of the field conducted over a decade show the improvements in the availability of reproductive health care to people in conflict settings, but also underscore the barriers to widespread coverage and use of services. The first review, the 1994 Women's Commission report discussed above, documented virtually no reproductive health services to those in the sites the researchers visited. Moreover, it documented virtually no interest in reproductive health among the agencies serving refugees (Wulf, 1994). By the time of the second overview in 1998, more agencies were providing care – primarily limited to some safe motherhood services and basic family planning – and beginning to make the institutional changes needed to include reproductive health in the standard package of services they deliver (RHRC Consortium, 1998).

The most recent overview was a large-scale effort by the Inter-agency Working Group. From 2002 to 2004, IAWG undertook a global evaluation of reproductive health services to refugees and IDPs, based on the framework for implementation

outlined in the *IAWG Field Manual*. The objectives of the evaluation were to assess the range and quality of services provided to refugees and IDPs, identify the factors that help or hinder care and identify lessons learned in the field's first decade of activity (IAWG, 2004). The global evaluation comprised six studies: a literature review; a global survey of reproductive health coverage for refugee and IDP populations in thirty three countries based on agency self-reports; an assessment of availability and quality of reproductive health care based on visits to three field sites (Uganda, Democratic Republic of Congo and Yemen); a review of prior experience and an on-site review in Chad of rapid reproductive health response in new crises; a review of NGO policy and institutional change based on key informant interviews; and a review of global resource trends over the decade based on an analysis of published and unpublished donor commitments and expenditures.

The global evaluation and other studies and programs suggest a wide range of barriers to care. For the purposes of this paper, barriers are grouped into four categories for discussion. These are: limited availability and quality of reproductive health care; variable demand for reproductive health services; structure and history of the humanitarian field; and global policy and funding constraints.

Limited Availability and Quality of Reproductive Health Care as a Barrier to Care

The most fundamental barrier identified in the global evaluation was, quite simply, the limited scope and quality of reproductive health services available. This was identified in the literature review, the global coverage survey and site visits, and corroborated earlier reviews and field studies (Palmer, 1998; McGinn, 2000; Hynes et al., 2002; Guy and Morris, 2003; McGinn et al., 2004). Specifically, the global evaluation showed variation in availability and quality of care by phase of emergencies, by specific reproductive health component, by type of site and by level of development of the host site.

As noted, the community of professionals working in reproductive health in conflict settings identified a set of basic services and activities, MISP, intended to be initiated within days of the start of new natural or man-made disasters (UNHCR, 1999). The Sphere standards, a set of minimum standards for humanitarian response to which humanitarian responders voluntarily agree to adhere, include the MISP (Sphere, 2004). Yet the global evaluation showed substantial gaps in reproductive health services during emergency response.

The retrospective study of response during past emergencies found that, of 33 sites reviewed, at least one MISP component was in place within one month of the crisis in three-quarters of sites, and that all MISP components had been implemented within three months in approximately half of the sites. However, no site reported implementing all components of the MISP within the first 30 days of the crisis (IAWG, 2004). In an on-site assessment of the active crisis in Chad in 2004 to determine to what degree the MISP had been implemented, reviewers found that most staff of responding agencies were unfamiliar with the MISP. Therefore, its

components were not put into practice: there was no overall reproductive health coordinator; limited activities to prevent sexual violence and limited availability of clinical services for survivors of sexual violence; poor observance of standard precautions to prevent transmission of infectious disease in health facilities; virtually no condoms available; incomplete distribution of clean delivery kits for visibly pregnant women; no availability of emergency obstetric care; and no planning for comprehensive reproductive health services (IAWG, 2004). The global evaluation suggests, then, that many refugees and internally displaced people in the acute phase of humanitarian emergencies do not have adequate access to reproductive health services.

In stable humanitarian settings, the most established reproductive health services at the time of the global evaluation were limited family planning methods (primarily oral contraceptives), antenatal care and condom distribution (IAWG, 2004). This is not surprising: these elements were most familiar from the development field and were introduced earliest to conflict populations. The less familiar services – a wider range of contraceptives, emergency obstetric care, response to gender-based violence, STI/HIV/AIDS services other than condom distribution and youth-friendly services – were not routinely available in most sites. In the last several years, however, observation and field reports suggest that these services, especially response to gender-based violence, HIV prevention and treatment of STIs, have expanded as more agencies in more sites gather the experience and confidence to address these needs and as donors recognize and support their efforts (RAISE Initiative and RHRC Consortium, 2008b).

The adequacy of scope and quality of some reproductive health care is a concern in the field. As reproductive health services are expanded, health care providers and their agencies raise questions about quality and, specifically, continuity of care to displaced people. Even if an agency has the technical, financial and other resources to deliver specific components of care, they may question whether it is appropriate to do so. For example, providers worry that women who opt for long-acting contraceptives such as the intrauterine device (IUD) or sub-dermal implants may be unable to obtain follow-up care or get them removed if they leave the service area. Similarly, although the Joint United Nations Program on HIV/AIDS (UNAIDS) and the United Nations High Commissioner for Refugees (UNHCR) promote equity in HIV prevention and treatment for all people and promote the inclusion of displaced populations in national anti-retroviral therapy (ART) protocols (UNAIDS and UNHCR, 2007), front-line providers are concerned about starting clients on ART if they will not have ongoing care available to them when they return home. The quality of care, cost and ethical implications of providing such care are substantial, and challenge agencies working among mobile populations.

Another imbalance in the availability of care was identified in the global evaluation: people living in non-camp settings have considerably poorer access to services of all kinds, including health and reproductive health, than those living in camps.

Concentrated populations are, of course, easier to serve than are dispersed populations, and it is not unreasonable for services to be introduced in areas of high

concentration, such as camps, first. However, if services remain only in camps, dispersed populations become or remain systematically disenfranchised. Distance may be an insurmountable barrier for dispersed populations trying to reach routine health care and may be a death sentence for those with emergencies. For example, a woman with a severe obstetric complication trying to reach a referral facility for emergency obstetric care – should such care be available – has limited time to get help which can save her life. The same is true for a person with any life-threatening health condition. Moreover, distance masks the related barrier of insecurity: the farther one must travel, the greater the risk of danger from organized military forces or bandits taking advantage of lawlessness. Travel at night is universally prohibited in insecure zones, lengthening the time patients will require to reach care.

A related disparity identified in the global evaluation was that between care available to refugees and to the internally displaced. IDPs were found to have poorer access to care than refugees, in part because they are more likely to live in dispersed areas where distance to health care may be great and security poor, as discussed above. Cost of care might also be a factor in the disparity between refugees and IDPs: refugees are provided free care, but this is not always the case for IDPs, especially in non-camp situations. Another important reason for IDPs' poorer access is that it may require an extension of humanitarian agencies' missions, often expressed as service to *refugees,* to work with IDPs. Indeed, in 2006 UNHCR articulated its commitment to IDPs to counter the assumption that they were concerned with refugees only, and also defined its mechanisms of working in IDP host countries (UNHCR, 2006). Agencies may also find it difficult to obtain necessary approvals to serve IDPs from host governments implicated in armed conflicts, and to work with authorities on the ground.

Yet another cause for variation in reproductive health services offered to those in conflict is a country's general level of development. The evaluation found that countries with good health and other systems at the start of a crisis – such as those in some parts of Asia and Latin America – can deliver more and better quality services, even in war, than can countries with poor systems. Many sub-Saharan African countries have weak health systems to start with, and they become weaker as conflict destroys what human and material resources exist. Problems include stock shortages; culturally inappropriate education and counseling; inadequate training and skills among staff tasked with providing services; and poor data systems. These problems are not unique to conflict; many of them also plague reproductive health and other health programs in stable, but very poor, countries. It is fair to state that in Darfur, for example, the generally limited scope and quality of health care predated the conflict and applied to all residents of the region, displaced or not. Nevertheless, even in countries with good general health systems, such as Colombia, care available to displaced people can be below the standard available to stable populations (Women's Commission, 1999; Krause and Morris, 2003; Profamilia, 2005).

Variable Demand for Reproductive Health Services as a Barrier to Care

The extent and speed of uptake of health services by populations affected by conflict is influenced by many individual, social, economic and political factors. Busza and Lush (1999) constructed a useful conceptual framework to illustrate how pre-conflict factors interact with the experiences of displacement to create a range of potential reproductive health outcomes. They explain that individuals, families and communities enter their displaced existence with their existing demographic profiles; reproductive health status and preferences; awareness, attitudes and beliefs about facets of life such as sexuality, marriage and gender; and experiences of health services at home. These aspects of their lives are then altered, perhaps dramatically, by their experiences of displacement. These include movement to new physical and possibly climactic environments; exposure to violence, possibly including sexual violence; changed familial and social structures and roles; altered economic systems and labor options; interactions with host populations and possibly unfamiliar groups from other conflict areas; interactions with humanitarian agencies and other official bodies; and exposure to health education, services and new service systems. As the migrants reformulate their lives, they change, and these changes may manifest themselves, over short or long periods, in altered awareness, perceptions, attitudes and behaviors related to reproductive health. The migrants' pre-existing status and the changes they experience over time may operate as barriers to care, or they may become opportunities for new ways for them to consider their health and rights.

Where the migrant populations' prior levels of awareness and use of reproductive health services are reasonably high, humanitarian agencies might expect to face relatively few barriers to demand for reproductive health care. Indeed, they may face a pent-up demand for services if care stopped during the active conflict. Thus, in Colombia where the national contraceptive prevalence rate (CPR) is 64% for modern methods and where the proportion of women who give birth with skilled attendants is 91%, displaced women are reasonably well accustomed to family planning, care during pregnancy and delivery and other elements of reproductive health services, even if not to the same extent as the general population (UNFPA, 2006). Informational and cultural barriers to demand for health care would be expected to be relatively low in such a site. A similar situation exists in Sri Lanka, another often forgotten crisis setting, where CPR is 50% and 97% of women deliver with skilled attendants (UNFPA, 2006).

Many of the world's current refugee and IDP situations, however, are in regions where the migrants' pre-existing reproductive health status is poor and pre-conflict levels of awareness and use of reproductive health services are low. In most sub-Saharan African conflict sites, indicators such as CPR and skilled attendance at delivery are far lower than in Colombia or Sri Lanka. For example, CPRs in Central African Republic, Democratic Republic of Congo and Sudan are under 10% (7, 4, and 7%, respectively) and the proportions of women who deliver with skilled

attendance in these countries are also relatively low (national rates in the three countries, likely higher than those in displaced and rural regions, are 44, 61 and 57%, respectively; UNFPA, 2006). Migrants' low awareness and limited experience of reproductive health services may therefore be a barrier to care, as they are unlikely to seek out such services and may in fact resist agencies' efforts at education and service delivery.

Ironically, it was in Africa where some humanitarian agencies were first faced with refugees' demand for family planning services: in the mid-1990s, Rwandan refugees, accustomed to a family planning program at home that made Depo-Provera and other contraceptives available, looked to health care providers in the refugee camps in Tanzania and Congo to help them obtain resupplies of their methods (Schreck, 2000). For the most part, organizations were not prepared to respond and they had to move quickly to adjust to their clients' demands.

Structure and History of the Humanitarian Field as a Barrier to Care

The challenges of delivering adequate health care on the ground and low pre-existing demand for services are barriers to care that can be addressed with humanitarian agencies' reproductive health program interventions; this is precisely what has occurred in many agencies and conflict sites in the past decade. Over 30 relief and development agencies endorsed the *IAWG Field Manual,* and these and other organizations are actively bringing reproductive health services to refugees and IDPs in the field (UNHCR, 1999). However, another set of barriers may arise as agencies shift their operations to incorporate this new sector. Their internal organizational structures and systems for responding to emergencies may themselves be a barrier to delivering good reproductive health services.

First, reproductive health is new to humanitarian agencies, and introducing any new component in an organization is challenging. By definition, there are no staff with the requisite skills, no internal policy or program guides, no technical systems in place, no institutional experience in the sector. Even when these elements are brought in – i.e., staff can be hired or trained and external guidelines adapted – each institution must determine how the new services fit in the context of its existing set of management and technical systems. While organizations can ensure that clinicians and educators acquire the specific skills they need to deliver reproductive health care, it is a more complex undertaking to make certain that generalist staff or specialists in other sectors effectively incorporate reproductive health into their responsibilities. So, in order to successfully integrate reproductive health into their operations, organizations must ensure that human resource systems recruit and hire staff with the requisite reproductive health skills; health sector supervisors provide reproductive health providers relevant support; that health sector managers design and evaluate reproductive health programs using best practices in the field; that logisticians integrate reproductive health procurement and distribution into their

systems; that data specialists add appropriate indicators to data tracking systems; that development staff expand their donor base to include those friendly to reproductive health; that advocacy staff articulate their issues to include reproductive health concerns; that senior officials incorporate the new sector in their interactions with other agencies and in their representation of their organizations. Moreover, these adjustments must occur at site, country, regional and headquarters levels.

While adding any new service would require such substantial changes in organizational structure, adding reproductive health is likely to raise additional concerns. Most health and social services in development or humanitarian response – such as child survival, provision of clean water and housing – do not provoke the partisan debate that often accompanies reproductive health. Thus, actual controversy or the fear of controversy may restrain agencies' willingness to commit to reproductive health programming, as they may believe they would risk the good will of their government donors or their public by doing so. Moreover, individual workers may feel most comfortable following their own beliefs, regardless of what their organizations prioritize. A study based on interviews with representatives of twelve humanitarian and development agencies in Europe, the US and Canada providing health care to displaced populations found that, while agencies identified material and human resources as serious difficulties in institutionalizing reproductive health, "the main challenge is to tackle ideological, managerial and policy barriers, and those related to donor influence" (Hakamies et al., 2008, p. 33).

In short, incorporating reproductive health as a routine sector within humanitarian agencies and ensuring that services function effectively require a breadth and depth of organizational commitment and change that must occur in all departments, at all levels and over time. Operating short of this goal is a barrier to good care.

Global Policy and Funding Constraints as a Barrier to Care

The shifts in service organizations from the familiar to the new – as humanitarian agencies adopt reproductive health service delivery and as development agencies respond to the needs of crisis-affected populations – are not yet as apparent in the policy and funding arenas. As is the case with provision of and demand for reproductive health services and with structural changes within humanitarian agencies, important developments have occurred in the global policy and funding domains regarding reproductive health of war-affected people in the last 15 years, but the current situation falls short of what is needed to ensure the reproductive rights of refugees and the displaced.

As noted earlier, two important policy developments occurred just as the lack of reproductive health services for war-affected populations gained notice in the mid-1990s: these were the statements on the reproductive health needs of displaced populations included in the reports of the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference

on Women in Beijing (United Nations, 1994; United Nations, 1995). The recognition of these needs at these high official levels gave impetus and credibility to the nascent field.

A further high-level policy development was the passage of UN Security Council Resolution 1325 on women, peace and security, passed unanimously in 2000 (UN Security Council, 2000). This was the first resolution ever passed by the Security Council that directly addressed the impact of war on women. It has served as a potent instrument with which women's groups, human rights activists, humanitarians and political leaders advocate for women's involvement in peace negotiations and peacekeeping, humanitarian assistance, development and political processes. It has most directly been applied to reproductive health through a focus on gender-based violence and through promotion of gender equity in humanitarian services (UN Department of Public Information, 2005).

Alongside these advances, however, broad policy gaps have been noted within the field. In their interviews with representatives of agencies serving displaced populations, Hakemies et al. (2008) found that the lack of an international legal framework to protect internally displaced people, such as exists to protect refugees, was identified as a barrier to serving IDPs. More certain and coordinated access to IDPs would facilitate the provision of all services, including reproductive health services, to these underserved groups.

In a major policy and operational reorganization of the way in which the United Nations coordinates emergency response, the cluster approach was introduced in 2005, a result of the UN's Humanitarian Response review (Adinolfi et al., 2005). In order to improve coordination and service delivery among the many responding agencies on the ground, agencies were identified as global cluster leads and made responsible for technical response in nine topical areas. The World Health Organization was named the cluster lead for health, and is thus responsible for ensuring that reproductive health is included in emergency operations. This is further complicated by coverage of some components of reproductive health by other clusters: gender-based violence sits in the protection cluster led by UNHCR, and gender, often a lens through which reproductive health programs are designed and implemented, sits in the early recovery cluster, led by the United Nations Development Program (UNDP).

A 2007 evaluation carried out for the Office for the Coordination of Humanitarian Affairs concluded, "The first two years of the cluster approach have been a mixed and often difficult experience, which on balance has demonstrated positive progress and some tangible added value." (Stoddard et al., 2007, p. 45). The report found that the greatest successes were in filling service gaps; least successful were any gains in accountability for performance by lead agencies. The health sector, in particular, was identified as one of the more challenging clusters, in part because WHO, as cluster lead, has substantial work to do to fully develop its organizational capacity to operate effectively in emergencies. In view of this situation within WHO and the newness of reproductive health to many of the humanitarian agencies active in the cluster approach, there is concern that the cluster approach could be a barrier to comprehensive reproductive health in crises (IASC, 2007). Reproductive health

response may be neglected or fragmented, with the more unfamiliar or controversial components, such as the full range of family planning choices, emergency obstetric care and post-abortion care, ignored.

The inclination to compartmentalize the relief and reproductive health sectors – with refugees and the displaced the natural sphere of humanitarian agencies, and reproductive health the domain of development groups – is a longstanding barrier to capitalizing on the best that each group has to offer. Many documents, research findings, and policy recommendations retain these conceptual divisions. For example, neither of two special series in *The Lancet* in 2006 on reproductive health and maternal mortality recognized displaced or conflict-affected women. The special series in the same journal on Health and Human Rights in 2007 had a strong though not exclusive focus on the displaced and noted the leadership of sexual and reproductive health in linking health and human rights. Strengthening conceptual linkages such as these can influence thought in practice and policy decision-making in both the humanitarian and development spheres.

Compartmentalization is also apparent in policy decisions and in funding streams, and remains a barrier to the best uses of resources and partnership. Policy and funding are linked; indeed, the amount of funding allocated to each global imperative by each donor agency is itself a policy statement. Donors traditionally linked to the humanitarian sector do not necessarily yet view reproductive health as a core humanitarian imperative. Similarly, development donors and planners do not yet routinely include displaced populations in their large-scale strategies, even in countries with substantial internally displaced or refugee populations. Even within the same funding agency, the office funding emergencies may have little communication with the health and reproductive health department(s), a barrier for programmers trying to bridge the sectors. Creating linkages may be even more difficult across donors. Yet, the best work on the ground may well be a result of forging collaborations across these professional and administrative silos.

The IAWG global evaluation (2004) demonstrated that funding for reproductive health in conflict declined from 2000 to 2004, following an increase from the mid-1990s to 2000. The evaluation identified weakened global support for reproductive health in general, not only for war-affected populations, as one factor influencing the decline. Inadequate funding, however common a complaint, is nevertheless a real barrier to adequate service delivery.

Conclusion

The barriers to providing good reproductive health care to refugees and the internally displaced are substantial, and some also apply to delivery of any health services in crisis situations. The barriers discussed here pertain to the availability of services, the demand for care, the substantial organizational shifts required and the policy and funding environments that affect what can be done on the ground.

By working through these barriers, important progress had been made in the 15 years since the absence of reproductive health care in emergency situations was

recognized. As the IAWG evaluation concluded, reproductive health services were more available in 2004 than they had been a decade before, though they were by no means comprehensive or universal (IAWG, 2004). Since 2004, more agencies have initiated and expanded services in more sites, a promising ongoing development (RAISE Initiative and RHRC Consortium, 2008).

A key reason for the achievements in reproductive health service delivery for displaced populations has been the contributions and collaboration of two separate fields: humanitarian response, with its expertise in rapid and efficient response in complex and often chaotic situations and reproductive health, with its decades of evidence-based, client-focused, politically astute experience. These fields could have worked independently of each other or, worse, competed in such a way as to create another barrier to progress. Instead, they created functional collaborative partnerships, such as the Inter-agency Working Group on Reproductive Health in Crisis Settings, the Reproductive Health Response in Conflict Consortium and, more recently, the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative and the SPRINT Initiative, to develop and share resources, set field-wide priorities and implement programs (Schreck, 2000; Barnes-Brown and Butler-McPhee, 2007; Austin, et al., 2008; SPRINT Initiative, 2008).

Just as humanitarian and development agencies have increasingly recognized the value of their complementary expertise in the field, there is a need for policy-makers and donors to look beyond their specific portfolios and bridge the sectoral and administrative divides that may inhibit creative advances. These groups, as well as the service and research organizations active in the field, must also hold themselves and each other accountable, through sound measurement of accomplishments and failures, sharing of results and transparent operations. Ultimately, they are accountable to the women and men who depend on them to break through the barriers and provide them with the reproductive health services they need and want.

Notes

1. In 1998, the Consortium expanded to seven members with the addition of the American Refugee Committee (ARC) and the Heilbrunn Department of Population and Family Health at Columbia University's Mailman School of Public Health.

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Culturally Competent Responses to the Effects of Armed Conflict on the Well-Being of Refugee Women

Elżbieta M. Goździak

Introduction

Armed conflict is often conceptualized as a gendered activity where fighters are men, and where women and children suffer, often differently and disproportionately. Sadly, "Violence is no longer merely the business of male combatants and trained militaries" (Rajasingham-Senanayake, 2004, p. 145). The postmodern wars and armed conflicts in the Balkans and in Africa that targeted and involved large number of civilians, including women and girls, present a fundamental challenge to how we conceptualize war and peace (Rajasingham-Senanayake, 2004) and analyze the effects of these "new wars" (Kaldor, 1999) on their survivors. Girl soldiers, women suicide bombers and women in battle fatigues carrying guns begin to blur both gender roles and conventional distinctions between military and civilian actors. As evidenced by the violence in Rwanda and Bosnia, for example, civilians can be both victims and perpetrators, sometimes seemingly in equal measure.

The battlefields are no longer the same either. Multicultural urban spaces and villages have replaced traditional combat zones. Neighbors have become enemies. The scale of armed conflict has intensified. Campaigns of organized violence against civilians have increased by 56% since the end of the 1980s (Mack, 2006). This figure supports the popular belief that civilians, including women and children, are increasingly being victimized in the post-Cold war era by perpetrators of political violence. Interestingly, more wars presently end in negotiated agreements rather than victories. This is encouraging news for peacemakers. However, wars that end in negotiated settlements last three times longer than those that end in victories and are nearly twice as likely to restart within a few years (Mack, 2006), rendering survivors more vulnerable to repeated victimization. The new wars where civilians are deliberately targeted have entailed immense disruption and radical transformation of historically multicultural societies (Mamdani, 2001; Rajasingham-Senanayake, 2001a and 2001b) and resulted in large scale forced migration and massive internal displacement.

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_8, © Springer Science+Business Media B.V. 2009

The benefits of engendering forced migration discourse and praxis are many. Making gender an integral part of the forced migration discourse allows for one to both identify the vulnerability and emphasize the agency of refugee and internally displaced women. We are all aware of gender-specific vulnerabilities that exist in emergency situations that often render refugee women more susceptible to different dangers, including sexual and gender-based violence, and increased rates of mortality and morbidity. However, these vulnerabilities do not stem solely from biological differences between women and men. They are also affected by social factors. Gender morbidity differences, for example, are "strongly influenced by social context, (. . .) by the position women and men occupy in society, the access each gets to services, and the kind of medical care each receives" (Boelaert et al., 1999, p. 166).

On one hand, refugee women experience increased vulnerabilities, but on another hand, refugee women and girls, even the very young ones, "often have well-developed moral, political, and philosophical understandings of the events in their lives and worlds" (Nordstrom, 1999, p. 78). Refugee women make important, life-and-death decisions at every stage of the migration process, but rarely get asked to be involved in political solutions or peace-building activities. Conceptualizing gender as a relational dimension of human activity and thought allows us to also pay attention to refugee women in different positions within the same society (female heads of households, orphaned girls, rural or urban refugee women) and in relation to different categories of men (husbands, fathers, brothers, spiritual leaders, clan leaders).

Furthermore, the variations among refugee women within the same category – their individual voices and personalities, the strategies they forged vis-à-vis husbands, kinsmen, ritual practitioners – are also central to the engendered forced migration discourse. The engendered discourse is particularly important when designing policy and programmatic responses aimed at alleviating the effect of armed conflict and political violence on women. Much remains to be done, including implementation of policies to improve protection of women and girls affected by armed conflict, assessment of the special needs of refugee and internally displaced women and girls in different countries and contexts, and improvement of systems of care set up to alleviate the consequences of armed conflict on women and girls.

In this chapter I focus on the psycho-social consequences of armed conflict on refugee and internally displaced women and girls. In particular, I discuss the strategies used by the international community to "treat the war" as well as its wounds. As the number of refugees and IDPs increases, so does the number of programs established to provide psychological help for refugees and victims of wartime violence (Bracken et al., 1997a). The expansion of such programs in the West and the considerable zeal with which they are exported to non-Western countries indicates the prominence of mental health concepts and approaches in the forced migration field. Particularly prominent is the discourse of "trauma" as a major articulator of refugees' suffering (Summerfield, 2000, p. 417). This prominence is based on the premise that ethnic cleansing, war, and civil strife constitute mental health emergencies and result in "post-traumatic stress," which has in turn led to the use of treatment modalities based on the Western biomedical model. At the same time,

other models, building on the refugees' own resilience, indigenous coping strategies, and spirituality, are beginning to emerge. I explore the potential of these programs to maintain women's strength and further empower them to deal with the consequences of armed conflict on their own terms.

Vulnerability and Resilience

"The short- and long-term impact assessments of armed conflict on women and girls (and men and boys) have been very scarce and studies focusing on experiences of socio-political violence, collective suffering, and presence of disease and trauma-related disorders are only beginning to emerge in the scientific literature" (Pedersen, 2002, p. 182). It is worth mentioning that a significant number of publications on the psychological impact of political violence are based on studies of victims of terrorist attacks in Western countries (see Difede et al., 1997; Parson 1995; Weisaeth 1993; Abenheim et al. 1992; Shalev 1992; Curran et al., 1990; Cairns and Wilson 1989; Bell et. al., 1988) or are based on studies of refugees or torture victims from Southeast Asia and Central America resettled in North America or Europe (see Mollica et al., 1987, 2004; Beiser, 1988; Beiser et al., 1989; Hauff and Vaglum, 1993). There is a striking absence of studies of the most affected populations in their original locations or those displaced within the region. According to a recent review of 135 studies on the epidemiology of PTSD, only eight studies (or 6%) were conducted in developing countries (Pedersen, 2002).

With few exceptions, existing studies favor a focus on the trauma of an individual, at the expense of research on the suffering of war-affected communities and populations. In *Writing at the Margin: Discourse between Anthropology and Medicine*, Arthur Kleinman (1995, p. 101) points out that suffering is "a universal aspect of human experience in which individuals *and* groups have to undergo or bear certain burdens, troubles and serious wounds to the body and spirit" [my emphasis]. Suffering is inextricably embedded in social contexts. "No matter how true it is that there must be an individual *locus* of suffering, the meaning of suffering arises out of the relations of individuals together in the society, so that in consequence the social fact of suffering is more than a sum of its parts" (Bowker, 1997, p. 363). Allan Young (1997, p. 245) emphasizes the social dimension of suffering in the sense that it is "understood locally, by identifiable groups and communities, in the context of ideas about redemption, merit, responsibility, justice, innocence, expiation. . ." and is "based on social codes (which include moral and religious codes)." John Bowker, author of *Problems of Suffering in Religions of the World* (1970) and *The Meaning of Death* (1991), writes: "while some items of suffering can indeed be isolated and treated in abstraction, this should not distract us from remaining alert to the far wider networks of constraints that contribute causatively to human suffering" (Bowker, 1997, p. 380). In the context of mass displacement of whole communities resulting from armed conflict, it seems particularly important to focus on the suffering of refugee and internally displaced communities.

Some authors suggest that focusing on individuals has resulted in overestimation of the magnitude of psychiatric disability among refugee populations. As Marshal

(Marshal et al., 2005) points out, much of the existing research on refugee mental health has focused on individuals seeking health and social services who may have more severe problems than the general population of refugees (Eisenman et al., 2003; Fernadez et al., 2004; Hinton et al., 2000) or individuals petitioning for political asylum who may be motivated to over report trauma exposure and related psychiatric symptoms (Keller et al., 2003; Laban et al., 2004). Furthermore, research is often conducted while refugees are in refugee camps or shortly after arrival in a resettlement country (Jaranson et al., 2004; Mollica et al., 1993; Turner et al., 2003; Van Ommeren et al., 2001; Weine et al., 1998). Marshall argues that "It is difficult to determine if the psychiatric distress documented in these studies represents an acute condition, which might resolve spontaneously or with a change in circumstances, or whether it reflects a chronic condition that will persist in the absence of a therapeutic intervention." They also stress that many studies of refugee mental health have relied on symptoms screening instruments to assess probable diagnoses and they typically overestimate prevalence (Marshall et al., 2005, p. 572).

In my view, the most overlooked group of women (and men) affected by armed conflict and political violence are the refugees and internally displaced who are doing well. As demonstrated above, the scientific literature focuses almost solely on pathology, few researchers study resilience despite the fact that resilience, not trauma, is at the center of many refugees' survival. Unfortunately, many more researchers, policy makers and service providers are interested in the five to 20% of refugees affected by armed conflict who exhibit symptoms of distress than in the 80% of those who survived political violence and are able to function rather well. While we have a moral obligation to support those who suffer and study risk factors, we also need to understand protective factors in order to maintain the resilience and well-being of those affected by war and prevent possible delayed onset of disabilities stemming from exposure to armed conflict as well as mitigate the effects of post-conflict experiences on the well-being of refugee women and girls.

The Growing Prominence of Medicalized Trauma Programs

Recent years have seen tremendous increase in the number of programs addressing "refugees" "trauma" and "post-traumatic stress" (Bracken et al., 1997; Summerfield, 1999, 2000; Watters, 2001). Indeed, trauma projects are becoming progressively more attractive for Western donors. In early 1995, the European Community Humanitarian Office (ECHO) funded 15 international non-governmental organizations (NGOs) from six European Union member states to establish psychological programs in the former Yugoslavia. A European Community Task Force (ECTF) review noted 185 such projects being implemented by 117 organizations. There were 10 times more projects in Croatia than in Bosnia-Herzegovina, the reason given being the state of the war. Sixty three percent of these projects offered direct psychological services and 54% ran psychologically oriented groups, mostly self-help. Thirty three percent of the projects provided psychiatric services and 63% had staff training programs focusing on war trauma (Summerfield, 1999, p. 1452).

The expansion of such programs in the West – as documented by van Ewijk and Grifhorst (1997) in the Netherlands, Muecke (1992) in the United States, and Watters (2001) in Britain – and their export to non-Western countries – as shown by Foster and Skinner (1990), Gibbs (1994), and Boyden and Gibbs (1996) in reference to South Africa, Mozambique, and Cambodia, respectively – are directly related to what Kleinman calls "medicalization of human suffering" (Kleinman, 1997) and Hughes labels "culture of victimhood" (Hughes, 1994). Bracken relates the proliferation of specialized centers for psychological care of refugees to the "modernist responsibility to act" and "control the disorder provoked by suffering and loss through instituting programs of analysis and therapy" (Bracken et al., 1997, p. 434) "that may eschew critical analysis in favor of pragmatism that proliferates, and adds credence, to bio-medical taxonomies" (Watters, 2001, p. 1710). They argue that the tendency to establish such centers and programs results from the "spectacular growth within Western culture in the power of medical and psychological explanations for the world, and in the pronouncements of mental health professionals" (Bracken et al., 1997, pp. 436–437).

Undeniably, trauma programs have acquired a new prominence in the refugee field. In the mid-1990s, the United Nations Children's Fund (UNICEF) established a National Trauma Program in Rwanda (UNICEF, 1996). The National Trauma Center, headquartered in Kigali, provided intensive therapy for traumatized children and their families. By 1996, over 6,000 "trauma advisors" had been trained in basic trauma alleviation methods. They reportedly assisted 144,000 children (Summerfield, 1999, p. 1451). Similar efforts to train mental health staff were undertaken by the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organization (WHO) in Bosnia and Croatia (Summerfield, 1999).

The prominence of mental health programs in refugee camps, resettlement sites, and detention centers seems to be directly related to the rise in the diagnosis of post-traumatic stress disorder (PTSD) that is considered by many mental health experts a "hidden epidemic" and the most important public health problem in countries recently torn by wars, such as Kosovo, Bosnia-Herzegovina, Croatia, and Rwanda (Agger et al., 1995). These assertions often influence international organizations and governments. Their mental health consultants, psychiatrists Inger Agger and Jardanka Mimica, told WHO and UNHCR that some 700,000 people in Bosnia and Croatia suffered from severe trauma and are in need of urgent treatment, and that local providers are able to address less than one percent of these cases (Agger et al., 1995, 1996). According to UNICEF, "10 million children have been psychologically traumatized by war in the past 10 years and [...] psycho-social trauma programs must be a cornerstone of their rehabilitation" (Bracken et al., 1997a, p. 439).

The Medical Model

Medicalization is a widespread tendency to expand the meaning of medical diagnosis and the relevance of medical care. Medicalization refers to the way in which medical jurisdiction now encompasses many problems previously not defined as

medical issues (Williams and Calnan 1996, p. 1609). As a result of medicalization, suffering is transformed into a psychiatric condition. An existential experience of tragedy, human rights abuse, and loss is converted into technical problems that transmogrify its existential roots (Kleinman, 1995, p. 34).

Furthermore, medicalization not only reconstructs human experiences, but also, as Illich (1976), Pupovac (2002), and Summerfield (1999) have argued, the exaltation of biomedicine may actually diminish the capacity of human beings to deal with anxiety and suffering, deny their resilience, render them incapacitated by their dramatic experiences and indefinitely dependent on external actors for their psychosocial survival. Margaret Lock (1997) reminds us about the dangers resulting from contemporary tendency in Western societies to appropriate, through biomedical technology, what was formerly taken as "natural," and thus largely beyond human control. This tendency not only changes our expectations about events such as illness and death, but also our view of suffering. When suffering is defined as a medical problem, it is removed from a public realm and is no longer within the purview or power of ordinary people; rather it is raised to a plane where only professionals – medical or mental healthcare providers – can analyze and discuss it. Moreover, when refugees suffer as a result of political dissidence or generalized political violence, medicalizing their experiences removes the matter from the political and social context that produced their anguish and loss (Wellman, 2000, p. 28).

Social scientists offer different explanations of the causes of medicalization. Some have argued that medicalization is a means of social control that serves the interests of particular powerful social groups such as the ruling capitalist class (Navarro, 1975, 1986; Waitzkin, 1979, 1983). Others agree that medicalization is a form of social control, but argue that it serves a heterogeneous array of interests and institutions – prisons, schools, the family – as well as particular segments of the medical profession (Freidson, 1970; Conrad and Schneider, 1980, 1985; Gabe and Calnan, 1988). Feminist writers stress the ways in which women's bodies and lives have been increasingly medicalized and subjected to control by patriarchal medical profession (Doyal, 1979; Scully and Bart, 1978). Illich (1976) suggests that the medical profession has not only persuaded the public into believing that medical professionals have an effective and valuable body of specialized knowledge and skills, but has also created a dependence through the medicalization of different life events and experiences which has in turn undermined and taken away the public's right to self-determination.

Post-Traumatic Stress Disorder

PTSD was first introduced into the Diagnostic and Statistical Manual of DSM-III (APA, 1980) "to address the need for a common diagnostic category covering a wide range of clinical syndromes associated with a traumatic experience" (Fischman, 1998, p. 28). The diagnosis, originally intended to apply to the aftermath of extraordinary experiences, has been increasingly applied to a wide range of life difficulties

such as crime, complicated childbirth or traffic accidents (Summerfield, 1999). Moreover, the most recent reformulation of PTSD in DSM-IV has included secondary traumatization; e.g., trauma resulting from listening to accounts of torture or war atrocities.

Many consider PTSD, along with depression, the most prevailing psychological disorder among refugees (Turner and Velsen, 1990). Surveys of populations who have experienced violence indicate that between 25 and 75% experience PTSD (Desjaralis et al., 1995). Arcel and colleagues (1995) at the International Rehabilitation Council for Torture Victims in Copenhagen assert that 25–30% of refugees develop PTSD and need the help of skilled mental health professionals. Similarly, Medecins Sans Frontieres (1997) claims that 20% of trauma survivors will not recover without professional assistance and that in refugee situations the morbidity rates are much higher. Many of these statistics stem from biased sampling (Watters, 2001; Silove, 1999). The literature shows that the highest rates of PTSD have been recorded within Western psychiatric clinic populations. For example, between 18 and 53% of Bosnian refugees in treatment presented PTSD symptoms (Mollica et al., 1999). Intermediate rates have been recorded in sampled community groups, and the lowest rates have been identified in epidemiological samples (Silove, 1999). In an epidemiological study Mollica found that only 15% of Cambodians in a refugee camp on the Thai-Cambodian border suffered from PTSD (Mollica et al., 1993).

Recent studies suggest that psychiatric illness among refugees might not be as prevalent as we have been led to believe (Hollifield, 2005, p. 1283). A meta-analysis of interview-based studies of the prevalence of PTSD, major depression, psychotic illness, and generalized anxiety disorder in refugees resettled in Western countries revealed that about one in ten adult refugees has PTSD, about one in 20 has major depression, and about one in 25 has a generalized anxiety disorder (Fazel et al., 2005). These prevalence estimates are much lower than some frequently cited claims based on less reliable estimates (Carlson and Rosser-Hogan, 1991; Watters, 2001). Furthermore, the investigators identified contextual variables that account for some of the heterogeneity of prevalence rates in earlier studies. The variability stemming from these contextual factors is not small. For instance, the reported prevalence of PTSD is 218% higher when non-random sampling is employed (versus random or complete samples), 288% higher when assessments are carried out through an interpreter (versus a bilingual/bicultural interviewer), 322% higher when sample size is small (versus large), and 411% higher when clinical assessment is used (versus a semi-structured interview).

Additionally, there is a continuing debate in the refugee mental health field whether rates of PTSD in survivors of community violence are enduring or transient (Becker et al., 1999; Berthold, 1999), and how well the PTSD diagnosis can assess the multiple effects of trauma (Silove, 1999). Also, high or moderate PTSD prevalence rates do not imply a universal acceptance of the diagnosis. The controversy surrounding PTSD stems from a variety of reasons. The diagnostic use of PTSD has been criticized on the grounds that a universal standard to define trauma leading to marked distress is difficult to formulate (Davidson, 1930 and that the diagnostic

criteria have been subjected to rapid changes (Loughrey, 1992), for its taxonomic inadequacy as a subcategory of anxiety disorders which in turn are classified under mental disorders (Donohue and Elliot, 1992), and for not representing other types of recognized or postulated trauma-related disorders (Davidson, 1993; Kantemir, 1994, p. 400).

Some argue that the term *post*-traumatic stress disorder could not be applied to most refugee women since for most of them traumatic stress is not an isolated incident. There is nothing *post* about post-traumatic stress; many refugee women continue to experience stress even upon resettlement (Willigen, 1992). Others question the use of the term *disorder*, which transforms experiences that are essentially a socio-political problem into medical pathology and implies victimhood, which is not a healthy identity for refugee women. Therapeutically speaking an important clinical goal for refugee women is to find meaning in their experience and assume personal responsibility for their own well-being, and not to live in the role of a victim (Frankl, 1985).

Allodi (1991) suggests that in the case of refugee women who survived torture, the PTSD model reduces what is often a complex human rights and political problem to the level of individual psychology. Ochberg (1989) asserts that trauma experienced by torture survivors is far larger than that encompassed by PTSD. Furthermore, Young argues that "traumatic memory and PTSD are constituted through a researcher's techno-phenomena and styles of scientific reasoning" (1995, p. 10). He also argues that PTSD and its traumatic memory "have been *made* real" (Young, 1995, p. 6) and that "the disorder is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized (and continue to do – my emphasis) these efforts and resources" (Young, 1995, p. 5).

The cultural appropriateness of PTSD as a diagnosis for refugee women is questionable because there is very little knowledge concerning its ethno-cultural aspects (Marsella et al., 1993). Most refugee women currently assessed and treated by Western mental health providers come from non-Western countries and draw upon cosmologies different from those used in the West to explain their suffering, therefore in their worldviews there is little room for a taxonomy which until very recently has been void of the term "culture" (Briody, 1990 in Eisenbruch, 1991). Moreover, what constitutes "disease" in one culture is not necessarily viewed as a disease in another (Engelhardt, 1975).

Trauma literature suggests that PTSD has a worldwide prevalence. However, it is a mistake to assume that because phenomena can be regularly identified in different cultural and social settings, they have the same meaning. Not surprisingly studies which have used standardized questionnaires, developed in the West, to assess the prevalence and distribution of mental disorders in non-western populations usually managed to identify signs and symptoms of diseases under study. The fact that symptoms are easily identifiable in different cultural settings does not guarantee that they mean the same thing in these settings. Kleinman (1987) calls this reasoning a "category fallacy." Assessment of psychiatric illness should begin with the

identification of local phenomenological descriptions of folk diagnoses, which only then can be compared to Western nosology (classification of diseases). For example, while there is a rather extensive body of knowledge about the response to torture among Indochinese patients (Mollica et al., 1987), “ethnographic studies have still to determine if a folk illness caused by torture exists in these cultures, and whether it is similar or vastly different from Western derived PTSD criteria” (Eisenbruch in Mollica and Caspi-Yavin, 1992, p. 265).

Too great a focus on PTSD may also lead to misinterpretation of refugees’ desire to tell their stories (Goździak and Tuskan, 2000; Goździak, 2002). Most clinicians operating within the medicalized trauma model view stories of trauma as examples of “working through” the suffering, while many refugee women see them as political testimonies aimed at bringing about justice and fighting human rights abuses. By medicalizing the *sequelae* of basic human responses to oppression, the focus is shifted away from human rights and the prevention of forced migration and associated suffering to the objectifying and politically neutral diagnostic categories of modern medicine (Mollica, 1992, p. 23).

The critique of the medicalized trauma model and the PTSD diagnosis does not dispute the need for services, including medical care, for refugee women. What is in question is the reduction of the refugee experience to a medical condition and the notion that psychological responses to war, torture, oppression can best be accounted for within the categories developed by Western biomedicine and that psychotherapy is the antidote (Bracken et al., 1995; Summerfield, 1999). Moreover, only a minority of refugee women will actually reach the door of a mental health provider. The majority of survivors of war, ethnic cleansing, and other atrocities become survivors without treatment. As McIvor and Turner suggest “it may be as beneficial to look at reasons for this in terms of individual, family and cultural factors as to inquire about what discrete ingredients seem to work in the minority who do seek treatment. Community, political and religious groups probably provide the majority of support and treatment” (1995, p. 709).

Alternative Approaches to Address the Effects of Trauma

The PTSD narrative has often marginalized alternative discourses based on survival, strength and coping in the face of adversity and minimized the role of individual agency or meaning which can have particular significance in armed conflict and civil war (Tribe, 1998, 2004; Bracken and Petty, 1999; Ahearn, 2000). Explanatory health models and idioms of distress held by individuals and communities are likely to be multi-layered and defined by both cultural and social meanings and contexts (MacLachlan, 1997; Tribe, 2002; Bemak et al., 2003). Culturally sensitive responses to the suffering of war affected refugee and internally displaced women should reflect the complex nature of the experiences.

Alternative approaches that have gained currency with ethnic-community based organizations, programs providing assistance to refugee women, and a slowly

increasing number of clinicians focus on the resiliency of refugee women as the best way to address traumatic experiences. Most refugee women do not see themselves as "victims" and have no interest in sharing their stories within the clinical framework. Rather than "conflate the terms of refugee and war victim into a generalized category of traumatized, associated with psycho-pathology" (Eastmond, 1998, p. 179), these newer approaches emphasize the centrality of indigenous coping strategies (including religion and spirituality), linguistic appropriateness, and cultural sensitivity in service provision to refugee women. There has also been increased recognition of the need to address the underlying causes of trauma and not just deal with the symptoms that trauma produces.

In Guatemala, Mozambique, Angola, Rwanda, and South Africa, programs aiming to heal war-affected refugees and IDPs are moving away from one-on-one psychotherapy to traditional community conflict resolution strategies, belief systems, and public truth telling to restore social fabric after community destruction (Bagilishya, 2000; Summerfield, 2000; Bloom, 1998). Newly emerging psychosocial programs are also trying to combine cultural, social, educational, and therapeutic interventions as well as combining individual and group counseling programs.

Indigenous Healing Strategies

In developing countries, traditional healers are a lot more important and plentiful than mental health professionals. For example, "In a population of 19.5 million Sri Lanka has only approximately 33 psychiatrists and three psychologists, very few of them in the conflict zone" (Tribe, 2004, p. 115). It is important, however, to realize that regions lacking western-trained mental health providers are often blessed with a range of indigenous healers who provide important support for individuals, families and communities suffering psychological distress. "These local helpers provide important psychological and practical support and may serve communities in ways that western-trained psychologists and psychiatrists cannot" (Tribe, 2004, p. 115).

Van Der Veer and colleagues report the use of *mediums*, *oracles,* and religious leaders to ameliorate the suffering in Jaffna after the war between the Indian Peacekeeping Force and the Liberation Tigers of Tamil Eelan in the late 1980s (Van Der Veer et al., 2003). Wilson (1989) discusses how traditionally many societies had particular rituals which were performed when people returned from war, for example the Sweat Lodge purification ritual of certain Native American groups. Tausig (1986) provides an interesting analysis of the relationship between colonial terror and folk healing among the Putumayo Indians in Colombia. Patrick Bracken discusses the role of traditional healers in the Luwero Triangle, known as the "killing fields of Uganda" where in the 1980s hundreds of thousands of civilians were killed in government counter-insurgency operations. The traditional healers played a double role in the post-conflict period. "On the one hand they were providing therapies for sick individuals while on the other hand they functioned as a link with the past

and thus contributed to a sense of continuity in the community. The healing activities of the traditional healers depended to a large extent on consultation with the ancient spirits of the tribe" (Bracken et al., 1995, p. 1079). The emphasis on the communal past tapped into protective factors that enabled the healing of both the traumatized individuals and the larger group of survivors.

Amani Trust, a non-governmental organization that rehabilitates survivors of torture and organized violence in western Zimbabwe has recognized the importance of belief systems and has responded to requests by community leaders and families in rural areas for interventions to appease the aggrieved spirits of people who had been murdered and buried in unacceptable graves. In pursuit of a solution to this problem, *Amani* became involved in exhumation and has been involved in longitudinal case studies of the consequences of exhumation and reburial from a cultural, psychological, individual, and group perspectives. "(. . .) the process of exhumation and reburial does physically what psychotherapists in the West do metaphorically – it encourages people to explore their past and see the links with their current experiences. Reburial of murdered individuals often restores psychological, emotional, and historical of the affected communities" (Eppel, 2002, p. 870).

The Role of Religion and Spirituality in Coping with Trauma

Is it possible to turn to religion in times of extreme suffering? During wars it often seems that God has forsaken the suffering. Some war survivors go through life with the cruel words of scripture "My God, my God why have you forsaken me?" on their lips (Matthew 27: 46). Not everybody finds consolation in religion in the time of extreme suffering. Elie Wiesel, writing about his experiences in concentration camps, said that after seeing innocent children burned alive, the "flames consumed my faith forever" and that the experience "murdered my God and my soul" (Wiesel, 1960, p. ix). Many soldiers returning from Vietnam remarked "I lost my soul in Vietnam" (Brende, 1993, p. 325). Others have written about the experience of trauma at the moment when "The spirit went numb" (Mahedy, 1986, p. 32) and soul development stopped (Baker, 1989), and have called it a disorder of hope (van der Kolk, 1988), a spiritual night (Mahedy, 1986, p. 32), and a loss of wholeness (Sinclair, 1993, p. 70, in McBride and Armstrong, 1995, p. 7).

Still others found refuge in God, referred to Him as a Shepherd and a cleft in the rock, and found religious beliefs and ritual helpful in trauma healing. Indeed, many religions not only offer a rationale for suffering, but also provide a community setting in which suffering can become a dignified performance. In Buddhism, suffering is explained as a burden of past *karma*, in Christianity, as a backlash from the original sin, but also as an opportunity for a closer association with the Savior on the Cross, and in Islam, as a God-willed destiny. In some societies healing and religion are inseparable, and medical mores are tied to ritual and theology (Fabrega, 1990). Clinical evidence establishes positive relationship between religious beliefs and behavior and physical and mental health (Larson et al., 1998). The

direct emotional stress-reducing function of religious beliefs is intuitively obvious. "Beliefs in God, saints, faith-healing, and life after death are indeed explicitly recommended by spiritual leaders for the lifting of the hopes and the relief of despair and suffering" (Pepitone, 1994, p. 148).

Refugee women's engagement with religion is often very different from the experiences of refugee men. Research indicates that faced with similar adverse circumstances men and women react differently. A study of prisoners in a Russian labor camp showed that women observed religious rituals and celebrated birthdays, while men fantasized about escape, solved chess problems, and talked incessantly about politics (Weinberg, 1992). Religion operates in compelling, competing, and contradictory ways as it shapes the experiences of refugee women. Religion can be a source of resiliency and facilitate integration, but it can also have a contradictory status in refugee women's lives. The close relationship between core religious beliefs and religious institutions with their associated rituals and customs means that the distinction between these is often overlooked. Refugee women's position within societies is regulated by religious institutions both at the family and community levels. Custom and tradition, often justified on religious grounds, ensure refugee women's conformity to conventional gender roles which can be sources of powerlessness and pain. In particular, notions of fatalism which are integral to many religions, from Hinduism to Orthodox Christianity, can offer comfort to the powerless and an explanation for suffering, while at the same time constrain women (and men) from seeking change.

Suffering has been an inseparable element of many refugees' lives. Religion is thought to help people cope with life's experiences by assigning meaning to events (Kelley, 1972; Roberts and Davidson, 1984). Both Eastern and Western religions may help refugees cope spiritually, cognitively, and emotionally with what has become known as the "survivorship syndrome" (Haines et al. 1980; Fraser and Pecora, 1985–1986; Skinner and Hendricks, 1979). Research also indicates that religious rituals play an instrumental role in trauma healing. One of the recognized effects of religious ritual is to create both sacred time and sacred space, "a moment out-of-time and a place apart, nearer to the supernatural and the center of the universe than to the streets and neighborhoods of everyday. Ritual renews the world by offering an opportunity for participants to step outside of it; it renews time by bringing the past, the present, and the future together" (Wellmeir, 1994, p. 17).

However, in some cultures women are often denied both the knowledge and the practical skills required to initiate rituals. In fact, most human religions, from tribal to dominant religions, have treated women's body, in its gender-specific sexual functions, as impure and polluted and thus to be distanced from sacred spaces and rites dominated by males (Radford Ruether, 1990, p. 7). In many denominations, women are officially barred from ordination and men run the spiritual and administrative affairs of the congregations.

The role of refugee women in formal and informal religious spheres is complicated and calls for a careful analysis of the conditions and ways in which religion both promotes and lowers status of women compared to men and helps to empower women. There is a body of research indicating that organized religions discriminate

against women, both theologically (Carr, 1982; Fiorenza, 1983; Himmelstein, 1986; Weaver, 1986) and institutionally, especially in opportunities for formal leadership (Chavez, 1997; Lehman, 1985; Nason-Clark, 1987; Swidler and Swidler, 1977; Wallace 1975, 1992). Other research suggests that women use religion and religious institutions to argue for equality (Briggs, 1987; Chartlon, 1987; Daly, 1973; Ice, 1987; Royle, 1984; Weaver, 1986; Weidman, 1985). Women also use them as social and physical spaces in which to network with other women and build feminist consciousness (Ammerman, 1997; Hargrove, 1987; Kaufman, 1991; Weaver, 1986; Inter, Lummis and Stokes, 1994; Wuthnow, 1994), and to assert informal power in the practice of unofficial, domestic religion (Brown, 1995; Diaz-Stevens, 1993; Dougherty, 1978; Jacobs, 1996).

Being a refugee – the suffering in wartime, loss of homeland and family members, and the challenges of life in a new country – is for many forced migrants, a spiritual crisis of unparallel severity. The basic spiritual needs – hope, meaning, relatedness, forgiveness or acceptance, and transcendence – are threatened in the forced migration process. The impact of being uprooted is particularly poignant and often very traumatic for refugee women, especially when rape and sexual abuse become commonplace. Unmet spiritual needs put refugee women's integration and well-being at risk. Supporting refugee women's faith is therefore important at every stage of the migration process.

Human Rights and Truth and Reconciliation Approaches

Application of a human rights framework to understanding and responding to refugees' and torture survivors' trauma has also been successful. For example, Argentineans focused their efforts on the identification of victims of political oppression buried in mass graves, while the Grandmothers on the Plaza de Mayo needed to discover the parental background of their grandchildren who had been taken from their tortured and murdered parents and given up for adoption (sometimes to the torturer's family). Both of these efforts were instrumental in the survivors' healing process, but at the same time they achieved major advances in anthropological taxonomy and forensic medicine (Joyce and Stover, 1991 in Mollica, 1992, p. 30) and returned full circle to the human rights framework that constitutes the very beginning of the modern crusade against torture.

In a similar way, truth commissions "allow victims, their relatives and perpetrators to give evidence of human rights abuses, providing an official forum for their accounts. In most instances, truth commissions are also required by their mandate to provide recommendations on steps to prevent a recurrence of such abuses" (http://www.usip.org/library/truth.html). In some cases, the commissions have recommended attention to the needs of those who have been the targets of human rights abuses: "With regard to certain categories of victims, such as amputees, war wounded and victims of sexual violence, the [Sierra Leone Truth and Reconciliation} Commission recommends that they be given free physical (and

where necessary, mental) healthcare for the rest of their lives or to the extent that their injury or disability demands" (Sierra Leone Truth and Reconciliation Commission, 2004).

Khulumani (Zulu for "speaking out") is an example of a program set up in early 1995 within the framework of the Truth and Reconciliation Commission (TRC) in South Africa. Initially, "speaking out" was seen as a linear process in which uncovering the truth would lead to psychological and social healing of individuals providing testimonies (Asmal et al., 1994). However, *Khulumani* not only became a respected program reflecting the "authentic views" of survivors, but also evolved into a forum where survivors learned to "speak out" in a very different register from that initially envisioned when they were asked to "tell their stories." The group used the press to "speak out' and they captured public and television space through organizing high-profile public demonstrations and marches; public healing ceremonies were also held and a play about their stories was developed which they took back into communities as well as overseas. What was initiated as a support network for victims who "spoke out" developed into ways that also contributed to the economic subsistence of its members, mainly women in their late 40s and older (Lykes et al., 2003).

In Guatemala, photography was used to "tell the story of violence" and of women's responses to the war. By speaking out through pictures and storytelling, the Association of Maya Ixil Women-New Dawn (ADIMI) project sought to prevent future violence through creating a public record as well as to build connections with other women in Guatemala and beyond who were engaged in similar processes. Equally importantly, project participants sought new skills and resources to develop economic and psychosocial resources for their communities thereby responding to the material ravages of war (Lykes et al., 2003). The ADMI project was inspired by the work of Chinese rural women, Visual voices: 100 photographs of village China by the Women of Yunnan Province (1995). The two photographic methods used by ADMI, "Photo voice" (Wang 1999; Wang et al., 1996) and "talking pictures" (Bunster and Chancy, 1989), formed a basis for a participatory action research project that resulted in a book about the past and present struggles of Maya women in Guatemala (Women of Photo Voice and Lykes, 2000; Lykes, 2001).

In Colombia, the League of Displaced Women in Cartagena has focused its attention on *afrodesplazadas* (or Afro-displaced women) and has taken the bold step of providing what the state rarely does for displaced Colombians: sturdy new homes, child care, emergency food and psychological and reproductive health counseling. The League has also adopted another mission: preparing for prosecution of gender-based war crimes against various armed groups in Colombia. The Center for Investigation and Popular Education (CINEP), also in Colombia, frustrated that many aspects of political violence, especially cases of torture and disappearance were not being recorded let alone prosecuted, started documenting such crimes. According to the US State Department, CINEP has the most influential database of human rights violations in Colombia (Howe, 2004).

It is important to remember that post-conflict community dialogue programs generally have involved only male representatives of communities and relied on male-dominated traditional reconciliation techniques. International organizations,

national governments and NGOs should "implement reconciliation programs, such as workshops and communal projects that specifically include women" and "incorporate cultural processes that allow women to convey histories" (Shoemaker, 2001).

Ethnography and Participatory Action Research

Much discussion about cultural competence of programs serving refugee women focuses on cultural characteristics of specific refugee populations. Unfortunately, this approach "may develop stereotyped views and assumptions that will not serve them (mental health professionals) well in dealing with individuals" (Thornton Garret, 1995, p. 67). Reliance on normative data may lead to what Ridley and colleagues (2000) call "unintentional racism."

Some utility may be derived from "ethnographies that canvassed concepts of coping styles, and ideas about and reactions to illness generally and mental illness in particular" as well as studies of "cultural beliefs about depression, bereavement, anxiety, and cultural influences on the ways emotions and mental disorders are experienced, including responses to psychiatric treatment" (Kleinman, 1988, p. 148). However, ethnography, including ethnographic methods and underlying epistemology, is the real bridge to multicultural mental health practice with refugees.

The goal of ethnography is to understand another way of life from the native point of view (Spradley, 1979, p. 3) and to grasp the native's point of view, her relation to life, to realize *her* vision of *her* world (Malinowski, 1922, p. 25). "Rather than *studying people*, ethnography means *learning from people*" (Spradley, 1979, p. 3). Ethnography "offers health professionals the opportunity of seeing health and disease through the eyes of patients from a myriad of cultures" (Spradley, 1979, p. iv). In mental health practice, ethnographic methods, including ethnographic interviewing, participant observation, and domain, structural, and taxonomic analyses, can be used to "elicit ethnopsychiatric beliefs of patients and families" and "evaluate the influence of cultural rules on abnormal behavior," as well as to "improve cross-cultural and cross-ethnic communication in the clinical interaction" (Kleinman, 1988, p. 149).

There has been much discussion about the utility of ethnographic methods and theory to the study of refugee mental health, as evidenced by a volume on Psychosocial Wellness of Refugees: Issues in Qualitative and Quantitative Research, edited by Frederick Ahern (2000). There is also a growing discourse on the role of ethnography in clinical practice, including clinical encounters with refugees. Eastmond (2000, pp. 84–85) emphasizes that "An ethnographic approach can also be a vital tool in clinical assessments of treatment, expanding the restricted context of the clinical encounter as well as the bases of the clinician's understanding, thus bridging anthropological and clinical traditions." Given the dynamics of refugee lives, she points out the usefulness of narratives and life stories to elicit "narratives of suffering" (Eastmond, 2000, p. 76). Herbst Robin (1992), Lifton (1993), and

Woodcock (1997) have also discussed how narratives can be used as therapeutic tools.

Arthur Kleinman, a Harvard psychiatrist and medical anthropologist, has been "writing at the margin" of anthropology and medicine for quite some time. He has been exploring the many ways psychiatry could benefit from greater knowledge of the concepts and methods of anthropology and conveying the relevance of cultural perspective for psychiatric practitioners (Kleinman, 1988). Kleinman argues for an ethnographic approach to moral practice in medicine and providing a provocative analysis – using an anthropological perspective – to indicate how biomedical concepts such as "trauma" and PTSD fail to incorporate the social worlds of patients (Kleinman, 1995). He also calls for using ethnography to reconstruct patients' "illness narratives" (Kleinman, 1988a).

Participatory action research is also gaining currency with programs aimed at documenting and addressing human rights violations against women. Women's Rights International (WRI) was founded with the specific purpose of developing methods that can accurately document human rights violations against women. WRI works with rural women living in countries at war using participatory action-oriented research. The women affected by armed conflict or state-sponsored violence choose the research questions, design the survey, and collect the information themselves. In 1995, WRI collaborated with the Women's Health and Development Program at the Mother Patern College of Health Sciences in Monrovia, Liberia, to document the experiences of women during the war. Using community participation research requires enduring commitment and carries substantial risks, but also has the potential for very positive and lasting changes at the local level (Jennings and Swiss 2001).

Psycho-Social Programs

Psycho-social interventions are the latest trend in programming for war and armed conflict-affected refugees. Although psycho-social programs have become a key component of international policy, there is much confusion over their meaning among aid agencies and the concept is under-theorized in academia (Pupavac, 2001, p. 358). The term "psychosocial" is often "used to indicate commitment to non-medical approaches and distance from the field of mental health, which is seen as too controlled by physicians and too closely associated with the ills of an overly biopsychiatric approach" (Ommeren et al., 2005, p. 71). However, as some opponents point out "in practice" it [the term "psychosocial"] had become too quickly collapsible into "psycho" (Summerfield, 2005, p. 76). Ager points out that "Activities that come under this label in aid agency documents and NGO reports range from trauma counseling to peace education programs, life skills, self-esteem and empowerment building activities, and sports and recreational pursuits, to name but a few elements. The aims of these programs are to prevent trauma and stressors that negatively affect mental health to the degree possible, and to strengthen the capacity of refugees to cope with the traumas and stressors when prevention fails (Ager, 1993).

The critics of psycho-social approaches stress that "The cornerstone of the international psycho-social model is its assumption of the vulnerability of the individual" (Pupavac, 2001, p. 363). In that regard, the psycho-social interventions do not seem to differ much from the biomedical programs centered on the concept of trauma. Within the psycho-social conceptual framework, refugee and internally displaced women in the global South are deemed to be at a greater risk of psychological dysfunction because of the economic, political, and social insecurities they face. However, as Pupavac argues "a history of insecurity should not be equated with a history of psychological problems or greater susceptibility to psychological breakdown – a distinction that is lost in the international psycho-social model." In fact, the reverse correlation may be true; i.e. communities used to hardship "are likely to be remarkably resilient in the face of adversity." In Pupavac's view, "this factor helps explain why international aid workers, including trauma counselors, appear to be more susceptible to secondary or vicarious trauma than the recipient populations who have experienced primary trauma. It may be noted that counseling as a profession attracts a high percentage of former clients who re-train as counselors; consequently the field includes many individuals with a history of psychological vulnerability. This phenomenon in turn encourages a professional culture that tends to project its own sense of psychological vulnerability on to others" (Pupavac, 2001, p. 363).

Additionally, the psycho-social model "posits life-long or even multi-generational dysfunctionality as individuals who have experienced trauma are considered merely to be "in recovery" or "in remission," never recovered, but ever after haunted by their trauma and at risk for being re-traumatized by their memories" (Pupavac, 2001, p. 365). Summerfield (2005) points out that psycho-social programs are often imported to war-affected or post-conflict contexts because outsiders thought it was a good idea. Most refugee women and children affected by conflict do not: counseling is not a culturally familiar activity, and women affected by armed conflict use all their energy to survive a deepening health and human rights crisis.

Proponents of psychosocial programs emphasize the "dynamic relations between psychological effects (e.g., emotions, behaviors, and memory) and social effects (e.g. altered relations as a result of death, separation, and family and community breakdown). The psycho-social approach "suggests that although people are affected in many ways, three areas in particular are affected: human capacity (i.e., skills, knowledge, and capabilities), social ecology (social connectedness and networks), and culture and values." Women affected by war "need support to enhance both their own and their community's psychosocial well-being by strengthening each of these areas" (Mollica et al., 2004, p. 2062).

The benefits of psycho-social programs are assumed by international aid organizations, rather than backed up by empirical research. The evidence base for specific psycho-social interventions is small. A study by Mollica et al. (2002) of Cambodian refugees at the Thai-Cambodian border showed that environmental conditions – such as opportunity for economically productive activities – reduced psychiatric morbidity in camp residents. In Bosnia and Herzegovina, Agger and Mimica

(1996) recorded positive assessments of services received, with higher ranking of group meetings and shared activities than of individual therapies. Methodologically speaking, assessments using feedback from refugees participating in psycho-social activities have certain limitations (Ager, 2000). On the other hand, initial results of the UN experience with emergency and peace education initiatives aimed at improving social capital seem promising, but need further assessment (UNHCR, 2001; UNESCO, 2001). "The jury is still out as to whether current strategies improve matters" (Scott and Stradling, 2001, p. 126).

Summary and Recommendations

The discussion presented above indicates that recent literature records a robust discussion of the concepts, values, and cultural appropriateness of mental health interventions to reduce the psychological burden of war and armed conflict in resource-poor countries (Bracken et al., 1995; de Vries, 1998; Dyregrov et al., 2002; Mezyey and Robbins, 2001; Pupavac, 2001; Silove et al., 2000; Summerfield, 1999). The PTSD construct and trauma-focused services are the main focus of controversy (Ommeren et al., 2005). The controversy is compounded by the recent development of a new field – introduced by international organizations working in resource-poor countries – that is labeled "psychosocial."

Critics of these concepts and approaches point to medicalization of normal distress and the possible harm of assuming that western models of illness and healing are valid across cultures, while others consider denial of the importance of traumatic stress a professional error and denial of preventable suffering. In an attempt to generate advice on strategies to program designers in war-torn countries, Ommeren and colleagues (2005) have attempted to survey expert opinion. As a result of their survey, the authors have put forth eight principles that should be used in formulating response strategies:

(1) contingency planning before the acute emergency,
(2) assessment before intervention;
(3) use of long-term development perspective;
(4) collaboration with other agencies;
(5) provision of treatment in primary health care settings;
(6) access to services for all;
(7) training and supervision, and
(8) monitoring indicators.

Derrick Silove (2005) and Derek Summerfield (2005) have responded to the proposed principles in two separate essays published in the *Bulletin of the World Health Organization*. In his response, Silove (2005) stresses that these principles "present a radical challenge to those single-issue advocates promoting trauma counseling programs or short-term psychosocial project" (2005, p. 75). Silove points out the

necessity to distinguish between common, self-limiting psychological responses to violence and the persisting reactions that become disabling. He believes that the best therapy for acute stress reaction is social: providing safety, reuniting families, creating effective systems of justice, offering opportunities for work, study, and other productive roles, and re-establishing systems of meaning and cohesion – religious, political, social, and cultural. He also points out the challenges inherent in changing entrenched perspectives and practices of international agencies and donors to give priority to supporting integrated community-based programs that focus on social needs arising from psychological disturbances, rather than special issues or particular diagnoses.

Summerfield (2005), on the other hand, points out the tension in international agencies' – such as the World Health Organization – materials on refugee mental health issues "between the wish to acknowledge local worlds and the wish to promote Western mental health technology as a reproducible toolkit" (2005, p. 76). He reminds us that the Western mental health discourse introduces core components of western culture, including a theory of human nature, a definition of personhood, a sense of time and memory, and a secular source of moral authority. None of this is universal.

What is needed, in my opinion, is support for empirical research, including epidemiological and qualitative studies to assess both the scope of the issues facing women and girls affected by armed conflict and the cultural appropriateness of implemented projects. This research needs to be formulated and packaged in a manner that translates readily into new program designs or policy approaches. More importantly, refugee and internally displaced women must be active participants in the design and implementation of this research and ensuing policy and programmatic recommendations.

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Sexual Violence during War and Forced Migration

Jennifer Leaning, Susan Bartels, and Hani Mowafi

Introduction

Rape as a Weapon of War

Rape in the context of war has been described since earliest historical times (Brownmiller, 1975). The vast literature on this topic has dealt with issues of military command and discipline, male violence, evolution of legal norms, and documentation of egregious instances of mass rape. In the conventional nation-state wars of the 20th century, such documentation often lagged long after the events, depending on delayed testimony of survivors, release of government archives, or shifts in political regime.

During World War II, civilians of all involved parties are believed to have suffered from sexual violence, although the gravest sexual atrocities were documented against Chinese and German women. An estimated 20,000 Chinese women were raped during the first month of the Japanese assault on Nanking in 1938 (Chang, 1997). In the Soviet advance towards Berlin and in the attack that captured the city (February–May 1945), it is estimated that hundreds of thousands of German women were raped by the attacking Soviet forces (Beevor, 2003). Widespread sexual violence was also documented in the 1971 war between Pakistan and secessionist Bangladesh, where approximately 200,000–400,000 Bangladeshi women were raped by Pakistan government troops (Brownmiller, 1975, 81–84).

These numbers are vast and still contested. As with the ongoing dispute between Japan and South Korea over what befell the Korean "comfort women" in World War II and at what level of authority this program was authorized by the Japanese government, there is strong resistance among national governments, military institutions, and societies as a whole to come to terms with this prevalent aspect of behavior in war. This resistance is shored up by the silence of survivors and their communities and by the usual absence of contemporaneous documentation.

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_9, © Springer Science+Business Media B.V. 2009

The last 15 years have seen marked advances in policy to address issues of norms and training, humanitarian impact and social recovery, and legal accountability and justice. Prevailing military norms have long prohibited rape on civilian populations. Formal military commands in virtually all organized states in the world enjoin against rape in all its forms. Training of officers and troops in the Geneva Conventions is mandatory and operational oversight is built into the chain of command. Increasingly sweeping legal sanctions have been developed since the judgments of the ad hoc International Criminal Tribunals for the former Yugoslavia (ICTY) and for Rwanda (ICTR) in the 1990s. The International Criminal Court at the Hague now provides a standing capacity for adjudicating war crimes, including allegations of mass rape in conflict settings. There is widespread public and governmental support for international legal pursuit of war criminals, with the aim of reducing a sense of impunity by bringing current perpetrators to judicial account. The world's political leaders have directly and indirectly engaged this issue of mass rape, by clarifying and reaffirming the obligations of states and military authorities to protect civilians in war and displacement, with particular attention to the vulnerabilities of women and children (Report of the Secretary General, 2005; International Commission, 2001).

In the last 25 years, as the preponderance of wars has shifted from nation-state conflicts to intra-state civil or communal wars, campaigns of mass rape by armed state and non-state actors have become widespread, appearing to take place as a structured aspect of organized hostile action against civilian populations. These campaigns, described by journalists, human rights investigators, and international humanitarian actors, have occurred in the Balkans, Sierra Leone, Rwanda, Liberia, Sudan, Uganda, and Democratic Republic of Congo (DRC).

Mass rape in these more recent internal wars can be seen to serve strategic aims. Its effects in these contexts are two-fold: to terrorize the civilian population, and thus force people to flee their homes and fields; and to inflict shame and humiliation, thus degrading possibilities for later social reconstitution and return (Reseau des Femmes, 2005; Gingerich and Leaning, 2004; Swiss and Giller, 1993). These effects assume strategic importance for armed non-state actors who lack heavy weaponry and advanced communications and transportation supports. To hold land it is necessary to clear it of people. These effects are also peculiarly suited to campaigns of ethnic cleansing and genocide, where the objectives of the conflict are to remove or destroy a stigmatized population and demolish the potential for regeneration. The stigmatization, betrayal and abandonment associated with having been raped greatly affect the capacity of women to raise children and participate in community life. It also affects the morale of the men who perceive their inability to protect their women as one final humiliation of the war (Rumble and Mehta, 2007; Thomas, 2007; Holleufer et al., 2001).

Widespread and often very brutal rapes also accompany the disruption of society and extensive forced migration that are close concomitants of these recent wars. Complex groupings of combatants and brigands assail civilians as these forces move through territory, set up encampments, and pillage and extract resources from surrounding communities either to support their war efforts or for personal gain. Peacetime administrative, police, and legal systems (often inadequate in the best of

times) fall apart under the stresses of chronic fighting, increased criminality, and pervasive insecurity. Social norms restraining gender-based violence appear to fray and the problem of rape escalates as it moves from a tactic of war to a pervasive form of abuse of women and the vulnerable. Understanding and addressing this aspect of rape in the context and wake of war requires redoubled efforts on the part of the international community.

Legal Framework

Although rape in times of war has long been discouraged by prevailing military norms, only in the last 150 years has this practice been proscribed in formal legal codes. The 1863 Lieber Code addressed the rules of engagement for combatants and commanders in the U.S. Civil War and is noteworthy for having provided one of the first official prohibitions of rape in war (Office of the Chief of Staff, 1863). This prohibition was carried forward to the Hague Conventions of 1907 (Askin, 2003).

When the term "crimes against humanity" was coined in 1907, the crimes themselves were largely unspecified. The 1945 charters of the International Military Tribunals for Germany and Japan defined such crimes as "murder, extermination, enslavement, deportation or other inhumane acts committed against any civilian population". Shortly after the Nuremburg Charter was signed in 1945, the Allied Control Council established Law No. 10, which extended the definition of "crimes against humanity' to include rape".

Despite the extension of "crimes against humanity" to include rape, the Nuremburg Tribunal did not actually bring any charges or produce any convictions for gender-based crimes. The Tokyo trials resulted in the conviction of only three individuals for sex offenses. It was not until the adoption of the Fourth Geneva Convention in 1949 that the prohibition of rape in war was firmly established in international humanitarian law. The Fourth Geneva Convention called for the special protection of women "against any attack on their honor, in particular against rape, enforced prostitution, or any form of indecent assault," (Geneva Convention, 1949). The First and Second Additional Protocols to the Geneva Conventions included the same provisions for international and non-international armed conflicts, respectively (International Committee of the Red Cross, 1977a, b).

Acts of genocide and sexual violence in the former Yugoslavia and in Rwanda were responsible for the expansion of protection against wartime rape. Partly because of the reported extent of sexual violence in those two conflicts, the United Nations established the ICTY and ICTR. Since their inception in the mid 1990s, the tribunals have been responsible for landmark convictions for genocide and for crimes against humanity, based on rape and other acts of sexual violence. The tribunals have produced precedent-setting definitions of rape and sexual violence, have declared that systematic rape with an intent to destroy a particular group of people constitutes genocide (International Criminal Tribunal for Rwanda, 1998), and have brought indictment for charges of genocide based on command to engage in sexual violence (International Criminal Tribunal for the Former Yugoslavia, 2002, 2000).

The ICTY also broke new ground in broadening the crime of sexual slavery when it issued the first conviction for rape in that context as a crime against humanity.

Sexual and gender-based violence were further codified as crimes under international law when they were listed in the Rome Statute of the International Criminal Court as constituting crimes against humanity and war crimes (International Criminal Court, 1998). As instances of systematic rape in current wars are reported and investigated, it is highly likely that the definition and prosecution of sexual violence will continue to evolve.

National law on gender-based violence applies to the increasing incidence of rape occurring in the periphery of low-intensity conflict, as sexual assaults propagate into domestic and criminal zones of these disrupted societies. International efforts are now focused on strengthening local legal frameworks and judicial systems to improve their capacity to investigate and prosecute this rising tide of violence against women.

Policy Analysis

The ongoing incidence of mass rape in current wars challenges the international community to explore further options, in terms of policy, program, and research. The following discussion first presents an analysis of current patterns of mass rape in internal wars, identifying key factors of opportunity, vulnerability, and impunity that support the ongoing practice of mass rape. In the light of these three factors, the second section offers an assessment of current approaches taken by the international community, highlighting possible avenues for further efforts that could help reduce the future incidence of this war atrocity and relieve the suffering of current survivors, their families, and their communities.

Current understanding

An empirically grounded picture of what actually constitutes mass rape in current wars involves looking first at the key population parameters (vulnerabilities, locations, and social settings) that describe the context in which these mass rapes take place (see Appendix 1 and 2).

Population parameters in organized attacks:

(1) Mass rapes have occurred in the course of attacks by outside armed groups on relatively sparsely populated areas, such as in villages or farming communities (in DRC or Darfur) or in suburbs and hamlet communities (in Rwanda and Bosnia).
(2) These attacks occur without direct or precise warning, although as the conflict has extended across the region the populations who have not yet been attacked live with a pervasive sense of general jeopardy and are often making preparations for flight.
(3) There are usually no members of opposing armed groups in these communities, or if they are present, they are grossly outnumbered and do not present an armed defense. In some contexts the civilian men stay and fight or they

flee at once, knowing, as in Darfur and in Bosnia, that if captured they will be killed.

(4) The women and girls are seen as the main targets of mass rape in these attacks on populated areas. In an unknown percentage of instances boys or men are also raped, but so far it has proven difficult to obtain testimony about assault on males and thus even a sense of relative incidence is not possible to estimate (Carpenter, 2006). (More accessible reports of male rape are those that occur to captured and incarcerated males, as in Bosnian internment camps.)
(5) Abundant descriptions of mass rapes of women and girls, offered by survivors and witnesses, can be found for Darfur and Congo. Women who were raped in the attacks on homes and villages in the Rwandan genocide were more often grievously mutilated and then killed (Human Rights Watch, 1996) so survivor testimony among Rwandan women reflects a smaller percentage of the incidence of rape that is believed to have taken place.
(6) The descriptions of the actual rapes given by survivors in these varied circumstances convey a stereotyped picture of settings, sequence, and time. Some elements of these fact pictures are common across all recent internal wars where mass rape has been prevalent, and some are particular to a given conflict. Common elements include the public nature of these rapes, high frequency of gang rape, and substantial risk of incurring severe harm or death in the course of or immediately after the sexual assault itself. It appears that this risk of severe injury or death increases if the victim is subjected to gang rape or penetration by non-penile implements, but the data are not sufficient to confirm this observation. Elements of sexual abduction and slavery are more common in some conflicts than others.
(7) The period of flight itself carries substantial hazard, including ongoing threat of rape from assailants in hot pursuit (as in Darfur) or from encounters with soldiers, militia, or bandits along the way. Victims are more often in small family groups and easily trapped in unfamiliar terrain. Little information has been gathered to permit further characterization of these attacks, in terms of their relative lethality for the target victim, her children, or members of her group at time of attack.
(8) Description and testimony can be obtained from local witnesses (other villagers or family members who saw what was happening as they managed to run or hide) or from survivors. These two kinds of observation furnish different kinds of information: the first more stark and contextual, the second more narrative and descriptive of intimate detail. Local health personnel and humanitarian NGOs working in the area (both local and international) are also in a position to provide substantial information relating to the general context and to individual instances of these war-time rapes.

This empirical inquiry into the local circumstances of mass rape in internal war also addresses the military context (legal status of the war, training and organization of the military forces, technological and material capabilities, and military objectives).

Military parameters in organized attacks:

(1) The conflicts are non-declared communal wars waged by non-state actors, arising in collapsing states or regions (eastern DRC) or as insurgency-counter-insurgency operations in oppressive states (Sudan).
(2) The non-state actors are armed groups comprised of fighters who are poorly trained and disciplined or malignantly led and incited.
(3) The armed groups have access to small arms but limited supplies of heavy weapons and often lack armored ground or air transport assets.
(4) The conflicts are one-sided, in that the armed groups operate relatively unchallenged throughout the region of hostilities. Opposing forces are weak, scattered, or do not exist. Despite what might be advanced as the putative target of these armed groups, the effective targets of these military operations are communally alien and/or communally stigmatized civilian populations.
(5) Within civilian populations, women are relatively easy targets. They are less likely to be armed than the men in their communities. Issues of relative physical strength may be relevant. But the major reason that women are easy targets is that they are encumbered by their reproductive roles. A high proportion of the younger women will either be pregnant or nursing an infant. Many of these women and those slightly older will also be holding on to toddlers or small children. Distracted and slowed down by these responsibilities for others in their care, women are more likely than men to be overtaken as they flee.
(6) For a given expenditure of force, the rape of women inflicts a wide symbolic injury on families and communities, well beyond the direct physical and psychological effects on the individual target. Rape can be seen as the weapon of choice for armed non-state actors intent on maximizing social disruption.

What follows from these observations is that there are strong symmetries and incentives that tightly link mass rape to the conduct of these internal wars.

(1) *Mass rape requires opportunity*. Armed groups will not take the time or assume the risk of deploying many soldiers for mass rape activities if there is any fear of being attacked by opponents. Only if the conflict is overwhelmingly one-sided can mass rape occur on a systematic scale.
(2) *Mass rape requires vulnerability*. Armed groups with meager resources and low-tech weaponry have a limited menu of tactical choices when trying to take territory, rout or destroy a civilian population. Of these choices, mass rape, primarily of women, has proved to be one of the more primitive, accessible, and efficient.
(3) *Mass rape thrives in a climate of impunity*. Internal wars fought within collapsing states create their own geographic and social isolation even when they are not located in a territory distant from world travel or political interaction. Witnesses and survivors are fearful; access to outside help is minimal; humanitarian actors are constrained. The key consequence is that few useful records are made or kept of these atrocities.

Widespread rape in conflict zones:

The features of population vulnerability and assailant opportunity and impunity apply as well to the growing phenomenon of widespread rape in zones affected by chronic conflict and instability. Women are often attacked on their way to fields or as they leave the village to forage for water and fuel. The patterns are more diverse, however, than what has been reported for organized attacks by large groups of military forces. In Eastern Congo, brutal rapes of women occur in the course of armed robberies in the home, with family members, including husbands, often present. Rape is now occurring as well in the workplace or in schools. Authority figures, such as teachers and police, or military forces deployed as protectors (the Congolese army, UN peacekeepers) are increasingly implicated in charges of sexual assault (Human Rights Watch, 2008; Kirchner, 2007).

This issue of escalation and diffusion of terrible violence against women in the wake of fierce conflict and campaigns of mass rape by combatants is observed in several settings, including Darfur, Chad, Central African Republic, DRC, Uganda, and Liberia. Analysts point to a number of additional factors: pervasive chronic insecurity and war often going back generations, waves of large-scale population dislocation from land and livelihoods, economic chaos and collapse in which only criminality thrives, inadequate disarmament and demobilization initiatives which spill great numbers of uneducated, unemployed, brutalized and armed youth back into villages and towns, and disarray in networks of trust and stability that promote local governance and social coherence, and complete breakdown in systems of law and judicial redress (Radcliffe Institute of Advanced Study, 2008).

The policy implications of this alarming phenomenon are relatively straightforward, with the burden placed on prevention: intervene early to stop these very brutal wars and organized campaigns of mass rape from sowing such social chaos in the first place. It is less clear what precisely should be done to address the plight of populations who are now enduring these crises of assault and grave violence. Certainly the international community must work with local actors to design and implement a vigorous combination of broad-based social, economic, and legal measures. But what is also needed is further research, engaging with people from the community, to explore what might be the underlying precipitants and accelerants of such observed catastrophic collapse of norms regarding the status of women, the role of men, and what presumably, in the past, were sustainable gender relations.

Current Practice

With regard to organized military engagements or large group attacks, the current list of measures now in use for prevention and intervention is very short and does not comprehensively address the issues of opportunity, vulnerability, and impunity noted in the preceding section. Even fewer measures have been designed or used to confront the society-wide diffusion of sexual violence now taking place during and after these atrocity-laden conflicts (see Appendix 3).

Constraints on opportunity:

Imbalances in military power will always exist and thus prevention strategies at this stage of world development are not in view – with one significant exception. The framework of International Humanitarian Law (IHL) is constructed with the intent of limiting the use of force in conflict, regardless of the relative strengths of the opposing sides. The Fourth Geneva Convention focuses on the distinction between combatants and civilians and prohibits a wide range of attacks, including rape and sexual assault, against civilians. These distinctions hold regardless of which of the warring parties holds a military advantage. Ensuring that all armed groups in the world are fully trained in their obligations under IHL is in theory one important prevention measure against the use of mass rape in war. Despite the enormous practical difficulties in accomplishing this goal, it would be a mistake to overlook the ongoing potential influence of this approach.

Faced with atrocities committed in these overwhelmingly one-sided conflicts, the international community can turn to a range of intervention strategies that do in fact exist and have, when undertaken decisively, proven effective.

One set of intervention strategies invokes diplomatic techniques of political and economic pressure, either unilateral or collective. Application of official demarches, diplomatic isolation or restriction, targeted trade, travel, and financial sanctions, embargoes, boycotts – all of these, depending upon the exposure and vulnerability profiles of the offending armed groups or their leadership, might prove influential in restraining their campaigns of sexual assault. State actors arguably are more susceptible to such diplomatic pressure, although as can be seen in the case of Sudan, partial application of the wide range of options can be deflected. Non-state actors could be weakened by a cut-off in trade in small arms, criminally extracted minerals, and illicit drugs, all of which are known to fuel these intra-state wars (United Nations General Assembly, 2001). The record of successful diplomatic intervention is lamentably thin.

Armed military intervention by a force intent on defeating the offending armed group changes the terms of the conflict by eliminating the opportunity enjoyed by the initial belligerents. No longer unopposed, these belligerents must divert their attention from pillaging villages and raping women to confronting an interposed real military threat. Such a force may be national, regional, or international, and in the recent past (Bosnia, Kosovo, Rwanda) has been variously sanctioned in advance by the international community. The insertion in adequate numbers of international or regional peace-keeping troops, provided their mandate is sufficient to effect real civilian protection, may also prove useful. Initial reports from DRC regarding the possible positive impact of UN peacekeepers in reducing the frequency of rape are now overtaken by charges that the Congolese Army has been responsible for many of these instances. Regardless, individual cases of attack seem to be still very high and are rising dramatically as the situation in North Kivu has deteriorated (fall 2008). The United Nations-African Union Mission in Darfur (UNAMID) forces are insufficient in number and means and lack an adequate mandate. Despite their presence in this conflict for many months, rape against civilians continues relatively unchecked.

Much international political will is needed to bring about powerful diplomatic pressure or capable armed intervention. Creating this political will takes time, which means that populations suffer grave abuse before external action is taken. In the record of the last 30 years, one can point to very few wars involving mass rape where diplomatic intervention proved effective (perhaps in Sierra Leone). Armed intervention (permissive or not), despite its proven effectiveness in some instances, requires such a high threshold for activation that it cannot be relied upon as an instrument of policy, although it remains a means of last resort.

Other measures to reduce opportunity – to redress the balance of power – have not been designed, developed, or tried.

Reductions in vulnerability:

Vulnerabilities, whether biological or socially constructed, will always characterize the human condition. The entire panoply of civilian protection policies that the humanitarian community has developed for the war context is based on recognizing these vulnerabilities and compensating for them. Specifically, reducing vulnerability to rape in war, at the level of prevention, requires identifying at-risk situations and protecting civilian populations, in the first instance, before they are attacked and forced into flight. Prevention prior to attack and flight has not been attempted, in part because early warning signs are not heeded and in part because the NGO community does not usually mobilize in large numbers at these early stages of conflict, in the period before the target populations have become IDPs or refugees.

Much more effort has been directed at prevention in the second phase of conflict, as populations have begun to flee sites of attack and congregate in a place of temporary refuge. The high vulnerability to rape in this phase can be reduced by the presence of international humanitarian workers, whose limited activity even in very insecure environments may serve to moderate the more gross attacks on civilians in the immediate geographic proximity of NGO operations. To attempt a wider scope of surveillance and potential witnessing, in the face of an armed and unopposed belligerent force, exposes aid personnel to serious risk. No less an authority than the International Committee of the Red Cross, in its important contribution to the problem of protecting women from mass violence in conflict settings, acknowledges that women are most vulnerable during their episode of flight, and that during this period the range of options is regrettably very small (International Committee of the Red Cross, 2004).

In practice, measures to reduce vulnerability to hostile attack have focused on developing options after populations have begun to amass in IDP and refugee camps. At this stage, relief workers have identified a number of ways to protect women from assault, either in the camps or as they leave the relative safety of the camp perimeters to forage for water or firewood (Shanks and Schull, 2000). These measures have included building fuel-efficient stoves, organizing firewood patrols, developing alternate fuels and introducing female police officials. However, these tactics may prove flimsy defense against an organized force that may surround the camps and often enter at will, as is the case in Darfur and increasingly in Chad.

A third stage of conflict, wherein marauding combatants or brigands attack without provocation throughout the countryside and sexual assault becomes increasingly

prevalent in all sectors of society, preventive measures are ever more urgently needed. A number of agencies (UN, NGO, local civil society) are at work developing intervention programs that range from raising community awareness to increasing job training and economic opportunities. All of these initiatives are in very early stages and little headway can yet be seen.

Reducing vulnerability also takes the form of intervention, rather than prevention strategies. In this category are the robust short-term measures the international community attempts to deploy to assist survivors after they have been raped, in terms of provision of medical, psychosocial and legal services (Lindsey, 2001). Despite some success in some areas, the reality is that these measures are woefully under-funded and under-staffed to stand as substantial contributions to an intervention strategy.

Also in this category of interventions to reduce vulnerability are the mid-term efforts to help survivors regain their dignity and sense of social standing (including engagement in economic activities), and to participate in community outreach campaigns aimed at reducing stigma and promoting recovery for the community as a whole. Longer-term efforts are those that focus on removing those social inequalities and gender imbalances that maintain women in subordinate roles of power and esteem. For the few programs that do exist in these categories, very little is known in terms of outcome or duration of impact.

Curbs on impunity:

The main preventive action against impunity is to create a world-wide culture of denunciation and stigma for all armed groups who engage in the practice of atrocity. As a climate of opprobrium has deterred the use of biological and chemical weapons, a similar climate against mass rape and sexual violence in war could be developed. The basis for this renunciation exists already in law and treaty documents; judicial decisions arising from Yugoslavia and Rwanda are contributing to public awareness.

Intervention measures designed to curb impunity rely on the main tactic of documentation and reporting, with the dual purposes (not always in tandem or coordination) of compelling some form of response from the international community or supplying evidence for possible indictment and trial. An important early alert is often sounded by intrepid journalists and photographers who gain access to the war zone and manage to capture testimony from survivors and witnesses. Visitations from international officials may serve to convey concern and raise international awareness.

More formal and systematic documentation of rapes is usually based on efforts of local human rights groups or international human rights investigators, who, if they cannot gain access, may manage to conduct more long-distance assessments. Much relevant information may be held as well by humanitarian organizations who are engaged in clinical care of people affected by rape. The extent to which this information is shared with the human rights and legal community varies, depending largely upon concern that disclosure of this information may draw attacks on NGOs in the field and jeopardize their access to the populations they serve.

Regardless of the source of information, if it is sufficiently credible and abundant it may contribute to the judicial process of indictment and trial in national or

international courts, as has been the case in the former Yugoslavia and Rwanda and is now under way in Sierra Leone, Liberia, DRC, Sudan and Northern Uganda.

Explicitly linked to these efforts, a further intervention option is to strengthen international communications with the offending party to abide by its obligations under IHL to protect civilian populations. Raising awareness among armed groups and militias who may never have heard of the Fourth Geneva Convention, and in particular making it clear that grave breaches of this law can lead to prosecution for war crimes, may well have a restraining effect. Much has been done in this regard by many agencies but in particular the International Committee for the Red Cross (ICRC). A cumulative record of such communications, including evaluations of outcome, has not been compiled.

All of these measures apply as well to the high incidence of gender based violence (GBV) in war-torn societies, where perpetrators are some mix of criminals, local inhabitants, and military authorities. The legal framework is different but the same principles of documentation, reporting, and strengthening networks of protection and avenues for legal redress are critical.

These efforts at curbing impunity all occur well after the fact. They are based on information acquired through laborious field investigation, unsupported by routine systems of ascertainment or report. Despite the significant expenditure of human and material resource required, they at best identify only a small proportion of the perpetrators. The extent to which the documentation and judicial processes provide an element of deterrence or assuage the suffering of survivors and their communities is not known. Anecdotal information suggests that both these intended outcomes do occur, in some instances.

Recommendations for Policy, Program, and Research

This assessment of potential and current options for prevention and intervention arrives at the following suggestions for future work. These suggestions are directed at levels of policy, program, and research.

Policy

The following proposed policy measures are based on sufficient information or experience to warrant their further development or broad dissemination. The United Nations Population Fund (UNFPA) will need to act in concert with other major national and international entities to advocate for these policies, since none can be accomplished at the level of a single agency.

In the category of constraints on opportunity:

(1) Provide funding and other necessary resources to ensure that all armed state and non-state actors are familiar with the basic tenets of the Fourth Geneva Convention and that their officers or leadership are well versed in key details as well as general principles.

(2) Develop a coherent and comprehensive package of diplomatic measures that can be taken to persuade or compel a wide range of state and non-state actors from engaging in the practice of atrocity in war.
(3) Accelerate the dispatch of international peacekeeping troops, supported by sufficient numbers and effective mandate, to regions afflicted by chronic low intensity conflict.

In the category of reduction in vulnerability:

(1) Embed in all relief and development programs an explicit theme and set of components that address the complexities of gender relationships, with a view of empowering women and enlisting men in efforts to establish mutual autonomy and respect.
(2) Mandate that attention to the health and rehabilitation needs of survivors of rape and sexual assault be included in all programs set up to provide relief to civilians in conflict settings.

In the category of curbs on impunity:

(1) Construct a concerted and long-term campaign to create an international climate of stigma against armed groups who used rape as a weapon of war.
(2) Encourage diplomatic and NGO efforts to engage with non-state actors directly, including outreach early and throughout the conflict, in order to reinforce messages of stigma and accountability for the practice of mass rape and sexual assault in war.
(3) Participate in initiatives that will promote more systematic and routine reporting of instances of rape and sexual assault in conflict settings, including the development of common indicators and protocols for transmission of information.
(4) Support development of stronger prosecutorial systems and increased community engagement in local campaigns against gender based violence in all sectors of society.
(5) Take the lead in developing protocols whereby NGO workers are shielded from reprisal but encouraged to transmit information related to rape and sexual assault through secure channels to appropriate human rights groups and legal authorities.
(6) Support further allocation of resources for national and international judicial systems of investigation, adjudication and accountability that pertain to oversight of atrocity in war.

Program

Many of these program recommendations are affirmations of current initiatives; some suggest refinements of current approaches. All are within the mandate of UNFPA, although necessitating consultation and coordination with other actors at many levels.

In the category of constraints on opportunity:

(1) Consider introducing educational programs for local NGO leaders in the basic principles of IHL and civilian protection. Disseminating norms at this level could enhance their capacity to intervene with armed groups in specific situations.
(2) In the context of widespread and more diffused sexual violence in war-torn societies, enlist men from the affected communities to help develop social and economic programs that will improve the well being of men, promote attitudinal shifts regarding the status of women, and shore up norms of respect for the dignity of all persons.

In the category of reduction in vulnerability:

(1) Ensure that in the emergency situation, all feasible measures are taken to protect those at risk of sexual violence. Such protective mechanisms include programs to build fuel-efficient stoves, the organization of firewood patrols, the development of alternate fuels and the introduction of female police officials. Water must be provided either in or very close to all refugee and IDP camps.
(2) Mandate that health care services are provided to survivors of rape and sexual assault. Such services must be readily accessible, completely confidential and free of charge. Essential services must include the capacity to diagnose, provide prophylaxis for and treat sexually transmitted infections and HIV/AIDS. Services available on referral must also include the ability to perform surgical repair of genital tears, fistulas, and other forms of genital trauma. Pregnancy prophylaxis must also be offered to all women victimized by vaginal penile penetration and traditional birth attendants must be present to ensure safer labor and delivery for all pregnant women. All bodily injuries arising from the attack must also be properly addressed.
(3) Mandate that psychological trauma resulting from sexual violence be addressed in a culturally sensitive and appropriate manner. All psychological interventions must be based on feedback and suggestions provided by women who have been affected and who are familiar with local culture, tradition and religion. Such interventions must include enlisting local women, outreach to the entire community and the creation of women's support groups in safe environments.
(4) Develop the processes and procedures to ensure that all measures taken in support of civilian protection, as listed above, are appropriately documented and evaluated in terms of short and longer-term outcomes.

In the category of curbs on impunity:

(1) Support and develop outreach to local communities to encourage men and women to come forward and report instances of rape and sexual assault. Private and confidential settings for the interview and tight controls over the custody of the information would need to be ensured.

(2) Ensure that adequate legal assistance and personal protection is provided for sexual violence survivors, with the dual aim of supporting claims for restitution and redress and of documenting assaults that might be used in judicial proceedings. Reporting mechanisms must be in place and obstacles that prevent women from bringing justice to their assailants must be overcome. Evidence of rape or sexual assault must be collected and preserved for future legal proceedings by people specifically trained in this process.

Research

These recommendations for further research or evaluation of current or proposed interventions may require coordination with other agencies but all lie within the mandate of UNFPA to initiate or support.

In the category of constraints on opportunity:

(1) Commission research into the extent, patterns and impact of wartime sexual violence. Such information is essential to support effective advocacy campaigns and to plan effective interventions. The absence of such data limits the capacity of stakeholders to grasp the real magnitude of the problem and hinders mobilization of diplomatic will.
(2) Support research projects that inquire of state and non-state actors what efforts by outside players (the international community or more regional or local agents) have served to modify or restrain tendencies towards the practice of atrocity in war. Both contemporary and historical approaches could be fruitful.

In the category of reduction in vulnerability:

(1) Participate in efforts to develop measures of early warning that would allow the international community to recognize the potential for a conflict to begin as or turn into one in which the practice of rape and sexual assault becomes generalized.
(2) Undertake research in patterns of individual and group vulnerability, based on particular conflicts and circumstances.
(3) Document the ways in which a particular pattern or method of inflicting sexual violence affects the survivors or results in death. Short and longer-term physical, psychosocial, and community impacts should be addressed in this inquiry.
(4) Create a system for understanding and documenting the fate of children born of rape, across a range of cultures and war contexts.
(5) Conduct an overall analysis of all known evaluations of current protection mechanisms and interventions to determine what actually stands up as effective. This analysis would require defining, according to local norms and customs, the meaning of “effective” outcome.

(6) Organize or commission an historical exploration of how other communities and societies have in the past dealt with the experience of mass rape. This exploration would look at how recovery was defined, what processes have supported it, and what negative effects linger over what time frame.

In the category of curbs on impunity:

(1) Support all efforts to improve documentation of sexual violence in war. In this regard, it is helpful that the Interagency Standing Committee in 2005 committed to work towards the development of a systematic process for collection and standardization of data relating to rape and sexual assault in conflict settings. Also helpful is its detailed assessment of the issues and challenges that need to be addressed in this undertaking (Social Science Research Council, 2005).
(2) Explore the feasibility of improving the capacity of local people to document attacks and instances of rape and sexual assault. Possible supports would include application of widespread consumer-based technologies, such as cell phones, with or without built-in cameras, to permit alerts and self-reporting. Any effort in this direction would require careful attention of such issues as battery life and many issues relating to security and coordination. Pilot tests of this suggestion would be necessary.

Appendix 1: Sexual Violence in Recent Conflicts – Case Examples

Democratic Republic of Congo (DRC)

From 1998 to 2003, the DRC was engulfed in a conflict that involved so many nations and took so many lives that it was dubbed “Africa’s First World War”. The total death toll is estimated to be approximately 5.4 million (International Rescue Committee) and thousands were displaced from their homes. The war was marked with extreme violence including widespread rape and torture. Although the true extent of sexual violence is not known, it is estimated that it runs into thousands (Medecins Sans Frontieres [MSF], 2004b). Statistics from local health centers suggest that 13% of all sexual victims were under fourteen years of age (Rodriguez, 2007). Allegedly, all armed parties were guilty of committing sexual atrocities (MSF, 2004b). Anneke Van Woudenberg, the Human Rights Watch specialist for Congo, believes that rape was so widespread that “it [rape] has become a defining characteristic” of the DRC war (Goodwin, 2004).

Gender-based violence in the DRC has been clearly documented. A recent retrospective study of 492 female rape survivors indicated that 79% of all informants had been gang raped (Reseau des Femmes, 2005). Forced rape between victims was not uncommon and usually involved incestuous sexual relations between mothers and sons, between fathers and daughters, and between brothers and sisters. About 72% of victims were tortured while they were being raped Reseau des Femmes, 2005).

Human Rights Watch described the extraordinary brutality of the DRC rapes – girls as young as five and women as old as eighty were reportedly shot in the vagina or mutilated with knives and razor blades (Human Rights Watch, 2002). Many women were attacked while their families were forced to watch (MSF, 2004b).

Among rape survivors in eastern DRC, 85% reported vaginal discharge, 79% reported lower abdominal pain and 10% reported that they were impregnated during the rape (Reseau des Femmes, 2005). Fistulas were common with 41% of assaulted women reporting urinary or fecal discharge from the vagina (Reseau des Femmes, 2005). Fear and shame were reported by 91% of victims and 77% of all women reported insomnia and nightmares (Reseau des Femmes, 2005).

The medical records of 658 rape victims were reviewed at Saint Paul Health Center in Uvira. Of those who received HIV testing, 9% were positive. Thirteen percent of victims were reported to have syphilis and 31% were reported to have gonorrhea (Reseau des Femmes, 2005). However, it is important to note that few women or girls seek medical treatment after rape. Health care is expensive, services are scarce and most health care providers are men. Seeking care makes it likely that knowledge of the rape will become widespread and that the victim will be stigmatized (Human Rights Watch, 2002).

Medécins Sans Frontières (MSF) reported that over half of all victims indicated that they had been raped while working in the fields (MSF, 2004b). Such attacks were usually conducted by a group of armed men, and the women were usually beaten up, raped and then left lying in the fields. Many other women indicated that they were raped when their villages were raided and pillaged, in what appeared to be planned attacks (MSF, 2004b).A substantial number of women reported being raped in the bush where they had sought refuge when insecurity had caused them to flee their homes.

Congolese women were asked for their opinions on the motives behind this sexual violence. In response, 83% indicated that lack of organization, training and discipline among the armed parties was a contributing factor (Reseau des Femmes, 2005). Fifty-seven percent felt that rape was used as a deliberate method of exterminating the Congolese people. In support of that statement, MSF concluded that, "Sexual violence has been so clearly linked to the military strategy of warring parties and has occurred in such a systematic way that it is wrong to think of it as a side effect of war" (2004b).

Darfur

United Nations (UN) has declared the conflict in Darfur to be the worst humanitarian crisis in the world (UN News Center, 2003). The fighting escalated in 2003 when the government-sponsored Janjaweed militia began a vicious campaign of ethnic cleansing against the black, non-Arab Sudanese (Amnesty International, 2004b; Depoortere et al., 2004; Gingerich and Leaning, 2004; Hampton, 2005; Physicians for Human Rights, 2006; US State Department, 2004). Recent estimates suggest that over 400,000 people have been killed and approximately 2.5 million

have been displaced from their homes (UN News Center, 2006). Systematic attacks and sexual atrocities have been documented against the Fur, Masalit and Zaghawa ethnic groups (Amnesty International, 2004b; Depoortere et al., 2004; US State Department, 2004).

The full extent of sexual violence in Dafur has not been accurately documented and systematic studies are lacking. In 2004, Amnesty International collected information on 500 rapes, but speculated that this represented only a fraction of the sexual violence that had occurred (Amnesty International, 2004b). Working in West Darfur, MSF reported that 14% of victims of violence admitted to being victimized sexually (MSF, 2004). Although it did not address the issue of sexual atrocities directly, the U.S. State Department documented that 16% of those surveyed had either been raped or had heard about a rape during the conflict (US State Department, 2004). MSF Holland described the treatment of almost 500 rape victims in South and West Darfur but this represents only passive surveillance data and most certainly underestimates the number of women who have been affected (MSF, 2005).

In Darfur, rape typically occurs in the context of Janjaweed attacks on non-Arab women and girls. MSF reported that almost 90% of rapes occurred outside a populated village and 82% of women were pursuing ordinary daily activities at the time they were attacked (fetching water, traveling to market, searching for firewood) (2005) Only 4% of women reported that they were raped during active conflict or while they were fleeing their village. Twenty-eight percent of victims described being rape more than once and at least half of the women were beaten or physically injured during the attack (MSF, 2005).

There are also reports of rape and sexual violence after women and girls have reached the supposed safety of refugee camps or internally displaced persons' (IDP) camps. In a five week period during July–August of 2006, the International Rescue Committee (IRC) reported that more than 200 women were sexually assaulted around Kalma, the largest IDP camp in Darfur (Integrated Regional Information Networks [IRIN]).

The strategic rationale for rape as a weapon of war has been described and Darfur provides an excellent illustration of such strategies. Rape and sexual violence are used to instill fear with the aim of restricting movement and limiting economic activity (Gingerich and Leaning, 2004). Rape is also used to humiliate and demoralize the population, thus reducing the will to resist. As a means to this end, the Janjaweed do not typically kill their rape victims.

The sexual violence being committed in Darfur has grave consequences for the individuals, their families and also their communities. MSF reported that 4% of rape victims had suffered serious physical injuries such as broken bones or burns (MSF, 2005). At the time they sought medical attention, 7% already knew that they were pregnant as a result of the rape. These women and their children were considered to be at high risk of HIV/AIDS. The psychological effects of the rapes are expected to last for years and will be prolonged by the social stigma surrounding rape (MSF, 2005). Married women are sometimes abandoned by their husbands and unmarried women may not be able to marry since they are viewed as "spoiled" as a result of the rape.

Sierra Leone

In 1991, the Revolutionary United Front (RUF) invaded Sierra Leone, triggering a civil war that would last 10 years. The conflict took tens of thousands of lives and forced over 1 million from their homes (Amowitz et al., 2002). Throughout the conflict, thousands of women and girls were subjected to widespread and systematic sexual violence (Human Rights Watch, 2003). Members of the RUF and the Armed Forces Revolutionary Council (AFRC) were the most common perpetrators of sexual violence although civil defense forces were also implicated (Human Rights Watch, 2001).

While there are no official statistics on the number of girls and women raped in Sierra Leone, multiple estimates have been provided. According to a 1999 study, 1,862 female victims of sexual abuse were medically treated and counseled following the January 1999 offensive on Freetown (de Jong et al., 2000). In a cross-sectional randomized survey conducted in 2001, 9% of respondents admitted that they had been sexually assaulted during the conflict. A population-based assessment performed by Physicians for Human Rights (PHR) found that 13% of interviewees had been subjected to conflict-related sexual violence (Physicians for Human Rights, 2002). From this data, PHR estimated that 50,000–64,000 female IDPs had been subjected to sexual abuse during the war. By adding extrapolated data for other types of victims, PHR calculated that as many as 215,000–257,000 Sierra Leonean women and girls may have been subjected to sexual violence during the 10 year conflict (Physicians for Human Rights, 2002).

The sexual violence in Sierra Leone was marked with extraordinary brutality. Although the rebels raped indiscriminately irrespective of age, there was a tendency to target young women and girls who were thought to be virgins (Human Rights Watch, 2003). Adult women were also raped; they were raped so violently that they sometimes bled to death. According to MSF, 55% of victims were gang raped (Human Rights Watch, 2001) and the assaults commonly involved the insertion of objects, such as knives and small pieces of burning firewood, into the vagina (Amnesty International, 2000). Pregnant women reportedly had their babies torn out of the womb as rebels placed bets on the sex of the unborn child (Human Rights Watch, 2003).

The consequences of war-related sexual violence will be felt for decades in Sierra Leone. Thirty-four percent of women self-reported sexually transmitted infections following wartime rape and 20% self-reported reproductive complications or miscarriages (Amowitz et al., 2002). Another 15% of rape survivors reported that they has been rejected or stigmatized by their family or community and 6% self-reported pregnancy as a result of the rape. Women who were abducted and forced to spend months or years in the bush have reportedly suffered from tuberculosis, malnutrition, malaria, skin and intestinal infections, and respiratory diseases (Amnesty International, 2004).

While sexual assault is a criminal offense in Sierra Leone, most acts of sexual violence remain either untried or are handled by the traditional community leaders (Kellah, 2007). In the latter case, sanctions imposed by community leaders are often

more harmful than helpful to the victim. For instance, the rape survivor is sometimes forced to marry her assailant. In many cases, the victim cannot even report sexual assault to police without first gaining the consent of the local chief, a decision which remains entirely at the discretion of the chief (Kellah, 2007).

Rwanda

From April to July 1994, up to one million Rwandans were killed by the Interhamawe in a genocide launched against the Tutsi minority (Human Rights Watch, 1996). Moderate Hutus suspected of working with Tutsis were also massacred. The Rwandan genocide is remembered not only for the sheer number of people killed in a short period of time but also for the lack of response by the international community.

Although the exact figures are unknown, it has been confirmed that rape was extremely widespread during the 100 day genocide. Some experts believe that almost all surviving women were victims of sexual violence (Human Rights Watch, 1996). Others estimate that at least 250,000 women were raped (Human Rights Watch, 2004).

Sexual violence during the Rwandan genocide included systematic rape and gang rape, inflicted even on pregnant women or women who had just given birth (Amnesty International, 2004). Women were tortured and killed by having arrows, spears or other objects pushed into their vaginas or by being shot in the genitals. Degradation was integral to the physical violence. Some women were forced to parade naked or to perform various humiliating acts while the soldiers and militia looked on (Amnesty International, 2004). The genitalia of Tutsi women were sometimes cut off and displayed, and members of the militia reportedly raped corpses. Assailants sometimes mutilated or chopped off body parts deemed characteristic of Tutsi women, such as thin fingers or long noses (Brownmiller, 1975). Unlike Sudan, Rwandan victims of sexual assault were typically killed, in keeping with the Interahamwe goal to exterminate the Tutsi race.

It is widely believed that many rape survivors contracted HIV/AIDS during the Rwandan genocide. Based on a study of 1125 women conducted in 2000, two thirds of women surviving the genocide were HIV positive (Brownmiller, 1975). The vast majority of these women do not have access to anti-retroviral treatment. As in other countries, stigma and marginalization can be severe for Rwandan rape survivors. The situation is worsened, however, for those women who have contracted HIV/AIDS. Rwandan doctors note other medical problems commonly diagnosed in genocide survivors, including sexually transmitted infections (particularly syphilis and gonorrhea), fistulas, mutilation, complications from botched abortions and psychological problems (Human Rights Watch, 1996). The conflict destroyed many pre-existing medical facilities and left widespread shortages of medical personnel (Human Rights Watch, 2004). Access to care is particularly difficult in the rural areas, where an estimated 90% of the population live.

The Rwandan post-genocide era presents many complex and often overwhelming problems for female survivors. Most women have lost their husbands and have become the head of their households (Human Rights Watch, 1996). They are faced with rebuilding their lives and with providing food, shelter and other basic necessities for themselves and their families. Such challenges are faced while attempting to cope with the social isolation and marginalization that accompanies rape. Many of these survivors deal with severe health complications and some are raising children that were born as a result of the rape. To complicate the situation further, many widows have not been able to return to their property because of discrimination under customary law, which does not give them the right to inherit (Human Rights Watch, 1996). The lack of judicial accountability for the perpetrators of the genocide is further intensifying the victims′ physical and psychological trauma.

Appendix 2: Physical and Psycho-Social Consequences of Mass Rape

Physical Consequences

Women who have been raped are always at risk of becoming pregnant, with the studies showing that the risk varies from 4% for US adult women to 15–18% in studies from Ethiopia and Mexico (Drug et al., 2002). Reliable estimates are not available for pregnancy rates among women raped in war settings, although a few reports (such as one from Bosnia) would suggest that the rate could be higher than non-conflict related rape (Loncar et al., 2006). The role of gang rape, in which multiple partners increase pregnancy exposure rates, has not been sufficiently studied from this perspective. Pregnancy among women who have been raped in war imposes serious added health risks, as well as adding further psychological and social distress. Abortions are difficult to obtain and often dangerous. Carrying a pregnancy to term and bearing a child may socially isolate the woman survivor. Children born of rape suffer ostracism, abandonment, and may in fact be allowed to die or actively killed. Instances of all these possible tragic sequelae are reported frequently from observers and health workers in refugee and IDP settings.

Victims are often injured physically as a result of the brutality with which the rape is committed. Genital injuries are typically exacerbated in women who have previously undergone female circumcision. Fistulas are one of the commonly reported physical consequences of wartime rape. Fistulas are abnormal openings between the reproductive tract and one or more body cavities such as the bladder or the bowel. Women with fistulas are unable to control the constant flow of urine and / or feces that leak from the tear and this serves only to heighten their stigmatization and social isolation. Other physical complications of mass rape include uterine prolapse, infertility and miscarriage. It is also common for women to suffer genital mutilation either during or after rape.

Women also suffer from intentionally inflicted torture and from injuries sustained while attempting to resist or escape. Victims are often beaten, resulting in head

injuries or broken bones. Lacerations are sometimes used to "mark" women as being sexual victims of the enemy.

The risk of contracting HIV/AIDS and/or sexually transmitted infections is quite high in the setting of wartime sexual violence. The risk of transmission is increased because gang rape is common, because vaginal tears and lacerations often result from the violent nature of the attack and because there is a higher likelihood of anal penetration (Klot and DeLargy, 2007). Furthermore, during migration it is not uncommon for women to be forced into "survival sex" as they struggle to provide food, water and shelter for their families. The risk of contracting HIV/AIDS is further heightened during conflict because insecurity and lack of health care infrastructure limit the availability of HIV testing and antiretroviral drugs.

Psychosocial Consequences

In addition to the physical consequences of rape, women suffer both psychologically and socially. The rape itself undoubtedly constitutes a gross violation of human rights. However, rape survivors face further prolonged suffering as a result of the associated shame and stigma. In some cultures, married women are disowned by their husbands and unmarried victims may never be able to marry since they are considered "spoiled" (Amnesty International, 2004). Without the economic support and protection traditionally provided by men, these women become exceptionally vulnerable. Many women suffer from depression, withdrawal and poor self-esteem. There is reluctance to speak openly about sexual violence and many women suffer the physical and psychological consequences in silence.

Consequences for the Community

Mass rape has a truly devastating effect, not only on the individual but also on the family and community. Sexual violence is used to destroy the bonds of family and society (Swiss, 1993), thereby weakening the community's coping mechanisms and survival strategies. The stigmatization and abandonment resulting from rape often prevents women from actively participating in community life and undermines their ability to raise children (Thomas, 2007). By raping women, the enemy is able to instill suffering on the community as a whole and the community's culture can be annihilated.

Appendix 3: Program Interventions for Sexual Assault in War

Among the many existing or past interventions undertaken by the international community in an effort to mitigate the individual, family, and community consequences of sexual assault and rape in war, the following have been selected as examples of programs with wide scope, duration in the field, and/or creative mix of methodology and approach.

International Rescue Committee in Sierra Leone

IRC has partnered with the government of Sierra Leone to establish three Sexual Assault Referral Centers (SARC), known locally as “Rainbo” centers (Kellah, 2007). Each center offers comprehensive care consisting of free medical, psychosocial and legal support. The SARC project has been singled out by UNHCR as a best-practice gender-based violence program and several particular strengths have been noted. By involving the government, non-governmental organizations and police, SARC takes a truly multidisciplinary approach, openly acknowledging that no single agency or organization has the capacity to independently address gender-based violence (Kellah, 2007). Each Rainbo Center offers confidential counseling, forensic medical examination with treatment, food, clothes and legal advocacy. Eight female doctors were trained to conduct the medical consultations such that all women would have the option of being seen by a female physician. The SARC project also includes community educational campaigns and regular training sessions for partner agencies that are also working on sexual violence (Kellah, 2007). All services will eventually be transferred to the Sierra Leone government.

Médecins Sans Frontières in South Africa and Burundi

MSF Belgium is currently running two particularly successful sexual and gender-based violence programs – one in Khayelitsha, South Africa and one in Bujumbura, Burundi (Lebrun and Derderian, 2007). From these successes and in comparison with other programs in Liberia, Sierra Leone, Ivory Coast, Sudan, Rwanda and Columbia, MSF has been able to draw from their experience to reflect on what makes such programs successful (Lebrun and Derderian, 2007). For instance, program officials believe it is essential that all services (medical, psychosocial and legal) are available at the same facility. They also note that sexual violence programs appear to work best in post-conflict or non-conflict settings. Because many women are reluctant to seek care, MSF believes it is important to provide an information/education/communication (IEC) message to the community, emphasizing the urgency for and availability of post-exposure prophylaxis (PEP) against HIV (Lebrun and Derderian, 2007). Where rape survivors seek care from traditional health care providers, MSF has found it useful to liaison with those provides in an attempt to have women referred for PEP.

International Rescue Committee in Darfur

In Darfur, IRC is operating ten Women’s Centers, which appear to have been successful in meeting the needs of rape survivors. IRC officials note that when rape occurs as a weapon of war, the actual experience of sexual violence is one that is shared collectively since women are often attacked in groups. For this reason, IRC’s Darfur programs have taken a somewhat different approach (Lowry, 2007). The Women’s Centers aims to create a safe environment where women share

their individual stories with each other as a method of breaking the silence and reducing shame and stigma. The Women's Centers also provide skill-building activities, literacy classes and social support activities such as drumming and dancing (Lowry, 2007).

Panzi Hospital in Democratic Republic of Congo

Eastern DRC has two referral centers dedicated to repairing fistulas that result from wartime rape. One of these centers, Panzi Hospital in South Kivu, offers comprehensive assistance to sexual violence survivors (Rodriguez, 2007). However, due to lack of funding and poor coordination, the referral system does not work effectively. Organizations providing medical services are working independently and various groups are focusing on different aspects of care – development, medical aid, psychosocial assistance and reintegration. There is duplication of some services and lack of other services. Victims are not routinely being referred within the recommended 72-hour period such that HIV PEPcan be provided. Health centers are also not providing the medical certificates necessary for judicial follow-up and there is no standardized training regarding how to investigate, collect data and assist women in reporting their cases to the proper authorities (Rodriguez, 2007). In recent years, several organizations, including Women for Women, have been active in the region and providing a wide range of services to support rape survivors, improve documentation and legal redress, and promote community integration (Women for Women International).

Various Initiatives in Darfur

In Darfur, initiatives have been introduced to protect women from sexual violence while they collect firewood. In late 2005, the Women's Commission for Refugee Women and Children assessed the status and impact of these initiatives (Patrick, 2007). Fuel-efficient stoves were found to reduce firewood consumption by 20–80%. It was believed that since less firewood would be needed to cook for the family, firewood could be collected less often, thereby reducing the risk of attack. However, the investigators concluded that fuel-efficient stoves should only be considered as an addition to other, longer-term fuel strategies since fuel-efficient stoves can never entirely eliminate the need for women to collect firewood. The Commission also commented on the use of firewood patrols. In Darfur, firewood patrols, involving both civilian police and troops from the African Union Mission in Sudan (AMIS), follow by truck when the women go out to collect firewood (Patrick, 2007). The patrols were viewed as being fairly successful in deterring would-be attackers. However, poor organization, lack of trust and ineffective communication were thought to have limited the overall success. The Commission recommended that patrols be organized by a committee comprised of vulnerable women, members of the civilian police force, members of the AMIS and NGO facilitators who would solicit feedback from all involved. With regards to provision of fuels other than

firewood, the Commission noted the large potential for impact but reported that there had been inadequate testing, interaction and cooperation among the involved stakeholders (Patrick, 2007).

International Rescue Committee on the Thai Burma Border

It is widely believed that men must be actively engaged if efforts to prevent gender-based violence are to be successful. However, as evidenced by one program on the Thai-Burma border, it can be quite challenging to engage men in such programs. In 2004, the IRC began a gender-based violence program, which included a "Men Involved in Peace – building" (MIP) initiative. Program leaders reported that focus group discussions, with both married and unmarried men, seemed to catch the men off guard (Alvarado and Paul, 2007). Although sexual violence had been well documented in refugee camps along the Thai-Burma border, the men in the program did not accept this as a problem for the community. They questioned why the program was focused only on the women's rights and women's issues when they too, had suffered a loss of self-esteem and power. The men believed that a wife's complaints were a form of violence against her husband (Alvarado and Paul, 2007).

Much has been learned from the IRC program. First, the emotions and frustrations of men must be addressed, but only when men have been given enough time and space to reflect on and internalize new concepts related to gender roles and sexual violence. Second, gender-based violence must be presented as a community-wide issue rather than as a women's issue. And finally, male program staff must be screened and chosen very carefully since the Thai-Burma program initially had hired men who were themselves abusing their wives (Alvarado and Paul, 2007).

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Gendering Space for Forcibly Displaced Women and Children: Concepts, Policies and Guidelines

Roger Zetter and Camillo Boano

Introduction

The provision of shelter and settlement is a basic need in all societies and their loss, destruction and replacement provide iconic images of conflict, forced migration and return. This chapter reviews these issues from the perspective of women and families, drawing on a wide range of published and grey literature, agency reports and the research and field experience of the authors.

Forced displacement differentially impacts women: gender mainstreaming seeks to ensure that effective policies and programs for assistance recognise these differences, build on the diverse skills and perspectives which women provide and promote their participation and empowerment (UNHCR, 1990; UNHCR, 2005a, b). At the same time, household space is primarily the domain of women in many societies. This conjuncture provides the basis for this chapter. Yet, despite the very extensive academic, policy and practice literature on shelter and settlement, and given the material and symbolic significance of shelter and housing to these specific social groups, there has been surprisingly little *systematic* research or policy guidance to respond to their needs and capacities. With some exceptions coverage is diffuse and lacks a coherent frame of discussion. This chapter seeks to fill this lacuna. It aims, from the perspective of women and families under conditions of conflict, forced migration and return, to widen the understanding of shelter in terms of design, production and governance. It reviews the range of settlement options and reconstruction opportunities, focusing mainly on camps and collective shelters, in a journey from pre-displacement housing to reconstructed post-displacement settlement. The short space available compels a generic study transcending the three categories of forcibly displaced – IDPs, refugees and returnees – but specific situations are highlighted where significant. The chapter goes beyond a gender-equals-women perspective, difficult though this is in a sector more dominated by masculine norms than any other. It examines transformative practices and consequences and demonstrates that only by a systematic

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_10, © Springer Science+Business Media B.V. 2009

gender-based reconceptualization of the sector can gender empowered polices and practices be put in place.

The chapter is in two parts. The first introduces the topicality and relevance of the paper, and outlines key concepts and policy issues which shape the shelter and settlement sector. The second, and substantive, part fulfils the main objective. This is to provide strategic and practical guidelines for policy makers and practitioners in governmental, intergovernmental, humanitarian and development agencies on how to involve and empower women caught up in forced displacement in shelter and settlement planning and implementation.

However, the interplay between these two parts is a key learning point. Improvements to practice cannot be made in isolation from a clearer overall conception of the shelter and settlement sector in terms of the complex functions of housing as a physical, social and developmental asset, and the rights-based needs it highlights. In other words, there is a meta-level requirement to adopt a *systematic* gender perspective at each stage from initial concepts through to practical on-the-ground options and actions.

Topicality of the Study, Key Concepts and Policy Issues

This section introduces the topicality and relevance of the chapter, providing the context for a gendered discussion of policies and strategic guidelines which follows in the main part. It outlines key concepts and policy issues which shape the delivery of shelter and housing assistance as an essential commodity for livelihoods, well-being and development, located within the broader dimensions of humanitarian interventions. The section stresses the complexity and the vulnerability of this asset under conditions of forced displacement.

Shelter and Housing in Forced Displacement – Overview

From a semantic perspective, shelter and housing juxtaposed with forced migration activate contradictory meanings: one is associated with the groundedness and finitude of buildings, the constitution of places and the delimitation of territories; the other represents uprootedness, forced mobility and the transience of families and groups of people for whom "homeless and 'placeness' are intrinsic by definition"(Cernea and McDowell, 2000:25, italics added). This tension lies at the core of the discussion.

Loss, devastation and the replacement of housing provide compelling images of forcibly displaced populations and the evidence that houses are highly vulnerable assets in this context is beyond doubt. The data are imprecise in detail but consistent in scale and the location of impact in the global south. Gilbert contends that from 1980 to 2000, 141 million people lost their homes, in 3,559 natural hazard events, of whom 97.7% lived in developing countries (Gilbert, 2001:1). More recent disaster data show that between 1994 and 2003, over 255 million people a year, on average, were affected by natural disasters globally. (CRED, 2005:14)., No

aggregate data have been found for housing loss incurred by refugees and IDPs: but specific cases, for example in Palestine, Colombia and Bosnia Herzegovina, and Sierra Leone illustrate dramatic loss.

By destroying both a significant material resource and a symbolic representation of social wellbeing (Zetter, 1995, 2005), the loss of housing seriously erodes the very meaning of life and its continuity (Skotte, 2005:3). Destruction is simultaneously a by-product and an instrument of war and conflict (Zetter, 2005:155; Skotte, 2005) – the destruction of a physical asset, but also an object to be "killed" in order to expel their inhabitants and annihilate their social worlds: this duality is captured in the current neologisms, "urbicide", (Bogdanovic, 1993) and "domicide" (Porteous and Smith, 2001).

The Shelter and Housing Sector: The Conceptual Problematic

In response to widespread destruction, the provision of durable shelter designed to satisfactory physical standards and which is technologically and culturally appropriate, constitutes a basic need for forced migrants. Thus there is a clear humanitarian imperative to provide victims of conflict and disaster with basic shelter, in the same sense as ensuring access to water, sanitation, food and healthcare.

The widely accepted premise that camps are a last resort for displaced people has failed to be applied in practice: rather camps have become the typical starting point for emergency shelter response as recently well demonstrated in the Tsunami emergency shelter response.

The dominance of a somewhat ill-defined sectoral model (Zetter, 1995, 2005; Skotte, 2003; Saunders, 2004), predicated on short term emergency provision and a restrictive "bricks and mortar" approach, has dominated shelter policies and practice for decades (Barakat and Ellis, 1995; Zetter et al., 2001; Boano et al., 2003). This model is driven by the top-down "implementation push" of project driven solutions and is characterised by a limited array of solutions, the fragmentation of donors and agencies, and the political imperatives of managing forcibly displaced populations, notably refugees and IDPs (Hyndman, 2004). In the present context the key point is that, in common with the other hardware sectors, shelter and settlement is *par excellence* male-dominated in terms of concepts and personnel: the predominance of a masculinised value system exacerbates the internalised subordination of women which is characteristic in much humanitarian intervention (Clifton and Gell, 2001:17; UNHCR, 2005a:111–112).

Despite recent improvements in defining principles and practices for the sector (UN, 2005; Sphere Project 2004), arguably it is the least successful sector in terms of implementation. There is a persistent need to "raise the bar" of refugee camp shelter and settlement planning. Characteristic weaknesses are: uncoordinated agency planning; conflicting mandates; inappropriate designs; lack of beneficiary participation; the "lumpy" nature of resources; inadequate resettlement planning (ALNAP, 2002:90, 95). The HRR clustering strategy divides between IFRC designated lead in natural disasters and UNHCR in conflict situations whilst addressing some of

these problems, inhibits generic learning. The neglect of gender perspectives and an embedding "gendered approach" is notable in both the practical and institutional dimensions.

Rethinking practice and concepts requires that shelter policies and programs serve not only physical needs but "higher order" objectives such as the long term development aspirations of the beneficiaries, social and civil society development, economic needs and strategies for post-conflict and post-disaster reconstruction (Zetter, 2005). Three generic dimensions are considered with discussion tailored to gender issues.

The Housing Nexus

Housing is a complex commodity with many attributes and levels of meaning; but only recently has this complexity been acknowledged in shelter policies and programmes for forced migrants. As Zetter has emphasised (Zetter, 2005), although one of the basic needs of refugees and forced migrants, it must embrace far more than a physical commodity and the product of basic standards codified in operational guides (Sphere Project, 2004; Shelter Project, 2003; UNHCR, 1999, 2005b, c; Corsellis and Vitale, 2005). Unique amongst the arenas of humanitarian intervention and post–conflict/post-disaster reconstruction, shelter and settlement has a diverse range of multi-sectoral characteristics which serve a rich nexus of needs and interest. It is a basic physical resource reflecting the narrowly defined output, "bricks and mortar" model of much current practice (Kemeny, 1992:4). Yet, it also serves a complex set of social, cultural, domestic and personal needs represented by the variety of ways in which space is identified, ordered and used (Dovey, 1985:39; Porteous and Smith, 2001; Kallus, 2004:341). Social meaning intersects with shelter as a vital economic multiplier (Rakoff, 1977:93; UN Habitat, 2003; Sheppard and Hill, 2005; Zetter, 2005:156). Housing (re-)construction is an on-going process in most societies, especially for forcibly displaced populations, not simply an end-state package delivered by humanitarian agencies (Saunders, 2004:164). Shelter interventions intersect different programme arenas (for example community strategies and livelihoods), and different spatial and operational scales (from field level projects to national recovery and development strategies).

These multi-dimensional characteristics notably impact women and families because the gendered boundaries of housing in most societies constitute an environment in which women lay claim to the house as their domain, as a locus of social and economic rights and obligations, and a space for social relations and identity: innovative research has explored these gendered dimensions in the context of forced migration (e.g. Hammond, 2004; Olwig, 1998; Hirschon, 1989; Martin, 2004), and post conflict reconstruction (Zuckerman and Greenberg, 2004:77–79). Self-evidently, therefore, a gendered perspective is essential in reconceptualising the shelter and settlement "sector" and thus improving policies and practices for these social groups.

Linking Relief, Rehabilitation and Development

An extensive literature is dedicated to discussing the links between emergency relief and the longer term development needs of forcibly displaced populations (Zetter, 1995; Macrae et al., 1997; Smillie, 1998; Harmer and Macrae, 2004; Skotte, 2005; Zetter et al., 2001; Zetter, 2005).Variously termed the *relief-to-development continuum*, or more recently the "relief and reconstruction complex" (Bello, 2006:281), this relationship poses complex conceptual questions, operational challenges for agencies working in the shelter sector (Saunders, 2004), and contradictory technical and political demands (Buchanan-Smith and Fabbri, 2005). Again, uniquely amongst the various sectors of humanitarian intervention, the shelter and settlement sector lies at the crux of this problematic. This is because shelter provision in humanitarian situations serves not just temporary needs. Essential though plastic sheets and tents might be in emergency phases, what is remarkable is the way in which forcibly displaced people very quickly commence the process of adapting, customizing and upgrading their shelter (Zetter, 1995:38). Structures and communities remain in place far longer than anticipated and represent durable physical assets which serve longer term recovery and development objectives, especially for returnee populations (Zetter, 2005). We are dealing, in other words with asset formation. The housing "sector" is thus a catalyst for relief *and* development interventions which can lead to sustainable development, particularly if the affected population is involved (Hazic and Roberts, 1999; Barakat and Chard, 2002; Barakat, 2003; El-Masri and Kellet, 2001). Relief *and* development occur both simultaneously and as a continuum, not as distinct and sequential phases predicated by much current practice.

There are significant gender perspectives here. Protracted exile in "temporary" camps, or return to permanent, but newly built, post-disaster or post-conflict houses and settlement inevitably mediate and transform daily patterns of life and the social fabric. Recalling the gendered attributes of the housing nexus outlined above, it is imperative that women participate as the key partners in the design of potentially permanent shelter and settlement options. Conversely, participation in the process of developing permanent physical symbols is an important vehicle for female empowerment in a forcibly reconstructed social world. Nevertheless these social transformations – some enforced by displacement, some an inevitable corollary to it – need to be handled in ways which alienate neither the displaced populations nor their hosts.

A rights-Based Approach to Shelter and Settlement

Disaster and conflict situations are periods of rapid social transformation not least in gender relations. But as noted above, "how the shelter job gets done" in emergency conditions reveals the dissonance between organizational rhetoric of gender equity and the deeper culture of humanitarian agencies. Still dominated by a highly

masculinized environment which internalizes the subordination of women's needs and values in agency cultures, the "sector" has a long way to go.

In order to pursue a social transformation agenda, humanitarian agencies need to address the underlying assumptions and values which inhibit gender equality. The growth of rights-base approach to humanitarian intervention (Slim, 2000) has specific resonance for the shelter and settlement sector.

A rights-based approach to humanitarian assistance involves the equal protection of the rights of women and men, special attention to the violation of human rights of women, and the equal and active representation of women and men at all levels of decision making (UNHCR, 2005a:111–112; IASC, 2005). Involving women in shelter and settlement policies and projects ensures that they will be able to cope better with enforced displacement: equally, the experience of participating on an equal footing with men can be a very empowering one for women as discussion of practical guidelines in the next part demonstrates. Crucially, accountability mechanisms must put in place and monitored (Clifton and Gell, 2001:14).

These prevailing conditions have been recognized for the shelter and settlement sector in the Sphere Humanitarian Charter and Minimum Standards (2004) which represent a comprehensive baseline of a rights-based approach to humanitarian intervention in this sector.

In disaster and conflict/post-conflict situations, protection and reducing vulnerability must be the key drivers of gender sensitive interventions, alongside the utilitarian requirements of meeting basic needs and ensuring that housing and infrastructure are convenient to use and preserve dignity and privacy. Accordingly, gendered responses in this sector require detailed attention in two interlinked respects: first, governance structures and processes which embrace the roles and resources and the participation and empowerment of women; second, their practical contribution at all stages of intervention – principles for design and layout at different spatial scales, the production and construction of space and place both in displaced and return settings, land rights (especially in repatriation or resettlement). If these principles are appropriately addressed, the coping capacity of communities will be strengthened in both the short and long term (Clifton and Gell, 2001:8). The paper now elaborates these requirements.

Shelter and Settlement Inteventions for Women and Families: Experiences, Policies, Practices and Options

This section draws on a wide range of published and grey literature, agency reports, research and the field experience of the authors. The objective is to outline strategic guidelines for policy makers and practitioners in governmental, intergovernmental, humanitarian and development agencies which will better address the needs and resources of women and families in shelter and settlement interventions. Building on the previous section, this part captures the multiple dimensions of shelter and settlements, and their role in serving not only physical needs but "higher order"

objectives for women and families under conditions of conflict, forced migration and return.

Risk Factors

Well documented in the literature is the evidence that, for most women, the experience of forced migration demands a stressful and continuous process of coping with new and frequently traumatic circumstances (Benjamin and Fancy, 1998; UNICEF, 1998; Indra, 1999; Sweetman, 2001; Khogali and Takhar, 2001; UNHCR, 2003; Martin, 2004; Bagshaw and Paul, 2004; WCRWC, 2006a). The development of sound shelter and settlement guidelines and policies must be rooted in a thorough diagnosis of these risks.

The vulnerability of women caused by their subordinate position in many pre-displacement societies, increases substantially in forced displacement (UNHCR, 2005), as a result of widespread human rights abuses, protection failures during flight, during displacement and during the return and reintegration processes (Matlou, 1999:133–136; UNHCR, 2005:112; Martin, 2004:25–59; WCRWC, 2006a). Forced displacement thus accentuates existing, and creates specific new, conditions for gender-based violence (GBV): women's vulnerability to sexual exploitation, domestic violence, abuse of power, abduction and rape dramatically increases (Benjamin and Fancy, 1998:14; UNHCR, 2003; Pittaway and Bartolomei, 2004; Olson and Scharffscher, 2004; WCRWC, 2006a). Inadequate shelter and settlement provision immeasurably increases this vulnerability and lack of protection. Failure to account for women's security and health needs can make refugee and IDP settlements dangerous for women, even when they are intended to provide refuge and safety as per definition. These conditions are accentuated by "the high level of poverty among refugees, limited monitoring of camp situations by international relief workers, and cultural attitudes on the part of some relief workers and refugee-led camp management" (United States General Accounting Office, 2003:6).

Alongside gender-specific physical risks are the stresses of enforced social transformation. Differentially affecting women and families, again there are specific shelter and settlement issues which need to be addressed. Forcibly displaced populations live in unfamiliar and mostly temporary circumstances. They may find it hard to maintain social structures and coping strategies in new, artificial and densely overcrowded environments which lack privacy. These physical constraints impose stress on families and make more difficult the mediating role which women play. Traditional cultural roles may be challenged and may have to be adjusted: for example, female headed households frequently predominate, perhaps requiring women to take an unfamiliar lead in house construction. New functional and economic constraints add to these pressures. For example, household tasks of water and firewood collection and food preparation, traditionally undertaken by women and/or children, are much more time consuming in refugee and IDP camps where queuing or long travel distances are familiar experiences.

These demands are exacerbated by women and children taking on additional household tasks such as income generation. Less time is available for participation in family activities, education for children, participation in camp committees and other activities. These outcomes all highlight the importance of ensuring that the location, design and layout of shelter and settlements fully address the needs of women and children. The additional burden of social and economic transformation may ironically re-enforce the subordination of women by preventing their empowerment in precisely the arena which could most positively affect their lives – active participation in the site planning, design and management of shelter and settlement policies and practices.

Thus for forcibly displaced women and families, camps and temporary settlements frequently present a physical environment which is not conducive to their personal safety and which enforces a lifestyle alien to their cultural norms. Ensuring physical security and ensuring that space and place are appropriately designed, constructed and managed for their needs, while taking steps to prevent their safety from being jeopardized by negligent management, is a major challenge in policy making and humanitarian practice. The production of the living environment for forcibly displaced populations should ensure that it is peaceful, free of violence and criminal activity, and conducive to the realisation of human dignity (Durieux, 2000).

Nevertheless, whilst shelter and settlement policies, programmes and projects may significantly accentuate or ameliorate these needs, it is important to recognise that reducing vulnerability requires much more than just physical improvements to housing design and settlement planning. A multi-sectoral approach is needed.

The Heart of Protection: The Policy of Providing Safe Places and Spaces

Protection is at the heart of responsibility towards refugees, IDPs and returnees. As Weiss Fagen (2003:77) notes, the specific qualities of protection and security for women and families depend on factors ranging from their family situations, their physical surroundings, their survival mechanisms, and whether legal and normative rules of conduct are enforced.

The UNHCR (1999) reinforces this contention by emphasizing that refugee protection must encompass measures to ensure physical security, social security (delivery of minimum standards of material assistance) and legal security (restoring and safeguarding legal rights in the search for durable solutions). It is important to note that these three dimensions of protection should interact in a "comprehensive approach that integrates protection with assistance and includes steps to defend the physical safety and rights of displaced" (Cohen, 2006:108). As a keynote, the UNHCR Handbook of Emergency (UNHCR, 2000) stresses the importance of preserving the original family and community structures.

Despite the limitations of the shelter and settlement sector already noted, policies and practices relating to the specific protection needs of women and families (OCHA, 2000; IASC, 2005; Kälin, 2005) are elaborated in many manuals (UNHCR,

1999; Sphere Project, 2004; Camp Management Project, 2004; Corsellis and Vitale, 2005). In the past decade there has been commendable progress in the degree to which physical protection needs have been incorporated into assistance projects and technical areas such as the physical layout of shelter and settlements and water and sanitation facilities.

Shelter

In terms of shelter provision and security, and in accordance with Sphere Guidelines (2004), UNHCR endorsed as standard the concept of "adequate dwelling" in camps and settlements. In terms of practice guidance, UNHCR (2005b:53) advocates that shelters should: provide a covered area that affords dignified living space with a degree of privacy; have sufficient thermal comfort with ventilation for air circulation; provide protection from the elements and natural hazards; ensure that inhabitants, especially women or groups with special needs, are not disadvantaged due to poor accommodation design and physical safety. The need for privacy in the dwelling (and beyond), for women, is also widely stressed: lack of privacy was noted as the biggest deprivation experienced by encamped Afghan women refugees (Dupree, 1998). Shelter density is also an important practical consideration both in this context and in relation to proximity to services such as water and food distribution points and latrines (discussed below). Barakat and Wardell (2004) note that Afghan women refugees from rural areas, who had relative freedom of movement pre-displacement, found the overcrowded and confined nature of high density camps dramatically and adversely affected their daily lives and social wellbeing.

The construction of shelter, whether temporary and permanent, poses particular issues for women. Owing to cultural constraints in many societies, women may be excluded from construction projects, which are not typically deemed "the work of women". Under conditions of enforced displacement, traditional roles may be forcibly changed. Thus female headed households may need to build their own shelters, or will certainly have to improve and consolidate temporary shelters provided by agencies.

In these circumstances, ICRC (2004:70) and Shelterproject (Corsellis and Vitale, 2005) stress that this particular phase may demand physical strength often exceeding the capacity of women and technical skills not taught to women. Shelter projects may exclude women for reasons as simple as lacking appropriate clothing to climb ladders (ICRC, 2004:70). Practice guidelines should advocate the provision of support, for example by small artisanal teams with relevant trade skills in order to carry out the construction or specific parts of the construction (e.g. to build the roof). As we shall see later, it is crucial to ensure that women are empowered by, not excluded from shelter projects where labour is rewarded in food-for-work programmes typically given to men.

Of course notions of physical weakness of women, compared to men, are socialised into hierarchies of social status too. Thus the challenge is not merely one of rethinking technology but of transforming social stereotypes as well. These observations emphasise the significance of proactive training policies and practices in

relation to women in respect of key aspects of the construction task: shelter form and design using technologies appropriate to the needs and skills available to women; the procurement and distribution of building materials which recognise the unfamiliar role of women in these processes; construction materials and technologies appropriate for/adapted to female needs and capabilities, and the provision of construction assistance where necessary. Equally important is the need to address generic factors to ensure female participation and empowerment – which are discussed in the last sub-section of this part. Notwithstanding the physical challenges, it is important to recognise that the task of building one's own shelter, either through self-help practices or through commissioning construction, can in itself be an empowering process for women. It offers opportunities for greater personal autonomy and choice in design and development as well as the autonomy that comes from exchange transactions – money, labour, bartering for house construction. Given the physical and symbolic role of housing, this practical guidelines to enhance the participation of women in shelter construction, may have far reaching consequences far beyond the construction activity and the sector itself.

Layout, Site Planning and Services

Progressing from the micro scale of the house to layout and site planning considerations, IASC (2005) has developed guidelines stressing the importance of "safe planning of sites" ensuring security-focused and gender-sensitive shelter arrangements during an emergency (IASC, 2005:54). Given the permanency of many apparently short term decisions about settlement and shelter, these principles are particularly significant.

In this context, practice guidance should promote the neighbourhood planning concept in the design and layout of camps and settlements to promote a sense of community and reinforce community-based protection (IASC, 2005:54), while also preserving the privacy of the family unit. Physical design considerations such as these can improve safety by enabling the residents to be more aware of their neighbours and by reinforcing the community through increased social interaction (Olson and Scharffscher, 2004). More specifically, Chalinder (1998:38) suggests attention be paid to clustering of female-headed households. However, this grouping may reinforce vulnerability by isolating individuals. A more viable approach to ensuring security is to re-group pre-displaced communities in camps and settlements. In this way former social bonds and trust can be "reconstructed" and safety promoted (UNHCR, 2005a).

Infrastructure, Services and Facilities

Chalinder (1998) and others (IASC, 2005:47–48), emphasise the need to provide close and visible access to facilities such as water points and latrines where women are particularly vulnerable to abuse or attack. IASC (2005:47) advices locating "water points in areas that are accessible and safe for all, with special attention to the needs of women and children", although prescribed standards vary from 200

m (Sphere, 2004; UNHCR, 2000) to 500 m (IASC, 2005:47). Apart from walk distance, experience varies in terms of the location of water and sanitation facilities such as tap-stands and latrines. Situated away from main camp roads, they are less likely to be used by passers-by, and more likely to be used (and maintained) by the community in which they are located, thereby reducing the likelihood of attacks on women. Conversely, if they are too secluded, vulnerability might be accentuated. Where water is pumped or distributed at given times, particular consideration must be given to the convenience and safety for women and children who usually have the main responsibility for water collection.

Oxfam experience in Sri Lanka is relevant here. Because water tanks and water points are crowded places where a lot of harassment takes place, Oxfam used the water distribution points for public notices promoting messages to end violence against women in the camps (Oxfam, 2006).

For sanitation stations, IASC (2005:48) and other technical literature (UNHCR, 2000; Harvey et al., 2002) point out that whilst the location and design of latrines should adhere to cultural preferences, particular consideration is needed to ensure that location and design ensure safety, privacy, and dignity for women and girls. Communal latrines should be provided with lighting and closed doors. Matlou (1999:137), cites evidence that refugees in the Ivory Coast risked attack by using unplanned sites outside settlements rather than using facilities which were near to male toilets. Cultural taboos exist against washing sanitary cloths in public and women need to be comfortable while caring for their basic needs in the camp environment which affords dignity and privacy (IASC, 2005). In Rhino camp in Uganda, construction of special shelters for girls and the provision/distribution of sanitary materials was assured in order to implement a comprehensive system of gender based violence (GBV) prevention and response (UNHCR, 2004:63).

A number of reports stress the importance of lighting to improve safety conditions for women in all public areas and facilities not just latrines (Chalinder, 1998; IASC, 2005:54; Olson and Scharffscher, 2004). Thus Matlou reports (1999:137), that in Botswana's main refugee camp, the location of administrative and other facilities for education, recreation and shopping in the centre of a large camp without lighting intensified risks to women who only had time to use these facilities at night.

Whether lit or not, this observation raises more general issue about the location of public facilities for women and children, as much in camps for refugees and IDPs as in settlements for returnees. Endorsing Matlou's comment, the IASC report (2005:54–55) emphasises the need to designate space for community centres for women and children, child friendly and gender-sensitive play spaces, and other facilities such as schools, day centres, recreation centres and especially safe houses for victims of GBV, which provide women with localised facilities which are convenient and safely accessible.

These principles similarly apply to the location and design of food distribution stations: women should be empowered to design and control their use. Food distribution points should be conveniently local, "safe spaces" which avoid the presence of large groups of men, allow "safe access" along well signed routes, are

frequented by other members of the community (IASC, 2005:51), and designed to ensure that the distribution process is visible and transparent. Physical separation of men and women is recommended if distribution is not made exclusively to women.

Health centres are a vital facility for women and children serving as a "neutral" environment to provide information, counselling and health services. Their needs must be prioritised in design and layout guidelines, following the same security/safety criteria already noted. The UNHCR recommend a standard of one health post or clinic per section of the camp (approximately 5,000 persons) (UNHCR, 1999). Corsellis and Vitale (2005) recommend at least one comprehensive health centre, capable of providing primary care, for every 20,000 displaced persons.

The Women's Commission emphasizes the problems of providing educational facilities for displaced populations. The task is vital in itself but also because schools are a symbol stability and hope for conflict affected populations (WCRWC, 2000:24). Adhering to the same location safety criteria already discussed for other services, and building on WCRWC's critique, basic guidelines must ensure: adequate numbers of classrooms for the school age population; satisfactory sizes of classrooms – large classrooms make it impossible for teachers to teach effectively; convenient access to water and latrines (WCRWC, 2000:24–25). The same reports notes the challenge of encouraging donors to invest in semi-permanent or permanent structures because of their susceptibility to military action and looting.

Site Selection and Location

Widening the scale further, decisions on the location of camps pay insufficient attention to gender considerations. In this respect IASC emphasises that appropriate site selection should "allow sufficient shelter space for the population and... not pose additional security and protection risks" (IASC, 2005:54).

It is important to select sites where there is sufficient flat land. Poorly chosen sites with hostile topography may result in exceedingly high densities on the small amounts of flat land, causing difficulties for women already noted above. Furthermore, displacement results in potentially dangerous modifications to normal domestic activities for women, for example in relation to water and firewood collection which are frequently female tasks (CASA Consulting, 2001; UNIFEM, 2005; WCRWC, 2006b). Because collection may involve protracted distances, these activities directly and indirectly expose women to numerous protection concerns in addition to potential gender-based violence (WCRWC, 2006a). In this respect Matlou (1999:137) notes that the high incidence of rape in Somali refugee camps in Kenya in the mid-1990s was attributed to the location of camps in isolated areas dominated by bandits and Somali militia. Risk prevention guidelines are advocated by WCRWC (2006b) stressing, as preventive measures, alternative fuel options, firewood collection techniques (biogas and solar energy) and the development of income-generation activities in order to give women and opportunity to earn a living in ways other than collecting or selling firewood.

In the same way, safe and convenient access for women to employment must also be considered in relation to settlement location and transport infrastructure.

Here, settlement issues underpin wider considerations of livelihood strategies and the empowerment of women. Under conditions of forced displacement and return, gender roles may alter dramatically with women finding access to outside labour markets or income generating activities provided by humanitarian agencies. But problems of safe and convenient access to employment and services must be addressed. This challenge is exemplified in the much lauded gender-focused, post-conflict programmes in Rwanda. Unfortunately, women had long walk distances which mitigated their wider participation in gender development activities (Zuckerman and Greenberg, 2004:73): similarly in West Africa where women are traditionally traders, insecurity because of the location of camps, impeded travel for work (ibid:78).

In terms of transport infrastructure, gender-sensitive policies and practices should take account of the fact that women may prioritise improvements to rural transport networks to improve access to local markets, schools, water and health facilities, whereas men may stress improving transport networks to access more distant large towns and cities for work (Zuckerman and Greenberg, 2004:78).

Despite the emphasis given to protection in layout and location planning, reality is a different matter. As noted by Olsen and Sharffscher (2004)in a detailed study on camp environments, rape and GBV are still prevalent experiences for women. Well over a decade after the publication of the UNHCR Guidelines (UNHCR, 1990, 1995), "refugee camps are still set up and run in negligence of these guidelines" (Olsen and Sharffscher, 2004:378).

Communal Shelters

In extreme emergency conditions, communal shelters such as schools, churches, barracks and halls are sometimes used – a temporary measure which is often a protracted "solution". Emergency guidelines (e.g. IASC, 2005) stress the importance of providing adequate material for partitions between families in order to increase security and privacy; appropriate lighting and security are also basic requirements. But recent reports on tsunami-affected villages in Aceh document threats to women's security in communal temporary shelters with incidents of sexual assault reported, for example, in poorly lit toilets (Oxfam, 2005), because the guidelines have not being followed by local authorities and NGOs. The report indicates that almost 90% of women interviewed were dissatisfied with their accommodation because of inadequate facilities, poor access to public services, insufficient sanitation, and lack of designated washing areas for sanitary cloths used during menstruation. Moreover, each family was provided a single room without internal partitions, decreasing privacy.

Land and Property Rights

Shelter and settlement projects for forcibly displaced populations frequently introduce complex issues of access to land for residential as well as agricultural use. In addition disputed property rights are an endemic feature in permanent resettlement

sites and especially for returnees. Ownership disputes and the effective restitution of property rights are major constraints in post-conflict return programs (Zetter, 2005; Fitzpatrick, 2001; Leckie 2005). The emergence of the rights-based agenda for those displaced in conflicts and natural disasters to repossess and return to their homes is, as noted by Hurwits et al. (2005:8), one of the most important developments in recent peace-building efforts. Even so, restitution processes have often been incomplete, generating additional frustration and grievance for the victims of involuntary displacement and often silent on gender needs. But, there are significant gender implications, as Zuckerman and Greenberg highlight (2004), because land rights inequitably affect women.

The flurry of law-making around property rights for returnees must include gender equal laws for property, other assets and inheritance. Policies and guidelines must pay special attention to these questions for female heads of household. Particular issues of equity arise in relation to inheritance, property rights and access to family land and homes where the displaced or returning women are widows, divorced or separated (WCRWC, 2006).

But once new gender equal laws are promulgated, as they have been in post-conflict countries like Namibia, Rwanda and Uganda, customary law usually continues to prevail, often impeding women's enjoyment of their newly established statutory rights. Thus other reforms are necessary that develop women's legal literacy and access to justice through the courts and legal professionals. The main impediments women confront are the lack of information about their legal rights, and the lack the capacity and resources to pursue their rights (such as literacy, money, and power within their families).

Self-Settled and Urban Settled Populations

The paper has concentrated on camps and communal shelters since these are the main focus of international humanitarian intervention. However the majority of forcibly displaced populations – certainly mass exodus refugees and IDPs – prefer to self-settle either in rural locations or increasingly in urban locations, despite host government resistance to both these processes. Ignored (Human Rights Watch, 2002) and outside the assistance "loop", the lessons which might be learned from these self help responses and the practice guidance which might be needed, are poorly documented or ignored: gender perspectives are notable by their absence. Data almost certainly underestimate, by large margins, the numbers of self settled refugees and IDPs. For example, most authorities indicate that the number of urban refugees far exceeds the UNHCR figure of c.18% of persons of concern (Jacobsen, 2006:275), although the demographic profile is more likely to be representative of the population as a whole (UNHCR, 1997).

In general, it has been assumed that, because they have exercised choice, self-settled populations must *a priori* enjoy better conditions than encamped populations – for example in terms of social networks, autonomous life styles rather than control and dependency, better livelihood opportunities, shelter conditions and access to food. In principle, these conditions might be more conducive to sustaining or

replicating pre-displacement norms and structures and so, from many perspectives, including gender, less likely to impose traumatic or stressful change.

In practice we need to look more specifically at the two alternatives, but there is an important caveat. With respect to self settled refugees, there is a major lacuna in documentary evidence, research and practice guidance on settlement conditions and processes in general and gender perspectives in particular, and so only tentative conclusions are provided. Certainly with regard to rural self-settlement there is a lack of contemporary research, whilst urban self-settlement has recently begun to rise up the agenda of researchers and agencies.

Rural self-settlement of refugees and IDPs displaced by civil war, notably in Africa, has been widely noted although there is a dearth of contemporary research. Typically, family or extended kinship links facilitate a process whereby displaced households are settled on land in, or close to, the settlements of host populations. In so far as social order breaks down under conditions of forced displacement, self settlement may largely help to replicate and reconstruct pre-existing social norms and practices. This may or may not provide a gender empowering environment. Indeed, the opportunities to promote transformative social conditions are self-evidently much more limited, with these hard to reach groups, than in organised settlements. However, we have no rigorous evidence to substantiate these processes of social agency. In any case, conditions will vary enormously even within a small locality.

The process of urban settlement by forcibly displaced populations has recently been the subject of growing research interest (Jacobsen, 2006; Jacobsen and Landau, 2005), although the phenomenon is certainly not new (UNHCR, 1997; Sommers, 1999). UNHCR policy statements (UNHCR, 1997, 2003) draw attention to the phenomenon but largely focus on protection issues. The scope for extending policy guidelines to other needs, including housing has been outlined (Jacobsen and Landau, 2005), but remains undeveloped. The evidence from many locations, for example IDPs in Bogota and Medellin in Colombia (Project Counselling Service, 2002; IDMC, 2007), and refugees in Cairo (Grabska, 2006; Kampala Macchiavello, 2004; Dryden-Petersen, 2006) Nairobi (Campbell, 2006), confirms that urban-settled displaced populations endure a high degree of marginality, severe impoverishment, degraded housing conditions and limited access to social and community infrastructure such as schools and medical assistance. These experiences are compounded by insecure or unrecognised legal status. Reflecting the process of rural to urban economic migration, the displaced typically settle on the urban periphery or marginal land in informal squatter settlements or, much more rarely, in extremely basic camp-like settlements are constructed by relief agencies. Again, at the margins of survival, the scope for gender aware and gender-orientated policies and practices are severely limited, since host governments and humanitarian agencies have, for different reasons, chosen to ignore these populations.

Despite these adverse conditions, some evidence suggests that urban refugees do, in time develop well organised coping structures and livelihood strategies, for example Somali refugees in Nairobi (Campbell, 2006; Lindley, 2007). In Cairo, family and community support structures are crucial and women are the major household

income earners in the emerging network of micro enterprises (Grabska, 2006). This evidence of gender-empowerment should not detract from the fact that much of the emerging research focuses on urban livelihoods and social needs, rather than shelter and settlement conditions and options. In so far as gendering space is concerned, the paradoxical outcome may be that forcibly displaced populations that self-settle will exercise greater autonomy, but, on the margins of survival, are probably less likely to experience gender-sensitive shelter and settlement opportunities.

The Challenge of Return and Reconstruction

Enloe emphasizes that the end of a war is crowded with gendered decisions (1993:561), but concerns about post-conflict reconstruction override the promotion of women's equal status and opportunities within a society. The policies and programmes of international funding agencies typically concentrate upon the 4Rs—repatriation, rehabilitation, reconstruction and resettlement (UNHCR, 2003), and the reconstruction of physical, political, educational, and economic infrastructures, not people's lives, nor gendered needs.

While rebuilding infrastructure is crucial, these initiatives must occur in tandem with developing community capacity, and enhancing collective human security (Commission on Human Security, 2003; McKay, 2004; UN, 2002). This is because in the post-conflict period, and indeed in post-disaster situations, communities play key roles in social and cultural reconstruction: thus community support is a crucial vehicle for ensuring and promoting women's human rights and security. Unfortunately, communities are typically low on the priority lists of governments and donors when they are planning reconstruction: too often they are left having to rely on their own meagre resources to cope with changes wrought by war (McKay and Mazurana, 2004).

For returnee and post-disaster affected populations, despite the heavy incidence of agency and contractor supplied shelter and reconstruction, field experience advocates the adoption of self-help approaches alongside technical assistance (Sørensen, 1998, Spees, 2004). It is ironic that such an approach needs to be emphasized, since it merely follows the pre-displacement housebuilding traditions found in many societies where people are used to building their own homes with the help of family and friends, and accustomed to hiring skilled labour to complete technically difficult aspects of the construction. But in such conditions of dramatic social change, self-help technology requires gender-aware policies and process to ensure that women have equality of access to decision making processes and the practical tasks. Thus, much of the portfolio of practical interventions discussed in earlier sections (related to conditions of displacement) applies here and reference back should be made. Nonetheless, a major gap in our knowledge is in knowing what women "take back" home in terms of new roles, skills, capacities and assets in this, and indeed other sectors.

More research is needed in this respect, although there are some examples of good practice. During the re-construction stage following the earthquake affected Indian state of Maharashtra, homeowners took on the responsibility of repairing, retrofitting and strengthening their houses, with materials, financial and technical

assistance provided by the government. In most villages, these committees consisted of women's self-help groups for whom training and facilitation was externally provided (Barakat, 2003:34). The adoption of self help approaches to housing reconstruction has also been widely adopted in the Balkans. Even vulnerable members of the community, including households headed by women, have managed to participate in self-build projects by securing help from relatives and friends, thereby increasing women's participation and social benefits (Barakat, 2003:35; Boano, 2004:15; Čucur et al., 2005). In post-hurricane Mitch Nicaragua, some organisations attempted to include more "strategic" as well as practical gender needs via consciousness-raising activities. Entry to the projects may have been at a "practical" level, but this served as a gateway to strengthen training, participation and credit schemes in addition to gender awareness activities (Bagshaw, 2001:83).

Experience in Kosovo shows that despite lack of participation in planning, some women from both Albanian and Serbian women's groups were proactively involved in project activities supported through the Kosovo Women Initiative but with marginal results (Kalungu-Banda, 2004; Baker and Haug, 2002). Minervini, in a review of housing reconstruction in Kosovo, found that a gender balance imposed on Village Reconstruction Committees produced fruitful results despite the stable male-dominated Kosovar society (2002:581).

Participation, Empowerment and Governance

As the preceding subsections have stressed, the role of shelter and settlement as a developmental resource, and its scope in embracing multiple issues and options, clearly offers substantial potential to empower displaced women. This is a consistent theme running through the chapter. As we have seen, women prioritise different needs for shelter settlement and infrastructure due to different gender roles in the division of labour and conceptions of well-being. However, empowerment depends on effective participation and the representation of gendered needs: but for this to be embedded in praxis for the sector, the male dominated characteristics must be reversed.

The positive rhetoric is poorly borne out in practice which, most usually, offers consultation rather than participation. There is a systemic failure to confront the double exclusion of displaced women: pre-displacement subordination can be further compounded by the experience of forced displacement. This is because many of their traditional and new tasks are inordinately time consuming – for example firewood and water collection – and thus they are further excluded from participation in vital activities such as attending school, skills training and income generation programs (WCRWC, 2006) and participating in leadership and decision-making bodies.

Some successful practice-based interventions in the technical tasks of construction have been discussed above. The principal reports and evaluations already cited also provide guidelines for enhancing women's participation in wider processes of planning and decision making in this sector. Thus, the UNHCR (2005:112) emphasises the need for targeted action *and* on-going support if effective participation by women is to be mobilised in the development of collective design and spatial

strategies. In practical terms UNHCR suggests the target of 50% female participation in management and leadership committees. Key here is participation in committees and other management structures with responsibility in two fields of policy and practice: first, situation analysis in the early stages of identifying needs since even emergency infrastructure and shelter and settlement decisions have long term and developmental implications; second, housing design and settlement layout including provision of/access to infrastructure such as water points, sanitation, food distribution points and other core services (IASC, 2005:54; UNHCR, 2005a:111–112), and public works contracts. Their involvement in these decisions is vital so as not to expose them to additional risks and to maximise locational convenience. Zuckerman and Greenberg (2004:78) make the same point with regard to post-conflict reconstruction.

Recently, cash transfers and food-for-work infrastructure projects have gained attention in emergency responses (Creti and Jaspars, 2006; Adams and Winahyu, 2006). Examples here are in Gujarat, Sri Lanka and Pakistan (Causton and Saunders, 2006; IRIN, 2005; Save the Children USA, 2005; Sewalanka Foundation, 2005) and post-tsunami programs which mobilised those displaced by disaster and encouraged them to return to their villages and, significantly, paid women and men equal wages (Gore and Patel, 2006:19; Adams and Winahyu, 2006).

A key advantage is that, unlike in-kind aid, cash allows households the flexibility to decide their spending needs, with some evidence that this may have beneficial results for children through impacts on nutrition, health and education. It is often a more empowering and dignified form of support: it can help generate local market activity and restart livelihoods whilst simultaneously giving women more decision-making power over resources (Gore and Patel, 2006). However the main challenge is the overt and embedded discrimination against women's participation. Often, (re-)construction programmes constitute so called "men's work" (Zuckerman and Greenberg, 2004:78) and women may in any case be excluded because of other demands on their time.

Oxfam experience is relevant here. Post tsunami reconstruction illustrates the importance of targeting women in an equal manner engaging them as a crucial catalyst in mobilizing the whole community in small scale rehabilitation and in cleaning works (Adams and Winahyu, 2006:54–60). A cash-for-work program developed by Oxfam in response to devastation caused by the cyclone in Orissa, India, produced similar positive outcomes (Khogali and Takhar, 2001:44–45). These and other field experience stress the importance of challenging the gender division of labor, and prejudices about women's capabilities, at both community and household levels.

Conclusions

Despite the profound changes in the characteristics of forced displacement in the last decade or so – the rapid growth in IDPs, the growing complexity of conflict and repatriation, the use of "domicide" and "urbicide" as weapons of war, the militarisation of humanitarian intervention, the incidence of massive natural disasters,

increasing use of resettlement options to serve political ends, greater reliance on host governments than before, the emergence of new types of humanitarian actors – the needs of forcibly displaced populations remain as they always have been. These are for shelter and settlement which provides protection, privacy, the space for personal and emotional security, and the capacity to provide for "human dignity and to sustain family and community life as far as possible in difficult circumstances" (Sphere, 2004:208).

These dynamic circumstances and the basic needs of forcibly displaced people have not, however, substantially advanced the cause of gender equality. This remains largely subverted to the programmatic, masculinized project driven ends of donors and implementing partners. Yet as this paper has demonstrated, the design, production and governance of spaces and places provides immense opportunities for empowerment of women and the transformation of gender roles. Indeed it is because the shelter and sector integrates and intersects with so many other sectors that these opportunities exist. It remains for all the actors in the humanitarian field, and above all women themselves, to realize these opportunities.

Notes

[1] e.g. IASC 2005, WCRWC 2006a

[2] Almost 80,000 houses were destroyed or damaged by Hurricane Mitch in 1998, leaving some 300,000 Central Americans homeless. The Gujarat earthquake in India in January 2001 left almost a million families without homes. The tsunami of 26 December 2004 hit coastal communities facing the Indian Ocean left some 231,000 people dead or missing, and more than one million displaced, across 12 affected countries. In Sumatra almost one thousand villages and towns, 127,000 homes and 1,488 schools were destroyed. Estimates of the numbers made homeless range between 500,000 and over 600,000. Over 100,000 homes were destroyed or badly damaged, leaving over half a million people homeless (Oxfam, 2005; OCHA, 2005; Rice, 2005). Approximately 3.5 million people were affected by the earthquake in northern areas of Pakistan and India in October 2005, and available statistics indicate that over 297,000 displaced persons are currently living in camps or in temporary accommodation due to housing loss (Returns Task Force, 2006:2).

[3] According to World Bank data losses due to natural disasters are twenty times greater in developing than in developed countries (Barakat, 2003:4).

[4] In the case of conflict displacement, it is estimated that during war in Bosnia Herzegovina, 24% of all housing stock in *Republika Srpska* and 68% of all housing stock in the Croat and Muslim Federation were damaged (Talmon L'Armee, 2001:22). During the Kosovo conflict, a third of the province's housing stock was destroyed, while war in Sierra Leone saw the destruction of an estimated 300,000 houses, leaving over a million people displaced (Barakat, 2003:5). Moreover, more then 10,000 Palestinians housing units have been destroyed in the Occupied Territories since 1967 (Halper, 2003; Graham, 2004). In the case of Colombia, whilst no data has been located on housing loss, the existence of over 2 million IDPs suggests a significant depletion of shelter assets.

[5] Two weeks after the disaster more than 597 welfare centres, in temples, schools and in "emergency shelters" or "transitional shelters" were spread all over the affected areas in Sri Lanka.

[6] According to Ferretti (2006) exact data are difficult to quantify given the ill-defined nature of the sector. Citing the CAPs (Consolidate Appeal Processes) source, from 2002, the sector accounted for 3% of expenditure (Babister et al., 2002). Moreover, studies such as Development Initiatives for OCHA pointed out that shelter is one of the sectors that has experienced a sharp decline in funding (see e.g. Vogel, 2001).

[7] Whether in natural disaster or conflict situations, the urgency and scale of crisis response provoke a militarised and masculinised internal environment for agencies. Hierarchical, typically male-dominated, top-down structures tend to be adopted, where action-orientation, quick decision-making, efficiency, risk taking, and heroism are valued as important attributes of professionalism, and a significant level of internalised subordination is often accepted without question. “Soft” behaviours such as consultation, cautious shared analysis, gender-sensitivity, or empathy with those affected by the crisis, more often displayed by women, are often disregarded as unimportant and irrelevant. This reflects the predominance of a masculinised value system. It is exacerbated by the fact that the “hardware” sectors of water, shelter, food aid, and logistics which represent the backbone of humanitarian response, and command the greatest resources, are mainly staffed by men, whereas the “software” sectors of health, community mobilisation, education, and human resources tend to be staffed by women (Clifton and Gell, 2001:17).

[8] This clustering was the outcome of the independent Humanitarian Response Review (HRR) of the global humanitarian system (UN, 2005). Shelter in emergency has achieved the “status” of a sector, at least at UN level, but still maintains the epistemological division between natural disaster and conflict.

[9] The Humanitarian Response Review recommendations gave further impetus to the humanitarian reform process championed by the Secretary-General. UN General Assembly, World Summit Outcome, A/60/L.1, 20 September 2005.

[10] Other sectors belong to UNICEF (water and sanitation, nutrition) WHO (health), WFP (logistics) and UNDP (early recovery). For a detailed review of the Humanitarian reform see ODI (2005).

[11] The principles of impartiality, proportionality, and a right to life with dignity are concerned with achieving equal rights for all social groups regardless of gender, ethnicity, religion, disability, age, or any other form of social identity. Equal rights for women and men are fundamental to this approach. This is reflected in the fact that among the wide range of human rights instruments that underpin the Humanitarian Charter is the Convention on the Elimination of All Forms of Discrimination against Women (UN, 1995, CEDAW).

[12] Although widely acknowledged as a useful practical guide and effective as an awareness-raising tool, the impact of the Sphere standards is still being assessed.

[13] Outside the remit of this chapter, but important to note is that violence within refugee communities is frequently neglected due to poor information, notions of non-interference in the domestic realm, narrow definitions of mandate and duty of agencies, poor shelter and settlement provision and sometimes indifference (Weiss Fagen, 2003:77).

[14] UNHCR Handbook for Emergencies (2000:144) states that “shelter must, at a minimum, provide protection from the elements, space to live and store belongings, privacy and emotional security”, while Sphere (2004:208) argues that “Beyond survival, shelter is necessary to provide security and personal safety, protection from the climate and enhanced resistance to ill health and disease. It is also important for human dignity and to sustain family and community life as far as possible in difficult circumstances”.

[15] Corsellis and Vitale advocate staggered layouts which avoid long straight roads (which reduce privacy and flexibility), and increase the funnelling of wind which in turn increases dust and the spread of fires (2005:390).

[16] Dukwe camp accommodated refugees from across the southern African region in the 1980s and 1990s.

[17] For example, WCRWC (20 mm) records that 40% of primary schools were destroyed in one district alone in the civil war in Sierra Leone, whilst 1000 schools were destroyed in the war on Angola.

[18] In August 2005, United Nations Sub-Commission on the Promotion and Protection of Human Rights endorsed the Principles on Housing and Property Restitution for Refugees and Displaced Persons (UN, 2005n). The Principles recognize the right of all refugees and displaced persons to have restored to them any housing, land and/or property of which they were arbitrarily or unlawfully deprived, or to be compensated for any housing, land and/or property that is factually impossible to restore.

[19] The issue of inheritance is a fundamental issue with regard to how wealth is transferred within a society, and directly relates to the protection of a woman's housing: for wider discussion see COHRE 2005.
[20] Gender relationships in post-war contexts tend to reinforce traditional patterns, rather than new roles that girls and women may have adopted during armed conflict. At community level, at the level of the institutions which distribute resources, and at the level of national policy formulation, women and girls are usually rendered invisible or are, at best, marginalized by being perceived only as leaders and facilitators of cultural and social reconstruction (McKay, 2004:20).
[21] This approach recognises that women tend to use resources differently from men, as they tend to spend more on their children. Empirical studies have shown that the percentage of income that a household spends on children and its allocations of food and medical care vary, based on the proportions of income earned by women and men (Visvanathan et al., 1997). Studies have shown that where women retain control over income, there is a greater positive effect on food expenditures and child well-being, compared to men retaining control (Hoddinott and Haddad, 1995). These findings suggest that it is critical to target women with cash interventions, if the objective of the project is to improve child nutritional status or food security. If it is impossible to target women in cash interventions, it may be better to distribute food rather than cash, since women are the main contributors to food preparation. In contexts where women cannot participate in cash for work programmes for some reason, men can be paid in food rather than cash to increase the likelihood that the benefits of the programme will reach women and children.
[22] In the case of Lamno in Aceh, (Adams and Winahyu, 2006:54) the Oxfam program targeted people living in temporary or semi-permanent structures and local traders operating from small kiosks. People were engaged in productive activities, and were able to stay in their home communities and clean them up. Freedom to spend, save and invest, participants had cash and freedom as to how it was used. Cash was available for purchase of fresh fish, fruit and vegetables, and other food items; cash was also saved (as gold) or invested in small business. Programme managers prioritised the involvement of women in the work, although the lack of attention to addressing constraints to women's participation (child care, for instance) resulted in some women who may have wanted to work being excluded (Adams and Winahyu, 2006:57). A similar experience in Chalang in Aceh, focused more on rehabilitation of agricultural land, shows that in terms of payment there was no difference in wages between men and women. In this experience was the first time that women received equal pay. Before the tsunami, it was not easy for women to get employment outside "traditional" work on the farm, e.g. planting, weeding and harvesting. The workers were happy with the higher wages; they also pointed out that the prices had increased since before the tsunami so the higher wages were justified. Moreover, as the work was done in a group it was not so heavy. Efforts were made to enable elderly women to participate as carers for children (Adams and Winahyu, 2006:60).

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Addressing the Needs of Displaced Women in Conflict and Post-conflict Situations

Sahir Abdul-Hadi

Introduction

In 2007, the Women, Peace, and Security Committee of the United Nations Population Fund (UNFPA) and the Center for International Studies of the Massachusetts Institute of Technology (MIT) collaborated to produce a series of research papers on the needs of women displaced by conflict. These papers provided policy action recommendations for UNFPA and its partners based on current empirical research, comparative analysis, and policy reviews. The recommendations, and the analysis that inspired them, aim to help UNFPA increase the effectiveness of its programming on urgent issues in the nexus of women, conflict, and forced migration. In particular, they offer insights into how UNFPA can address the ways shelter, livelihoods, legal status, and mental health relate to the issues that comprise UNFPA's core mandate, namely, reproductive health, sexual and gender-based violence (SGBV), and HIV/AIDS.

In May and June 2007, the papers (virtually all in this volume) were shared with a "knowledge network" made up of UNFPA staff working around the world, with discussion conducted over e-mail to allow broad participation. Participants offered insights and analysis founded in UNFPA's wide practical experience; they also looked ahead to how UNFPA might address these interrelated issues in its work on the ground. Specifically, the knowledge network answered the following questions with regard to each paper:

1. What is your most significant achievement [on the topic in question]?
2. What was the chief obstacle you faced?
3. Based on your experience, what future action should UNFPA undertake [to address effectively the topic in question]?

Perhaps the clearest message to emerge from the discussion was that in situations of armed conflict, UNFPA's traditional areas of concern cannot be addressed in

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S.F. Martin, J. Tirman (eds.), *Women, Migration, and Conflict*,
DOI 10.1007/978-90-481-2825-9_11, © Springer Science+Business Media B.V. 2009

isolation from the issues of shelter, livelihoods, and mental health. For UNFPA to implement its mandate effectively, programming must take into account the way all of these issues together can act to compound or alleviate the risks to refugee and internally displaced women.

As it attempts to do this, UNFPA faces certain challenges that recur wherever conflicts erupt: lack of security, impediments to access, paucity of data, and the need to ensure long-term sustainability of programs. The discussion made clear, however, that a number of opportunities and innovations are available to help UNFPA overcome these challenges. These include new ways to address mental health, the creation of women's centers and/or committees, the involvement of men in programming, and multi-sector collaboration. Participants noted furthermore that the legal environment in which UNFPA must operate and the resources that already exist for practitioners present both challenges and opportunities in their own right.

This chapter summarizes these responses from the field, providing dimension to the scholars' chapters and demonstrating anew the interplay between empirical knowledge and field-based practice – particularly, how each can reinforce the other to produce both new knowledge and improved practice, and, one hopes, better policy.

Challenges

Lack of Security

Insecurity is one of the most difficult obstacles for UNFPA to overcome in its work with female refugees and internally displaced persons (IDPs) at all stages of armed conflict. On the one hand, physical and political insecurity can impede programming by UNFPA and its partners. Lack of security can prevent national and international organizations from being able to reach the populations they are trying to serve, or even maintain day-to-day operations. The tendency of the security situation to degenerate rapidly and with little warning hampers the ability of UNFPA and its partners to respond effectively and fulfill their mandate to protect. Lack of security can distract donor attention from so-called soft issues like reproductive health and SGBV, making it difficult for programs to obtain the human and financial resources they need to succeed in the long term.

Insecurity can also affect women and girls directly: It can prevent women from being able to reach and benefit from UNFPA programs where they are available. The planning of IDP and refugee camps can itself be a cause of insecurity for women and girls – because the camps tend to be planned and built quickly, by men, and needs of females are neglected – although integrating these needs into standard planning practice could alleviate this problem. And displaced women whose livelihoods have been disrupted by conflict can face increased risk of trafficking and sexual exploitation and abuse. It is clear that for UNFPA to fulfill its mandate vis-à-vis Security Council resolution 1325 on women, peace, and security,[1] it must find ways to reach its target populations even in insecure and deteriorating environments.

Impediments to Access

Access, like insecurity, is a multidimensional challenge. IDPs and refugees are all too often displaced to remote areas that are difficult to reach. This has a negative impact on displaced women's ability to obtain consistent, high-quality reproductive health services, emergency obstetric care, and mental health services. It also prevents displaced women from being able to reach, on a regular basis, markets large enough to provide sustainable livelihoods. Remoteness hampers UNFPA's ability to spread essential health-care information. It decreases the likelihood that perpetrators of violence against women will be brought to justice, a particular problem in rural areas where the reach and influence of the security sector are inadequate. Moreover, where IDPs or refugees assimilate into urban environments with easier access to some services and markets, they may nonetheless face problems of access because they cannot benefit from the resources that are made available in a camp environment and are specifically designed for displaced communities.

Data Collection

Insecurity and impediments to access, alongside other obstacles, make data collection a challenge in itself. Although necessary to provide a solid foundation for good programs, to serve as a baseline against which to measure the success of those programs, and to provide information for policy makers and researchers, data that is disaggregated by sex and that focuses specifically on refugee and IDP women is often incomplete or absent. Although data collection is an institutional priority for UNFPA, the organization lacks the capacity to support reliable data collection and analysis in conflict settings.

It is hampered on the one hand by the insecurity faced by both researchers and sources, and on the other by the challenges inherent in collecting information on displaced populations – challenges that include difficulty of access (particularly where the displaced have assimilated into urban environments) and the possibility of repeated displacement. Underreporting of SGBV, particularly in conflict situations, impedes knowledge of the extent to which such violence occurs; along with a lack of forensic evidence that can be used in court, such underreporting can help to create a culture of impunity for perpetrators, as well as hinder appropriate protection and response from UNFPA and its partners.

Long-Term Sustainability

The long-term sustainability of programs that support women displaced by conflict is at once necessary and difficult to ensure, and is itself undermined by insecurity, paucity of data, and the many impediments to access that arise during and after conflict, including weakened or absent infrastructure. A major challenge UNFPA

will need to address, alongside its partners, is the apparent contradiction inherent in conflict-related work: whereas programs that respond to conflict are generally seen as temporary measures to respond to a temporary emergency, displacement is too often a long-term condition requiring a long-term response – a "development" rather than an "emergency" response. Psychosocial support services, for example, should be available in the long term to be truly effective, yet many are provided by NGOs rather than governments and thus are difficult to maintain for an adequate length of time. Camps for the displaced, and the shelter they offer, are designed to be temporary, but displacement is increasingly a state that persists for decades. And while "make work" projects can provide some psychosocial benefit, they do little to create sustainable livelihoods, which, as Dale Buscher writes, are those that can "cope with and recover from stress and shocks, maintain or enhance [their] capabilities and assets, and provide sustainable livelihood opportunities for the next generation" (Buscher, Women, Work, and War) In light of these contradictions, the traditional model of conflict-related emergency programming must be revised.

Opportunities and Innovations

Alongside the challenges are new strategies that participants in the knowledge network highlighted that UNFPA might use to ensure its effectiveness in addressing the needs of women displaced by conflict as they relate to reproductive health, SGBV, and HIV/AIDS.

Women's Centers and/or Committees

The establishment of women's centers and/or committees in refugee or IDP camps and conflict-affected areas can fulfill a variety of needs and provide a number of services to women displaced by conflict. Women's centers can consolidate reproductive health and referral services, skills training, childcare, and/or psychosocial health services; act as a locus for information and awareness-raising campaigns; and provide a safe space for women to gather in order to avail themselves of these various services and support each other.

Examples of such programs already exist. In Sri Lanka, UNFPA brought women together for "women's story circles" in which women shared their experiences of SGBV. These forums served a dual function: first, as a safe and supportive environment in which women could deal with traumatic incidents; and second, as a means to collect data that could later be used for advocacy and action. In Darfur, UNFPA supported a local NGO to establish a women's center that would be run on profits from the sale of firewood purchased in safe locations. In addition to providing skills training to support sustainable livelihoods, the centre also served a protective role by reducing the need for women to collect firewood in unsafe areas.[2] In Timor-Leste, UNFPA supported the establishment of women's committees in IDP camps. These committees created a safe space for women to discuss the

issues important to them and provided a strong platform from which women could raise these issues with camp managers. In all of these cases, in addition to the services and networks they provided, these centers and committees gave women the opportunity and skills to empower themselves and helped them take an active role in bettering their lives, even in the face of the instability and insecurity that arise from war.

New Ways to Address Mental Health

By providing women a positive outlet and facilitating their active participation in the decisions that affect them most, the centers and committees mentioned above may have contributed positively to the mental health of the women they were created to serve. The new approach to mental health discussed by the knowledge network separates pathology from well-being, and emphasizes the latter. Mental well-being has a significant cultural component and may be understood differently by women and men. UNFPA can help to promote such well-being among the women it serves by supporting strategies that bring out their inherent human resilience. This can be done through a variety of complementary strategies, such as those outlined above, to address the problems faced by women and girls and relieve some of the anxieties causing mental distress. Ensuring sustainable livelihoods, for example, can remove the stress of financial instability (and idleness) and thereby increase mental well-being. Involving communities alongside individuals in recovery processes recognizes that personal empowerment and collective empowerment are interrelated. Transitional justice processes, post-conflict reintegration, addressing HIV/AIDS, and coping with SGBV are all areas in which communities can support (or impede) individual recovery and mental well-being. Where tradition and religion do not promote harmful practices or human rights abuses, they can be powerful tools in helping women find the strength within themselves.

Increasing Men's Involvement

The strategies that might be used to support women's well-being can of course have a similar impact on men, and thus have an indirect but important effect on women's lives. This may explain, at least partly, why the idea of involving men in programs aimed at supporting conflict-displaced women arose in the context of nearly every issue the knowledge network discussed. Participants noted first that where men are part of the problem, they can and must be part of the solution. Where, for example, men are perpetrators of SGBV, or carriers of HIV/AIDS, or ignorant of what HIV is and how it can be stopped from spreading, solutions to these issues as they affect women cannot be found without working with men. However, participants also stressed that just as it is crucial not to see women as merely passive victims of violence, the opposite is also true: men must not be seen as merely perpetrators of violence. Engaging men in addressing SGBV and educating men on their

role in halting the spread of HIV/AIDS acknowledges and encourages their positive contribution. Moreover, men, like women, are traumatized by conflict and forced migration and everything these entail. It has often been observed that men have difficulty coping with the bereavement, enforced idleness, economic insecurity, and possible gender-role reversals that result from conflict and displacement, and that many blame these factors for their violent behavior towards their wives and daughters. It is possible that offering men and boys (civilians as well as ex-combatants) the kinds of training and support described above for women could help break the cycle of violence that often follows conflict, and in the short term could relieve family and community tensions created by the perception of unequal treatment. Finally, men can also use their power in the community as religious, civil, and military leaders, as teachers, as fathers – in short, as gatekeepers of society – to contribute positively to gender equality, protection, and prevention. Men are thus important potential partners in UNFPA's programs to women's full enjoyment of their human rights.

Multi-Sector Collaboration

The knowledge network placed considerable importance on multi-sector collaboration as a key strategy in addressing the nexus of livelihoods, shelter, mental health, SGBV, reproductive health, and HIV/AIDS in situations of armed conflict. UNFPA must develop and foster strong partnerships at multiple levels simultaneously: with governments, particularly on issues pertaining to the IDPs they are responsible for protecting; with other UN agencies, either through the mechanisms established to facilitate collaboration or, failing that, through determined and consistent ad hoc efforts; with local civil society (broadly conceived) and international NGOs; and, like this knowledge network begins to do, with UNFPA staff worldwide, to share experience, strengthen intervention, increase effectiveness, and widen participation. Not only are there best practices and lessons learned to be shared among all these actors, but the knowledge and expertise each would bring to such partnerships are essential to designing successful programmes and policies.

Areas Where Opportunities and Challenges Coincide

It is to be expected that with issues as complex and interrelated as those UNFPA and its partners must confront when addressing the nexus of women, conflict, and forced migration, some of the challenges the organization must face can present opportunities at the same time.

The Legal Environment

The legislative environment that provides the backdrop to UNFPA's work in conflict-affected countries is one of these areas where opportunities and challenges

collide. On the one hand, solutions to the problems UNFPA is trying to address are hampered by numerous factors: gender-blind legislation; national laws and policies that ignore IDPs; uncertain timelines for the promulgation of important laws (e.g., on domestic violence); unfair land tenure and inheritance laws, restricting women's ability to establish sustainable housing; implementing parties' (e.g., judges, or police) ignorance of legislation actually in place; slow or dysfunctional formal justice systems that undermine trust; and underreporting of sexual violence crimes. On the other hand, UNFPA has a long-standing and unique position from which to support governments to promulgate laws sensitive to the needs and rights of women in general, and displaced women in particular. The organization is also in a position to bring displaced women into the legislative process so they can shape the laws that most affect them. And it has an important role to play in ensuring that relevant actors have the knowledge and capacity to implement existing legislation.

Practical Tools

Similarly, knowledge network participants noted that while many checklists, guidelines, and other practical tools already exist, few practitioners either know about or use them. Part of the challenge UNFPA faces is thus to ensure that its staff and partners are aware of the resources available to them as they grapple with these issues, and to support them to use these resources in ways appropriate to the local context. At the same time, there are significant deficits in knowledge and experience – whether among governments, NGOs, or the UN – on how to address these issues effectively and in a way that reflects their interconnectedness. UNFPA has much to contribute to the development of "how to" tools that will offer practical help to policy makers and other actors, such as work plans, step-by-step guidelines for action (where these do not already exist), and concrete examples upon which to build future policies and programs. These were felt to be a very important next step, despite being missing from some of the papers discussed in the knowledge network; it is a step that must, however, be driven by the practitioners on the ground in order to take their experience fully into account.

Conclusion

The challenges raised by the knowledge network and by the issues addressed here are clearly daunting. But the profusion of recommendations and ideas that came from this discussion and the energy and passion of the participants are positive signs that these challenges can be overcome. As one participant noted, windows of opportunity do open as a result of conflict and crisis. The massing of displaced men, women, and children in IDP and refugee camps, for example, and their close interactions with NGOs and humanitarian agencies, create an environment in which education campaigns could potentially flourish.[3] Out of conflict, opportunities arise for women to be empowered economically and politically. These windows are often

small, and open for a just short time. Taking advantage of them is difficult and hampered by lack of funding, human resources, and security. But the opportunities are there; what is needed is the flexibility, creativity, and ability to take advantage of them when they do arise.

These opportunities include the experience, resilience, and determination of displaced women themselves. Strengthening their capacity to respond to the issues they face in times of war, and after wars have ended, is one way to build sustainability into the community. One of the messages participants in the knowledge network articulated most forcefully was that women must be involved at every stage of UNFPA's programming, not just as beneficiaries, but as designers and implementers of programs, as drafters of legislation, as advisors to camp managers, as midwives and service providers, as researchers – as agents of their own future. Women's ability and desire to play an active, powerful, and central role in the decisions and actions that affect their lives – whether in times of peace or in times of war – are among the most important assets available to UNFPA. The organization's efforts to assist and protect women forcibly displaced by conflict cannot succeed if the contributions these women bring to the table themselves are overlooked or cast aside. It is UNFPA's responsibility and challenge not just to support women to fully enjoy their human rights, but also to recognize their agency in securing and defending those rights.

Notes

1. Resolution 1325 requests and urges all UN agencies, the Secretary General, and the Member States to take action to ensure "the protection, rights and the particular needs of women, as well as on the importance of involving women in all peacekeeping and peace-building measures," among other related responsibilities. The resolution refers to the Beijing Declaration and Platform, to which UNFPA adheres. The resolution is an effective tool for the advancement of women, which is one of the UNFPA Strategic Plan's goals – to achieve gender equality and empowerment of women so they can exercise their rights, particularly their reproductive health rights, and live free from discrimination. For the full text of 1325, see http://www.un.org/events/res_1325e.pdf.
2. UNFPA found that women continued to put themselves at risk collecting firewood despite the sale of safe alternative fuel because the firewood could be sold and provide another source of much-needed income. This complication highlights the complex way in which livelihoods and SGBV are connected, and underlines the need for UNFPA to analyse these relationships carefully in order to address them successfully.
3. These could pay particular attention to children, particularly since, as Elzbieta Godziak noted, boys who get into violent situations at an early age, before they have been socialized to know right from wrong, continue to engage in violence later in life. Gozdziak cited research to this effect during a 22 June 2007 working group session that was part of the UNFPA Expert Group Meeting in Hammamat, Tunisia, 21–25 June 2007.

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