INTERNATIONAL ALERT

Women Waging Peace

INCLUSIVE SECURITY,
SUSTAINABLE PEACE:
A Toolkit for Advocacy and Action

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Protecting Vulnerable Groups

Refugees and Internally Displaced Persons

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The existence of **refugees** and **internally displaced persons (IDPs)** is often seen as an indicator of the spread and intensity of armed conflict. Facilitating their return home is often a key goal of peace processes. Refugees and IDPs are vulnerable economically, socially, psychologically and politically. Uprooted from their homes, having lost access to their accustomed livelihoods, resented by their hosts and often viewed as a burden or as opponents by governments responsible for their protection, they may be unable or unwilling to speak out when they are denied their rights and face dependence on their neighbours and on the international community. However, they also bring with them resilience, skills and determination to survive, and often constitute an asset to their new environment. Exposure to new lifestyles can in turn offer refugees and IDPs resources that will prove valuable to them when they return home and that will enable them to contribute towards stabilising their home environment.

The impact of life in exile on women and girls is often paid little attention by assistance providers. This chapter provides an overview of issues relating to refugees and IDPs in the context of conflict, with emphasis on the experiences of women and girls.

1. WHAT ARE REFUGEES AND IDPs, AND HOW ARE THEY DIFFERENT?

Refugees and internally displaced persons (IDPs) have been forced to flee from their homes, as individuals or groups. While the experiences of refugees and IDPs are similar in many regards, there are also significant differences. **Refugees** have crossed international borders and are entitled to protection and assistance from the states into which they move and from the international community through the United Nations (UN) and its specialist agencies. **IDPs**, on the other hand, are displaced within their own country. Although international law generally provides them with protection, there is no international law or standard specifically covering IDPs, and no UN agency is specifically mandated to ensure their welfare.

REFUGEES

The 1951 **Convention Relating to the Status of Refugees**, the cornerstone of refugee protection, defines a **refugee** as "a person who, as a result of 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."[1] The basic principle of the Convention is that the rights of refugees in the country of refuge must be at least equal to those of other resident foreigners in that country. Refugees are protected by the principle of **non-refoulement**, meaning that they cannot be forced to return to their home country if they have a reasonable fear that to do so would endanger their lives.[2]

The Convention was introduced in the wake of refugee movements in Europe after World War II. Although the Convention does not specifically address persons from armed conflict, some interpretations accept such people as refugees. This is enshrined in, for example, the **Organization of African Unity (OAU) Convention Governing the Specific Problems of Refugees** in Africa drawn up in 1969,[3] and the 1984 **Cartagena Declaration on Refugees in Central America**.[4] The UN High Commissioner for Refugees (UNHCR) generally accepts those fleeing from conflict as refugees. However, a number of governments (including the US and most European governments) determine the

status of asylum seekers on the basis of individual fears of persecution.

INTERNALLY DISPLACED PERSONS (IDPs)

The 1998 **Guiding Principles on Internal Displacement** (the Guiding Principles) describe internally displaced persons 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 generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised State border."[5] Armed conflict and other forms of mass violence are specifically mentioned as possible causes of flight. Both individuals and groups fall within the definition.

International humanitarian and human rights law protects civilian IDPs through a number of instruments. These include the 1949 **Geneva Conventions** and 1977 **Additional Protocol**,[6] which, among other things, prohibit parties to an armed conflict from arbitrarily displacing civilian populations. Other relevant mechanisms include the **Convention on the Elimination of All Forms of Discrimination Against Women** (CEDAW), which establishes women's human rights (see chapter on human rights). However, there is no single mechanism designed specifically to address IDP rights. Since the early 1990s, the international community has been increasingly concerned about IDPs because of their growing numbers and a growing awareness of their vulnerability. This concern was reflected in 1992 in the appointment of the **Special Representative of the UN Secretary General on Internally Displaced Persons**. The Special Representative drew up the Guiding Principles to clarify the status and rights of IDPs and to identify the responsibilities of different parties towards them (see box). While not legally binding, they are drawn from, and are consistent with, existing laws and conventions.

In 2003, the number of IDPs was estimated to be more than twice that of refugees (see section 3 below). The increase in IDP numbers may reflect continuing reluctance by governments to accept responsibility for refugees, so that people in flight are increasingly unable to cross borders.[7] It may also reflect the growing number of contexts in which governments are unable or unwilling to protect citizens from abuse or from the absence of adequate care in the face of disaster. IDPs are often considered to be more vulnerable than refugees. It has been estimated that half the countries with IDPs crises have failed to provide protection with reported abuses including sexual exploitation and forced labour.[8] Moves to introduce specific protection measures for IDPs have been resisted by many countries on the grounds that to do so would infringe on national sovereignty.[9] However, while international law upholds the concept of national sovereignty,[10] because IDPs remain resident in their own country, their protection is the responsibility of the government concerned.

The Guiding Principles confirm that the rights of IDPs (assuming they are citizens of the country within which they have moved) are equal to those of other citizens and are therefore protected by international human rights legislation (see chapter on human rights). The Guiding Principles assert the rights to protection and assistance for IDPs in all phases of displacement. If observed, the Guiding Principles can prevent displacement as a result of conflict, provide protection if it happens and help IDPs return home after hostilities have ceased.[11]

2. WHAT PROBLEMS DO REFUGEES AND IDPs FACE?

People who have been displaced, whether within their own country's borders or internationally, often have to leave behind all but a few of their worldly possessions. In most cases their search for refuge takes them long distances, often on foot. Flight itself is arduous: families can lose contact with each other, sick and elderly relatives may have to be left behind and refugees in flight can be vulnerable to violent attack and exploitation. The trauma of being uprooted from one's home and of becoming separated from family members adds to the terrifying experiences that many undergo before and during their flight. Lack of language skills and unfamiliarity with new surroundings, coupled with fear and concern about events back home, create added burdens.

The Guiding Principles on Internal Displacement (1998)[12]

The Guiding Principles are not binding but are based on, and consistent with, existing international legal instruments. The 30 principles are divided into 5 sections:

Section I	**General Principles:** assert that national governments and other authorities must ensure that displaced persons enjoy the same rights as other citizens of the same country.
Section II	**Principles Relating to Protection From Displacement:** particularly urge protection from arbitrary displacement and from violent treatment.
Section III	**Principles Relating to Protection During Displacement:** emphasise that universal rights (e.g., to family life, livelihood and free association) apply equally to the displaced.
Section IV	**Principles Relating to Humanitarian Assistance:** provides an overview of the responsibilities of national governments working in collaboration with humanitarian agencies and statutory protection bodies.
Section V	**Principles Relating to Return, Resettlement and Reintegration:** provides an overview of the rights of IDPs to return voluntarily and in safety, not be discriminated against and be helped to recover or be compensated for property left behind.

IDPs and refugees have usually been torn from their established environment and their economic resources. As a result they have lost their livelihoods and the means of generating an independent income. They may be obliged to settle in isolated or economically marginal areas where land is poor or where the potential for formal or informal employment is restricted. Where violence ravages rural areas, those displaced may be forced into towns and trading centres where a precarious living in the informal sector may be the only option. Legal restrictions on employment and income generation often make refugees and IDPs permanently dependent on the good will of hosts and on humanitarian assistance. This can reduce their capacity for self-reliance and their determination to survive, giving rise to what assistance providers sometimes describe as a "culture of dependency."

Host communities often see refugees and IDPs as a drain on their already meagre resources, and assistance provided to them may become the source of resentment from hosts, who may themselves be among the most marginalised segments of their own community. Refugees and IDPs can be exploited by employers, receive harsh treatment at the hands of the authorities and be at the mercy of landlords. They are vulnerable to abuse (including high levels of sexual violence and exploitation) from officials and other powerful members of their own and host communities.

Especially when flight is the result of armed conflict, resolving the situation of IDPs and refugees may require political agreements that are hard to come by. **Palestinian** refugees have been unable to return home for four generations, pending a political resolution to their situation, and their existence has been used as justification for further aggression by all sides in other conflicts. Many long-term refugees and IDPs feel that politicians manipulate their situation. In the Caucasus, given the still unresolved status of Abkhazia after the **Georgia-Abkhazia** conflict in which national boundaries were being disputed, ethnic Georgians returning to Abkhazia are viewed as internally displaced by Georgia, but as refugees by Abkhazia. In **Bangladesh**, the government has provided displaced Bengalis with land in areas inhabited by the ethnic minority Hilly people in the Chittagong Hill Tract, a move seen by the Hilly as part of a process of denying them their identity.[13]

Where refugees and IDPs are living in camps or organised settlements, conditions can be damaging to their physical, psychological and social health. Conditions in camps are often overcrowded, leading to public health problems and a lack of privacy. Living in such conditions for prolonged periods can prevent people from maintaining links with family members and may lead to the erosion of cultural practices that contribute to the socialisation of children and a sense of identity. In **Northern Uganda**,

1.4 million IDPs now live in camps, where overcrowded and impoverished living conditions have eroded the tradition of firesides after the evening family meal, when older people would tell stories and offer advice to the young.[14] The psychological impact of camp life is particularly marked in cases where the situation of refugees or IDPs has remained unresolved for a number of years, as with the approximately 400,000 **Bhutanese** refugees who have lived in **Nepal** since the early 1990s.[15]

Health and educational facilities are crucial to all displaced populations. Education is often ignored by assistance providers working with the displaced, as it is seen as a long-term, rather than an emergency, requirement. Yet for many displaced, education is a way out of their impoverishment and cultural isolation. Displaced populations are particularly poorly served with secondary education, without which adolescents and young people have difficulty finding employment. Health services for displaced populations are critical because of the physical and psychological stresses of displacement. Sexual and reproductive health is a major issue for refugee and IDP populations (see chapter on sexual and reproductive health) although, like education, it is often overlooked by assistance providers. Displacement, and the unaccustomed lifestyles encountered in exile or in IDP camps, can change sexual behaviour—refugee and internally displaced populations often experience increased transmission rates of HIV/AIDS and other sexually transmitted diseases (see chapter on HIV/AIDS). Population growth among such communities can be a politically sensitive issue, affecting access to contraceptives and to maternal and child health services.

The return of displaced populations to their homes may also raise a broad range of problems. Refugees and the internally displaced have the right to a safe return. They cannot be forced to return to a country where they are likely to face persecution or torture. Those who wish to return may not have the funds to do so, especially when intensive efforts are required to renovate homes, fields, equipment, markets and to restock animals. For communities returning to rural environments, food aid will be required until crops can be harvested. When flight has been caused by armed conflict, returnees may face unexploded landmines and other ordnance in fields, roads and even homes (see chapter on landmines). Avoiding these dangers may mean not one but several relocations before security can be assured.[16]

Where displaced populations have been away a long time, the size of the community may have increased in exile, generating heightening pressure on resources upon return.[17] Displaced populations who wish to return home may face difficulty claiming property and other entitlements. Repossessing rights to houses or land, for example, can involve lengthy legal procedures. The problems are particularly acute for IDPs, who have no single UN agency mandated to ensure their welfare and who are primarily dependent on their own government to uphold their rights. In many cases it is these same governments whose neglect and abuse has given rise to the displacement and who have failed to put in place adequate mechanisms for IDPs to express their grievances.

Refugees and IDPs also may be seen as contributors to the insecurity of others, especially where they themselves have been directly involved in political disturbances. They can perpetuate conflicts through fundraising, supporting the shipment of arms, international public relations and other activities. In many instances the connection is more direct. Many of the Rwandan Interahamwe militias who fled to the **Democratic Republic of the Congo** (**DRC**) in 1994, were widely seen as the perpetrators of the April 1994 genocide, continued their attacks, while hiding among refugee populations.[18] In addition, long-term camps—such as those for **Burmese** refugees in **Bangladesh**, originally set up in the 1980s—can effectively be forgotten by the international community, leaving refugees to become prey to arms and drugs smugglers.[19] The September 11, 2001, events in the US gave rise to concerns in some quarters that refugee and IDP populations (see chapter on sexual and reproductive health) might be harbouring terrorists. This prompted UNHCR to issue a statement, in September 2004, emphasising that the 1951 Refugee Convention excludes persons who have committed serious crimes and provides terrorists with no protection from prosecution. The statement further urges governments to seek to improve security measures but to ensure that during the process, refugees are not exposed to racism and xenophobia, exclusion, withdrawal of refugee status, deportation and the suspension of resettlement programmes.[20]

Despite the complexity of their experiences and the challenges that many displaced populations face, it is important not to generalise about their plight. Many refugees successfully settle and thrive in their new environments. They gain new skills and experience, often bringing home expertise and financial resources, as well as new perspectives and views. In **Iran** for example, despite receiving limited international assistance, Afghan refugees, including women, have had access to education, health care and jobs. Many Iraqi and Afghan refugee women who settled in Pakistan, Iran, Europe and North America have returned home in recent years and have been instrumental in advancing women's rights.[21] They have established NGOs to build the capacity of women and advocate for empowerment and channelled direct resources to efforts on the ground. In states of the **former Yugoslavia**, expatriates are a liberalising force, promoting the transition to democracy.[22] **Malian** women refugees in **Mauritania** often resisted calls from their husbands to return home, as they had found new opportunities in exile.[23] In many other places, refugees and IDPs who have permanently resettled are an extremely significant source of capital for the home country.

3. WHO PROVIDES PROTECTION AND ASSISTANCE TO REFUGEES AND IDPs?

THE UN SYSTEM AND REFUGEES

The UN Relief and Works Agency (UNRWA)[24] was established in 1949 following the 1948 Arab-Israeli war. It has since provided education, health care, social services and emergency aid to four generations of Palestinian refugees living in the West Bank, the Gaza Strip, Jordan, Syria and Lebanon. Palestinian refugees under the care of UNRWA numbered over 4 million in 2003.

The **Office of the UN High Commissioner for Refugees (UNHCR)** was established in 1951, initially addressing the needs of refugees from World War II. While UNRWA continues to take responsibility for the welfare of Palestinian refugees, the mandate of UNHCR was eventually extended to cover all other refugees worldwide as numbers continued to mushroom. In January 2004, UNHCR was caring for 10.3 million refugees, 2.4 million recently returned refugees, 1 million stateless people and 5.8 million IDPs (at the special request of the UN Secretary General), making a total of 17.1 million people "of concern to UNHCR." About 49 percent of the refugee population is female.[25] Over 46 percent of refugees are in Asia, 22 percent are in Africa, 21 percent are in Europe, 10 percent are in Latin America and 0.3 percent are in Oceania.[26]

UNHCR's role is "to lead and coordinate international action for the world-wide protection of refugees and the resolution of refugee problems."[27] To achieve this it oversees registration, protection and assistance to specific groups of refugees in 115 countries; monitors compliance with international refugee law and advocates for international refugee rights standards; seeks durable solutions to refugee flows; coordinates the provision of basic needs to refugee populations; and funds and supervises voluntary repatriation programmes. Where requested by governments, it administers the process of status determination for asylum applicants.

Different interpretations of basic refugee law have been incorporated into regional and national conventions, so that in practice, responsibilities may vary in different countries. Food relief for refugee settlements may be provided by UNHCR, the World Food Programme (WFP), the host government or various combinations of these. The responsibilities of host governments include registration and physical protection of refugees and protection of their rights to livelihood and security. Three out of four of the world's refugees are under the protection of host countries in the developing world.[28] This places pressure on welfare and social services, shouldered by host communities already weighed down by poverty.

THE UN SYSTEM AND IDPs

As the Guiding Principles on Internally Displaced Persons makes clear, primary responsibility for the protection and assistance of IDPs lies with national governments. Within the UN system, the **Office for the Coordination of Humanitarian Affairs (OCHA)** is responsible, among other things, for policy development and coordination of humanitarian issues, "ensuring that all humanitarian issues, including those that fall between gaps in existing mandates of agencies such as protection and assistance for internally displaced persons, are addressed'."[29] **OCHA** also

advocates for humanitarian issues within the UN Security Council, and coordinates humanitarian emergency responses through its chairmanship of the **Inter-Agency Standing Committee (IASC)**,[30] bringing together UN humanitarian agencies, major international NGOs and the International Committee of the Red Cross (ICRC). IASC formulates humanitarian policy to ensure a coordinated and effective response to emergencies and disasters. OCHA's Inter-Agency Internal Displacement Division[31] networks on internal displacement issues with other UN agencies. In specific emergencies, OCHA ensures co-ordination and information sharing among humanitarian agencies at the field level. OCHA does not generally intervene in humanitarian emergencies.

UNHCR is not charged with providing protection or support to IDPs in general. However, in 2003, it supported some 5.8 million IDPs, either as a result of the UN Secretary General's request (with the consent from the country concerned) or in support of other UN agencies.[32] Estimates of IDPs vary between 20 and 25 million in some 52 states worldwide.[33] In 2003, Sudan (4 million), Democratic Republic of the Congo (3 million), Colombia (2.9 million), Uganda (1.2 million) and Iraq (1.1 million) had the highest numbers of IDPs.[34]

Within the UN system, UNHCR and UNRWA are the main bodies charged with providing direct assistance to refugees. OCHA (for IDPs) and UNHCR (for refugees) coordinate the work of other UN and NGO bodies, although there may be some overlap. Other UN bodies often in evidence in displacement situations include the World Food Programme (WFP), which provides food relief and the International Organization for Migration (IOM), which organises the movement of people (including refugees and IDPs) in need of international assistance. UNHCR, UNRWA and OCHA all work closely with specialized UN bodies such as UNICEF (on children's issues), UNDP (on development matters) and UNIFEM (for women).[35]

BILATERALS

In addition to host countries that shoulder some of the burden in terms of providing aid and relief, the largest government contribution to humanitarian assistance generally, and to refugee assistance in particular, comes from the US. The US budget is three times that of the Netherlands or the United Kingdom, the second and third largest donors respectively.[36] The Office of Foreign Disaster Assistance (OFDA) of the US Agency for International Development (USAID), in common with most government agencies, does not generally distinguish between aid to displaced populations and to other types of emergencies, but includes many displaced populations among its recipients (e.g. in Kosovo, Sudan, and Colombia). USAID's Displaced Children and Orphans Fund supports work with children affected by war and HIV/AIDS in 19, mainly African, countries.[37]

A large proportion of government-funded humanitarian aid is composed of contributions to UNHCR and other UN or regional bodies (e.g. the European Humanitarian Aid Office, ECHO). Most government donors also provide financial support to their own national refugee supporting agencies, which address needs in the donor country and elsewhere. For example, the Norwegian Refugee Council receives funds from the Norwegian government to operate the Global IDP Project (see below under international organisations) on behalf of the international community. Governments also disperse funds to specific emergencies according to their geographical priorities.

INTERNATIONAL NON-GOVERNMENTAL ORGANISATIONS

International organisations working with refugees and IDPs fall into two groups: operational and non-operational agencies. International operational agencies carry out projects to ensure basic material needs (e.g. food, water, shelter, sanitation, registration, medical care), social development and representation, psychosocial support, skills training for the new environment or for return, health and education services, access to livelihoods support and micro-finance, protection and advocacy. The International Committee of the Red Cross (ICRC), Médecins Sans Frontières (MSF), Save the Children, Oxfam and CARE are among the major agencies involved in this work.[38] These agencies work with both displaced and non-displaced populations.

The ICRC is mandated by the Geneva Conventions to "protect and assist the victims of armed conflict," including both refugees and IDPs.[39] It is strictly non-governmental, although its mandate has been approved by states. It has both a "watchdog" and an

operational role. Its operational delegations in conflict-affected countries perform protection, assistance or preventive services for the victims of existing or emerging situations of armed conflict or violence. The ICRC is a neutral and impartial intermediary concerned with ensuring that all parties to a conflict abide by international humanitarian laws to protect and assist displaced persons. In specific cases, ICRC also distributes food aid, medical supplies and agricultural tools and provides clean drinking water and health care (including reproductive health care).

Non-operational agencies generally carry out policy, advocacy and research work around displacement and some also provide direct assistance. Of these, those that focus particularly on displacement include **Refugees International**, which provides assistance and protection for refugees and displaced persons and advocates to end the conditions that create displacement. The **Women's Commission for Refugee Women and Children** advocates for displaced women and children (see section 7 below).[40] The **Global IDP Project** documents the situation of IDPs globally, providing background reports on relevant countries, updating factual information regularly and offering training materials about displacement. Other research and policy initiatives include the Humanitarian Policy and Practice Committee of Interaction, the American Council for Voluntary International Action and the Humanitarian Policy Network of the Overseas Development Institute in London.[41]

Assistance provision from the above sources supports a vast number of host government initiatives and local organisations that provide services and support to the displaced and advocate to improve their conditions and bring displacement to an end. Beyond that, the displaced are supported informally by spontaneous family and neighbourhood initiatives. These local forms of support, although hard to quantify, are of critical importance in the survival of individual refugees and IDPs and their communities.

4. HOW ARE WOMEN AFFECTED BY DISPLACEMENT?

In all aspects of the situation of displacement—flight, asylum-seeking, living in exile and the return home—women face particular problems, which are often poorly understood by assistance providers. When displaced communities migrate, women are particularly vulnerable, especially if they are pregnant or caring for small children. Stories of women giving birth while fleeing violence are not uncommon.[42] Others are vulnerable to sexual exploitation from officials and military personnel.

Figures from UNHCR indicate that women represent approximately half of refugee populations overall. The balance of male to female displaced varies from situation to situation. In **Colombia**, for example, women represent more than 50 percent of IDPs and head more than 30 percent of IDP households.[43] Life in displaced situations often brings about changes in gender roles. Women, usually the sole caretakers of children, the sick and the elderly,[44] frequently assume additional tasks and roles traditionally allocated to men, including physical labour, heading the household and providing food and protection for their families. When men lose their livelihoods and their resources, the implied loss of status may result in depression and self-harm, as well as a backlash against women and an escalation of domestic violence. The additional responsibilities women take on may have positive psychological impacts for them. Many gain greater self-confidence and pride as a result. However, the burden of extra work places serious constraints on women's health and welfare, and the contrast between men's and women's responses can put huge strains on family relationships.

Taking on larger economic roles can increase women's decision-making status within the family, and to some extent outside it. However, it would be unwise to expect radical or long-term change to take place as a result.[45] In fact, when women return to their home countries or communities, men often re-assert their control over women's lives and the household. In **Guatemala**, despite the demands of women's organisations formed in exile that women be allowed to join new cooperatives and own land, local men threatened them with expulsion if they did not back down. As a result, few women believe they have the right to own land or exercise that right.[46]

Moreover, interventions designed to encourage women's participation in projects and in political life

may have unintended effects on relations between men and women. One study of a camp for **Burundian** refugees in **Tanzania** described how UNHCR's policy of empowering women through encouraging their participation in camp management committees led men to feel marginalised and frustrated. At the same time, women were reluctant to take the opportunities offered to them since doing so would affect their relations with their men. Both men and women shared the belief that women were vulnerable and lacking in knowledge and political skills. The policy overlooked the need to address these attitudes at a fundamental level.[47]

Women's legal status is often ambiguous and may undermine their economic and physical security. Many women lack their own identification papers, as documentation is often issued to male household heads. Women lacking proper identification may not be able to move freely or complete daily activities, including buying and selling goods in markets and accessing supportive networks.[48] Further, where food ration cards are distributed only to men, women remain dependent on men for food and basic services.[49] It has been noted that "when humanitarian aid, such as ration cards and food distribution, is channelled through women, as in **Sudan**, women and children are more likely to receive their fair share of assistance."[50]

Gender-based violence is widespread in displaced communities and takes many forms including domestic violence, trafficking, enforced prostitution and sexual violence. Sexual violence may come from within the displaced community or from officials and others preying on the vulnerability of the displaced, made worse by overcrowding, the circulation of small arms (see chapter on small arms, light weapons and landmines) and the breakdown of family life. Camps for refugees and displaced people are often hastily constructed with little consideration for their impact on women's physical security. In **Angola**, countless women were maimed by landmines while seeking food and charcoal—basic elements for survival.[51] Women are also at risk of rape, other forms of sexual or physical violence and robbery when they go to collect needed supplies or goods.[52]

Those responsible for protecting refugees and IDPs—including UNHCR, host governments and peacekeeping forces—often ignore the problem and fail to provide protection, as with **Somali** refugee camps in **Kenya**[53] and **Liberian** refugee camps in **Sierra Leone**.[54] Worse, they may themselves be perpetrators, as has been documented by UNHCR in **Guinea, Liberia, and Sierra Leone**[55] and the UN peacekeeping force (MONUC) in the **Democratic Republic of the Congo**.[56]

An additional area of concern relating to gender-based violence is female genital mutilation (FGM), which 130 million women and girls are estimated to have undergone worldwide, and which may be revived among displaced communities as they try to reassert their cultural identity.[57] For example, **Sierra Leonean** secret societies, into which women are initiated through FGM, reappeared among refugees in **Liberia**, resulting in some women who had spoken out against the practice being afraid to return home.[58]

Women seeking asylum on grounds of gender-based violence have often found it hard to argue their case. Although some countries changed their policy on this in the late 1990s and early 2000s (see section 6 below), in practice immigration officers suffer from "a tendency to misrepresent gendered forms of persecution as personal rather than political."[59] Even where policies have changed, judges and immigration officers may lack appropriate training and knowledge.[60]

Sexual and reproductive health needs of women and girls in situations of forced migration are exacerbated by the likelihood that health services will be extremely limited.[61] "Until very recently, reproductive health care has been a neglected area of relief work, despite the fact that poor reproductive health is a significant cause of death and disease in camp settings."[62] Key problems include the lack of adequate provision for safe motherhood, lack of family planning and contraceptive services and lack of attention to gender-based violence: 20 percent of women of reproductive age living in camps are estimated to be pregnant at any one time,[63] and 25-50 percent of maternal deaths in refugee situations are believed to result from post-abortion complications[64].

5. HOW DO WOMEN CONTRIBUTE TO THE PROTECTION OF REFUGEES AND IDPS?

Women are important actors in situations of displacement, although their contributions usually go unnoticed. In addition to women's individual actions as mothers and caretakers, they often organise themselves and play a pivotal role in refugee and IDP camps and in ensuring the most vulnerable groups have access to support. Their activities have included:

Organising to Implement Programmes in Difficult Circumstances—Afghan women's organisations have successfully implemented programmes for displaced persons in both **Pakistan** and **Afghanistan**. The Afghan Women's Resource Centre has provided health, education, income generation, skills training and relief distributions since 1987. Another women's organisation, Shuhada, has provided health and education inside and outside Afghanistan since 1989. The Afghan Women's Education Centre has provided trauma counselling and advice to destitute women, projects for street women and children and relief distributions since the early 1990s. The Afghan Women's Welfare Department offers health, income generation, skills training, education and relief distributions.[65]

Providing Assistance Despite Personal Risks—In **Colombia**, women's groups provide health and social services to victims of violence and IDPs and remain outspoken on peace and security issues. As a result of this type of activism, it is estimated that 17 percent of assassinated and disappeared leaders in **Colombia** in 2002 were women.[66]

Facilitating Communication and Information—In refugees camps in **Tanzania**, UNHCR invited women to form their own committees or participate in mixed committees in order to facilitate communication between camp authorities and grassroots women. The women then organised to ensure vulnerable neighbours (e.g. the elderly, pregnant women and separated children) were linked to programmes run by international agencies.[67] The NGO Assist Yourself in Georgia publishes a newspaper for displaced women from Abkhazia and circulates information to them as a way of bridging the gap between them and local women. In 1999, it published a book called *Assist Yourself*, which provides information about local services, procedures and entitlements for IDP women.[68]

Women's groups are often skilled in creative ways of communicating their situation to each other and to others: a **Ugandan** displaced-women's group supported by Isis-WICCE devised and performed plays and dances about their life in "protected villages,"[69] while the **Sri Lankan** organisation Suriya used participatory video projects to enable women from different sides to express the pain and to record the reconciliation that follows.[70] The Ashtar Theatre Company in **Palestine** annually tours schools, youth, women's and disabled peoples' groups, devising plays that raise awareness of issues such as early marriage and sexual violence.[71]

Promoting Reconciliation and Peacebuilding—**Bosnian** women's organisations took the lead in providing services to returning refugees, welcoming back returning displaced and refugee populations into their communities of origin and providing gifts of food and supplies to displaced women. They took on this task as their contribution to peacebuilding.[72] In **Burundi**, another context where violent intercommunal conflict led to displacement, women held "cultural days" during which resident and returning women shared food and performed dances for each other, and helped the returnee women resettle by providing land and labour for farming.[73] The **Sierra Leonean** woman Binta Mansaray has been active in organising humanitarian and human rights groups to advocate on behalf of **Liberian** refugees, as well as conducting an in-depth analysis of IDP women and elections in **Sierra Leone**.

Partnering with the International Community—Many projects supporting women refugees and IDPs are designed by professional women from the community, using their expertise in development and humanitarian work to draw the support of the international community. Fawsia Musse, encountering a huge outbreak of rape cases in **Somali** refugee camps in northeastern **Kenya**, worked with **UNHCR** to develop strategies such as improving security and protection, dialogue with camp elders and locally appropriate counselling.[74] At a **Macedonian** refugee camp for **Kosovar Albanians**, the **Bosnian** women's group Kvinna til Kvinna worked with German relief agencies

to utilise surplus tents for women in the camps to meet for counselling and support, as well as for discussion forums for their needs and concerns as refugees. As a result of these meetings, the women's recommendations and the advocacy of Kvinna til Kvinna, outdoor lighting was installed and guards patrolled the camps at night.[75]

In recent years, some international groups have begun to capitalise on women's agency in the camps and encourage their active participation in the design and management of services and projects. Under UNHCR administration, the camp management committees composed of **Bhutanese** refugees in **Nepal**, for example, introduced a requirement in 2003 that 50 percent of all members of the distribution committees, the counselling board and senior leadership in the camps must be women.[76]

Consulting women can have demonstrable impacts for the whole community. In **Afghanistan**, UNHCR worked with local women to design the New Shamshatoo refugee camp. According to one woman involved: "We were able to redesign it so that the baths were put in the centre of the camp, near the refugees homes. Now, women are much less likely to be attacked."[77]

6. WHAT INTERNATIONAL LAWS, POLICIES AND GUIDELINES EXIST PERTAINING TO REFUGEE AND IDP WOMEN?

Women are entitled to the same protection as men in international humanitarian and human rights law: "In addition, recognising their specific needs, international humanitarian law grants women additional protection and rights…(often) related to their child-bearing role."[78] Article 6 of the **Declaration on the Protection of Women and Children in Emergency and Armed Conflict** states: "Women and children belonging to the civilian population and finding themselves in circumstances of emergency and armed conflict in the struggle for peace, self-determination, national liberation and independence, or who live in occupied territories, shall not be deprived of shelter, food, medical aid or other inalienable rights, in accordance with the provisions of the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Declaration of the Rights of the Child or other instruments of international law."[79]

UN Security Council Resolution 1325 (see appendix for full text) makes reference to the protection offered to women and girls affected by armed conflict in the Geneva Conventions, CEDAW, the Convention on the Rights of the Child, the Refugee Convention and the Rome Statute governing the International Criminal Court (see chapter on international mechanisms). These provide women and girls with rights as civilians. In relation to refugee and displaced women, the resolution urges that states, their armies and peacekeeping forces should receive training in the rights of women and girls to protection, and invites those responsible for camp design, protection, repatriation and resettlement to take into account the special needs of women and girls.

In 1991, **UNHCR** adopted the **Guidelines on the Protection of Refugee Women**,[80] which aimed to integrate the needs and resources of women into all programming to ensure protection and assistance. The Guidelines describe the process of assessing women's protection needs in both emergency and long-term refugee situations, addressing such factors as the characteristics of the refugee population and local attitudes towards them, the physical organisation of camps, social structures, physical safety provisions and access to services and legal systems. They describe typical protection needs and possible responses, presenting advice on gender-sensitive interviewing techniques and how humanitarian assistance projects can contribute to protection (e.g. through following guidelines when distributing relief items or the organising health care and education). An evaluation in 2000 noted that the Guidelines were not being adequately implemented and did not address current challenges.[81] An update to the Guidelines, including IDPs, domestic abuse and urban refugees, was under way in 2004.

In 1995, UNHCR issued guidelines on the protection of refugees against sexual violence, updated in 2003.[82] These propose preventive measures to be taken by UNHCR, host country authorities and assistance providers (through information, education

and training). They include advice on identifying incidents, conducting interviews, dealing with sexual violence in domestic situations and organising medical and psychosocial responses.

UNHCR later developed its **Five Commitments to Refugee Women**:[83]

1. to develop integrated national strategies to address sexual violence (including domestic violence);

2. to register women individually and provide them with individual documentation to ensure their security, freedom of movement and access to services;

3. to ensure that 50 percent of refugee representatives on management committees are women;

4. to ensure that women participate in the management of food and non-food distribution so that these goods are directly controlled by a household's adult women; and

5. to provide sanitary materials to all women and girls as standard practice.

Following a review carried out by the Women's Commission for Refugee Women and Children, the Sphere Project—a group of humanitarian NGOs revised its manual on standards to include guidance on women's needs in humanitarian situations. The manual includes minimum standards in camp layout and facilities (e.g. the location of latrines, lighting and distribution centres), taking into account women's security needs. It urges the participation of women in needs identification and protection activities and stresses the need for agencies to be proactive in preventing gender-based violence and sexual exploitation.[84]

In 1984, the **European Parliament** determined that women facing cruel or inhuman treatment because they seemed to transgress social mores should receive special attention for the purposes of determining refugee status.[85] **Canada**, the **US**, **Australia**, and the **UK** have issued guidelines for immigration officers and judges relating to gender-based persecution.[86] FGM is a generally accepted form of persecution for refugee status in many western countries.

7. WHAT INTERNATIONAL ASSISTANCE IS AVAILABLE FOR REFUGEE AND IDP WOMEN?

UNIFEM, the UN Development Fund for Women, "provides financial and technical assistance to innovative programmes and strategies that promote women's human rights, political participation, and economic security."[87] UNIFEM's three priority areas are (as of September 2004): economic security and rights; women's human rights; and governance, peace and security (emphasising women's participation in decision-making and leadership as an essential component of the latter). UNIFEM does not offer direct assistance but provides strategic and catalytic support to women's participation in peace processes and policy reform. It has catalysed support for refugee and displaced women by means of a needs assessment for Burundian refugees in Tanzania, carried out by its African Women in Crisis programme (AFWIC), and ensuring that the 2002 Consolidated Appeals for the Great Lakes addressed human rights abuses of displaced women.[88]

UNICEF, the UN Children's Fund, provides important support to children in war-affected contexts, including protection, support to schools and out-of-school activities, training for young people in landmine awareness and HIV prevention and advocating against the sexual abuse of children (see chapter on children's security).[89]

The **World Food Programme** (**WFP**) specifically targets women to ensure equal access to food, in the belief that women are the first and fastest solution to alleviating hunger and poverty. WFP's experience is that food placed under women's management reaches children more efficiently and frequently. In 2003, over 50 percent of WFP's food recipients were female.[90] Its goals are to ensure that 80 percent of its food relief will be distributed to women and 50 percent of its educational resources allocated to girls.

UNRWA supports 71 women's centres throughout the refugee community that offer training and advice on legal and civic matters and operate a "legal literacy" programme.[91] UNRWA supports the work of **Palestinian** women's organisations, including the Women's Studies Centre,[92] which documents women's voices and helps develop the skills of women writers and the Women's

Centre for Legal Aid and Counselling,[93] which offers services through its social work, legal aid, health, advocacy and legal literacy units.

The Women's Commission for Refugee Women and Children (the Women's Commission) works to improve the lives and defend the rights of refugee and internally displaced women, children and adolescents. Its activities include advocating for their inclusion and participation in humanitarian assistance and protection programmes; providing technical expertise and policy advice to donors and organisations that work with refugees and the displaced; making research-based recommendations to policy-makers; and ensuring that the voices of refugee women, children and adolescents are heard at all levels—within communities, governments and international organisations. The Commission's work includes projects on adolescents and youth, detention, asylum, reproductive health and participation and protection.[94] Refugees International[95] advocates for displaced women's rights based on local experience and research. It has raised the awareness of international peacekeepers in **West Africa** of the need to establish monitoring systems for gender-based violence, urged the Government of **China** to take action over the kidnapping of **North Korean** women as brides and their consequent vulnerability to deportation, ensured that UNHCR addresses the lack of protection for refugees serving as counsellors in refugee camps in **Tanzania** and identified the need for psychosocial programmes to support refugee women in **Guinea**. The Reproductive Health Response in Conflict Consortium runs a gender-based violence initiative stressing the need for coordinated and multisectoral approaches.[96] Human Rights Watch documents examples of the trafficking of women refugees.[97]

Multilateral organisations and international NGOs provide support—financially and through information, training and networking—to women's initiatives at national and local levels. For example, the Women's Commission on Refugee Women and Children runs the Protection Partners Project, a partnership with local women's organisations and individuals who monitor and report on the needs of women and girls in **Colombia** and **Afghanistan/Pakistan**.[98] A statement from the Protection Partners Project, for example, stresses that "effective participation includes women in decision-making, management, monitoring and implementation. It also involves centering our decisions on what the conflict and the rebuilding means from a woman's perspective with equal weight to the views of men."[99]

In western countries, women's organisations have worked closely with their governments on asylum issues. For example, in 2000 the European Women's Lobby campaigned for a draft directive of the **European Union** that focused attention on four aspects of women's persecution—FGM, rape as a war crime, forced marriage and guilt by association (with male family members). In **Britain**, the Refugee Women's Legal Project worked alongside the UK Home Office in developing the 2000 Asylum Gender Guidelines. In the **US**, the Women's Commission researched detention conditions for women asylum seekers and campaigns on specific cases.

Despite these extensive laws, guidelines and structures, there remain gaps in policies and implementation. The Women's Commission asserts that there is a lack of effective guidelines on how **UNHCR** staff should respond to domestic abuse.[100] There is still a significant challenge in raising awareness and understanding policies among front-line personnel, (e.g. under international law, refugees have a right to seek asylum in a third country), yet often refugee women are not aware of their right to file a claim separate from that of their husband's. Many governments view men as the sole applicant and only register a male head of household without respect to other members of the household.[101] More connections between headquarters and the field are necessary to implement existing policies and mechanisms for protecting refugee and IDP women.

8. TAKING STRATEGIC ACTION: WHAT CAN WOMEN PEACEBUILDERS DO?

TO ENSURE REFUGEE AND IDP WOMEN'S PROTECTION

1. Review basic documents such as the Guiding Principles on Internal Displacement and consider how they apply to women in the context that concerns you. Are its provisions being respected? How can you address those areas that are not being addressed adequately?

2. Find out which body or bodies within your context (national government and UN) are responsible for protection and assistance to refugees and the internally displaced and how they intend to implement the Guiding Principles.

3. If you are a refugee or displaced woman, find out about your rights in the country where you are located to determine the opportunities and support to which you are entitled.

4. Find out the procedures for determining the status of asylum seekers, and advocate against inadequate implementation of international laws and guidelines.

TO ENSURE REFUGEE AND IDP WOMEN'S VOICES ARE HEARD

5. If you wish to support refugee women and IDPs, find out about their background—what circumstances have they come from, what led them to flee, their experiences en route, the skills and expectations they bring with them, how they are living, what problems they and their families face now and what laws and other opportunities exist for them.

6. Identify the gaps in understanding between the displaced and their hosts. Work to establish mutual understanding and practical links between women of the displaced and host communities, building on their common concerns.

7. Ensure that assistance-providing organisations recognise the contribution that women's organisations already make, and ensure they are supported so that practical and other barriers can be overcome.

TO ENSURE EFFECTIVE ASSISTANCE FOR REFUGEE AND IDP WOMEN

8. Consider the specific vulnerabilities of refugee and IDP women and make provisions to combat them. This might mean demanding increased maternal and child health or education services, advocating for survivors of human rights abuses or removing legal impediments faced by women entrepreneurs

9. Enable refugees and IDPs to participate in the management and implementation of assistance programmes to help people overcome the impact of displacement and dependency and increase self-reliance. Ensure that assistance programmes are run with this in mind.

10. Organise with other women and disseminate information to refugees and IDPs about the rights and opportunities available for work, access to services and social or legal support. Consider how to advocate with government and other assistance providers to address your needs.

WHERE CAN YOU FIND MORE INFORMATION?

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ACRONYMS

AFWIC	African Women in Crisis
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
ECHO	European Commission Humanitarian Aid Office
FGM	Female Genital Mutilation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IA	International Alert
IASC	Inter-Agency Standing Committee of the United Nations
IDPs	Internally Displaced Persons
IOM	International Organization for Migration
IRC	International Rescue Committee
MONUC	United Nations Mission in the Democratic Republic of the Congo
MSF	Médecins Sans Frontières (Doctors without Borders)
NGO	Non-Governmental Organisation
ICRC	International Committee of the Red Cross
OCHA	Office for the Coordination of Humanitarian Affairs of the United Nations
OFDA	Office of Foreign Disaster Assistance of the United States Agency for International Development
UK	United Kingdom
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development
WFP	World Food Programme

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Sexual and Reproductive Health, Rights and Services

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Sexual and reproductive health, rights and services (SRH R&S) are important for everyone. Men and boys often suffer from a lack of sexual and reproductive rights through inadequate access to information, services and care, but women and young girls of childbearing age are generally more vulnerable to sexual assaults and reproductive ill-health. This is exacerbated in situations of conflict when women are exposed to increased levels of violence, lack of security and poor access to safe medical health services.

In the early 1990s, a number of factors focused global attention on the provision of reproductive rights, health and services to refugees and displaced populations. Crises in the **former Yugoslavia** and **Rwanda** heightened awareness of the specific reproductive health needs of refugee women. As a response, the Women's Commission for Refugee Women and Children published a report highlighting the increased health risks women face in refugee settings.[1] The report noted the serious neglect of many aspects of reproductive health care in these situations and called for increased international attention to the provision of full reproductive health services.

In 1994, at the **International Conference on Population and Development** (**ICPD**) in Cairo, 179 countries agreed on a plan to transform and fund reproductive health programmes. The final document and **Programme of Action** (**PoA**) call for universal access to basic reproductive health services and specific measures for fostering human development and the social, economic and health status of women.[2] Despite sound arguments based on public health concerns, human rights and social justice, in many countries comprehensive reproductive health care is still insufficiently understood or applied. The situation is even worse in conflict and post conflict situations.[3] This chapter examines reproductive health issues, rights and services that affect populations primarily within conflict and post conflict situations.

1. WHAT ARE SEXUAL AND REPRODUCTIVE HEALTH, RIGHTS AND SERVICES?

Reproductive health is defined by the PoA of the ICPD as "a state of complete physical, mental and social well-being in all matters relating to the reproductive health system and to its function and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so."[4] Reproductive health is not merely about the absence of disease or infirmity.

Reproductive and sexual rights, according to the ICPD, include human rights already recognised in national laws and in international human rights documents such as the Universal Declaration on Human Rights. They include a person's right to:

- information, education, skills, support and services needed to make responsible decisions about sexuality consistent with their own values;
- bodily integrity and voluntary sexual relationships;
- a full range of voluntary and accessible sexual and reproductive health services;

- express one's sexual orientation without violence or discrimination;
- decide freely and responsibly the number, spacing and timing of their children and the information and means to do so;
- attain the highest standard of sexual and reproductive health; and
- make decisions concerning reproduction free of discrimination, coercion or violence.

Sexual and Reproductive Health Rights and Services (SRH R&S) covers a wide range of services and rights defined in the PoA that contribute to reproductive health and well-being by preventing and solving reproductive and sexual health problems. These include family planning, counselling, information, education, communication and services; education and services for prenatal care; infant and women's health care; prevention and appropriate treatment of infertility; prevention of abortion (although prevention of unwanted pregnancies is given the highest priority); provision of safe abortion services (where legal) and the management of the consequences of abortion; treatment of infections of the reproductive organs; sexually transmitted infections (STIs) including HIV/AIDS; breast cancer and cancers of the reproductive system; and active discouragement of harmful traditional practices such as female genital mutilation (FGM).[5]

REPRODUCTIVE HEALTH OF WOMEN AND GIRLS

Reproductive behaviour is governed by complex biological, cultural and psychosocial relations; therefore, reproductive health must be understood within the context of relationships between men and women, communities and societies. Women bear the greatest burden of reproductive health problems and their vulnerability to reproductive ill-health is increased by biological, cultural, social and economic factors.[6]

The challenge often starts in childhood. For example, a female child who is malnourished from birth, or who is subjected to harmful traditional practices such as FGM,[7] may enter adolescence and adulthood with anaemia and other physical problems as well as psychosexual trauma related to the traditional practice. This can cause problems during pregnancy and childbirth. Women who have undergone FGM can have problems relating to menstruation, pregnancy and childbirth.

Adolescent girls are often at risk of unwanted pregnancies and are vulnerable to STIs, including HIV/AIDS, due to their lack of accurate information about reproduction and access to reproductive health services, including contraception.[8] In conflict-affected societies, adolescent girls are particularly vulnerable to sexual abuse and rape. Pregnancy and childbirth during this period carry considerable risks. Girls 15–19 years old are twice as likely to die in childbirth as women in their twenties. An estimated 46 million abortions are carried out annually across the world. Approximately 20 million are considered to be unsafe,[9] and between 25 to 30 percent are carried out on adolescent girls.[10]

FAMILY PLANNING, CONTRACEPTION AND PREGNANCY

A woman's ability to space or limit the number of her pregnancies, as well as the outcome of her pregnancy, has a direct impact on her health and well-being. In enabling women to exercise their reproductive rights, family planning programmes can improve the social and economic circumstances of women and their families. The World Health Organization (WHO) estimates that about 123 million women around the world, mostly in developing countries, do not use contraception despite their expressed desire to space or limit the number of pregnancies and births they may have.[11] Family planning needs are often not met due to poor access to quality services, a limited choice of contraception methods, lack of information, concerns about safety or side effects or a partner's disapproval.

Pregnancy and childbirth bring their own particular problems. Every day it is estimated that 1,600 women in developing countries die from complications during pregnancy. In addition to maternal deaths, half of all the estimated eight million infants born each day die in the first month of life, due primarily to inadequate maternal care during pregnancy. If women were healthy during pregnancy and had access to basic medical care before, during and after childbirth, the majority of mother and infant deaths could be prevented.[12]

An estimated 28 percent of all pregnancies occurring around the world every year are unintended.[13] According to WHO, millions of women around the world risk their lives and health to end unwanted pregnancies. Every day, 55,000 unsafe abortions take place with 95 percent of them occurring in developing countries. This can lead to the deaths of more than 200 women daily. Globally, one unsafe abortion takes place for every seven births.[14] WHO estimates that globally, one maternal death in eight is due to abortion-related complications. In some settings a quarter or more of all maternal deaths are abortion-related.[15]

Many women are afraid to seek treatment for abortion-related complications, leading to countless - deaths outside of hospitals. Between 10 and 50 percent of all women who undergo unsafe abortions need immediate medical care for related complications including haemorrhages. Long-term health problems range from chronic pelvic pain to infertility. Such problems can limit women's productivity inside and outside the home, hinder their ability to care for children and adversely affect their sexual and reproductive lives.[16]

Yet unsafe abortion is one of the most easily preventable and treatable causes of maternal death and injury. During the ICPD, governments recognised unsafe abortion to be a major public health issue and called for prompt, high quality and humane medical services to treat the complications resulting from unsafe abortion. They also called for compassionate post-abortion counselling and family planning services to promote reproductive health, reduce the need for abortion and prevent further unsafe abortions. Governments also called for the provision of safe abortion services where they are not against the law.[17]

REPRODUCTIVE ILL HEALTH

Research has shown that reproductive ill health accounts for approximately 36 percent of the total disease burden among women of reproductive age (15–44 years) in developing countries, compared to an estimated 12.5 percent in men. For women, three conditions are particularly relevant: pregnancy-related deaths and disabilities, STIs and HIV/AIDS.[18] A number of factors increase women's vulnerability to reproductive ill health, including:

- restrictions on information about sexuality, condoms and other contraception, disease, prevention and healthcare;
- harmful traditional practices such as ritual intercourse with a male relative after the death of a husband, FGM, ritual scarification, tattooing and bloodletting;
- early marriage;
- inability to negotiate safe sex;
- discrimination against women in education, employment and social status;
- laws that reinforce women's economic dependency on men and reliance on prostitution for economic survival (of adults and children); and
- war, famines, natural disasters, political oppression, poverty and displacement.

2. HOW DOES CONFLICT AFFECT THE DELIVERY OF REPRODUCTIVE HEALTH AND SERVICES?

During conflicts, health services and health facilities may be destroyed and health personnel may become targets. During the genocide in **Rwanda**, over half of the health workers were killed. In **Bosnia and Herzegovina**, 40 percent of physicians left the country and did not return. Sanctions against countries in conflict may also affect women's reproductive health and their access to health care and services. In **Iraq**, after the Gulf War, women's access to gynaecological care decreased and in **Serbia**, during the sanctions period, more women between the ages of 25–44 years died than in the previous years.[19]

Conflict also adversely affects the safe and effective delivery of SRH R&S in various ways, including the breakdown of health services, forced mobility of refugees and internally displaced persons (IDPs) and malnutrition and epidemics that diminish the strength and immunity of ill and breast-feeding women. Women's vulnerability is exacerbated in situations of conflict because of increased levels of violence, lack of security and poor access to safe medical health services. For example, much of **East Timor's** medical facilities were destroyed during the violent conflict and unrest there, thus affecting the

reproductive health of countless women.[20] In **Bougainville**, the blockade by the **Papua New Guinean Defence Force (PNGDF)** and the destruction of hospitals and health clinics severely affected maternal and child health.[21] In **Afghanistan** in 2001, hundreds of Afghans crossed the **Iran** and **Pakistan** borders, among them thousands of pregnant women fleeing violent conflict.[22] Poor Afghan health services and the rise of malnutrition increased the dangers to women during pregnancy and childbirth. Additionally, the **United Nations Development Fund for Women (UNIFEM)** reports that African countries with the highest maternal death rates—including the **Democratic Republic of the Congo (DRC)**, **Sierra Leone and Eritrea**—are also countries that have experienced years of conflict and instability.[23]

THE VULNERABILITY OF WOMEN: SEXUAL AND GENDER-BASED VIOLENCE (GBV)

The term sexual- and gender–based violence (GBV) includes a variety of abuses, sexual threats and coercion, exploitation, molestation, humiliation, incest, trafficking, smuggling, forced marriage and forced prostitution[24] (see chapters on HIV/AIDS and peace support operations). This section focuses primarily on rape and domestic violence.

The United Nations High Commission on Refugees (UNHCR) has stated that "during war and armed conflict, violations of human rights and gender-based violence increase dramatically. Gender-based violence and persecution are often adopted as tactics of war and terrorism. Indeed, recent history has all too often seen sexual violence and rape used deliberately and strategically as a weapon of war. Sadly this kind of abuse can follow a refugee woman throughout her life as a refugee."[25] Additionally, the **United Nations Special Rapporteur on Violence Against Women** has highlighted the continuum of violence from the private to the public sphere. This was reinforced by many speakers at the recent high-level conference, *Gender Justice in Post Conflict Situations: Peace Needs Women and Women Need Justice*, organised by **UNIFEM** and the **International Legal Assistance Consortium (ILAC)**.[26]

Rape and sexual violence as a weapon of war: Rape can be used as a symbol of domination, as a means of instilling terror, as an instrument of torture, to dehumanise sections of the community, to impregnate as a means of ethnic cleansing, to infect with STIs and to destroy family and community relationships. It is estimated that in **Sierra Leone**, over 50 percent of women experienced sexual violence during the war and, during the collapse of the **former Yugoslavia** in the 1990s, over 20,000 Bosnian women were raped.[27]

Between 2003 and 2004, the unprecedented level of violence, degradation and humiliation experienced by women in the **DRC** led many to call such actions "a war within a war and a war against women."[28] In 2004 in **Darfur, Sudan**, the rape and sexual assault of women has been widespread and systematic.[29] In **Haiti**, research by the Centre Haitien de Recherches et d'Actions pour la Promotion Feminine highlighted that in 1996, 60 percent of women reported experiencing violence, 37 percent of whom had suffered sexual violence, including rape, sexual harassment and sexual aggression.[30]

Women face sexual violence during all phases of the conflict and displacement. For example, during the years of conflict in **Bougainville**, both women and girls were at risk of rape.[31] Perpetrators of violence often include:

- police, military, guerrilla forces, peacekeepers or prison officers in detention centres, concentration camps and rape camps. Male camp leaders use women as exchange for arms, ammunition or other benefits;
- bandits, pirates, smugglers and border guards. Members of the security forces can also demand sex in exchange for women's safe passage into countries where they seek asylum or when they try to return to their homes;
- camp residents, the local population and international and national camp staff. Limited resources and lack of protection from male members of the family can leave women vulnerable to sexual exploitation; and
- hostile communities, government and security officials in post conflict situations.[32] In addition, there may be a resurgence of FGM as a way of reinforcing cultural identity.

Women raped in conflict and post conflict settings may become pregnant, but often do not want to give birth to the children conceived in such circumstances. Some **Bosnian** and **Kosovar** women who became pregnant as a result of sexual violations chose abortion or abandoned their babies at birth.[33] One viewpoint within the health service community is that access to emergency contraception or the morning-after pill may be an inexpensive and effective means of ensuring that unsafe abortions are avoided.

Domestic violence: In conflict and post conflict situations, the roles undertaken by men and women are often reversed due to the breakdown of societal structures. Men who are not employed may be stressed and frustrated and may spend most of their time socialising or drinking. In such situations, the incidence of domestic violence also surges.[34] Surveys of **Sudanese** refugees in **northern Uganda** have highlighted a high rate of domestic violence due to inadequate employment opportunities for men. In **Angola**, during 1997–99, there were 3,550 cases of violence of different types against women, with 60 percent registered as domestic violence.[35] In some instances, this is related to men's stress and the humiliation they experience in the public sphere, often at the hands of state or official security forces.

In other cases, as men return home from war, they are often traumatised, accustomed to violent behaviour and not equipped to resolve issues non-violently. As a result, women are forced to live with the threat of violence on a daily basis. In many places, domestic violence in particular is still not regarded as a serious offence. Effective prevention strategies, therefore, must focus on men, changing their attitudes to gender-based violence (GBV) and building their support against such violence. In **Cambodia** and **South Africa**, for example, men's networks against domestic violence have emerged and, have begun campaigns to end violence against women.[36]

THE VULNERABILITY OF MEN AND BOYS

As in the case of women, the SRH R&S of men and boys are affected in situations of conflict, displacement or detention. Sexual violence against adult males, adolescents and boys escalates. In conflict situations, men, like women, may experience humiliation and confusion about their sexuality. In some societies where men have been discouraged to be open about their feelings, they may find it very difficult to recognise what has happened to them. With little or no services, they are often forced into silence and ignorance. In conflict situations, adult men and older boys may also be victims of sexual violence and gender-based abuse, such as sex-selective massacre and forced recruitment.[37]

THE IMPACT OF MEN AND BOYS' ACTIONS ON THE REPRODUCTIVE HEALTH OF WOMEN

WHO has categorised men's impact on women's reproductive health as the following:[38]

Men as service users: Men and boys are at risk of contracting STIs and HIV/AIDS during conflict and displacement as they may develop risky sexual relationships that increase their vulnerability. It is important that education on safe sex, STIs and HIV/AIDS counselling and services are accessible to all. Family planning programmes should deliberately target men, not only to inform them of the dangers associated with risky sexual behaviour, but also about effective family planning and how to care for their partners and children. Condom distribution programmes should also target men directly.

Men as recipients of education and social-behaviour programmes: There is a growing perception of the need to focus resources on programmes seeking to educate men and boys to change their attitudes and behaviour concerning SRH. Men's improved knowledge and access could protect and promote women's reproductive health and rights.

Men as decision-makers: Men may have an influential role in decision-making related to the provision of sexual and reproductive health care and services to communities and to their own families. In many cultures, men often make the final decisions about family planning, economic spending on SRH medical services or even on the type of ante-natal, pregnancy and breastfeeding care that their partners receive. At the community level, men as political, religious or other leaders, may also influence the type, quality and quantity of services and rights the community in general is allowed to receive.

REFUGEES, INTERNALLY DISPLACED PERSONS (IDPs) AND REPRODUCTIVE HEALTH CARE

While their need for comprehensive reproductive health care and services remains, refugees and

internally displaced persons (IDPs) often have limited access to such care. Where it does exist, it is often basic and for emergency purposes. In such situations women's vulnerability is increased. In **Colombia**, violence and displacement are leading causes of an increase in unsafe abortions,[39] while in IDP camps in **Sri Lanka**, births are less well–spaced, resulting in worse outcomes than before displacement.[40]

During displacement, women also suffer a variety of mental health problems caused by the violence they experience, and this can affect their reproductive health. Studies conducted with **Afghan** women during the Taliban rule found that 97 percent of women suffered from depression, 86 percent displayed significant anxiety, 42 percent suffered post-traumatic stress disorder (PTSD) and 25 percent frequently contemplated committing suicide and did not want to become pregnant.[41] Additionally, women's childbearing role exposes them to a range of potential problems including:

- stress and malnutrition, which endangers the health of pregnant and lactating women and their children;
- loss of the extended network of family support when a woman is pregnant and breast-feeding;
- lack of practical or emotional support for traumatised women;
- young, single, widowed or disabled women may be at particular risk of sexual violence;
- the breakdown of family and social networks can result in many female-headed households. These women may be forced to offer sex in exchange for food, shelter or protection; and
- social changes associated with conflict may erode women's authority to control their own reproductive lives. For example, women may be pressured to become pregnant to produce children to replace those who have died.

THE IMPACT OF CONFLICT ON THE SEXUAL REPRODUCTIVE HEALTH, RIGHTS AND SERVICES OF ADOLESCENTS

During conflict, the destruction of social structures adversely affects the emotional and psychological growth as well as the sexual development of adolescents. The absence of traditional forms of guidance in the transition to adulthood may result in earlier and increased risk-taking behaviour, including the use or abuse of tobacco, drugs and alcohol. Poor nutrition and violence can be inflicted both by and on adolescents.

Their desire to plan for the future may diminish, affecting adolescents' motivation and ability to take the necessary steps to avoid STIs, HIV/AIDS and unwanted pregnancies. Adolescent girls, both married and unmarried, who become pregnant may find themselves without the support to cope with pregnancy, childbirth and raising a child.

The risks of unsafe abortion may also increase when both social support networks and health services are disrupted. The WHO representative in **Liberia** estimates that up to 80 percent of displaced girls have an induced abortion by the age of 15.[42] Unaccompanied minors, whether boys or girls, are especially vulnerable to violence and other forms of sexual exploitation. They may turn to prostitution in order to survive. They are also far more vulnerable to poor health in general. In **El Salvador**, studies show that there is a high rate of suicide among refugee adolescents.[43] Additionally, the ideas of aggressive masculinity learned by child and adolescent soldiers can have a profound and long-term negative impact on their own reproductive health and on that of the communities with which they come into contact.

ADDRESSING SEXUAL REPRODUCTIVE HEALTH, RIGHTS AND SERVICES

Since the ICPD and the PoA, attention has focused extensively on women's SRH R&S. The rights of women in situations of conflict have been strengthened by **United Nations (UN) Security Council Resolution 1325** and other developments at the international level that condemn violence against women and call for effective care. Ongoing debates centre on the merits of comprehensive health care, including affordable, equitable and rights-based reproductive health that will take account of the needs of women and girls in refugee settings. However, the effective delivery of SRH services, especially during conflict, depends on political commitment as well as sustained and adequate funding.

Insufficient funding is made worse by the policies of some governments. The US government, the largest supporter of reproductive health services for refugees

and IDPs, has currently withdrawn or restricted the use of funding for some UN agencies and other organisations. The **Mexico City Policy** (also known as the Global Gag Rule) restricts **United States Agency for International Development** (**USAID**) funding to organisations that are involved in abortions and abortion-related cases that have not received prior approval.[44] Other donors such as the **European Union** (**EU**) have tried to fill the gap, but as the funding priorities of donors shift, the ability to maintain current levels of SRH services is threatened. Moreover, an estimated 37 million displaced persons are also at risk. Many programmes, including HIV/AIDS prevention, have been reduced and family planning, the provision of contraceptives and other services, have been cut. This increases health risks and endangers the lives of the many women, men and children living in conflict-affected situations.[45]

With the increased focus on HIV/AIDS, there is also the danger that attention will be focused primarily on this disease, rather than on a comprehensive address of health care needs that also includes attention to other infectious STIs such as chlamydia, syphilis or gonorrhea.[46]

3. WHAT INTERNATIONAL MANDATES AND POLICIES EXIST TO ADDRESS AND DELIVER SRH R&S ?

The Convention on the Elimination of All Forms of Discrimination against Women (**CEDAW**): Article 12 of CEDAW requires states to eliminate discrimination against women in access to health services throughout their life cycle, particularly in the areas of family planning, pregnancy and childbirth. The Convention stressed that access to health care, including reproductive health, is a basic right.[47] It also calls on governments to provide appropriate services relating to pregnancy, birth and breast-feeding.[48]

The Convention on All Forms of Racial Discrimination promotes the right to the highest standard of health, including reproductive health in paragraph 5e (IV).[49]

The **International Conference on Population and Development** (Cairo, Egypt, 1994) resulted in the **PoA** that sets out the context of health promotion and protection in all situations, including reproductive health. Paragraphs 7.2–8.35 calls on governments to take a number of actions to promote the right of an individual to the highest standard of health, including reproductive health and rights. The Review of the ICPD deals with the issue in paragraphs 52–72.[50]

The Beijing Platform for Action (**BPFA, 1995**) **and Beijing +5** (**2000**): The BPFA incorporated much of the ICPD language on reproductive rights. The platform states that "good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment." It further states that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."[51]

International Covenant on Economic Social and Cultural Rights (**ICESCR**): Article 12 of the ICESCR recognises the right of everyone to the highest standard of physical and sexual health. Governments are required to take all steps necessary to reduce stillbirths and maternal deaths.[52]

The Convention on the Rights of the Child (**CRC**) recognises the responsibility of governments to promote the rights of children (see chapter on children's security). It also promotes the right to family planning services. Article 24 requires government to ensure appropriate prenatal and postnatal health care for mothers. Article 34 requires governments to protect the child from all forms of sexual exploitation and sexual abuse, and asks governments to take all effective and appropriate measures with a view to abolishing traditional practices that harm the health of children. Nearly all governments have signed this convention. It is therefore a strong tool for holding governments accountable.[53]

United Nations Special Rapporteur on Violence Against Women: Since the appointment of a Special Rapporteur on violence against women in 1994, the UN has received regular reports on the prevalence of different forms of violence, the legal responses that exist and recommendations for action. These

reports, available in English, French and Spanish, address violence within the family, including battery, marital rape, incest, forced prostitution, violence against domestic workers, child abuse and female infanticide; violence in the community, including rape, sexual violence and sexual harassment; trafficking in women and forced prostitution; violence against migrant workers and refugees; violence against women in wartime and in the criminal justice system; and religious extremism. The Special Rapporteur on Violence Against Women has also addressed policies and practices that have an impact on women's reproductive rights.[54]

UN Security Council Resolution 1325 (October 2000): While this resolution does not specifically mandate the protection of women's SRH R&S, it does call on all parties to armed conflict to take specific measures to protect women and girls from gender-based violence.[55]

4. WHO IS INVOLVED IN THE PROVISION OF SEXUAL AND REPRODUCTIVE SERVICES?

Many organisations and agencies are involved in the provision of sexual and reproductive health care services. They include UN agencies, bilateral aid agencies, governments and international and national non-governmental organisations (NGOs), some of which are noted below.

UN AGENCIES

United Nations High Commissioner for Refugees (UNHCR): This agency leads and coordinates international action to protect refugees and resolve their problems worldwide (see chapter on refugees and IDPs). Its primary purpose is to safeguard the rights and well-being of refugees. In addition, UNHCR has produced practical guides such as *Sexual Violence Against Refugees: Guidelines and Prevention, A Response* (UNHCR 1995) and *An Inter-Agency Field Manual on Reproductive Health in Refugee Situations* (UNHCR 1999).[56]

United Nations Population Fund (UNFPA): UNFPA is the world's largest international source of funding for population and reproductive health programmes. UNFPA works with governments (including of countries affected by conflict) and NGOs in over 140 countries, at their request and with the support of the international community. UNFPA support programmes that help women, men and young people to plan their families and avoid unwanted pregnancies; to undergo pregnancy and childbirth safely; to avoid STIs, including HIV/AIDS; and to combat violence against women. UNFPA has produced a reproductive health kit for emergency situations to facilitate the implementation of the *Minimum Initial Service Package (MISP)*. These kits contain basic reproductive health materials for use at care centres. They include condoms, oral and injectable contraceptives, drugs for the treatment of STIs and kits with emergency contraception for women.[57]

World Health Organization (WHO): WHO promotes the attainment by all peoples of the highest possible level of health and health care. WHO has designed a management guide titled *Reproductive Health during Conflict and Displacement: A Guide for Programme Managers* (2000). The Guide provides tools to assess, plan, implement and evaluate reproductive health within the broader context of planning and preparation for conflict and emergencies. It includes guiding principles. The WHO Guide also endorses a core package of reproductive health care measures and provides details of the implementation and actual delivery of the package of services. This guide is an orientation, awareness-raising and training tool for health care providers.[52]

The Inter-Agency Working Group on Reproductive Health in Refugee Situations (IAWG): IAWG was set up in 1995 to strengthen reproductive health programmes in refugee situations. It is made up of about 30 organisations, including NGOs, UN agencies and academic institutions. The IAWG has produced the *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* to facilitate the introduction of reproductive health services in all refugee settings.[59 60]

At the regional level, there is **The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa**. Article 14 on Health and Reproductive Rights requires that governments respect and promote women's right to health. This includes control of their fertility, the right to decide

whether and when to have children and, protection against sexually transmitted infections—including HIV/AIDS—as well as the right to information about their own and their partners' health.[61]

Within the EU there is the ***Communication from the Commission to the Council and the European Parliament: Health and Poverty Reduction in Developing Countries***.[62] The European Commission adopted its Health and Poverty Communication in March 2002. This commits the EU to protect the most vulnerable people from poverty through support for equal and fair health. The EU's development policy on sexual and reproductive health is based on the ICPD's PoA. The EU policy also reflects the specific targets of the Millennium Development Goals (MDGs) that call for the empowerment of women and the reduction in maternal and child mortality.

Bilateral agencies such as the **Canadian International Development Agency (CIDA)** support empowering girls and women through better access to education, more economic and political participation in their communities and health services geared toward reproductive health and fewer and safer pregnancies. Protecting women against violence is also becoming an increasingly important health and development issue. The **Swedish International Development Cooperation Agency (SIDA)** has produced an Issue Paper on *Health and Human Rights,* which sets out SIDA's Department for Democracy and Social Development Health Division's policy on an individual's health.[63]

Additionally, USAID, one of the most influential funders of reproductive rights and services, has a Global Health programme that includes a focus on, and funding for, child survival and maternal health, HIV/AIDS, infectious diseases, family planning and reproductive health.[64]

NGOs AND OTHER AGENCIES

The **Marie Stopes International (MSI) Global Partnership** is at the forefront of worldwide initiatives to institutionalise reproductive health care in refugee settings. Active in 37 countries worldwide, the initiative collaborates with national governments and non-governmental actors, providing training in a range of issues and health care services to target populations.

The **Women's Commission** was founded in 1989 and is an independent affiliate of the International Rescue Committee (IRC). It works to improve the lives and defend the rights of refugee and internally displaced women, children, and adolescents. The Women's Commission's reproductive health projects promote quality comprehensive reproductive health care for refugee women, men and adolescents in the areas of safe motherhood, family planning, HIV/AIDS, STIs and sexual and gender-based violence. The Women's Commission also undertakes advocacy work to ensure that reproductive health is on the agenda of humanitarian assistance organisations, policy-makers and donors.[65]

The **Reproductive Health Response in Conflict Consortium (RHRC Consortium)** This consortium is made up of the American Refugee Committee (ARC), CARE-America, the International Rescue Committee (IRC), John Snow International Research and Training Institute (JSI), Marie Stopes International (MSI) and the The Women's Commission. It is dedicated to the promotion of reproductive health among all persons affected by armed conflict. The RHRC Consortium promotes long-term access to comprehensive, high-quality reproductive health programmes in emergencies and advocates for policies that support the reproductive health of persons affected by armed conflict. Its three fundamental principles are to use participatory approaches to involve the community at all stages of programming, to encourage reproductive health programming during all phases of an emergency and to employ a rights-based approach as defined by the PoA of the ICPD.[66]

KEY INITIATIVES TO DELIVER REPRODUCTIVE HEALTH, RIGHTS AND SERVICES

While the challenges remain, advocacy on the part of international NGOs and agencies dedicated to the protection of women and subsequent international resolutions, debates and policies have led to increased media and political attention to gender-based violence in conflict situations. This heightened profile has encouraged the development and implementation of gender-aware programmes and successful initiatives. The initiatives listed below provide examples of the range of activities that are taking place to address reproductive rights and can stimulate women peacebuilders to replicate or adapt the most appropriate ideas to their specific conflict or post conflict setting.

- Enlisting the Armed Forces to Protect Reproductive Health and Rights: Lessons from Nine Countries (UNFPA, 2003)—The organisational and human resources of military institutions are being drawn on to protect reproductive health and rights in both peacetime and conflict situations. UNFPA has worked with the military sector to reach out to men with information, education and services on family life, family planning and other sexual health concerns, including maternal health, HIV/AIDS prevention and the reduction of gender-based violence.[67]

- Reproductive Health Care for Afghan Refugees in Pakistan (The Women's Commission, October 2003): The Women's Commission conducted a reproductive health assessment focused on the implementation of priority reproductive health activities among **Afghan** refugees in the Northwest Frontier, Baluchistan and Punjab provinces of **Pakistan** from August 2002 through June 2003. The assessment of these priority activities, also known as *Minimum Initial Services Package (MISP),* revealed that while isolated efforts have been made to improve the quantity and quality of reproductive health care for Afghan refugees in Pakistan, many programmes are limited to traditional maternal and child health care services and the quality of RH care is a significant concern.[68]

- Increasing leadership and action to prevent GBV: In the displaced camps of **Burmese** refugees on the **Thai** border, UNHCR has provided training to NGOs and Burmese women's organisations to prevent and address gender-based violence. The training focused mainly on building capacity and has resulted in a GBV response protocol known as the *Automatic Response Mechanism (ARM)*, a step-by-step guide for assisting survivors.[69]

- Providing reproductive health services to the internally displaced: Population Services Lanka (PSL), with the assistance of MSI and USAID, has carried out a project to provide integrated reproductive health care to communities affected by armed conflict in the northern and eastern parts of **Sri Lanka**. Initiated in 1995, the programme provides clinic and outreach services to IDPs.[70]

- Saving Women's Lives—Hope after Rape is a programme in **Uganda** that counsels and assists abused women and children, including refugee children abducted into sex slavery. This NGO was set up by a female psychiatrist to counsel rape victims, who in Uganda were traditionally shamed. They are referred to the programme through police and health care facilities. The programme has developed a manual for community volunteers to use in abused families, including those in which women abuse men. Hope after Rape focuses on research, training, advocacy, networking and providing psychosocial support.[71]

- Skills development for health professionals: A joint project on the reproductive health needs of women victims of violence in **Rwanda** was initiated by the Ministry of Family, Gender and Social Affairs, WHO and the Ministry of Health. As a result, a training-of-trainers course was conducted in January 1998. During the ten-day course, participants received increased knowledge about the medical and psychological results of violence and how to recognise post-traumatic stress disorder (PTSD).[72]

- Marie Stopes Mexico is providing affordable reproductive health services for **Guatemalan** refugees and internally displaced Mexicans. The programme provides information, education and communication as well as family planning and maternal child health services.[73]

5. TAKING STRATEGIC ACTION: WHAT CAN WOMEN PEACEBUILDERS DO?

Almost all countries struggle to expand access to health services. Because of insufficient resources, many countries initially offer a core package of basic services that are expanded as more resources become available. For the convenience of health users and state management, reproductive and sexual health services should be integrated into primary health care initiatives as well as services that cater to more specialised health needs. In order to ensure that governments and other actors comply with international policies and mandates, women's groups, NGOs and others could:

1. Advocate and lobby for adequate funds to support family planning and birth spacing services.

2. Develop alliances across sectors to promote information, education and communication on reproductive health services for men, women and adolescents.

   - Consider developing alliances with youth to lobby and advocate for the effective provision of services to adolescents and youth.
   - Initiate networks of men to support advocacy, public awareness-raising and education about reproductive health care issues among men. For example, in **South Africa**, they have set up a South African Men's Forum (SAMF) to address men's violence against women.[74]

3. Reach out to traditional leaders, faith-based organisations and religious leaders, to gain support for public campaigns against gender-based violence, or for promoting safe sex and family planning etc.

4. Educate women on their reproductive health rights and policies that address services so that they may be able to demand their rights.

5. Educate women, girls, men and male youth about safe contraception methods and family planning services.

6. Launch a campaign together with other organisations on the impact of GBV on women. Include young girls, men and boys.

7. Document women's experiences with sexual and other gender-based violence. Develop a photo exhibition that you can show around the community on the dangers of reproductive tract infections and STIs, including HIV/AIDS.

8. Support breast-feeding initiatives and advocate to women of its benefits. Emphasise the importance of good nutrition before, during and after the birth of the child.

9. Organise round-table discussions with relevant officials of your government, community or regional policy-makers on gender-responsive delivery of sexual and reproductive services. Raise awareness of cultural issues such as FGM that can negatively affect women's reproductive health.

10. Work with traditional birth attendants, midwives and community-based women who perform FGM to raise awareness about the dangers and encourage prevention.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARC	American Refugee Committee
BPFA	The Beijing Platform for Action
CEDAW	The Convention on the Elimination of All Forms of Discrimination Against Women
CIDA	Canadian International Development Agency
CRC	The Convention on the Rights of the Child
DRC	Democratic Republic of the Congo
EU	European Union
JSI	John Snow International Research and Training Institute
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IAWG	The Inter-Agency Working Group on Reproductive Health in Refugee Situations
ICESCR	International Covenant on Economic Social and Cultural Rights
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
ILAC	International Legal Assistance Consortium
IRC	International Rescue Committee
MDGs	Millennium Development Goals
MISP	Minimum Initial Service Package
MSI	The Marie Stopes International Global Partnership
PNGDF	Papua New Guinean Defence Force
PSL	Population Services Lanka
PTSD	Post-Traumatic Stress Disorder
PoA	Programme of Action
RHRC Consortium	Refugee Health Response in Conflict Consortium
SIDA	Swedish International Development Cooperation Agency
STIs	Sexually Transmitted Infections
SRH R&S	Sexual Reproductive Health, Rights and Services
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WHO	World Health Organization

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HIV/AIDS

ANCIL ADRIAN-PAUL

HIV/AIDS is the fourth most common cause of death worldwide. It is a direct threat to stability in many parts of the world. Governance may be threatened, as serious crimes and sexual violence increase. For example, UN Security Council Resolution 1308 states that "HIV/AIDS is exacerbated by conditions of violence that increase the risks of exposure to the disease through large movements of people, widespread uncertainty over conditions and reduced access to medical care. If unchecked, HIV/AIDS may pose a risk to stability and security."[1]

The death of men and women may result in significant reduction in productivity and labour. In 1999 in sub-Saharan Africa, 860,000 teachers died of AIDS, thus affecting the education of countless children.[2] In the South Pacific, in **Bougainville**, HIV/AIDS is affecting the sexually active, highly educated and economically productive members of communities, resulting in the loss of skilled labour and productivity, and increasing the socio-economic impact.[3] The social burdens on the state also increase as children are orphaned. It is estimated that there are 14 million AIDS orphans in the world today and this figure is growing.[4]

The fundamental rights of infected persons are often violated based on their known or suspected HIV status.[5] At the individual level, in addition to the physiological effects of the virus, fear, stigma, discrimination, shame and ignorance keep people from practicing prevention and seeking treatment, care and support. Women, due to gender inequality, poverty and other factors, make up the majority of newly infected persons.[6] They face double stigma and discrimination if they or their partner contract HIV/AIDS. Many are blamed for the disease and can be treated badly as a result.

1. WHAT IS HIV/AIDS?

HIV is the **human immunodeficiency virus**.[7] HIV attacks the immune system by replicating itself and overwhelming the human body over time, thus opening a way for **opportunistic infections** (**OIs**) such as tuberculosis (TB) and pneumonia. The **Acquired Immune Deficiency Syndrome** is the life-threatening condition known as **AIDS**, which is described "as a combination of symptoms that attack the human body following progressive damage to the immune system by the HIV virus. AIDS is not a disease but a syndrome."[8] The length of time between when a person becomes infected with HIV to when they develop AIDS varies from person to person. Individuals with HIV can remain healthy for any length of time between a few years to more than ten years before developing AIDS. Being infected with HIV does not necessarily mean that an individual has AIDS, as some people can be **carriers** and **transmitters** of the HIV virus without developing full-blown AIDS.[9]

Once the disease has progressed to a moderately advanced state, an HIV positive person (HIV+) needs a three-drug combination of anti-retroviral (ARV) drug therapy to prevent the virus from destroying their immune system. This treatment is expensive, but is effective in prolonging a person's life. There is currently no known cure for HIV/AIDS.

The HIV virus can be transmitted through:

- **Sexual intercourse**: The vast majority of HIV/AIDS infections are sexually transmitted, typically between men and women or men and men and in at least one case, between women.[10]

- **Pregnancy-related vertical transmission (mother to child transmission, or MTCT)**: Women can transmit HIV to their babies during pregnancy or childbirth. Transmission during pregnancy is possible, but very rare. Approximately one-quarter to one-third of all untreated pregnant women infected with HIV will pass the infection to their babies when they give birth. HIV can also be spread to babies through the breast milk of mothers infected with the virus.[11]
- **Blood transfusions** with unscreened or infected blood: Between 5 and 10 percent of HIV/AIDS infections worldwide are estimated to be transmitted through infected blood transfusions.
- **Sharing of infected needles and syringes** between drug users of either sex who inject drugs intravenously: Small quantities of infected blood may remain in needles or syringes and may contribute to the spread of the disease.
- **Tattoos and body piercing** may introduce tainted fluids into the bloodstream, resulting in the transmission of the hepatitis B virus as well as HIV.
- **Disfigurement**: Some traditional practices such as circumcision, female genital mutilation and ritualised scarring may also contribute to the spread of the hepatitis B and HIV viruses.[12]

MYTHS, TABOOS AND BELIEFS ABOUT HIV/AIDS

Many people do not understand what HIV/AIDS is or how it is spread, treated or prevented. This lack of understanding gives rise to incorrect beliefs about the virus, often derived from, and strengthened by, cultural and religious practices and traditions. Research conducted among 400 college students in **India** demonstrated that 55 percent of males and 68 percent of females knew that the disease was communicable and was spread by a virus, but only 9 percent knew exactly how it was transmitted.[13] Innumerable myths exist about condoms carrying the virus. Many people still believe the myth that sex with a virgin or young girl can cure men of HIV/AIDS. In **Botswana**, where nearly 40 percent of the adult population has the virus, this myth is particularly widespread, and some men may deliberately seek out young girls for intercourse as a way of avoiding HIV infection.[14] Another lesser-known myth is that sex with older women can cleanse men of HIV/AIDS. This belief is said to result from the perception that when women stop menstruating, they become clean again. Other incorrect beliefs include that HIV can be transmitted through:

- everyday contact such as shaking hands, hugging, coughing or sneezing;
- using public toilets or swimming pools;
- sharing bed linen, eating utensils or food; and
- contact with animals, mosquitoes or other insects.

GENDER DIFFERENCES AND HIV

Gender relationships and sexuality are significant factors in the sexual transmission of HIV/AIDS. They also influence the treatment, care and support of those infected and affected by the disease. Gender is a culture-specific construct that results in differences in women's and men's roles and authority, including access to information relevant to decision-making about health. Women's sexual autonomy is affected by the power imbalances between men and women, thus increasing their vulnerability to HIV/AIDS within male-female relationships, including marriage.

Physiologically, women have a greater vulnerability to HIV as the soft tissue in the female reproductive tract tears easily during intercourse, especially during incidences of forced penetration. Women are also more likely to have other untreated sexually transmitted infections (STIs), which may not have noticeable symptoms. Additionally, women's differential access to medical care, counselling and information means that they are less likely than men to receive accurate diagnosis, care and treatment once they have contracted HIV/AIDS.

Additionally, in many societies, a culture of silence surrounds sex. Women are often ignorant about, and passive in, sexual interactions. This makes it difficult for women to be informed about risk reduction or, even when informed, to be proactive in negotiating safe sex.[20] Moreover, unmarried girls are often expected to remain virgins. The taboo of premarital sex restricts women's access to information, and this increases

Global Trends in HIV/AIDS[15]

Over 20 million people have died of AIDS since 1981. An estimated 4.8 million people became newly infected with HIV and 2.9 million died of AIDS in 2003. Some 37.8 million people are currently living with HIV.[16]

Asia: In Asia, about 7.4 million people are living with HIV. Around 500,000 are believed to have died of AIDS, and about 1 million are estimated to have been newly infected with HIV in 2003. The United Nations Population Fund (UNFPA) estimates that within the next decade, China and India, the two most populated nations in Asia, will be the most widely affected.[17]

The Australian Subcontinent: Over a five-year period, annual new HIV diagnoses have increased from around 650 cases in 1998 to about 800 in 2002.

Sub-Saharan Africa: Sub-Saharan Africa, with just over 10 percent of the world's population, has close to two-thirds of all people living with HIV—some 25 million. In 2003 there were an estimated 3 million people newly infected, while 2.2 million died of AIDS.[18]

North Africa and the Middle East: Available information, based only on case reporting, suggests that about 480,000 people are living with HIV in the region. Some 75,000 people are believed to have become newly infected in 2003.

Eastern Europe and Central Asia: At the end of 2003, about 1.3 million people were living with HIV, compared with about 160,000 in 1995. During 2003, about 360,000 people in the region became newly infected, while 49,000 died of AIDS. The Russian Federation, Ukraine, Estonia, Latvia and Lithuania are the worst affected countries. Women in these regions account for 33 percent of those infected.[19]

Latin America: About 1.6 million people are living with HIV in Latin America. In 2003, almost 84,000 people died of AIDS, and 200,000 were newly infected.

The Caribbean: Around 430,000 people are living with HIV in the Caribbean. In 2003, around 35,000 people died of AIDS, and 52,000 were newly infected.

the risks of infection and pregnancy. In places where it is believed that sex with a virgin "cleanses" or "cures" men of HIV/AIDS, young girls are at particular risk of rape and sexual coercion. Attempting to access treatment for STIs can be stigmatising and may be dangerous for adolescents, young women and young men.[21]

A woman's economic dependence on a man may result in her giving priority to his decisions on matters of sexual relations, the use of condoms or other protective measures. Men may also dictate the amount of financial resources to be spent on accessing health care. Women migrants, those employed in the informal economy, as market sellers for example, and women who work at home are less likely to have access to testing and counselling, care or prescription drugs. As a result of their disadvantaged status, women may engage in commercial sex thus increasing their vulnerability to the virus. There is a direct correlation between women's low status, the violation of their human rights, and HIV transmission.[22]

Violence against women is the most disturbing form of male power. It contributes both directly and indirectly to women's vulnerability to HIV. The threat of violence, actual physical violence and the fear of abandonment, act as significant barriers for women who have to negotiate the use of a condom, discuss fidelity with their partners or leave risky relationships.[23]

MEN'S VULNERABILITY

Among other factors, the risk of men contracting HIV can increase as a result of cultural attitudes to

masculinity, fatherhood and the stigma of homosexuality. In some cultures, men are expected to be more knowledgeable and experienced about sex than women. Prevailing norms of masculinity that idealise men who have multiple partners can put men, particularly young men, at risk of infection, while shame, fear or stigmatisation can prevent them from seeking information or admitting their lack of knowledge about sex or protection. It can also encourage them to experiment with sex in unsafe ways to prove their manhood at a young age.[24] There is also the practice of late-age marriage in some societies, where men do not marry until they have built up economic resources. Meanwhile they may have no legitimate access to sex with women and so may engage in sex with other men, often younger men, thereby increasing their vulnerability.

HIV/AIDS, STIGMATISATION AND DISCRIMINATION

HIV/AIDS is strongly associated with stigmatisation, scapegoating, blame and discrimination. Stigma and discrimination affect everyone especially from children to AIDS widows, who are particularly vulnerable to violations of their inheritance and property rights. Orphans are frequently denied their right to schooling, and adoptive parents sometimes take away their inheritance unlawfully. Efforts to prevent HIV have at times unintentionally reinforced prejudice and stigma, resulting in an increased burden on those most badly affected. Research undertaken by the global consortium Agency for Cooperation and Research in Development (ACORD) in northern **Uganda** and **Burundi** indicate that stigmatising attitudes and discriminatory behaviour pervade all spheres of life, i.e. the home, family, workplace, school, health settings and the community at large.[25]

HIV positive persons suffer neglect and lack of care and are frequently excluded from community gatherings. Children of **people living with HIV/AIDS (PLWHA)** may be cruelly teased at school and excluded from games and social interaction with their peers. In addition to their social exclusion, the basic human rights of PLWHA to health, housing, education and employment protection are affected. The ACORD research identified employees who were dismissed or denied access to training and employment opportunities once their HIV status had been discovered. Such stigmatising and discriminatory attitudes negatively affect PLWHA and can seriously affect their emotional and physical health. Stigma and discrimination, and fear of being labelled, may also prevent people from being tested or from using condoms. In many cases, fear prevents people from attending clinics where they can seek and receive treatment, including ARVs.

Key factors contributing to the incidence and perpetuation of stigma and discrimination include ignorance and fear, cultural values, religious teachings, the absence of legal sanctions, lack of rights awareness, the design of government and NGO programmes and inaccurate and/or irresponsible media coverage.

HIV/AIDS AND SECURITY

HIV/AIDS is increasingly regarded as a security issue that can negatively affect social and economic progress. In its 2001 publication, the International Crisis Group (ICG) identified HIV/AIDS a threat on five levels:

1 personal security: as adult illness and fatality increases, there may be a decline in health and longevity and an increase in infant mortality. Families and communities can fall apart, and young people particularly "cease to have a viable future;"[26]

2 economic security: increases in adult infection and fatality can reduce national growth and income;

3 communal security: HIV/AIDS "directly affects police capability and community stability. It breaks down national institutions that govern society. Furthermore, it affects those most educated and mobile—civil servants, teachers and health care professionals;"[27]

4 national security: this is most evident in Africa, where military forces have higher infection rates than civilian populations. Severely weakened military and security structures can make states vulnerable to internal and external threats; and

5 international security: weakened military forces may mean that states cannot participate effectively in international peacekeeping operations.

2. WHAT IS THE IMPACT OF HIV/AIDS AND CONFLICT ON WOMEN?

The breakdown of societal structures resulting from conflict often means that women of all ages can become caretakers of family members and relatives, including orphans affected by and infected with HIV/AIDS.[28] This can prevent girls from going to school and women from contributing to the workforce or engaging in political activities, which in turn weakens the economic and social participation of the population at a crucial time of national crisis.

In such insecure situations, when life is threatened on a daily basis and poverty is on the rise, people—particularly women and girls—may sell sex to local populations as well as to peacekeepers, humanitarian, and other foreign workers as a means of economic survival. This increases their exposure to HIV/AIDS. Moreover, where security is a concern and men are seen as protectors, it is unlikely that women will be able to negotiate safe sex or to leave a relationship, even if it is perceived to be risky. The following also increase women's vulnerability to HIV/AIDS:

GENDER-BASED VIOLENCE

During armed conflict, women and girls are at greater risk of domestic violence, sexual exploitation, trafficking, humiliation, and other types of violence. Gender-based violence and sexual exploitation may include the use of small arms and light weapons (see chapter on small arms, light weapons and landmines). This type of violence increases women's vulnerability by lowering their self-esteem and limiting their mental and physical freedom. The use of sexual violence such as rape and systematic rape as a strategic, tactical weapon of war contributes to the spread of STIs, including HIV/AIDS. Recent examples from **Bosnia** and **Herzegovina** and **East Timor** reveal systematic use of rape and sexual violence as tools of war.[29] Rape victims in the **Rwandan** genocide report that HIV infection was deliberately used as a weapon of war against women. Such reports are further corroborated by the fact that the HIV infection rate among women surviving these rapes is high, with two-thirds of a recent sample of Rwandan genocide widows testing HIV positive. Human Rights Watch also estimated that over 5,000 children were born to raped and infected Rwandan women. Little data is available, however, reflecting the number of these children with HIV/AIDS.[30] In **Sierra Leone** it is estimated that 70 to 90 percent of rape survivors have contracted STIs, including HIV/AIDS. Abducted girls were also particularly at risk, due to the many episodes of sexual violence they faced.[31]

DISARMAMENT, DEMOBILISATION AND REINTEGRATION (DDR)

As peace processes are negotiated and agreements made, DDR processes become very important (see related chapters). However, there is often a failure to consider women's forced or voluntary participation in conflicts as combatants, camp followers, sex slaves, spies, cooks, porters and wives. As a result, DDR programmes are rarely designed in a gender-sensitive manner that takes into consideration women's physical, vocational, psychosocial and reproductive health care needs.

During the demobilisation period, women are vulnerable to abandonment by their combatant partners. Women and girls, particularly those with children born of rape or other relations with armed actors, often find it difficult to reintegrate into their communities. Few programmes combine training or education with childcare provisions to enable their participation. If women or their children suffer from HIV/AIDS, the stigma and discrimination against them can be severe.[32] In **Mozambique** in the early 1990s, little attention was given to HIV/AIDS or any form of STIs among dependents of armed actors.[33] While awareness and concern has risen over the last decade, the challenges are still immense, as demobilisation itself can trigger the spread of the disease into previously uninfected communities as ex-combatants return to their families, or to new relationships.[34] For example before 2003 in Angola, demobilised soldiers and returning refugees were said to be carriers of the virus, resulting in an increase in infections across the country.[35]

PEACEKEEPING PERSONNEL, WOMEN AND VULNERABILITY TO HIV/AIDS

The presence of peacekeepers can help maintain the peace in societies emerging from violent conflict (see chapter on peacekeeping). The international community is becoming increasingly dependent on peacekeepers drawn from military and police forces of both developed and developing countries to staff such operations. Most of these soldiers are of a sexually active age, are geographically mobile and

are away from home for long periods. To relieve the stress of combat, they often engage in risky and sometimes violent behaviour as they have greater opportunities for casual sexual relations. Such behaviour increases the risk of HIV infection for them and their sexual partners.

Some of the armed forces from which these troops are drawn exhibit high levels of HIV infection. The risks of sexual transmission to local populations as well as among peacekeepers must therefore be considered. For example, the National AIDS Co-ordinating Agency of **Botswana** estimates that HIV infection in the armed forces is between 35 and 40 percent. Similarly recent studies have found that in **Tanzania**, **Uganda**, **Zambia** and **Zimbabwe**, 75 percent of soldiers were dying of AIDS within one year of discharge.[36] In response to the problem of troops being both victims and transmitters of the virus, the **United Nations Security Council** (**UNSC**) has adopted Resolution 1308, which calls for national strategies to address the spread of AIDS among uniformed services, including through awareness-raising and training among their ranks.[37]

The UN itself is involving peacekeepers in activities to raise awareness and slow the spread of HIV. In **Sierra Leone**, 15,000 peacekeepers are being trained in HIV/AIDS prevention, gender awareness and women's rights. The UN peacekeeping mission in **Eritrea** and **Ethiopia** (**UNMEE**) has taken the lead in providing training on HIV/AIDS.[38] Other such training initiatives are taking place in **Botswana** and other affected countries. The United Nations Population Fund (UNFPA) is also partnering with other UN agencies, national health ministries, and military and police forces to provide HIV prevention training.[39]

Trafficking and Prostitution: Trafficking in persons, particularly women and children, is among the most serious crimes of international concern in the Rome Statute of the International Criminal Court (ICC).[40] Women who are trafficked for sexual exploitation are vulnerable and at risk of HIV. Trafficked women are often unable to access health services or information because they may be unable to communicate due to language difficulties, are unfamiliar with the local environment, are being held captive or are afraid of their captors. Additionally, fear of deportation or continued threats of violence towards them may ensure that they remain silent.

In conflict-affected situations, including **Mozambique**, **Cambodia**, **Sierra Leone**, the **Democratic Republic of the Congo** (**DRC**), **Bosnia** and **Kosovo**, peacekeepers and others with responsibility for providing protection and security to local populations have been implicated in trafficking and prostitution. Since the deployment of an international peacekeeping force to Kosovo in 1995, the International Organization for Migration (IOM) has identified Kosovo as a major destination, changing its status from a route, for women trafficked into forced prostitution.[41] Additionally, in 1999, peacekeeping troops and personnel of private security firms based in Kosovo were reported to be clients of brothels that practiced forced prostitution.

REFUGEES, INTERNALLY DISPLACED PERSONS (IDPs), FORCED MOBILITY, AND THE SPREAD OF HIV/AIDS[42]

Refugee and displaced populations (see chapter on refugees and IDPs) are particularly at risk, as the camps in which they are housed may be the settings where women and children are most vulnerable to exploitation, violence and abuse.[43]

Poverty, economic disparity and the effects of conflict often lead to migration, forcing both men and women as well as girls and boys into commercial sex work and survival prostitution. Forced population movements such as refugees or IDPs as a result of armed conflict affect the spread of HIV/AIDS. Changed personal circumstances of forced migrants—including separation from family and sexual partners, the stresses and vulnerabilities associated with the displacement process, broken community relations, and loss of social support networks—may lead to personal risks such as multiple partners and engagement in sexual activity with local providers of sexual services.[44]

Refugee women's marginalised status or cultural and linguistic barriers may prevent them from accessing health and social services, and may increase their vulnerability to HIV. In **Angola**, for example, after nearly three decades of war, refugees are returning, but they are bringing HIV/AIDS home with them.[45] In most

cases, **Angolan** refugees were based in neighbouring countries such as **South Africa, Namibia** and **Zambia,** countries that are devastated by the disease. In the **DRC,** massive displacement and systematic rape during the last violence in 1998–99 have had a severe impact on HIV/AIDS infection rates in the country, and it is estimated that the disease has increased dramatically.[46] A high incidence of rape was also reported among **Somali** refugees in Kenya in 1993.

Often refugee communities can become centres of sex work. Sexual harassment and exploitation of mobile populations by soldiers and other armed groups is commonplace, and refugees and other forced migrants have little or no recourse to legal or social protection. UNAIDS, the Joint United Nations programme on HIV/AIDS concludes that war or violent conflict and forced migration promote increased sexual intimidation of women and states that "as physical, financial and social security erode in the refugee setting, women are often forced into high-risk sexual behaviour, by trading or selling unprotected sex for goods, services and cash, in order to continue their travel."[47] Furthermore, when refugees and IDPs return to their place of origin, women may find that the self-reliance and skills they acquired during displacement are viewed negatively. Younger women in particular may experience strong social pressures to conform to their pre-conflict roles, including early marriage and childbearing—often with men who continue to have multiple partners—thus putting them at risk of contracting HIV/AIDS.[48]

ARMED NON-STATE ACTORS AND THEIR IMPACT ON WOMEN'S VULNERABILITY TO HIV/AIDS

Armed groups such as paramilitaries and guerrillas may target women and girls during violent conflict. Research by Human Rights Watch into sexual violence against women in the **Eastern DRC** has highlighted that rape and sexual crimes are not just committed by armed factions but also increasingly by police and others in positions of authority and power.[49] These include opportunistic criminals and bandits, who take advantage of impunity and the culture of violence against women and girls forced to ally themselves with such groups, offering sex in exchange for protection or for economic remuneration.[50] In such situations, vulnerability to HIV may increase. Additionally, many rape survivors infected with the HIV virus have no recourse to justice and are unable to demand reparations and accountability from those who commit sexual crimes against them.

ADDRESSING AND COMBATING HIV/AIDS: TREATMENT, CARE AND SUPPORT

HIV/AIDS often spreads where there is a lack of security resulting from violence and conflict. An effective response demands an integrated multi-sectoral strategy focused on education, information and communication, training, care and protection. HIV/AIDS prevention requires a strategic focus on empowerment and redressing gender imbalances, reducing vulnerability of individuals, providing treatment and care including voluntary counselling in pre- and post-testing phases, monitoring and evaluating trends and progress, and building knowledge through education and information.

Partnerships and alliances of different types need to be developed as HIV/AIDS affects many different sectors. A key measure is to ensure that women have access to affordable reproductive health care including free condoms.[51]

The research and development of vaccines is also critical. For the last 15 years, international organisations, the pharmaceutical industry and others have been involved in such work. In addition there is ongoing research into the development of **microbicides**—substances applied in the form of creams or gels that could reduce the transmission of STIs, including HIV.[52]

Voluntary counselling and testing (**VCT**) and access to affordable and long-term treatment can be effective in preventing HIV transmission. It can also be an important entry point for treatment of related illnesses such as TB. The **World Health Organization** (**WHO**) recommends that VCT be introduced to serve people's overall sexual and reproductive health needs. In fact, results from two pilot projects in **Côte d'Ivoire** and **India** indicate that integrating VCT into sexual and reproductive health services can reduce the stigma associated with HIV/AIDS, strengthen healthy sexual behaviour and increase access to and use of services.[53]

3. WHO DESIGNS POLICIES AND PROGRAMMES TO ADDRESS AND COMBAT HIV/AIDS?

There are currently many organisations, governmental bodies and others involved in this field. The list below provides an overview of key entities, including UN agencies, regional institutions, international non-governmental organisations (NGOs) and bilateral development cooperation agencies.

THE UN FAMILY

UNAIDS is a joint response to HIV/AIDS. Established in 1994 by a resolution of the UN Economic and Social Council (ECOSOC) and launched in January 1996, UNAIDS is the main advocate for global action on the epidemic, leading responses aimed at preventing transmission of HIV, improving care and support, reducing vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic. UNAIDS guides global responses to AIDS through leadership and advocacy for effective action; provides strategic information to guide efforts against AIDS worldwide; tracks, monitors and evaluates the epidemic and responses to it; and promotes civil society engagement, partnership development, and mobilisation of resources.

The nine UNAIDS co-sponsors each have their own programmes and priority focus. They are United Nations Children's Fund,[54] World Food Programme,[55] United Nations Population Fund,[56] United Nations Office of Drug Control,[57] International Labour Organization,[58] United Nations Economic, Social and Cultural Organisation,[59] World Health Organization,[60] the World Bank,[61] and United Nations Development Programme.[62] In addition, United Nations Fund for Women (UNIFEM) has set up a web portal with information on a range of conflict-related issues, including HIV/AIDS.[63]

GOVERNMENTS AND DEVELOPMENT COOPERATION AGENCIES

The United States (US) government has several initiatives including ones led by the Global AIDS Co-ordinator and the Director of the Office of National AIDS Policy. It has provided an annual AIDS budget of US $2.4 billion that will be spent globally, primarily by the US Agency for International Development (USAID). Among the United Kingdom (UK) government initiatives to combat and address HIV/AIDS globally is the programme by the Department for International Development (DfID).[64] Canada also provides funding for HIV/AIDS globally; information can be accessed from the website of the Canadian International Development Agency (CIDA).[65] Information on Swedish support can be accessed from the website of the Swedish International Development Cooperation Agency (SIDA).[66] Information on the European Union (EU) initiatives can be accessed from their website.[67]

4. WHAT POLICIES EXIST TO ADDRESS HIV/AIDS?

The majority of key human rights or health-related declarations to emerge from the international community in the past two decades highlight the spread of HIV/AIDS and the need for integrated and concerted preventive measures. Those particularly related to women are noted below and can be used to strengthen advocacy strategies and hold governments accountable.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). While there is no mention of HIV/AIDS, as the disease was discovered after CEDAW was drafted, Article 12 addresses the area of health. CEDAW remains the most widely recognised convention on women's rights internationally. In 1990, the CEDAW Committee issued **General Recommendation on the Avoidance of Discrimination Against Women in National Strategies for the Prevention of AIDS**, which recommends that states that are parties to CEDAW make information more widely available to increase public awareness of the risks and effects of HIV infection and AIDS, especially to women and children.

The International Conference on Population and Development (ICPD). Section C, 7:30–33 of the Programme of Action (PoA) deals with sexually transmitted infections including HIV/AIDS. Section D calls on governments to mobilise all segments of society to control the AIDS epidemic. At the review session of the ICPD in 1999 (ICPD+5), the UN General Assembly (UNGA) agreed a new set of targets, including that by 2005 at least 90 percent of young women and men aged 15–24 should have

access to preventive methods to reduce vulnerability to HIV/AIDS infection, e.g. male and female condoms, voluntary testing, counselling and follow-up.

Fourth World Conference on Women: Beijing Platform for Action (BPFA): Strategic Objective C.3 under Health recommends that governments involve HIV positive and HIV affected **women living with HIV/AIDS (WLWHA)** in decision-making on development, implementation, monitoring and evaluation of policies and programmes on HIV/AIDS and other STIs. Governments should also review and amend laws and combat practices that may contribute to women's susceptibility to HIV infection and other STIs. At the Beijing +5 Review, the UNGA organised a special session entitled *Women 2000: Gender Equality, Development and Peace for the 21st century*. At this meeting, governments adopted *Further Actions and Initiatives to implement the Beijing Declaration and PFA*, including agreement to adopt measures to promote respect and privacy for, and non-discrimination against, those living with HIV/AIDS and STIs.

United Nations General Assembly Special Session on HIV/AIDS (UNGASS): In 2001, member states unanimously agreed to a *Declaration of Commitment on HIV/AIDS* to reduce infection rates by 25 percent by 2005, to end discrimination by challenging "gender stereotypes and attitudes" and to provide AIDS education to 90 percent of young people by 2005. Specific timelines and targets include the development and implementation of multi-sectoral national strategies and finance plans for combating AIDS by 2003. These should involve partnerships with civil society and the business sector and should include the full participation of PLWHA, including those in vulnerable groups and people most at risk, i.e. women and young people.

Other notable policies include the **Millennium Development Goals (MDGs)** in the *Millennium Declaration* agreed on at the Millennium Summit in 2000. Goal 6 deals with combating HIV/AIDS, malaria, and other communicable diseases and seeks to halt and reverse the spread of HIV/AIDS by 2015. **UN Security Council Resolution 1308, 1308 S/Res/1308** (2000), calls for national strategies addressing the spread of AIDS among uniformed services to be in place by 2003 and employment of uniformed personnel to conduct AIDS awareness and prevention training among their ranks. In response, an HIV/AIDS Awareness Card was produced for peacekeepers containing facts about HIV/AIDS, a Code of Conduct for Uniformed Services, prevention instructions and a sleeve to carry a condom.

Additionally, **Security Council Resolution 1325 (October 2000) on Women, Peace, and Security** requests the UN Secretary General to provide member states with training guidelines and materials on the protection, rights and particular needs of women. It also invites member states to incorporate these elements, as well as HIV/AIDS awareness training, into their national training programmes for military and civilian police personnel in preparation for participation in peace support operations. It also recommends special measures to protect women and girls from all forms of violence in situations of armed conflict, particularly rape, other forms of sexual abuse and gender-based violence.

At the regional level, notable policies developed include the *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases: Africa Summit on HIV/AIDS (2001)* and the *Communication from the Commission to the Council and the European Parliament. Programme for Action: Accelerated Action on HIV/AIDS, Malaria and Tuberculosis in the context of poverty reduction.*[68]

There are also a number of other initiatives, including **UNHCR 2002-2004 Strategic Plan on HIV/AIDS and Refugees**, which is based on a human rights framework and the US-led **ABC** approach: **A**bstain, **B**e faithful, and use **C**ondoms. For this approach to be effective in reducing HIV/AIDS, it needs to be supported by addressing issues of gender inequality, women's empowerment, and improved and increased access to affordable reproductive health, rights and services.[69]

The **World Health Organization's (WHO) 3x5 Initiative** is a joint WHO UNAIDS effort to provide anti-retroviral therapy to 3 million people with HIV/AIDS in developing countries by the end of 2005. It is based on the core principles of "urgency, equity, and sustainability."[70] Additionally, People Living with HIV/AIDS launched the Greater Involvement of PLWHA Initiative (GIPA) in 1983 to

protest their exclusion from the planning process. Since then the acronym GIPA has been agreed on and a set of five principles developed to support PLWHA. The GIPA principles are endorsed by the UN Declaration of Commitment (2001).[71]

5. WHAT HAS BEEN DONE AT THE LOCAL, NATIONAL, REGIONAL AND INTERNATIONAL LEVELS TO ADDRESS HIV/AIDS?

Some initiatives that address women's concerns regarding HIV/AIDS in both post conflict and peace are listed below.

GLOBAL

The **International AIDS Candlelight Memorial** is a global movement, involving over 1 million people in more than 3,000 communities, who each May celebrate those living with AIDS and those who have died as a result of the disease. Increasingly, the community organisers and principal subjects of the Candlelight Memorial are young women."[72]

UNAIDS Global Coalition on Women and HIV/AIDS was created by UN AIDS in February 2004. It is a movement of people, networks and organisations launched in London. It has four key goals: to raise the visibility of issues related to women, girls and AIDS; to catalyse action to address those issues; to facilitate collaboration at all levels; and to scale up action that will lead to concrete, measurable improvements in the lives of women and girls. The Coalition seeks to build global and national advocacy to highlight the effects of HIV and AIDS on women and girls and stimulate concrete, effective action.

Stepping Stones is an international initiative first developed in 1995 in **Uganda**. Since then it has been used by over 2000 organisations in 104 countries worldwide. The initiative targets young men and women to redefine gender norms and encourage healthy sexuality. Local groups have translated and adapted it for their own use in many different countries, including **Sri Lanka** (Sinhala), **Cambodia** (Khmer), **Russia, South Africa, Tanzania** (Ki-Swahili), **Argentina** (Spanish), and **Mozambique** (Portuguese). Stepping Stones is based on three principles: that the best solutions are those developed by people themselves, that men and women each need private time and space with their peers to explore their own needs and concerns about relationships and sexual health, and that behaviour change is much more likely to be effective and sustained if the whole community is involved. Stepping Stones works through individual groups of women or men of similar ages: older women, older men, younger women, and younger men.[73]

The **International Community of Women Living with HIV/AIDS (ICW)** is the only international network, representing 19 million women living with HIV/AIDS (WLWHA) in the world. The ICW was formed in 1992 by 52 WLWHA. Thirteen of the founding members are still alive. The network focuses on research, advocacy, capacity building and networking. Members include mothers, professionals, academicians, researchers, sex workers, injecting drug users, religious leaders, wives, partners, sisters, daughters, poor and rich women. ICW has 4000 members in over 90 countries.[74]

In April 2004, the United States and 15 other wealthy nations signed up to an international agreement to streamline HIV/AIDS programmes in developing countries so that funds can be more efficiently used. Donor nations and developing countries have developed three principles called the **Three Ones** to help streamline the international community's response to AIDS. These principles are: 1. One HIV/AIDS Action Framework to coordinate all involved parties, 2. One National AIDS Authority with a mandate that cuts across all sections of society, and 3. One Country-Level System that monitors and evaluates programmes. The US, Britain, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Japan, Luxembourg, the Netherlands, Norway, and Sweden have all signed this agreement.[75]

Increasingly there is a widespread effort to clarify incorrect beliefs about HIV/AIDS. One powerful way of doing this is by showing PLWHA as they really are—human beings from every walk of life who are learning to live with their diagnosis as well as their hopes and dreams. For example, **Photo-Voice**, a London-based NGO, worked with women in the **DRC** living with HIV/AIDS, teaching them how to take photographs of each other as a form of healing, a source of sustainable income and a coping mechanism for positive self-representation. These photographs were exhibited in London. Participants in this initiative are using their

skill to earn an income by taking photographs and recording the lives and memories of PLWHA.

There are countless national-level initiatives launched by governments and NGOs, often in partnership. For example, in **Guatemala APAES-Solidaridad**, an NGO founded in 1990, has trained several thousand teachers to provide information on HIV/AIDS to students. Solidaridad has also held seminars for both men and women in Guatemala's prisons and provides nutritional and medicinal programmes for patients and their families.[76] In **Cambodia, the Reproductive Health Association (RHAC)** runs voluntary counselling and testing programmes, raising awareness of the consequences of risky behaviour and contributing to the reduction of infection rates.[77]

In **Northern Tanzania,** after an influx of refugees and the accompanying health and social problems, a one-stop medical project was launched by the African Medical Research Foundation (AMREF), local civil society and government organisations. The project targeted primarily women but actively sought the involvement of male partners where possible. AMREF and its partners provided a variety of integrated services, including HIV testing, counselling, family planning, life education skills, and training culturally acceptable counsellors for the community outreach support of women and families that suffered from violence and abuse.[78]

In Freetown, **Sierra Leone**, the **Women in Crises** project has two drop-in centres where women and girls can learn how to protect themselves against HIV/AIDS.[79] In **Rwanda**, the Polyclinic of Hope established in 1995 addresses the medical, psychological and economic needs of women victims of rape and related crimes. The Centre provides HIV awareness programmes, testing, special care and support to victims of HIV.[80] Commercial sex workers who were the victims of the **Ethiopia-Eritrea** war benefited from an integrated programme of counselling, care and income generation.[81] And, as noted in the table below, there are also a number of private sector initiatives across Africa.

Private Sector Actor	Initiative
Eskom—a South African utility company	Implements a programme to upgrade the skills of medical practitioners in rural areas. Complements ESKOM's own in-house response to prevention, care and support activities.
Coca-Cola	Provides voluntary counselling, HIV testing and anti-retroviral therapy to all eligible employees.
Private Investors for Africa—a group of multinational companies, including **Barclays**, **Diageo**, **UNILEVER**, and others	Has created a Working Group on HIV/AIDS to better understand how joint action and shared experiences of the private sector and broader community can improve efficiency in addressing AIDS.
The Global Business Coalition on HIV/AIDS—an organisation of large multinational companies	Members of the Coalition must adopt a set of company principles and practices for dealing with HIV/AIDS including non-discrimination, prevention and awareness, VCT and care, support and treatment.
Merck and Company, the Bill and Melinda Gates Foundation, and the Government of Botswana	Have developed the African Comprehensive HIV/AIDS Partnership to scale up the country's national programme to provide ARV treatment.[82]

6. TAKING STRATEGIC ACTION: WHAT CAN WOMEN PEACEBUILDERS DO?

1. Women can lobby and advocate for the implementation of local, national, regional and global policies developed and adopted to address HIV/AIDS.

   - Develop alliances with men's groups in order to form a more powerful advocacy platform, e.g. examine the UN Declaration of Commitment (2001), identify which articles most respond to the needs of your community, and advocate for them, targeting local and national authorities.
   - Organise a policy dialogue between women's organisations and policy-makers in your country.
   - Set up a village or community AIDS Council that could have the following functions:
     - organising AIDS prevention efforts;
     - increasing access to health services; and
     - creating projects to re-educate the community in order to lessen stigma and discrimination.

2. Conduct assessment analyses to identify the sectors of the community most at risk and plan appropriate interventions. For example, if there are sex workers in the area, training and awareness-raising programs could be targeted at them.

3. Identify and include local men into the network of activists—and encourage men to initiate awareness-raising or training programmes among men in the community.

4. Link up with PLWHA groups to provide counselling services tailored to men, women, youth, children and older people. Develop an alliance and perhaps engage in a campaign for the inclusion of these groups in decision-making to address or combat HIV/AIDS.

   - Launch initiatives to unite orphans with other family members and relatives.

5. Reach out and work with refugee and IDP communities. Draw on Article 75 of the **Declaration of Commitment** (that focuses on emergency situations) to inform groups of their rights.

   - Make contact with your local, national or regional UNHCR office and other relevant policy-makers to generate support.
   - Provide basic services to AIDS victims. In **Uganda**, for example, PLWHA groups provide services to infected refugees and IDPs.

6. Focus on national policies and monitor the government's implementation of its international commitments and the time frames and targets they have set themselves.

   - Build the capacities and knowledge of members of your organisation to monitor commitments, lobby the government and launch public awareness-raising campaigns.

7. Develop an alliance with targeted businesses to secure funding for multi-sectoral initiatives on community information, education and communication.

8. Where peacekeeping operations are present, work with the Gender Units and HIV/AIDS Officers to educate, inform and raise awareness of HIV/AIDS issues among the peacekeeping personnel (both military and civilians) of these missions.

   - Reach out also to humanitarian workers and offer training workshops on addressing HIV/AIDS in a culturally appropriate manner.

9. Traditional healers, religious and even military leaders, and other such actors can play a role in changing perceptions, correcting false beliefs and addressing stigma and discrimination. Develop a project to build the capacity of such actors to become peer educators and champions to address and combat HIV/AIDS in your community.

10. Training is also an important issue. UNFPA is training health care providers and their families in the knowledge and skills needed to prevent the disease. You can engage in training local men and boys as well as security forces and the police in your country. Launch a programme to train and

educate demobilised soldiers—either on their own or if possible with their families—and include both men and women. Try to link up with local UNFPA offices and other agencies that fund and support such projects. Wherever possible, involve men as partners for change.

11. Counselling services: Integrate the prevention of HIV/AIDS infection with reproductive health, including family planning services.

    - Set up counselling services that are tailored to women and also to husband-and-wife teams to educate both women and men on HIV/AIDS.
    - Create polyclinics where counselling services and medical help are combined with economic support programmes to assist victims of rape and the HIV infected.

12. Condom provision: Launch a campaign to educate local women and adolescents as well as sex workers about the benefits of using female condoms if male condoms usage is low.

    - Launch promotional campaigns for condom distribution at parties, group discussions, local plays, etc.
    - Contact UNAIDS or any one of the individual UN partners for help in how to engage effectively.
    - Make condoms available to refugees and IDPs in food and non-food distribution centres.

13. Target and support refugee communities, providing basic health care as well as education, information and counselling about HIV/AIDS, free condoms, confidential testing and, if possible, medication.

14. Target commercial sex workers, combining income-generating projects with integrated counselling and information on HIV/AIDS prevention.

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ACRONYMS

ABC	**A**bstain, **B**e faithful, and Use **C**ondoms
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-Retroviral Drugs
BPFA	Beijing Platform for Action
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIDA	Canadian International Development Agency
DDR	Disarmament, Demobilisation and Reintegration
DFID	UK Department for International Development
DRC	Democratic Republic of the Congo
ECOSOC	Economic and Social Council
FGM	Female Genital Mutilation
GIPA	Greater Involvement of People Living With AIDS
HIV	Human Immunodeficiency Virus
HIV+	HIV-Positive Person
ICC	International Criminal Court
ICG	International Crisis Group
ICPD	International Conference on Population and Development
ICW	International Community of Women Living with HIV/AIDS
IDP	Internally Displaced Person
ILO	International Labour Organization
IOM	International Organization for Migration
IPAA	International Partnership on AIDS in Africa
MDGs	Millennium Development Goals
MSM	Men Who Have Sex With Men
MTCT	Mother-to-Child Transmission
NGO	Non-Governmental Organisation
OIs	Opportunistic Infections
PFA	Beijing Platform for Action
PLWHA	People Living with HIV/AIDS
POA	Programme of Action
PTCT	Parent-to-Child Transmission
RHAC	Reproductive Health Association, Cambodia
RHRC Consortium	Reproductive Health Response in Conflict Consortium
SIDA	Swedish International Development Cooperation Agency
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Economic, Social and Cultural Organisation
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commission on Human Rights
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
UNODC	United Nations Office of Drug Control
US	United States
UNSC	United Nations Security Council
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WBG	World Bank Group
WFP	World Food Programme
WHO	World Health Organization
WLWHA	Women Living With HIV/AIDS

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Children's Security

CAMILLE PAMPELL CONAWAY AND KELLY FISH

International humanitarian law has long recognised two groups of civilians—women and children—who deserve particular protection during times of armed conflict. The impact of war on children has been the subject of increasing attention by the United Nations (UN) and other international bodies, and most recently, a new focus has been placed on the specific needs and concerns of girls. It has also been increasingly recognised that children play a variety of roles in conflict—not only as victims, for example, but also as armed actors. An overall framework for addressing the needs and concerns of children and youth in times of armed conflict and post conflict reconstruction has not been comprehensively developed, although significant progress has been made in defining the many issues involved.

This chapter outlines these issues, addresses gender considerations for children in times of war and post conflict reconstruction, and describes the vital role that women play in their survival, protection and rehabilitation. The definition of a "child" or "youth" is itself an unresolved issue in many situations; for example, in parts of Africa a mother (no matter how young) is not considered to be a child regardless of her own age. For the purposes of this chapter, however, a child is defined as anyone under the age of 18; youth or adolescents refer to older children, generally above the age of 15.[1]

1. WHAT HAPPENS TO CHILDREN DURING WAR AND POST CONFLICT RECONSTRUCTION?

CHILDREN'S SECURITY DURING WAR

"War violates every right of a child—the right to life, the right to be with family and community, the right to health, the right to the development of personality, and the right to be nurtured and protected."[2] For children who survive, war completely disrupts their structures of social support by undermining networks and connections between families and communities. In many cases, they are left abandoned or orphaned and face the difficulty of finding their own means of survival. In extreme cases, children experience profound trauma as a result of the violence surrounding them. A **UN Children's Fund (UNICEF)** survey in **Rwanda** following the genocide found that 80 percent of the children surveyed had lost family members and more than 33 percent witnessed their murder.[3]

Individuals, families and entire communities may be forced to flee their homes due to conflict or violence, becoming **refugees** (crossing international borders) or **internally displaced persons (IDPs)**. According to the **UN High Commissioner for Refugees (UNHCR)**, children comprise 39 percent of refugees, and estimates place children at over half the total number of displaced people worldwide.[4] Displaced populations face physical risks such as landmines, attacks by various fighting forces and limited food and other resources, leaving children especially prone to malnourishment and illness. Children are also at risk of being separated from their parents, family members and other caregivers during their flight, leaving them vulnerable to exploitation and abuse, sexual slavery and forced recruitment into the fighting forces. While refugees are given some protection and assistance, IDPs are often stranded within or near zones of conflict and do not receive even the basic protection given to refugees (see chapter on refugees and IDPs).

Children in communities are often coerced or forced to commit violent acts to gain protection, food, shelter or other resources for themselves or their family. Drug smuggling, grave digging and carrying

messages or equipment are activities forced upon children. In addition, war affects girls in different ways than boys. "The impact on girls is different because of their lower status before conflict begins; often powerless before and during conflict, girls are prone to be subjected to humiliation and abuse."[5] Prostitution often increases during times of conflict, and the presence of a peacekeeping force may actually lead to the recruitment of prostitutes (see chapter on peace support operations). It has been documented that UN peacekeepers recruited young girls into prostitution during the UN Operation in **Mozambique**.[6] Sexual exploitation is devastating for children, leading to serious health issues including pregnancy and psychological trauma. Communities and families often ostracise the children of peacekeepers, also known as "UN children."

Abductions of both boys and girls are a common occurrence during armed conflict and most often are part of a strategy to recruit child soldiers. Some are taken from their homes during raids; others may be pulled from their classroom or other public areas. In **Myanmar (Burma)**, for example, groups of children from 15 to 17 years old have been forcibly conscripted from the classroom.[7] Some are forced to abuse or kill members of their own family in the course of their abduction—both to provide them with no alternative to their participation in the armed group and to initiate them into violent acts.

Children are often targeted for conscription as combatants because they are seen as easily manipulated; in some cases, children have been drugged to ease them into fighting. Although children are forcibly recruited or abducted in most cases, some children may choose to become soldiers due to dire circumstances and few alternatives: "They may join for economic reasons, because their families are too poor to provide them with food and education. Children surrounded by war and chaos may come to associate armed groups with power and protection. Or they may be motivated in response to injustices suffered by their families and communities… If they are unable to attend school and have no opportunities for vocational training, soldiering may seem to be the only option."[8] In some cases, family members may encourage their participation.

Whether through forced recruitment or by choice, girls and boys perpetrate violence while serving as child soldiers in the rebel groups and as part of government forces. Though it is prohibited by international law for children under 18 to participate in armed hostilities,[9] it is estimated that 300,000 children are soldiers worldwide, with recruitment, for the most part, beginning at age 10.[10] In **Liberia**, for example, UNICEF estimates that 50–60 percent of fighters in the recent conflict were under the age of 18.[11] Children are often treated as adults once recruited or abducted; they participate in brutal induction ceremonies soon after recruitment. They have been perpetrators of some of the worst human rights abuses, including rape, looting and murder. In addition to participating in combat operations, child soldiers may serve as guards, lookouts, messengers, spies, porters, cooks and food gatherers. If they fail in their duties or are taken prisoner, severe abuse or death may result.

Once in the fighting forces, girl soldiers are disproportionately oppressed. They are often subjected to sexual violence or forced to become "wives." In **Northern Uganda**, the Lord's Resistance Army (LRA) has abducted thousands of girls. Many are "repeatedly raped, and many bear children in the harsh conditions of the bush or in LRA encampments with barely enough food to survive or no health care."[12] Girls also work more hours than boys, have lower literacy rates and suffer from death and disease due to lack of reproductive healthcare. At the same time, girls take on leadership roles in some armed groups, commanding all-girl units, and are placed in charge of loot or of defending the camp while male combatants are on raids. Girls face particularly harsh circumstances upon their reintegration, disowned by their own families and excluded from official programmes for ex-combatants who do not recognise them as such. Many have young children of their own as a result of repeated sexual violence. Former girl soldiers are among the most vulnerable populations in the post conflict period.

CHILDREN'S SECURITY IN THE AFTERMATH OF WAR

Children's security concerns do not end with the cessation of armed conflict and the signing of peace agreements.

Street Children: A major side effect of war that occurs in nearly every post conflict state is a surge in crime

and other forms of violence. Due to the availability of small arms, as well as poverty and instability, many children become "street children," often carrying arms and forming gangs—in some cases, a welcome option for children destitute and living in the streets of urban areas. In Bujumbura, **Burundi**, it is estimated that there are 5,000 street children, often accused of committing violent crimes, including rape.[13] Yet street children are often victims of post conflict violence as well. In fact, in **Ethiopia**, as child prostitution is on the rise (along with the rate of HIV infection), nearly half of young prostitutes said they had been raped before turning to the streets, with one third becoming pregnant as a result.[14]

Landmines: Another consequence of war is the existence of landmines and other unexploded ordnance, a particular hazard to children, who are a large percentage of landmine victims (see chapter on small arms, light weapons, and landmines). "Children in at least 68 countries live amid the contamination of more than 110 million landmines. Added to this number are millions of items of unexploded ordnance, bombs, shells, and grenades that failed to detonate on impact."[15] There are more landmines on the African continent than elsewhere, although **Cambodia** and **Afghanistan** have very high numbers as well. In **Angola**, there are an estimated 10 million landmines and 70,000 amputees, including 8,000 children.[16]

Trafficking and Labour Exploitation: Children are at an increased risk of trafficking and labour exploitation during and following conflict. It is estimated that 800,000 people are trafficked internationally each year and millions more within their country's borders.[17] Of all trafficking victims, the United States (US) Department of State reports that 80 percent are female and 50 percent are children.[18] Victims of trafficking may be sold into slavery or forced to work as prostitutes, child soldiers, domestic servants or labourers in sweatshops or quarries.

Violence in the Home: Following a conflict, children are also threatened within their homes, as there is usually a rise in domestic violence. Child abuse—physical and psychological—was listed as a top-five concern of children surveyed in **Northern Uganda**.[19] Children of raped women—often of mixed race or ethnicity—are at particular risk of abuse by their own families and communities, which in some cases refuse to allow their daughter or sister to remain in their home, forcing her to fend for herself and her children. In other cases, mothers abuse or abandon their own children, who remind them of their attackers. In **Rwanda**, some mothers even named their children "little killers."[20]

Health: The overall breakdown in established social values, limited access to reproductive health services, increased population movements and incidences of rape facilitate the spread of sexually transmitted diseases, including HIV/AIDS during war (see chapter on HIV/AIDS.) An estimated 11.8 million young people (15–24) are living with HIV/AIDS, and 14 million children have been orphaned as a result of the disease.[21] Young women and girls are at greater risk of infection for a variety of reasons including:

- biological factors that physically put women at greater risk of contracting the disease;
- economic needs that compel women to engage in sexual activity for money or other resources; and
- cultural and social norms that encourage older men to engage in sexual activity with young girls and that allow even married men to remain sexually active with multiple partners. Women are often discouraged from taking preventative steps.

HIV/AIDS in particular has a devastating impact on children: "Because HIV/AIDS so often impoverishes and stigmatises the children it affects, and claims the lives of so many of their extended family, these children are at high risk of having to eke out livelihoods on the street or in other potentially dangerous situations."[22] Parents or caretakers who die of AIDS may leave children with no one to look after them, forcing them to assume the responsibilities of the head of household and reducing prospects for education or vocational training. In **sub-Saharan Africa** alone, 12 million children have lost one or both parents to AIDS.[23] In **Cambodia**, one in three children in AIDS-affected families had to provide care and take on major household work; most left school and went without basic necessities including food and clothing.[24] This has a tremendous impact on the political, economic and social future of these countries.

Armed conflict severely impairs the psychosocial health of children as well. In **Iran**, more than a decade after the end of the Iran-Iraq War, adults who were children during the war continue to suffer from stress and trauma. In addition, the loss of family members, breakdown of their support networks, the witnessing of severe forms of violence and involvement in abuses can have long-term effects on children and youth. These issues must be addressed in the post conflict period through, for example, the provision of psychosocial counselling, education and sports and arts programs that help rehabilitate and normalise life for children.

CHILDREN'S ROLES IN POST CONFLICT RECONSTRUCTION

Although children suffer tremendous abuse as a result of war, they are also often more resilient than adults in the aftermath. Many adapt to the post conflict environment and are motivated to pursue education and employment opportunities.

Disarmament, Demobilisation and Reintegration (DDR): The existence of children in fighting forces was, until recently, unacknowledged internationally. Children have been historically left out of DDR programmes designed to disarm, demobilise and reintegrate combatants (see chapter on DDR). Governments, in particular, continue to deny that child soldiers are among their ranks. UNICEF, Save the Children and other organisations have begun programmes to address the needs of child ex-combatants, and it is increasingly recognised that DDR programmes should aim to improve the conditions and treatment of all children in a community—not only the child soldier.

The recognition of girls as child soldiers (usually as part of fighting forces, not government groups) has been an even more difficult issue to tackle. Despite the fact that humanitarian aid organisations work with female abductees, DDR programs implemented by governments and international organisations have rarely recognised women and girls as "combatants," and thus they are ineligible to receive the benefits of a reintegration programme. In **Sierra Leone**, of the 137,865 in the fighting forces (rebels and government), 48,216 were child soldiers (17 years of age and younger). Of those, 12,056 were girls. As of 2003, only 6,181 boy soldiers had participated in DDR, and only 506 girls had gone through the process.[25] Various international NGOs have begun rehabilitation programmes specifically for girl ex-combatants to fill this gap. Save the Children, for example, worked intensively with families in the **Democratic Republic of the Congo** (**DRC**) to sensitise them to the needs of returning girl soldiers.

Governance and Political Participation: Although children are rarely considered in discussions of governance and political participation, their involvement is imperative (see chapter on governance). The World Bank points out, "An important, but yet under-utilized voice in helping to address some of these concerns [such as corruption, poverty, and abuse of power] is the role of youth…. [They] can be resilient, resourceful, and responsive, and there is a need to encourage and establish mechanisms in countries to involve youth in playing a role in addressing corruption and consequently improving governance in their countries."[26]

The Oxfam-funded International Youth Parliament was formed in 2003 to bring together 300 youth each year from around the world to discuss issues ranging from conflict and HIV/AIDS to education.[27] Regional initiatives, including the African Youth Parliament and the European Youth Parliament, have also been developed in recent years.

On a national level, in **Rwanda**, following the genocide, the transitional government, recognising the severe effects of the civil war and genocide on youth, allocated special representation for youth in the local and national governing structures. There are two youth seats in the Rwandan Parliament and a Ministry of Youth, Culture and Sport, which focuses on children's concerns.[28] In **Kenya**, youth are elected by children in Nairobi Province to fill an 11-member youth cabinet with a mandate to raise awareness and advocate for the protection of children's rights throughout the country.[29] In 2003, the **Republic of the Congo** launched the National Children's Parliament, composed of 36 members and an executive council of four girls and one boy. The new initiative will "serve as an official body entrusted with promoting children's rights…and with finding solutions to problems that affect children."[30]

Transitional Justice and Reconciliation: Children's involvement in transitional justice and reconciliation in post conflict societies is imperative (see chapter on transitional justice and reconciliation). Mechanisms, whether in the form of truth commissions, special courts or grassroots initiatives, must take into consideration the needs and concerns of children and youth. Children, as victims and perpetrators, have important roles to play to ensure the sustainability of peace.

To date, no international court or tribunal has prosecuted anyone under the age of 18, and the **International Criminal Court** (**ICC**) prohibits itself from any prosecution of children. In national courts, however, children have been tried for atrocities committed during war. Some were mistreated while in custody, were imprisoned with adults or juvenile criminal offenders, or were given the death penalty. In **Colombia,** child soldiers from left-wing guerrilla groups have been incorporated into the armed forces or detained in military institutions. In 2001, in the **DRC**, civil society organisations advocated for setting aside the death penalty verdicts against six children and were successful, but for one who died in prison as a result of disease.[31]

At the national level, only one truth commission has addressed the special needs of children in its mandate, though most have included children in lists of victims and witnesses. In **Argentina,** the National Commission on Disappeared Persons was required to "determine the whereabouts of children removed from the care of their parents or guardians…and to intervene as appropriate in organisms and tribunals for the protection of minors."[32] Its final report includes details of crimes against children and adolescents.

In local judicial processes, there are concerns that children do not have access to international judicial standards. In **Rwanda,** children over the age of 14 at the time of the genocide may be judged as part of the ***gacaca***, a community-level, traditional justice mechanism. Yet, in this process, children will not have access to counsel and must represent themselves publicly before the community.

With regard to reconciliation efforts, special initiatives have been made to involve children in a variety of transitional justice mechanisms. In the **South African** Truth and Reconciliation Commission, special hearings and workshops were established for children to engage with the process. In many societies, traditional healing practices and rituals of reconciliation involve children. "Traditional cleansing and healing ceremonies for former child soldiers have been important means for some communities to recognize and assuage the guilt that child soldiers carry…. [They] are intended to provide a clean break from past atrocities."[33]

Education and Training: In general, opportunities for education and vocational training for children and youth should be an essential component of reconstruction and development, particularly as war causes years of lost time in this area. According to the Women's Commission for Refugee Women and Children, educational programs "provide them [children] with structure, purpose, skills for the future, integration within the community, identity, hope, and more."[34] An estimated 27 million children and youth are without education in conflict zones.[35] Although boys and girls may equally access pre-primary and grade one, girls' enrollment drops at each successive level.[36] **UNICEF** has made girls' education a priority in its development planning, noting that, with education, women marry later, have fewer children, are more productive, are better paid in the workplace and have less chance of contracting HIV/AIDS.

Vocational training is particularly important for adolescents and older youth, many of whom entered the war as children but may now be adults. Training should be geared toward available jobs according to the needs of various communities. The European Union and UNHCR have funded a programme that offers apprenticeships to former **Afghan** refugee youth in 27 areas including mechanics, leatherwork, baking and electricity.[37] A programme for **Mozambican** refugees prioritised the most vulnerable groups, including women and youth, for training in farming, blacksmithing, pottery and bicycle repair, among other fields.

Peace Education[38]

Peace education is a preventive and restorative tool for raising awareness about the causes and consequences of violence among children and adults. The goals of peace education include:

- developing attitudes of non-violence, justice, tolerance and respect for human rights;
- increasing knowledge of relevant subjects such as landmines and HIV/AIDS; and
- learning specific skills such as critical thinking, compromise and communication.

When taught in a classroom environment, activities might include story telling, self-expression, cross-cultural exchanges and active participation in discussions and groups.[39] Peace education can be taught using a variety of media and in many locations. UNHCR ran a programme in **Kenya**, for example, in refugee camps for adults and children. Search for Common Ground, a US-based NGO, broadcasts a children's television show in **Macedonia** that encourages conflict resolution and includes a wide range of youth.

2. WHO AND WHAT CAN PROMOTE CHILDREN'S SECURITY IN CONFLICT?

It is increasingly evident that the only way to ensure children's security is to take a holistic approach, involving a wide range of actors and resources and drawing from a solid base of international law and policies.

In 1994, Graça Machel was appointed by the UN Secretary General to submit a study on the impact of armed conflict on children.[40] Following the report's publication in 1996, the **Special Representative of the Secretary-General (SRSG) for Children and Armed Conflict** was appointed. The SRSG has played a significant role in mainstreaming child protection issues into the UN system, including child protection mandates in peacekeeping missions for **Sierra Leone** and the **DRC**. Together with UNICEF, he has also played a key role in maintaining the issue of children and conflict on the UN's priority list, highlighting developments in regular reports and offering recommendations for action.

The success of these initiatives is evident in a number of ways. For example, the 2003 peace agreement in **Liberia** specifically calls for "special attention to the use of child combatants…. It shall, accordingly, mobilize resources…to address their special demobilization and reintegration needs."[41] Subsequently, the UN Secretary General assigned two child protection advisors and a gender advisor to work with his Special Representative for Liberia. A detailed programme was developed for the estimated 21,000 child soldiers in the country with plans for separate camps for girls and special assistance that included psychosocial support and reproductive health (see chapter on reproductive health).[42] Yet its implementation has been delayed, reflecting the many challenges to providing services to children in conflict.

CHILDREN IN THE CONTEXT OF INTERNATIONAL LAW

There are numerous international treaties that promote children's security. The following are among the most important:

1. **The Universal Declaration of Human Rights (UDHR)** and the **Geneva Conventions** are the foundation of international human rights law and international humanitarian law (see the appendix for the UDHR full text). The UDHR specifically calls on the need for special care and protection for women and children in Article 25 (2): "Motherhood and childhood are entitled to special care and assistance."[43] The Fourth Geneva Convention (1948) and the subsequent Protocols (1977) outline necessary protection of civilians during armed conflict, specifically addressing children as follows:[44]

   - Parties to a conflict must respect children, provide them with any care or aid they require and protect them from any form of indecent assault. (Protocol I, Art. 77, Sec. 1)

- Children under 15 must not participate in hostilities and must not be recruited into the armed forces. (Protocol I, Art. 77, Sec. 2; Protocol II, Art. 4, Sec. 3C)
- Those children who do participate in hostilities do not lose their protections under the Geneva Conventions. (Protocol II, Art. 4, Sec. 3d)
- Children who have committed an offence related to the armed conflict before their 18th birthday cannot be subject to the death penalty. (Protocol I, Art. 77, Sec. 5)
- If arrested, detained or interned, children must be held in separate quarters from adults, unless they are with their families. (Protocol I, Art. 77, Sec. 4)
- Warring parties must try to make local agreements to allow the removal of children from besieged or encircled areas. (Convention IV, Art. 17)
- Warring parties must allow the free passage of medicine, food and clothing intended for children under 15. (Convention IV, Art. 23)
- Warring parties, to the extent possible, must ensure that orphans or lost children are not left alone and that they are cared for according to the religious and cultural traditions to which they are accustomed. (Convention IV, Art. 24)

2. The **Convention on the Rights of the Child (CRC)** and its Optional Protocols are the most important international legal instruments to date for ensuring children's security. Entering into force in 1990, the CRC recognises children's rights as human rights and has been ratified by 192 states, more than any other treaty (only two countries are not signatories—the United States and the Sudan). The Convention binds states to protect the social, cultural, economic, and political rights of children. Its four guiding principles are non-discrimination (Article 2), best interests of the child (Article 3), survival and development (Article 6) and participation (Article 12). It includes special protection measures to address children affected by armed conflict (Article 38, 39).[45]

3. The CRC **Optional Protocol on the Involvement of Children in Armed Conflict**, which was adopted on 25 May 2000 by consensus of the UN General Assembly, raised the age for participation in armed conflict from 15 to 18 years and established a ban on compulsory recruitment below the age of 18.[46] The second CRC **Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography**, also adopted in May 2000, prohibits the sale, sexual exploitation and forced labour of children. Although both documents entered into force in 2002, far fewer countries have ratified the optional protocols than the initial CRC.[47]

4. The 1995 **Beijing Platform for Action**, adopted at the UN Fourth World Conference on Women, makes specific reference to advancing the rights and concerns of the "girl child."

5. The **Rome Statute of the International Criminal Court** includes provisions against the conscripting of children under the age of 15. Article 8 specifically defines conscripting or using children in international or internal conflicts as a "war crime." In addition, the ICC statute gives itself no jurisdiction for children under the age of 18. Together, these advances enable prosecution of the recruiter, rather than the child, before the ICC. Cases are brought before the court by a government that is party to the treaty, by the ICC's prosecutor or by the Security Council.

The first prosecution of child recruiters under international law was under way at the time of this publication. The Special Court of **Sierra Leone** is prosecuting members of the pro-government militias on war crime charges of "child recruitment."[49]

6. Since 1999, the **UN Security Council** has passed four resolutions on children and conflict, all of which are international law:

   - **Resolution 1261** (1999) reiterated the importance of protecting children during armed conflict, condemned their use as soldiers and encouraged programmes to facilitate their disarmament and reintegration.
   - **Resolution 1314** (2000) urged children's inclusion in official peacebuilding processes, noted the special needs and vulnerabilities of girls and provided examples of regional initiatives to protect children.

- **Resolution 1379** (2001) noted the need to protect children during peacekeeping operations, expressed the importance of ending sexual violence and exploitation of women and girls and requested that UN bodies and external agencies direct resources to these issues.
- **Resolution 1460** (2003) noted that the recruitment of child soldiers is now a war crime under the Rome Statute of the International Criminal Court and recognised the need to prevent the sexual exploitation and abuse of women and children by peacekeepers and humanitarian workers through training and punishment.

INTERNATIONAL ACTORS

Although a number of UN agencies address children's issues in the scope of their work, UNICEF is the primary UN branch involved in children's security. **UNICEF** outlines eight elements of a protective environment for children:[50]

1. attitudes, traditions, customs, behaviour and practices that protect children from abuse;
2. governmental commitment to fulfilling protection rights;
3. open discussion and engagement with child protection issues;
4. protective legislation and enforcement;
5. the capacity to protect among those around children;
6. children's life skills, knowledge and participation in their own protection;
7. monitoring and reporting; and
8. services for recovery and reintegration.

In its advocacy role, UNICEF promotes the ratification and implementation of treaties to protect children, and monitors and reports on violations of these agreements. UNICEF recently partnered with the UN Department of Peacekeeping Operations to develop training materials so that peacekeepers are fully aware of children's rights, specifically the right not to be victimised by sexual violence. In its programmatic role, UNICEF funds and conducts programmes as varied as family reunification, drug abuse treatment, peace education and landmine awareness. In **Afghanistan**, UNICEF is working in partnership with local and international non-governmental organisations (NGOs) to demobilise child combatants and to reintegrate them with sensitisation and psychosocial programmes, including formal education and skills training.

The **International Labour Organization (ILO)** has adopted various tools for child protection. The most prominent among these is the **Worst Forms of Child Labour Convention** (Convention 182, 1999), which applies to all children under the age of 18 and aims to eliminate the most brutal forms of child labour, including child soldiering, prostitution and slavery. The ILO has field offices around the world that offer a variety of programmes for children and adults. For example, in the conflict zones in **Colombia**, the ILO is conducting a project for child victims of sexual violence.

The **Committee on the Rights of the Child** (established by the CRC) is the key entity that monitors compliance of states that are parties to the Convention by evaluating the country reports required by the CRC. The committee has also developed new standards of protection and pressed governments for specific reforms.[51] The advocacy and watchdog role of NGOs is necessary to the work of the Committee, as each review process for country reports begins with working group meetings during which NGOs can highlight specific areas of concern regarding the government under review.

Multilateral development agencies, such as the World Bank, also contribute to post conflict reconstruction efforts. **The World Bank**, in particular, aims to incorporate child protection and development into its programmes. It runs projects specifically for children that address girls' education, adolescent reproductive health, child labour, immunisation, nutrition and safety.

Donor countries and their respective bilateral development agencies (e.g. the US Agency for International Development, the British Department for International Development, and the Canadian International Development Agency) play a key role in

programme development. For example, the Canadians set aside CAD$122 million for child protection for the years 2001–06.[52] Their programmes address child labour, children affected by armed conflict, street children and child victims of sexual exploitation, among other priorities.

There are a variety of international NGOs that focus specifically on the protection of children during armed conflict. CARE International, Save the Children, the Women's Commission for Refugee Women and Children and others have combined to create the **Watchlist on Children and Armed Conflict**.[53]

Programmes by NGOs range from advocacy in the international arena to funding and implementing projects to assist children and families in war-torn countries. On an international level, the NGO **International Tribunal for Children's Rights** conducts inquiries into violations of children's rights, holds public hearings on the issues and proposes practical solutions. One set of hearings was dedicated to war-affected children.[54] In contrast, **Save the Children** works on the ground in a variety of conflict areas conducting reunification and rehabilitation projects; in 2004, the organisation was working in **Liberia** to fill the gaps in DDR benefits for children, operating interim care facilities and supporting skills training and apprenticeship initiatives.

REGIONAL INITIATIVES

There are also regional policies aimed at strengthening children's rights and security. In 1998, the **European Parliament** passed Resolution B4-1078 on child soldiers. It rejects the use of child soldiers, urges countries to adopt the CRC, and calls on the European Commission to direct resources to children in DDR programmes.[55] In addition, the **Organization for Security and Cooperation in Europe** devoted a paragraph in its 1999 Summit Declaration to its commitment to children's rights during times of conflict.[56]

The African Charter on the Rights and Welfare of the Child (**"the Charter"**) entered into force in November 1999.[57] It requires its state parties to take "all necessary measures to ensure that no child shall take a direct part in hostilities and refrain, in particular, from recruiting any child." The Charter also established a Committee on the Rights and Welfare of the Child to ensure application of its principles.

The **Inter-American Children's Institute**, an organ of the **Organization of American States** (**OAS**), works for children's rights in the Western Hemisphere. In 2000, the OAS General Assembly passed Resolution 1709 on **Children and Armed Conflict**, calling upon member states to ratify the CRC, to respect international humanitarian laws that protect children and to support DDR programmes for children.[58]

Also in 2000, representatives of government and civil society groups issued the **Kathmandu Declaration on the Use of Children as Soldiers** at the Asia-Pacific Conference.[59] The declaration calls on Asia-Pacific states, other armed actors and civil society to prevent the recruitment and use of child soldiers.

Government and civil society representatives from Middle East and North Africa issued a similar declaration in 2001. The **Amman Declaration on the Use of Child Soldiers** calls on governments and armed groups to end the recruitment and use of children under 18, specifically referencing girls, and to provide for the reintegration and rehabilitation of child soldiers.[60]

NATIONAL ACTORS

According to the CRC, the state is obligated to protect children "from all forms of physical or mental violence, injury or abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."[61] The CRC has provided a framework model for national governments to mainstream children's protection in laws and constitutions. Article 28 of **South Africa**'s Constitution, adopted in 1996, outlines specific rights of the child. Many countries have also appointed special representatives to focus specifically on children.

Parliamentarians can help mainstream issues of child protection into their national and regional legislation. In **Algeria**, a minimum age for recruitment was defined in the National Service Act as 19 years old. In **Kenya**, the 2001 Children's Act was passed by Parliament to protect children from violence, trafficking and other forms of abuse. In addition to creating laws, parliamentarians can ensure that funding and resources are allocated specifically for child protection. **Chile**'s parliament is considering a budget law to increase funding for child protection by 25 percent.[62]

CIVIL SOCIETY AND THE COMMUNITY

Civil society organisations—including women's groups, student organisations, churches, human rights groups and others—are often the first to document cases of the abuse of children's rights and are well-placed to bring these matters to the attention of governments and the international community.

National and local NGOs may launch advocacy campaigns for the adoption of international legal standards for the protection of children, as well as measures within the national system. In **Cambodia**, for example, several groups formed the NGO Committee on the Rights of the Child for Cambodia, which works to monitor and implement the CRC in Cambodia. NGOs may also organise sensitisation programmes in their communities to engage people on issues of child protection. In **Rwanda**, HAGURUKA, a women's human rights group, conducts training to teach Rwandans about existing laws and the importance of child protection.

In other cases, NGOs formulate programmes to implement children's security and protection initiatives. Some of these projects directly prevent the recruitment of children into armed groups. In **Nepal**, the Institute of Human Rights Communication conducts the Children and Zones of Peace campaign, seeking a pledge from the government, political parties and armed opposition not to recruit children; it has been successful with all but the insurgents. In **Cambodia**, religious leaders have engaged with the local community to openly discuss AIDS, mobilise resources for AIDS-affected families and provide vocational training to AIDS orphans.[63]

In some cases, international NGOs coordinate with local groups to promote the rights of children. Save the Children began Community Child Protection Networks in villages in the **DRC**, which engaged local authorities (civil administration and traditional chiefs), religious leaders, representatives of service sectors (health, education, sports and culture), NGOs and associations, as well as children themselves to respond to alleged child abuse, raise awareness of children's rights and prioritise the needs and interests of the community for development projects. Activities of the networks have included direct negotiations with authorities and armed groups to prevent recruitment and re-recruitment of child soldiers.[66]

Parents, extended family members, and guardians "can be the single most important factor in determining whether or not a child is protected."[67] Some family members have organised to protect children. The "Go-Go Grannies" in **South Africa**'s Alexandria township support each other while raising their grandchildren orphaned by AIDS.[68]

Although parents and family members can be a source of protection, they also can be a source of insecurity in a child's life due to domestic violence, exploitation or other forms of abuse.

Children, as the primary stakeholders, have an important role to play in their own security and future. Yet often they are neither consulted nor included in decisions related to their welfare. Increasingly, organisations are involving youth in designing and implementing programmes for children. In the course of their work, the **Women's**

The NGO Group for the Convention on the Rights of the Child (CRC)

This organisation convened in the early 1980s to advocate for, and provide input into the CRC. Since the CRC's adoption by the UN General Assembly, the NGO Group has continued to promote, monitor and advocate for the implementation of the Convention. The membership of the NGO group includes human rights groups, women's organisations, trade unions, religious charities and others. Subgroups have formed to work on themes including sexual exploitation, displacement and armed conflict.

A core project of the NGO Group is the Liaison Unit, which creates tools[64] and provides training to enhance NGO advocacy on these issues and assists them in accessing the working groups of the Committee of the Rights of the Child to provide input into country reports.[65]

Commission for Refugee Women and Children has engaged youth as researchers in the field, designing their own questionnaires and methods for soliciting information from fellow youth. UNICEF also funds programmes at the local level in **Nepal** through which schoolchildren advocate for children's rights as outlined in the CRC. In an innovative programme in **Zambia**, youth are trained as caregivers of people affected by AIDS; they assist with cleaning, nursing care and counselling. Interestingly, "contrary to early concerns that youth would only do tasks according to expected gender roles…male and female caregivers provided similar care-giving services, including counselling and housework."[69] In addition, youth themselves became increasingly aware of the risks of contracting AIDS and took appropriate preventative measures for themselves.

3. HOW DO WOMEN PROVIDE SECURITY FOR CHILDREN?

Regardless of the conflict or culture, children are primarily cared for by women, particularly in situations in which families have broken up and communities have dispersed. Even in the most dire conditions, such as in refugee and IDP camps, women are the primary source of basic security for children, caring for them, providing water, food, shelter, medication and where possible, encouraging their education and general well-being. This basic role is often taken for granted and thus not supported.

In cases where women have participated in peace negotiations, they have often focused on the needs of their communities and the future for their children. In **Guatemala**, for example, the participation of women in the formal peace process led to a national health program for women and girls and a programme to reunite families and locate children and orphans, among other initiatives.

Beyond the peace process itself, women are at the forefront of advocating and changing policies that affect children at the national level. Women parliamentarians often draft new laws and propose programmes and policies that contribute to children's security. For example, in 2004, all 14 women senators (out of a total of 100 senators) in the **US** Congress introduced a bill that would authorise federal funding for programmes to protect and promote women and children's rights in **Iraq**.[70] In **South Africa**, women parliamentarians have influenced efforts to frame safety and security in terms of human security, prioritising education, for example, over the needs of the military.

As decision-makers in government, women have also historically sought to address the issue of children's rights and protection. A woman directing the Ministry of Women and Family Affairs in **Rwanda** instituted a national programme to care for the nearly 500,000 orphans following the genocide.[71] This unique project was successful; Rwandan women, regardless of ethnicity, accepted foster children into their homes.

Women in **civil society** are also catalysts for change. During conflict, women often organise themselves through widows' and mothers' associations to advocate for the end of war and to influence the peace process. They are able to draw on their "moral authority" as mothers to impact public opinion and decision-making on issues of war and peace.[72] In **Russia**, women have formed the Committee of Soldiers' Mothers of Russia with offices in 300 cities throughout the country to seek news of missing soldiers, accurately document the casualties and costs of war and nationally advocate to end war and forced military service.[73] In addition, women may reach across the conflict divide to other mothers. In **Sri Lanka**, mothers of missing soldiers and youth from the north and south have participated in a woman-led reconciliation process and dialogue, seeking a solution to the ongoing civil war. During war, women have also creatively provided forms of stability for their families. In **Colombia**, women in conflict zones informally arranged with the various fighting forces for safe passage of food and medicine for their families.

When children are marginalised in the post conflict environment, women are most often the actors that address their needs. Internationally, women's groups advocate for the ratification of the CRC and monitor its implementation. MADRE, for example, is a women's organisation based in New York that partners with women's groups on the ground, providing information and training to promote children's rights. At the national level, women's

Abduction, Escape and Return[74]

A mother in **Uganda**, Angelina Atyam, made international news through her campaign for the release of thousands of child abductees by the Lord's Resistance Army, including her own 14-year-old daughter, taken from a boarding school with 138 other girls in 1996. Ms. Atyam, co-founder of the Concerned Parents Association, was offered the return of her daughter if she would stop speaking out against the abductions—a deal she refused. According to news sources, after eight years in captivity, her daughter escaped in 2004 along with two of her own children, conceived with a rebel commander.

organisations, such as the Women's Resource Centre in the **Caucasus**, lobby governments to address the needs of children recovering from armed conflict. Other groups may broadcast the mandate of international instruments for children's rights throughout their country; the Centre pour la Promotion des Droits de l'Enfant et de la Femme in the **DRC**, for example, has as its main mission the translation of the CRC into local languages.

Women also work to fill gaps in official programmes to address the needs and concerns of children. In **Sierra Leone**, the Women's Progressive Movement works to find abducted children, provide financial and medical assistance and facilitate their adoption, as necessary. The Afghan Women's Resource Center provides education and training for women and girl refugees in **Pakistan**, monitors protection issues for refugee women and children, and prepares reports for use internationally in advocacy efforts.

As individuals, too, women are at the forefront of care for children following conflict. Given the gendered nature of violent conflict, women heads-of-household become the norm in many post war societies. The care and reintegration of children naturally fall to women. In addition, they are often the nurses, teachers, community leaders and social welfare workers who address the physical and psychosocial trauma that children experience during conflict.

4. TAKING STRATEGIC ACTION: WHAT CAN WOMEN PEACEBUILDERS DO?

1. Develop and conduct training for government forces on the rights of children during war, including international law on the recruitment and use of child soldiers. Raise awareness among traditional leaders, parents and family members to prevent the recruitment of children into government or opposition forces.

2. Encourage public awareness, acknowledgement and acceptance of the trauma experienced by children and others during war through special forums, traditional healing mechanisms or memorials.

3. Start sensitisation campaigns to inform the community about the importance of children's security, including the rights of children, the return of child soldiers, the trauma children have experienced and the specific needs and concerns of girls.

4. Conduct surveys to assess the needs of children in the community, involving children directly in the process.

5. Identify relevant international, regional and national laws for children's rights and protection. Advocate nationally for the ratification and implementation of the Convention on the Rights of the Child and other international and regional mechanisms to promote children's security. Insist on enforcement of laws related to children's security, holding those in violation of these rights accountable for their crimes.

6. Work with donors and the national government to assist children's post conflict recovery. Advocate for reintegration and reconstruction programmes that address the needs of the community as a whole, including children, rather than just individuals.

- Raise awareness at the national and local level of the needs of child abductees and returnees, especially girls, so that they are included in official reintegration, resettlement and rehabilitation programmes.
- Establish housing centres for children during war and for street children to provide access to food, shelter, healthcare, education and vocational training so that girls, in particular, have alternatives to prostitution, crime or joining an armed group.
- Begin programmes to care for orphans and facilitate their placement in homes and adoption.
- Sensitise children and youth to the dangers of landmines and unexploded ordnance.

7. Ensure that children and youth, especially girls, are directly involved in reintegration and reconstruction programs for children.

8. Work with women's groups, social workers, religious leaders, teachers and nurses to provide rehabilitation assistance to child victims of conflict, specifically addressing psychosocial trauma. Reach out to teenage mothers, in particular, providing childcare to allow them to complete education and skills training.
9. Advocate for specific mechanisms to include children in transitional justice processes. Co-ordinate with the international community to ensure the prosecution of recruiters of child soldiers.

10. Work with the national government and donors to begin peace education campaigns to promote children's rehabilitation and long-term security.

- Utilise the media to broadcast radio and television messages that provide local models and examples of efforts to promote non-violent conflict resolution.
- Conduct training in schools; encourage the integration of peace education throughout the curriculum.
- Develop context-specific methods to reach out to children, and include drama, sports, arts and recreation.

11. Work with the national government to encourage the participation of children and youth in decision-making and governance through youth parliaments, specific positions in political parties and community leadership posts.

WHERE CAN YOU FIND MORE INFORMATION?

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ACRONYMS

CRC	Convention on the Rights of the Child
DDR	Disarmament, Demobilisation and Reintegration
DRC	Democratic Republic of the Congo
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICC	International Criminal Court
IDP	Internally Displaced Person
ILO	International Labour Organization
LRA	Lord's Resistance Army
NGO	Non-Governmental Organisation
SRSG	Special Representative of the Secretary General of the United Nations
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund

ENDNOTES

1. There is no standard definition of adolescents or youth. It varies by culture and society and can be defined by chronology or age, as well as functionally, such as when a child transitions to an adult. See *Untapped Potential: Adolescents Affected by Armed Conflict* by the Women's Commission for Refugee Women and Children for a more detailed discussion at <http://www.womenscommission.org/pdf/adol2.pdf>.
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Design: D.R. ink, info@d-r-ink.com
Printed at Jason Print and Design, U.K.

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