



World Health  
Organization

# HEALTH IN EMERGENCIES

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## WOMEN'S HEALTH IN CRISES - LEADING OFF

*Jan Egeland, United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator*

This issue of the WHO's "Health in Emergencies" newsletter focuses on a subject that is of vital importance during humanitarian crises: the protection, diagnosis and treatment of women's health needs, particularly in situations of violent conflict.

Sexual violence in warfare has been a problem throughout history. In the past decade, however, the incidence of such violence employed as a deliberate act of warfare has escalated. In Kosovo, Rwanda, Burundi, the Democratic Republic of the Congo and Darfur, sexual violence has been used to intimidate and denigrate local populations. Its deliberate use as a weapon of warfare is as despicable as it is wholly unacceptable.

Mass rapes, abductions, sexual slavery, and other brutal sexual violence has become commonplace in far too many contexts. In many if not most cases, perpetrators are never caught or punished, adding further insult to injury for those who have been brutalized. We cannot – we must not -- allow impunity for such crimes to continue.

Women who have been assaulted carry with them both physical and emotional scars. Oftentimes their sexual injuries are so serious that they require treatment by specialized gynecologists and other personnel. Victims of sexual abuse face an increased

risk of sexually transmitted infections, including HIV, and the possibility of pregnancy.

Emotional scars also run deep. Victims of sexual violence experience shame, stigmatization, social and economic isolation, and possibly long-term psychological distress. They need readily accessible places of refuge- places where they can be offered the health care and support they need to help heal from their trauma.

Our capacity to provide such support must be strengthened. I am reminded that 10 years after the genocide in Rwanda, those who suffer most are the survivors who were raped and abused, and who are now HIV positive and suffer from lack of access to economic, medical and psycho-social support. As a developing nation, Rwanda's health and social services are still inadequate to provide anything but rudimentary support to its population.

But we should not relegate these issues to the aftermath of the conflict. We need more information on the extent of current needs so that humanitarian health workers can properly identify and care for those who so desperately need assistance. We must also make every effort to ensure that in camps for refugees or the displaced, women are protected through the proper design and layout of camp facilities, as well as adequate camp security.

As an international community, we also must address the causes as well as the symptoms of sexual violence. We must advocate to ensure that women and girls are protected from violence, abuse and exploitation. I have already raised these concerns with the UN Security Council, as well as the humanitarian community at large. We must encourage the International Criminal Court to address these issues in a more systematic manner to ensure that the perpetrators of these heinous crimes are punished.

Together we must find ways to give women's health, particularly women who have been victims of sexual violence, the higher priority it deserves.

This newsletter describes in greater detail some of the health threats facing women in crisis areas. I urge you to read it with an eye toward your own work, and with a view toward how we might better protect and serve women around the globe who have a right to health care – a fundamental right shared by all.

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## WOMEN'S HEALTH IN CRISES

### Overview on women's health in crises

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Armed conflicts have significant effects upon the physical and mental health of populations — women, men and children. Displacement and the deliberate targeting of civilian institutions are hallmarks of recent and ongoing conflicts. As a result, food, clean water, and shelter are often scarce. Attempts to access basic necessities, including health services, may place individuals at increased risk either as a direct result of active conflict, assaults or from landmines. Conflicts also result in severe disruption to or destruction of medical services and infrastructure and adversely affect the health of populations by interrupting ongoing disease prevention and control efforts.

Women and girls often bear the brunt of conflicts today. It is estimated that at least 65% of the millions displaced by conflict worldwide are women and girls. These women and girls face daily deprivation and insecurity. Many face the threat of violence including when they engage in basic survival daily tasks such as fetching water or gathering firewood. They lack access to health services that address the physical and mental consequences of conflict and displacement and may die in childbirth because basic reproductive health services are not available.

Violence against women -- including sexual violence -- is increasingly documented, particularly in crises associated with armed conflict. In these circumstances, women submit to sexual abuse by gatekeepers in order to obtain food and other basic life necessities. Rape is used to brutalize and humiliate civilians, as a weapon of war and political power and as a tactic in campaigns of ethnic cleansing. The violence and the inequalities that women also face in crises do not exist in a vacuum. Rather, they are the direct results and reflections of the violence, discrimination and marginalization that women face in times of relative peace. As is the violence against women by an intimate partner or husband, reportedly also common in refugee and internally displaced camps. The association of sexual violence with a range of sexual and reproductive health problems, including unwanted pregnancy, sexually transmitted infections, and genital injuries, and the importance of ensuring safe motherhood makes the provision of reproductive and sexual health services in crisis settings especially important.

Insecurity, witnessed and experienced violence, and other traumatic experiences during crises have psychological, emotional and social effects on women. These can affect their ability to engage in daily tasks and, if not properly addressed, can undermine long term goals for reconstruction and development. The burden of caring for ill or wounded family members also takes a toll. Despite all of this, services to address the psychological and emotional effects of conflict, displacement and other trauma are rare and more must be done in this area.

Access to health care for women in crisis settings is often virtually nonexistent. In many cases women must line up for days to obtain registration documents, food, water or materials for shelter. They must, therefore, make impossible decisions between trying to access health care for themselves or watching their children die for lack of water or food. Cultural restrictions may also affect women's access to care when female clinicians are not available or when male family members refuse to allow women to seek care or are not available to accompany women to clinics. In too many settings today, the devastation of the health care system due to years of conflict or neglect means that even those services that can be accessed are woefully inadequate and do not address the specific health needs of women. Many women therefore die from treatable conditions and many lose children or die in childbirth because they lack access to basic health services.

While the current situation for women and girls in crises is bleak, increased attention to the specific issues that they face in conflict and the health needs that arise from them is part of the answer. There is a growing awareness of the need to address gender-based violence in crises, but lasting solutions require coordinated action by all key stakeholders:

- Agencies and organizations that provide health services in crisis and post crisis settings must engage in learning from and sharing experiences of addressing the health needs of women and girls in these settings and work to develop joint responses.
- Assessments of the particular health needs of women and girls must be a standard part of program planning and implementation in crises. These assessments and the response of the health sector should include affected women and girls.
- Donors should direct funds towards addressing the needs of women and girls in crises, including gender-based violence.

WHO is committed to making this a reality.

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In the context of humanitarian law, "rape, sexual slavery, enforced prostitution, forced pregnancy and enforced sterilization or any other form of sexual violence of comparable gravity" may constitute crimes against humanity.

*Article 7.1 of the Rome Statute of the International Criminal Court*

## A human rights-based approach to the health of women in war

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Today's conflicts are mainly internal and increasingly target civilians - the vast majority of them being women and children, often targeted specifically because of their gender. Recent reports from the UN human rights bodies reveal that in armed conflict women and girls face widespread sexual violations, sexual violence, sexual slavery and forced marriage. Other related violations range from the enslavement of civilian populations, especially of women and girls, to the abduction of girls for use as child soldiers or workers.

Increased awareness of the plight of women in wartime has generated, in recent times, new standards of international human rights and humanitarian law. A UN declaration on gender-based violence was adopted in 1993, a Special Rapporteur appointed to report annually to the UN Commission on Human Rights on these issues, and most recently a Rapporteur was appointed specifically on sexual violence by the UN Sub-commission on the Promotion and Protection of Human Rights.

The Common Understanding of a Rights-Based Approach adopted by UNDG/ECHA 2003 as applied to humanitarian action implies that:

1. Humanitarian assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments.
2. Human rights standards contained in, and principles derived from, the Universal Declaration of Human Rights and other international human rights instruments, should guide all programming in all sectors and in all phases of the programming process.
3. Humanitarian action should contribute to the development of the capacities of 'duty-bearers' to meet their obligations and/or of 'rights-holders' to claim their rights.

A human rights-based approach to addressing women's health in emergencies means that the overriding objective is realizing women's health rights both in terms of process and outcome.

The criteria to guide and evaluate the implementation of the right to health include not only issues such as ensuring that health facilities, goods and services, as well as programmes, are *available* but also that they are *accessible* without discrimination, including freedom from discrimination on the basis of sex and gender roles; *affordable*; and within *safe physical reach* for all sections of the population, especially vulnerable or marginalized groups. It also means that we must strive to ensure that health facilities, goods and services are *acceptable*, including culturally appropriate and sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned. Finally, *quality* is a key criterion covering issues such as skilled health

personnel, unexpired drugs and quality equipment.

The human right to health is inclusive, which means that assistance must extend beyond health care to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and shelter, healthy environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

In relation to women's right to health, moreover, provisions of the UN Convention on the Elimination of All Forms of Discrimination Against Women and its general recommendations on gender-based violence, HIV/AIDS, and health generally, set out specific additional considerations, such as access to sexual and reproductive health services, health education, health information for adolescents about family planning and, overall, the importance of a gender perspective to be applied across all health programmes.

In addition to equality and non-discrimination, a human rights-based approach to programming incorporates principles of participation, accountability, and the building of the capacity-building of rights-holders to claim their rights and duty-holders to fulfill their obligations.

Operationalizing the right of individuals and groups to participate in all decisions that may affect their health can contribute to more sound and sustainable health programmes. Women can contribute to an understanding of the cultural factors and customs that affect health, as well as the special needs of vulnerable groups within the affected populations. Active participation of women has led to humanitarian aid being channeled more effectively. It has been demonstrated that through women's use of ration cards and involvement in food distribution, women and children are more likely to receive their fair share.

The human rights principle of accountability has become increasingly recognized as essential to break vicious cycles of impunity that have allowed human rights violations against women to continue throughout history and particularly during times of conflict. As soon as war crimes, crimes against humanity and other violations of international humanitarian law, including rape, are alleged, international commissions of enquiries should be established. Perpetrators of attacks on civilians, including violence against women, must be brought to justice in trials that meet international standards of fairness, including witness protection.

In relation to the final pillar in a rights-based approach to health programming- the development of the capacities of 'duty-bearers' to meet their obligations and 'rights-holders' to claim their

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rights-, it is important that humanitarian action incorporate capacity-building. Duty-bearers- primarily governments, including national and local health authorities- should be supported, even when fragile in the context of emergencies, to fulfill their health-related human rights obligations. Similarly, the rights-holders- in this case, women- should be empowered to claim their human rights. War conditions may override established patterns of patriarchy and can provide windows of opportunity for women to assume leadership roles. In refugee and internally displaced settings, women may have an opportunity to come together and participate in the organizing and running of camp life. Grassroots women's networks can emerge focusing on women's human rights issues, including their rights to inheritance, land and property. This capacity-building, in the context of humanitarian action, must then be linked to longer-term strategies which build the capacity at all levels to respect, protect and fulfill human rights. Only with this sustained commitment can we transform unequal power relations that fuel women's human rights violations and effectuate real and sustainable change.

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### **Sexual violence in populations affected by armed conflict**

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Sexual violence is a widespread international public health problem, and adequate, appropriate, and comprehensive prevention and response are lacking in most countries worldwide<sup>1</sup>. Sexual violence is especially problematic during armed conflict and in displaced settings, where civilian women and children comprise the greatest numbers, are often targeted for abuse, and are the most vulnerable to exploitation, violence, and abuse by virtue of their gender, age, and status in society.

Since the early 1990's, the humanitarian community has increased its attention to the problem of sexual violence. In 2001, WHO and UNHCR jointly produced guidelines<sup>2</sup> to enable the development of clinical management protocols for post-rape care in displaced settings. See page 15 of this newsletter for further information on these guidelines.

In 2003, UNHCR issued *Sexual and Gender-Based Violence Against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response* (UNHCR, May 2003), which includes minimum standards for prevention and response action and roles and responsibilities of specific staff and organizations in displaced settings.

Although the UNHCR/WHO guidelines and other relevant publications lay out guidelines, standards, and recommendations for prevention and response to sexual violence, many humanitarian actors are not aware of their specific responsibilities and many

have not been trained to carry them out. And, there are many staff and leaders of humanitarian organizations who view sexual violence interventions as 'luxury' or 'fashionable', rather than essential life saving humanitarian aid.

Response to sexual violence comprises a group of services for survivors that reduce the harmful after-effects and prevent further trauma and harm. These include health care, psychosocial support, security, and legal justice. The health sector can provide life saving treatment. The availability of a set of minimum health services for post-rape care in displaced settings, however, is still the exception rather than the norm. The reasons for this are complex, but can be partially attributed to negative attitudes and to limitations in knowledge, capacity, and funding.

Health care for sexual violence is often put into place in humanitarian settings due to the interest and commitment of a few dedicated nurses or midwives on staff. One example occurred in two separate refugee camps in Thailand. Two nurses working separately in reproductive health each began working closely with the refugee women's organizations. The refugee women identified that sexual violence was a serious problem but that few survivors disclosed the abuse because there were very few services available to assist them, and they feared retribution and social stigma. Over time, these two nurses gained the women's trust and established informal networks for receiving reports of sexual violence and providing life saving health care to survivors. Using medicines and supplies that were already available in the health clinic (e.g., for wound care, STIs, emergency contraception), the nurses established basic health care response to sexual violence in two of the health clinics serving refugees along the Thai-Burma border.

Several years later the networks continue and sexual violence survivors in these camps are receiving confidential, compassionate, and comprehensive health care and emotional support.

Individual and informal efforts can achieve good outcomes when the formal and established health and protection system fails to respond adequately. In the absence of a functioning interdisciplinary and interagency team addressing sexual violence, informal efforts provide essential life saving help by improving health status and supporting survivors' reintegration into the community.

#### **Endnotes**

<sup>1</sup> Heise, Lori, Pitangy, L., Germain, A. *Violence Against Women: The Hidden Health Burden*. World Bank Discussion Paper 255, 1994. Ward, Jeanne, *If Not Now, When?: Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-conflict Settings*, Reproductive Health for Refugees Consortium, 2002.

*World Report on Violence and Health*, World Health Organization, 2002.

<sup>2</sup> *Clinical Management of Survivors of Rape*, WHO/UNHCR, 2001  
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**Conflicts, AIDS, women and the military**

U. Kristoffersson, Director UNAIDS Office on AIDS, Security and Humanitarian Response

As the millennium unfolds, the impact of AIDS on regional and global stability has become significant, with many more people dying of AIDS than as a result of conflict. There are more than 40 million people worldwide living with HIV/AIDS and more than 20 million people have already died as a result of AIDS.

Recognizing the security implications of HIV/AIDS, the UN Security Council adopted Resolution 1308 in July 2000 which stressed that 'the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security'. The Council's actions laid the groundwork for the prominence given to AIDS as a security issue, including a gender component, in the Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly in June 2001. The epidemic impacts every part of the society, and it is threatening international and national security.

With the breakdown of physical, social and financial security in times of conflict, girls are especially vulnerable to coerced sex, and may be forced to exchange sexual favours for money, food or shelter in order to survive. Recent conflicts have seen an increase in the use of rape and sexual violence as tools of war; increasing the risks of contracting HIV. For example in Rwanda in early 1993, between 250,000 and 500,000 women were raped during the genocide resulting in 17% of them testing HIV positive as opposed to a prevalence of only 11 % among women who haven't been raped.

Of the over 25 million men and women serve in the uniformed services across the world, women comprise as much as 30 percent of the ranks. UNAIDS estimates that in peacetime rates of sexually transmitted infections (STIs) among armed forces are generally 2 to 5 five times higher than in civilian populations, and in times of conflict the difference can be much higher. As well as being at higher risk of HIV for physiological reasons that all women share, female military personnel are often at a disadvantage in sexual negotiations, including negotiations for condom use.

Young people are at particular risk: approximately half of all people who acquire HIV become infected before they turn 25. Soldiers are generally young and sexually active and their knowledge on sexual health can be very limited. Soldiers are also accustomed to a risk-taking lifestyle, are far from their families and partners and often have money for sex workers. Although military personnel are highly susceptible to STIs and HIV infections as a group, the military setting is also a unique opportunity in which HIV/AIDS prevention and education can be provided to a large "captive audience" in a disciplined, highly organized setting. HIV/AIDS and sex education programmes among soldiers benefit both the individual and their families. UNAIDS and the Department of Peacekeeping Operations launched the 'HIV/AIDS Awareness Card for Peacekeeping

Operations'. This plastic card contains an inner condom pocket and outlines the basic facts about HIV/AIDS and the code of conduct for peacekeepers.

STI/HIV/AIDS interventions among uniformed services need close collaboration with civilian health and education authorities. Involving uniformed services as advocates in the fight against HIV/AIDS is also an effective tool. Voluntary counselling and testing, prevention and treatment of sexually transmitted infections and strengthening of health care services, community education and changes in laws and policies for ensuring HIV/AIDS prevention among uniformed services should be an integral part of national HIV/AIDS Strategic Plans. In strategic planning it is also important to include strategies related to sexual exploitation and sexual abuse. UNAIDS Office on AIDS, Security and Humanitarian Response is working in 73 countries and 16 peacekeeping and observation missions to promote these issues and is especially targeting young uniformed services with emphasis on awareness raising strategies and peer education.

UNAIDS estimates that by 2005 US\$ 12 billion will be needed each year to fight AIDS effectively. Engaging the uniformed services in the fight against AIDS should be a crucial element of national strategies.

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**Young girls and HIV/AIDS in conflict:**

M. Zucca, Child protection section, HIV/AIDS in emergencies, UNICEF

Humanitarian crises, and conflicts in particular, are situations in which women and girls may be at particularly increased risk of infection with HIV/AIDS. Some circumstances directly constitute risk factors, such as rape by soldiers or militia, which has been systematically utilized as a weapon of war. Young girls are at particular risk of infection due to their biology and to the violent nature of the act, often repeatedly inflicted by more than one perpetrator. Rape and forced sex are not only perpetrated by armed factions. During conflicts and in situations of displacement and forced migration, women and girls are also at risk of rape from members of their own or hosting communities.

Other circumstances indirectly put women and girls at risk of HIV infection by pushing them into at-risk behaviors. Commercial sex or the exchange of sex for protection or food may become survival strategies. Those who have "purchasing power" and who exploit women and young girls are professionals, traders, soldiers and even peacekeepers and NGO workers. Some of these groups are at higher risk of being infected HIV/AIDS. HIV prevalence rates among soldiers, for instance, have often been found to be higher than those of the general population in their home countries. Peacekeeping forces stationed in conflict areas may also come from countries with high prevalence of HIV.

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### Reproductive health in crisis situations

W. Doedens, UNFPA Humanitarian Response Unit

Reproductive Health is a human right as well as a psychosocial health need. The need for reproductive health services often increases in crisis situations:

- Sexual violence may increase in times of social instability
- STD/HIV transmission increases in areas of high population density
- Childbirth occurs on the wayside during population movements
- Malnutrition and epidemics increase the risks of pregnancy complications
- A lack of access to emergency obstetric care increases the risk of maternal deaths
- Discontinuation of family planning methods increases risks associated with unwanted pregnancy

In 1995, UNFPA and UNHCR, in collaboration with UNICEF, WHO, and some thirty NGOs, UN agencies, governmental agencies and donor institutions, founded the Inter-Agency Working Group for Reproductive Health in Refugee Situations (IAWG). This organises and facilitates reproductive health in refugee and IDP situations. An evaluation of 10 years of work showed an increased awareness of reproductive health among humanitarian actors implementing programmes in emergencies.

The IAWG developed the Minimum Initial Service Package for reproductive health in refugee situations (MISP) and produced an Inter-Agency Field Manual giving guidance on putting the MISP into practice.

The MISP aims to reduce mortality by providing basic reproductive health services during the acute phase of an emergency situation. The components of the MISP are:

- Appoint a Reproductive Health coordinator to coordinate MISP implementation
- Prevent and manage the consequences of sexual violence, including safe site planning of camps, services for medical treatment of rape survivors, early referral of survivors, and coordination between health, community, security and protection services.
- Reduce transmission of HIV, by making condoms available and assuring universal precautions against HIV, and safe blood transfusion services
- Prevent excess neonatal and maternal morbidity and mortality by providing clean delivery kits to pregnant women and birth attendants, midwifery delivery kits to clinics, and initiating a referral system to manage obstetric emergencies
- Plan for the provision of comprehensive RH services, integrated into primary health care, by establishing a data collection system, collecting information on RH mortality, STD/HIV and contraceptive prevalence, identifying sites for the future delivery of services, training of staff, and ordering the necessary supplies.

Reproductive Health was defined during the International Conference on Population and Development (ICPD) in Cairo in 1994:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It also includes sexual health, the purpose of which is the enhancement of life and personal relations.

*(ICPD Programme of Action, paragraph 7.2)*

Experience has shown it is important to add to the following elements to the MISP core package:

- Manage sexually transmitted infections
- Provide post-abortion care
- Meet pre-existing family planning needs
- Meet needs for menstrual protection

In order to provide the material resources needed to implement these activities, the IAWG also created Reproductive Health Kits. There are thirteen kits, each of them containing a three month supply of drugs, equipment and supplies for a specific component of reproductive health.

The IAWG and UNFPA evaluated the use of the RH kits in 1999 and again in 2003. The kits are most often used to provide services to populations affected by conflict, in the acute and post-acute phases of the crisis. In some instances RH Kits are ordered as stock for emergency preparedness.

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#### Reproductive Health Kits:

0. Administration and Training
1. Male and Female Condoms
2. Clean Delivery
3. Rape Treatment
4. Oral and Injectable Contraception
5. STI Treatment
6. Clinical Delivery
7. IUD
8. Management of Miscarriage and Complication of Abortion
9. Suture of Tears, Vaginal Examination
10. Vacuum Extraction Delivery
11. Referral Level
12. Blood Transfusion



## Addressing women's mental health in emergencies

J. Morris, M. van Ommeren and B. Saraceno, *Noncommunicable Diseases and Mental Health, WHO/Geneva*

Women and girls are at increased risk of sexual violence during humanitarian crises. Although rape is the most common form of sexual violence, women and girls are also at heightened risk for other forms of violence, including forced marriage, physical abuse by an intimate partner, child sexual abuse, forced prostitution, and other types of sexual exploitation (Ward & Vann, 2002). Acts of sexual violence may be unsystematic, due to the breakdown of social norms and laws, but may also reflect an organized strategy to harm a particular community or ethnic group.

Any response to sexual violence should not be seen in isolation of context. During most conflicts, many women face a host of losses in addition to sexual violations (e.g., potential loss of family and community members, loss of income, loss of property, and changes in community structure). Sociocultural factors, including available resources in the community, will have an influence on how these events are experienced and may determine what generic or culture-specific interventions are most appropriate. Moreover, some women may have mental problems that predate the emergency, making them particularly vulnerable.

Women who have experienced sexual violence are at risk for a number of mental health problems including increased rates of depression, anxiety, stress related syndromes, pain syndromes, substance use, medically unexplained somatic symptoms, poor subjective health, and changes to health service utilization (WHO, 2000). In many societies survivors of sexual violence are at risk of social isolation due to social stigma if the sexual violation becomes public knowledge. The effects of sexual violence often extend beyond the individual and can impact women's intimate relationships, including - in some cases - the ability to care for children (Shanks & Schull, 2000). On a more positive note, certainly not all survivors of gender-based violence will have mental or social problems. More needs to be known about factors that may contribute towards resilience to improve humanitarian response.

Given that reactions to sexual violence are complex and may impact multiple domains of health, including social health, intervention strategies need to be integrated and executed at multiple levels. Unfortunately, services are often fragmented, and stand alone programs designed to treat one specific problem, such as post-traumatic stress disorder or so-called rape trauma syndrome, exist. All too often physical care is available to rape survivors without the option of mental health care, or vice versa. *The mental and physical sequelae of rape should be treated within an integrated care system.* In response to challenges such as this, the WHO Department of Mental Health and Substance Abuse recently summarized its position with respect to prin-

ciples and intervention strategies for during and after emergencies (WHO, 2003). The Department promotes the development of mental health care in general health services. Such services need to have the competence to treat mental health problems of women who have been violated.

Informed by the general framework and principles outlined in WHO (2003), specific intervention strategies for treating women exposed to sexual violence are briefly outlined. With respect to the acute emergency (when mortality is substantially elevated due to the crisis), recommended early social interventions include access to information (including information where help may be sought) and active participation of women in community and aid activities (WHO, 2003). Recommended early mental health interventions focus on (a) psychological first aid to women trauma survivors (i.e., non-intrusive emotional support, coverage of basic physical needs, protection from further harm, and - when feasible - organization of social support; National Institute for Mental Health [NIMH], 2002) at all health care settings and (b) (ongoing) care and protection for those with pre-existing disorders, which are prevalent in most communities. Of note, depression and anxiety disorders tend to be already more common among women than men in populations before experiencing disasters. With respect to severe mental illness, women in custodial hospitals need protection because they may be at risk of sexual assault as was the case during the recent conflict in Iraq (van Ommeren et al, 2003). With respect to currently popular interventions, we unfortunately need to emphasize that one-off (single-session) psychological debriefing and prescription of benzodiazepines may be harmful when applied in an indiscriminate manner (NIMH, 2002). The *Mental and Social Aspects of Health Standard* in the recently revised *Sphere Handbook* on minimum standards in disaster response (Sphere Project, 2004) includes the early interventions recommended in this article.

After the acute emergency, social interventions should continue, including the promotion of functional, cultural coping mechanisms (Ager, 2002). Moreover, efforts should be made to start make available a more comprehensive range of community-based mental health interventions that are sensitive to women's mental health issues. This would involve work towards:

(a) ensuring that women with severe mental disorders (e.g. psychosis, severe depression) can receive effective acute and follow-up care in the community. This may, for example, be organized through community mental health teams working from general hospitals or from community mental health centers.

(b) ensuring that mental health care is available at all levels of health care. This may involve teaching health staff in identifying women (and men) with disorders, treating common mental disorders (i.e., anxiety and mood disorders), and referring and following-up on severe mental disorders. Health staff need to be taught how to have confidential and culturally appropriate con-

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versations with patients about taboo topics, such as women's sexuality. Of note, some times health staff are more inhibited to talk about sex than their patients.

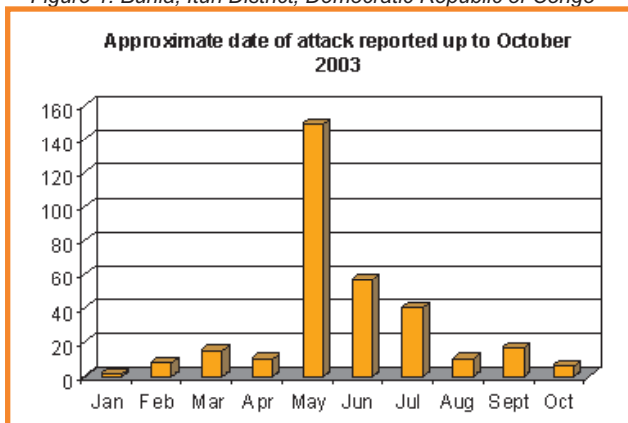
(c) creating linkages outside the formal health sector by, for example, training female social services workers, teachers, community leaders, traditional birth attendants and, when feasible, traditional healers in: identifying mental health problems, basic problem-solving counseling, facilitating women's self-help groups, and referral to formal mental health care.

Gender-based violence is a threat to women's mental health. We recommend addressing trauma-related mental health problems within gender-sensitive general health and general mental health services.

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Figure 1: Bunia, Ituri District, Democratic Republic of Congo



## Sexual and gender based violence program in Bunia, Ituri district

F. Duroch, Senior Gender Based Violence Advisor, and A. Tamrat, Médecins Sans Frontières-Switzerland

Bunia is located in the Ituri District of eastern Democratic Republic of Congo, an area that has been the center for conflict in the multidimensional inter-ethnic confrontations ravaging the region since 1999. Violence has been the norm, and the peak was in May of 2003 when, upon the withdrawal of Ugandan troops from Bunia, a confrontation between two parties representing main warring ethnic tribes resulted in the death and displacement of thousands of civilians. People fled for their lives, and spontaneous IDP camps were created by people seeking protection and shelter. A makeshift emergency hospital was setup by MSF-Swiss in mid-May 2003, responding to the extreme violence. As much as 70% of the surgical cases seen in 2003 were related to violence, mainly caused by fire arms and machetes.

Despite the deployment of international peace keeping force and various peace dialogs and signatures, Bunia remains one of the most volatile areas of eastern Congo.

The program for providing care for victims of sexual and gender based violence (SGBV) was started as part of the emergency response in Bunia. A total of 1684 cases were seen between June 2003 and June 2004. An average of 5.5 consultations per day are conducted in the hospital. The program has benefited from an inter NGO collaboration with COOPI (Cooperazione Internazionale) who have setup a program of psychological support and social network with the help of a local organization known as Psychological Intervention Center (CIP). Close to 90% of the patients seen in the MSF program are referred from the Centre. MSF provides curative and prophylactic medical care including the possibility of PEP (post exposure prophylaxis) for HIV/AIDS. A psycho-social link has also been established in order to bridge the care provided by MSF and COOPI, there by insuring a continuum of care for the victims/survivors.

The general understanding of the motivation behind the attacks remains versatile. Collective violence seems to be dominant during the early stage of the conflict (as seen on the graph in Figure 1), driven by ethnic based attacks and revenge. Absence of a governing body for an extended period also led to lawlessness and victimization of the weak (especially after the fighting in May 2003 subsided). Despite the success achieved by the project in addressing relatively large number of victims, several drawbacks still remain to be addressed. The project is still limited to Bunia and its immediate surrounding and issues on termination of pregnancy and medico-legal assistance are still at a primitive stage. The program needs vigilance to maintain the delicate balance of ethnical impartiality and access to all, which is already under preparation through outreach care. The

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fact that only 14% of the victims come within 72 hrs after the attack also needs to be improved. Maintaining quality support needs the full integration of actors in the various fields providing medical, social and legal care. Perhaps the most striking of the lessons learned from the project in Bunia is that starting proper medical care for SGBV victims should always be part and parcel of any emergency intervention but should also strive to address other needs as soon as possible.

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### The fragility of women's mental health with denial of rights in conflict: A case study of Afghanistan<sup>1</sup>

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For more than 20 years, the Afghan people have suffered the effects of war, extreme poverty and violations of international human rights.<sup>2</sup> During its years in power, the Taliban systematically restricted and institutionalized women's rights, such as freedom of expression, association, movement and access to work, education and many health services. After more than two decades of international isolation and the fall of the Taliban regime in early November 2001,<sup>3</sup> how best to reconstruct Afghanistan and redress the violations of Afghan women's human rights became crucial issues for the international community and new government in Afghanistan.<sup>4</sup>

Afghanistan remains among the poorest countries in the world with the highest maternal mortality<sup>5</sup> and infant and child mortality rates of all countries.<sup>6</sup> Life expectancy of women is 43 years.<sup>7</sup> After years of war, the health care system in Afghanistan heavily depends on external assistance,<sup>8</sup> and mental health systems in Afghanistan have fallen into disrepair or are non-existent in many areas.<sup>9</sup>

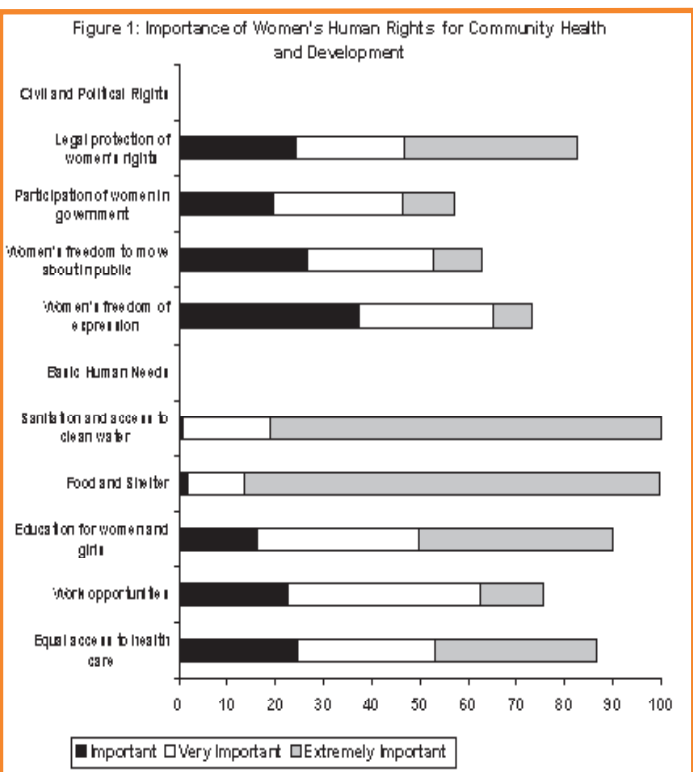
The multiple roles women have and responsibilities that they fulfill in society have been shown to put them at inordinate risk for mental disorders such as depression. Other factors such as gender discrimination and denial of human, social, economic and cultural rights or basic needs such as food, shelter, clean water, access to health care, and the access to work also put additional burdens on women further predisposing them to mental health disorders.<sup>10</sup> Afghan women are an example of the effect of institutionalized human rights violations on women's mental health.

Physicians for Human Rights study<sup>11</sup> surveyed household residences in two regions in Afghanistan (Taliban-controlled Jalalabad and non-Taliban-controlled Faizabad), a refugee camp and a repatriation center in Pakistan. Structured interviews were

completed by 724 Afghan women and 553 male relatives.

Our findings indicated that restrictions on women's human rights during the years of Taliban rule had a profound effect on Afghan women's mental health, with considerably higher rates of depression among women in Taliban compared to non-Taliban controlled areas. As important, even though respondents were surveyed while the Taliban were still in power, the Afghan women and men in the sampled populations overwhelmingly expressed support for women's human rights and considered the protection of basic human rights essential both for meeting basic needs and for rebuilding Afghan society (see Figure 1).

The high rates of depression among Afghan women present a formidable challenge for groups now working to provide humanitarian and developmental assistance in Afghanistan. While the majority of women exposed to Taliban rule attributed their symptoms of depression to official Taliban policy, not all women attributed their depression to Taliban rule. The combined impact of gender disparities and sustained stressors such as low-socio-economic status have been found to be critical determinants of poor mental health.<sup>12</sup> Based on in-depth interviews with Afghan women, other factors that may have contributed to the high prevalence of depression include the on-going war, poverty, denial of basic needs, international isolation, and family loss. Depression among women in other developing countries has been estimated to account for 30% of neuropsychogenic disorders.<sup>13</sup> However, depression, suicidal ideation and suicide attempts among Afghan women, particu-



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larly women exposed to Taliban policies, were also alarmingly high, in contrast to the worldwide average.<sup>14</sup>

Women living in poor environments with a lack of formal education, low income, difficult family and marital relationships are more likely to suffer from mental disorders.<sup>15</sup> Afghan women will continue to experience many of these predisposing factors of depression in spite of the end of Taliban rule. A gender- and rights-based, social model of health needs will be necessary to effectively promote women's mental health in Afghanistan. Simply treating depressive symptoms without promoting rights including basic needs will not substantially change the issues for women. As important, without the full participation of women, it will not be possible to rebuild communities in Afghanistan or effectively improve the mental health of Afghan women.<sup>16</sup>

### Endnotes

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- For further information please write [lamowitzrics@imcworldwide.org](mailto:lamowitzrics@imcworldwide.org)  
For a complete list of references please write [egane@who.int](mailto:egane@who.int)

Unfortunately, most of the conflict areas are in the poorest countries of the world which have very low mental health resources and are unable to cater to the mental health needs of the refugees and IDPs at times of war.

Excerpted from *Mental health needs in conflict situations*  
*Health in Emergencies Issue12, 2002*

## Reproductive health and displaced women in Colombia

S. Helfer Vogel. M.D.; cM.P.H; MsC.

In the last 9 years, internal conflict has generated 1,512,000 registered displaced people (51% women and 50% children under 15 years old) of Colombia's 42 million inhabitants.<sup>1</sup>

Displaced women are at a greater health risk than their poor counterparts who are not displaced: Between September 2002 and March 2003, PAHO/WHO conducted a survey of the health status<sup>2</sup> of 1,046 displaced households and 1,041 non-displaced poor households living in the same area in 4 main urban areas in Colombia (Soacha, Cali, Cartagena and Montería).

The study illustrated the disadvantages of displaced adolescents when compared to their poor counterparts who are not displaced. Displaced adolescents have less formal education when compared to non-displaced poor adolescents. More displaced adolescent women (14%) have had children when compared to non-displaced (8%). Also, less than 50% of the pregnant adolescents are having regular prenatal check ups, leading to higher-risk pregnancies and births.

Among adults, almost 21% of the displaced population did not have a formal education compared to 9% of the non-displaced population. The consequences for women are that they are not aware of their reproductive rights and have more difficulty accessing health services and information. Respiratory infections, diarrhea, and genital lesions are more common in displaced women and men (4.7% comparing to 1.9% non-displaced). Among displaced women, 42% did not use any birth control methods, compared to 15% of non-displaced poor women. However, 11.5% of displaced women over 45 had a mammography compared to 7% of non-displaced women. Table I compares Reproductive health in displaced women with the Colombian national average.

In Colombia, complications related to pregnancy and childbearing are the second leading cause of death among women between the ages of 15 and 44. Around 80% of these deaths are preventable. Maternal death in Colombia is caused primarily by hypertensive disorders of pregnancy (35%), complications during delivery (25%), pregnancy terminated in abortion (16%), other complications of pregnancy (9%), post-partum complications (8%), and hemorrhages (7%).<sup>3</sup> Frequent pregnancies are a common cause of maternal mortality. There are no studies to document induced abortion in displaced women. Nevertheless a national study financed by WHO in 1993, showed that 29% of women who have been pregnant admitted to having had at least one induced abortion.<sup>4</sup>

### Conclusions

Displaced women are at higher risk of health and reproductive problems. The coverage and quality of health services provided



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to displaced populations must improve in family planning, promotion of breastfeeding, adequate nutrition, mental health, gynaecological services, screening for breast and cervical cancer, among others. Women with inadequate diet during pregnancy and lactation become more vulnerable to diseases. Support should not overlook providing female-specific needs (such as providing soap, washing facilities and cloths for menstruating women) in a culturally acceptable way. Birth control in adolescent and mature women and men is not always available for the displaced and poor population due to their lack of knowledge, cultural and economic barriers, and inadequate coverage of health services especially in conflict areas. Despite governmental efforts, there is still underregistration of maternal deaths especially in rural and specific geographical areas under conflict in the country.

Lack of information about available health services and reproductive rights are some of the reasons why displaced women (and men) do not seek and obtain health care. Therefore, health education (and formal education) is a must in order to improve the general and health situation of displaced women. Health workers should also be more sensitive and knowledgeable about the early detection, consequences and treatment of induced abortion to avoid ill health and death of women.

Colombia has adopted measures to protect women's rights through laws and regulations and the country has directed its efforts to reduce maternal mortality by half.<sup>5</sup> It is monitoring changes in sexual health and demography by issuing a study every five years. The challenge is to improve women's health in vulnerable conditions (specifically displaced women and female victims of war) which requires efforts by the government and the international community. Although it is a great challenge, it is not an impossible challenge.

**(Endnotes)**

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<sup>5</sup> Colombia. Ministerio de la Protección Social, *Politica Nacional de Salud Sexual y Reproductiva*. Segunda Versión. Bogotá. 2002. p.4. For further information please write [helpersu@col.ops-oms.org](mailto:helpersu@col.ops-oms.org)

**TABLE I**  
**Reproductive health in displaced women compared with the Colombian national average**

Type of Woman	Event	Displaced population (1) %	National average (2) %
Adolescents	Are already mothers	23.0	15.1
	Pregnant with first child	6.9	4.0
	Total been pregnant at least once	30.0	19.1
Women at reproductive age	Pregnant at the time of survey	8.0	4.7
	Average of live births	2.7	1.8
	Average of surviving children	2.5	1.7
Pregnant women	Without prenatal attention	46.9	9.0
Women in general	Use of birth control	70.0	77.0
	Menaced of getting abandoned by spouse or male companion	34.2	23.2
	Experienced physical violence by spouse or male companion	52.3	41.1
	Raped by spouse or companion	13.9	11.0
	Reports lesion produced by physical violence	57.7	54.0

Source: (2) Colombia Profamilia. *Encuesta de Demografía y Salud*, Bogotá, Colombia, 2000

**The trauma of war and its consequences for women and girls: A case study from Medica Kosova**

K. Griese, Programme Advisor, Medica Mondiale

Although the extent of the violence can never be determined precisely, many women and girls in Kosova were exposed to sexualised violence during the military escalation in 1998 and 1999. Sexualised violence is a taboo in Kosova and most survivors of sexualised violence are deeply traumatised. There are physical, psychological and social repercussions of these experiences. This is exasperated by the extremely difficult living conditions of post-war society.

The counselling and therapy centre for women in Gjakova, Medica Kosova, opened in October 1999 with an interdisciplinary and holistic approach based on three pillars: psychosocial counselling, gynaecological treatment and legal support. The work of Medica Kosova is based on a dual strategy: the direct and individual work with clients and the sensitization of society by means of public information and special training for professionals and disseminators.

The stigmatization of the survivors and the lack of appropri-

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ate health services makes it hard for women in Kosova to get professional help. However, the gynaecological practice was accepted by many women – they quickly became familiar with its psychosomatic programme and often claimed psychosocial help afterwards. The gynaecological ambulance regularly visits villages in which sexualised violence was prevalent during the war and the gynaecological team received special education and training to work with traumatised women.

The following case study exemplifies the problems women face after the war and demonstrates at the same time the work of Medica Kosova.

### Background

The female client is 28 years old and has two small children. She was unemployed and lived with her in-laws at the time of her first contact with Medica Kosova. Her education level is low and economic situation difficult.

In 1999 the family was attacked by the paramilitary in the house of an uncle. The client was held captive for more than a week and raped repeatedly. She was not told the whereabouts of her husband or her children during that time. Later her husband's corpse was found. The client realised she was pregnant as a result of the rapes and the pregnancy was terminated in a clinic.

The client complained about incessant menstruation-like bleedings (meno-mentrorraghia) and other psychosomatic and trauma-conditioned physical and psychological symptoms including: frequent abdominal and back pains, lack of appetite, sadness, confusion, addiction to sedatives, recurring nightmares, increased irritability and frequent outbursts of rage. She had lived in isolation for a very long time and experienced strong feelings of shame and guilt along with very low self-esteem.

After the initial treatment in the ambulance the client came to the centre in Gjakova for further gynaecological treatment where organic causes for her symptoms were ruled out. When the client eventually spoke about the loss of her husband and her difficulties, the gynaecologist explained the connection between her symptoms and her traumatic experiences.

At her own request the client then had frequent appointments for psychosocial counselling to discuss the difficult living situation with her in-laws, the loss of her husband and her economic situation. With the help of the counsellor she began to receive a monthly supplementary benefit and her in-laws gave permission for her to move close to her parents, which slowly ended her social isolation. The counsellor helped the client to regain a feeling of security and control over her own life. Information on the consequences of traumatising, physical stabilisation, regular sleep and meals, and the habituation to a daily routine with the children were of great importance in this process. Together they worked out methods to improve the client's control over her post-traumatic stress symptoms and the focus on

her own personal strengths and resources. The client was able to slowly overcome the death of her husband. The counsellor worked closely with the client when she experienced a general destabilisation and worsening of post traumatic stress symptoms following the discovery of the mass graves in Serbia.

After the client had significantly stabilised in the following months she was included in the 'Knitting-Project' where women with missing relatives worked in groups to manufacture clothing. The groups offer opportunities for social contact and common leisure activities. The client enjoys the acceptance and esteem she experiences in her work group along with the opportunity to share her grief.

### Results

The client's health condition and general life situation has improved significantly in the two years. She has started to understand the reactions of her body and her physical symptoms have decreased significantly. With the help of the Medica Kosova staff she managed to reduce her consumption of sedatives. The client is less aggressive towards her children and is able to pay more attention to them. She confided her experiences with sexualised violence with both the counselor and her mother and her mother was partially included in the counselling process. The client, however, is not able to reveal her experiences to her in-laws as she is concerned with receiving blame for destroying the family's honour.

### Conclusion

The work with this client showed that to provide optimal help, medical, social and therapeutic help has to be combined. Psychological help can only begin when the basic economic needs of the client are covered. Therefore, it is important to build shelters and support networks for survivors of sexualised violence in post-war regions for the long term. In addition, staff of health services and NGOs in post-war regions should receive training in dealing appropriately with survivors of sexualised violence in order to avoid re-traumatisation and to refer the clients to other aid programmes if necessary.

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#### Useful websites:

UNFPA: [www.unfpa.org](http://www.unfpa.org);

UNHCR: [www.unhcr.ch](http://www.unhcr.ch);

WHO: [www.who.int/reproductive-health](http://www.who.int/reproductive-health); [www.who.int/hac/techguidance/pht/womenhealth/en/](http://www.who.int/hac/techguidance/pht/womenhealth/en/)

Reproductive Health Response in Conflict Consortium:  
<http://www.rhrc.org/>

Amnesty International and its new Stop Violence against Women Campaign: [www.amnesty.org/actforwomen](http://www.amnesty.org/actforwomen)

"Guidelines on HIV/AIDS Interventions in Emergency Settings",  
<http://www.humanitarianinfo.org/iasec/IASC%20products/FinalGuidelines17Nov2003.pdf>

## 'Tears you never see': A perspective from Bangladesh on women's health in crisis

Dr Q. Huda Humanitarian Worker, Directorate General of Health Services

Bangladesh is one of the most disaster prone countries in the world. Every year countries like Bangladesh experience nature's fury and devastation. Often we think about the population and the suffering at large. While thinking about the sufferings of the most vulnerable group, 'women'.

Women suffer more during crises due to their constraints that address biological, physical and social contexts. Even in crisis situations, women still bear the responsibility of feeding and taking care of children. Coping with crisis situations is women's gender-assigned task in Bangladesh. Male members of the families work outside for a living and during crisis, do not go to work. But women carry on with their daily household activities even if they work outside as well.

Women are vulnerable socially and this affects their security during times of uncertainty. This results in an increased number of rapes, abuse and violence. This especially happens in the temporary shelters where the displaced population takes refuge. One example is during the 1971 liberation war when many women were abused and raped. Most of those victimized women suffered from various diseases, unwanted pregnancies, physical disability and severe mental trauma. Many were rejected by their families; refused by the society to lead a normal life.

In cases of natural hazards or conflict, the husband may abandon the family when they are unable to feed them. Mothers are forced to take care of the children, other family members, household and livestock etc. They may be forced to make choices (e.g. to become sex workers in order to support their family) which increases their exposure to various forms of violence and abuse.

Women need privacy. It may not be possible to provide privacy in a crisis situation, or the need is ignored. It can cause physical problems and mental trauma to women in some cultures, especially pregnant and lactating women. Mothers and babies suffer when the woman feels unable to feed because of privacy issues. During disasters and their aftermath when sanitation becomes a grave concern and the existing system collapses, women may not be able to take care of their basic toilet needs because of privacy concerns. Women will wait until dark to use the sanitation facilities which puts them at risk of injury, violence, snake bites, etc.

Women often suffer more from under-nutrition as they prepare food and tend to feed other family members first. Fatigue increases as the workload is no less than normal. This can be fatal in the cases of pregnant and lactating mothers. The starvation

and overwork during disasters puts women at health risk.

Women are at greater risk of disease than men as they are more exposed to the polluted environment. For example, they



wash their household utensils in the unclean flood water and they need to swim or walk in the flood water to collect the safe water and medicine for their family members. When they are sick they may not be able to access medical facilities due to the distance or a lack of child care. Also cultural/religious embargoes may inhibit them from approaching the medical care.

Their cultural dress and long hair also puts them at risk. They may get entangled with a tree or other objects while moving to a shelters or have difficulties in swimming. They even become easy target for electrocution and strangulation.

The extreme family burden, situational uncertainty, diseases threat and personal insecurity can lead to mental trauma. Psychosomatic disorders are often a result of this trauma.

What can be done then?

The most important thing is to provide and ensure the security of women. Women have to be treated equally as human beings. In order to ensure the 'health of women' in crisis situations, the state should encourage and make certain ethical practices and human rights are enforced through legislation.

Along with this, there must be increased integration of women at the different levels of the humanitarian response operations and in the different level of the working forces within the government, non-government, international and UN organizations. There should be an increase in the number of gendered physicians in the medical teams and at the mobile outreaches. In natural hazard situations, the temporary shelters should have separate facilities for women which offer at least a portion of services.

The humanitarian assistance being offered to the survivors should be designed and planned to address the cultural prejudice towards women. Community level awareness programs specially customized for women with essential tips for self protection should be included in the entire development program's agenda

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in the country.

A revolutionary social movement with extensive implementation of a literacy program combined with needs based awareness programs along with appropriate legislation could solve the problem. Local programs bounded by national monitoring supervision will give a 'human touch' to solve these problems and adequately address the health of women in crisis. Evidence based research should be conducted in all the disaster prone areas in the country to identify the best practices and needs of the coping efforts of women

Regional collaboration and coordination will offer a better understanding and more comprehensive local response to any crisis in a country. This will as an awareness campaign for developing a strong network among all the stakeholders to protect women's health in any crisis situation.

Women in Bangladesh are acquiring their economic freedom through several micro-credits and rural based programs that are in turn helping them to be empowered. The UN, human rights associations and women's rights organizations are addressing the concerns. The education and basic needs of women are being provided with incentives by the government. Still it demands coordination among all these partners to find a sustainable solution.

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### Rape guidelines

M. Colombini, *Reproductive Health and Research, WHO/Geneva*

Refugees and internally displaced people are especially at risk of sexual violence—in particular rape—during every phase of an emergency situation.

Over the past eight years, humanitarian agencies have been working to put in place systems to respond to sexual violence as well as to support community-based efforts to prevent such violence.

WHO, UNHCR, UNFPA and the ICRC are updating the first edition of a publication entitled *Clinical Management of Survivors of Rape*, which was published in 2001. The new edition includes the most recent technical information on the various aspects of care of the sexually abused. It also takes account of the feedback received from the first edition field-tests.

The guide describes best practices in the clinical management of people who have been raped in emergency situations. Intended to be used by health care professionals working in emergency or in other similar settings, it helps the users to develop specific protocols for medical care of rape survivors. It recommends a number of actions, including: identification of a team of professionals and community members who are involved or could be involved in caring for rape survivors; creation of a referral network comprising of different sectors involved in caring for sexually abused people (community, health, security, protection, justice); identification of available resources (drugs, materials, laboratory facilities) and the relevant national laws, policies and procedures relating to rape (standard treatment protocols, legal procedures, laws relating to abortion, etc.); development of a situation-specific health care protocol; and training of providers in the use of the guide. The new guide is expected to be available by the beginning of 2005.

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## WHO initiative on women's health in crises

The overall goal of the WHO Women's Health in crises Initiative is to improve the impact of health services on the health of women caught up in violent conflict, or post-conflict settings. The initiative is being implemented under the auspices of the Global coalition on women and AIDS. Services that better address women's needs, especially when they are subject to sexual violence, will reduce the impact of trauma, rates of undesired pregnancy, and the incidence of sexually transmitted disease and HIV infection.

The specific purpose of the programme is to establish best practices of health services that operate in conflict so that they promote women's health, improving sexual and reproductive health, reducing risks of HIV infection, and pursuing effective health care to those who have acquired HIV (including seeking, where feasible, access to ARV-treatment). A plan of action

has been developed but the successful implementation of this program will depend on the availability of dedicated external support.

Currently implemented, the scoping phase of the programme for which WHO collaborate with UNAIDS is designed to examine the prospects for using a service responsiveness diagnosis as a base for building better capacities for women responsive service development. The first objective of the WHO/UNAIDS joint activity is the development of an appropriate tool for a rapid assessment of the quality and responsiveness of health services to women's health in crisis affected settings. In order to achieve this objective, field visits are carried out in two countries in the Southern Africa region: Angola and Zimbabwe.

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## Worldwide campaign to stop violence against women

T. Ulltveit-Moe, Amnesty International

In March 2004, Amnesty International (AI) initiated a world-wide campaign to stop "violence against women," (VAW) defined as any act of gender-based violence that leads to physical, sexual or psychological harm to women and girls. Gender-based violence against women are acts directed against women because they are women, or that affect women disproportionately, and can include:

- Violence in the family or home (domestic violence, marital rape and slavery-like conditions)
- Violence in the community (forced prostitution and forced labour)
- Violence carried out or condoned by the state (rape by government officials, torture in custody and violence by immigration officials)
- Violence during armed conflict, committed by both government forces and armed groups (attacks on civilians, who are often mostly women and girls, rape and other sexual violence.)

AI campaigned for many years to end unlawful killings, torture (including sexual violence) and other abuses that devastate the lives of men, women and children. Its current focus on violence against women and girls is a response to the fact that their needs are frequently overlooked, while women organizing to demand their rights are often ignored.

The organization will mobilise its 1.8 million members worldwide to work alongside the many courageous women's rights activists and groups already working to expose and redress forms of gender-based violence.

AI will investigate acts of violence against women and the underlying discrimination. It will demand that these violations are acknowledged, publicly condemned and redressed, and will campaign to end discriminatory laws and bring perpetrators to justice.

AI's campaign will also draw attention to the differential and sometimes disproportionate impact on women and girls of conflict and militarization, including the clear link between conflict-related violence against women and the scourge of HIV-AIDS. AI will also lobby for women to be included and their needs addressed in peace keeping and peace building operations and in all post-conflict demobilization, disarmament, reconstruction and reintegration initiatives.

To learn more about Amnesty International and its new Stop Violence against Women Campaign, visit AI's web-site at: [www.amnesty.org/actforwomen](http://www.amnesty.org/actforwomen) For further information

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## Recommended Readings

- ICRC, *Women and War-Special report*, 2003.

Despite a full panoply of laws to protect them, women continue to suffer unnecessarily in wartime. The ICRC study on the impact of armed conflict on women describes the numerous initiatives that the ICRC has undertaken to respond to women's needs in crisis and to ensure and reinforce observance of legal instruments designed to protect women and girls affected by armed conflict.

- Rehn Elisabeth and Ellen Johnson Sirteaf. *Women, War and Peace: The Independent Expert's Assessment on the Impact of Armed Conflict on Women and Women's Role in Peace-building*, UNIFEM, 2002.

The Independent Expert Assessment was commissioned by UNIFEM in response to Resolution 1325 on Women and peace and security as part of the effort to continue to document and analyse the specific impact of war on women and the potential of bringing women into all aspects of peace processes.

- WHO, *Reproductive health services during conflict and displacement: a guide for programmes managers*, 2000.

The guide from the Department of Reproductive Health and Research produced in collaboration with other WHO programmes (Violence and Injury prevention, Gender and Women's Health and Health Action in Crisis) is a tool that defines how to develop practical and appropriately-focused reproductive health programmes during each phase of conflict and/or displacement.

- UNHCR, *Sexual and gender-based violence against refugees, returnees and Internally Displaced Persons, Guidelines for Prevention and Response*, 2003.

These guidelines offer practical advice on how to design strategies and implement activities aimed at preventing and responding to sexual and gender-based violence. Because GBV is a cross-cutting issue, information is also available on basic health, legal, security and human rights issues relevant to those strategies and activities.

- RHRC (Reproductive Health Response in Conflict Consortium) *Gender-Based Violence Tools Manual For assessment, program design, Monitoring and Evaluation in conflict-affected settings*, 2004.

The tools have been formulated according to a multi-sectoral model of GBV programming that promotes action within and coordination between the constituent community, health and social services, and the legal and security sectors.

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