

Gender, health and human rights in sites of political exclusion

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Background to the Women and Gender Equity Knowledge Network

The Women and Gender Equity Knowledge Network (WGEKN) of the WHO Commission on Social Determinants of Health was set up to draw together the evidence base on health disparities and inequity due to gender, on the specific problems women face in meeting the highest attainable standards of health, and on the policies and actions that can address them.

The work of the WGEKN was led by two organizational hubs – the Indian Institute of Management Bangalore (IIMB) and the Karolinska Institute (KI) in Sweden. The 18 Members and 29 Corresponding Members of the WGEKN represent policy, civil society and academic expertise from a variety of disciplines, such as medicine, biology, sociology, epidemiology, anthropology, economics and political science, which enabled the work to draw on knowledge bases from a variety of research traditions and to identify intersectoral action for health based on experiences from different fields.

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POLICY BRIEFING PAPER

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The key messages for members of the political executive, particularly Ministers of Health and their senior advisors:

First we begin with the same key messages of the Knowledge Network on Women and Gender Equity’s May 2007 Report:

“Gender inequality damages the health of millions of girls and women across the globe. Because of the numbers of people involved and the magnitude of the problems, taking action to improve gender equity in health and to address women’s rights to health is one of the most direct and potent ways to reduce health inequalities and ensure effective use of health resources. Deepening and consistently implementing human rights instruments can be a powerful mechanism to motivate and mobilize governments, people, and especially women themselves.

Addressing the problems of gender inequality requires actions both outside and inside the health sector because these are inter-related.”

In this report, we investigated the intersections of gender, health and human rights in sites of political exclusion. We used the conceptual framework of political philosopher Giorgio Agamben concerning ‘states of exception’ and ‘bare life’ to better understand how the recent ‘war on terror’ is driving gendered health outcomes for refugees and Internally Displaced Persons (IDP) living inside and outside camps.

From our investigation we have identified five additional key messages:

1. Sites of political exclusion are increasing in magnitude, scope, and harshness of conditions, especially since the onset of the global ‘war on terror’:
 - Contemporary wars occur in the sites of the most severe social divisions, calling forth multiple forms of crisis all at once. Militarization is integrally linked to systemic violence.
 - These sites include the proliferating sites of involuntary confinement, including detention points for suspects in the war on terror, camps for refugees and internally displaced persons (IDPs) and prisons with physical walls as well as those with legal and civil barriers that constitute the limbo in which undocumented migrants and trafficked persons find themselves all over the world.

- National borders have hardened and anti-immigrant policies intensified in the US, UK, EU and Australia since 11 September 2001.
- The nature of conflict has changed in the last twenty years. Wars have moved from inter-state to intra-state conflicts with civilian women, men, and children as the main casualties. Most displaced by conflict now remain inside their own borders as IDPs and as such lack the formula protection and coordinated services available to refugees under the UNHCR .

2. The health outcomes of conflicts are highly gendered:

- Women and children constitute between 70 and 80% of all IDPs, and women are roughly half of all refugees and asylum seekers. The gender disparity in IDP situations is directly related to militarized violence, many men and boys having been killed or recruited to join combatant groups.
- Traditional complex emergency health indicators obscured the health impacts on women and girls.
- Until quite recently, international agencies and NGOs concerned with the health of refugees and IDPs were focused primarily on malnutrition and communicable diseases. Recently formal recognition of the need to include reproductive health and HIV/AIDS services has occurred, however there is not always effective implementation on the ground, especially for IDPs.
- Gendered relations of power in the sites of exclusion are highly complex, context and culture-specific, and begging for further research.

3. Refugee and IDP camps embody a number of striking contradictions:

- While they are supposedly governed by international law and human rights, in reality the operation of such law and rights in these ‘exceptional’ spaces is often nonexistent. Those displaced by conflict (refugees and IDPs) are also those most lacking in any reliable forms of protection, respect, accountability, and methods of making claims and seeking enforcement.
- The lines between war-making and nation-building and between the peacekeeping and humanitarian functions of UN agencies have blurred.
- Camps are inaccurately understood as an ‘emergency’ intervention, however in many instances the conflict and the camp stay is long term. According to a recent UNFPA report, the average stay in refugee camps is 17 years.
- This leads to a final key contradiction: refugee and IDP camps are supposed to be just that—‘refuges,’ shelters; yet typically they are places of demoralization, dehumanization and extreme danger.

In the long term, camp-like situations should be abolished in favor of solutions that both (a) integrate displaced populations into local communities as full citizens with rights and (b) link refugee and IDP camps and their populations to neighboring communities through common services, organizations, schools, clinics, etc. Major pressure by IGOs and NGOs should be brought to bear on governments to welcome and integrate forcibly displaced populations. However, when extremely violent and insecure conditions make camps temporarily unavoidable, the following measures should be taken to insure the safety, dignity and respectful treatment of their residents:

1. Recognize that there is a direct connection between political participation and health prerogatives and outcomes by
 - Ensuring that women’s entitlements, rights and health and gender equity are protected and promoted for everyone but most especially for migrants, refugee and internally displaced populations.
 - Increasing all conflict-affected populations and especially women’s “participation in political and other decision-making processes from household to national and international levels so as to increase their voice and agency.”
 - Providing the structural determinants that underlie an ability to participate, including decent housing, safe water, sanitation, physical safety, affordable cooking fuel, child-care, care for the elderly, educational and economic possibilities, and freedom of movement and expression.
2. Mainstream and catalyze gender equity in humanitarian relief through
 - Gender-sensitive policies and programs that address the needs and disempowerment of men and boys as well as those of women and girls and discard old stereotypes of women as always victims and men as always abusers.
 - Ensuring that such programs encompass all aspects of service provision, including reproductive, sexual and primary health care, sexual and gender-based violence, employment and decision-making. Like the emergencies themselves, responses must be complex and multi-dimensional.
3. Rights-based humanitarianism is a necessary and fundamental beginning.
 - Investment must be made in strengthening local and national institutions, giving local governments adequate human and financial resources to protect the rights of refugees and IDPs.

- Resources should be devoted to support and strengthen new models of accountability in relief operations and the more complete implementation of existing rights-based guidelines like Sphere and those for IDPs.
- A genuine human rights approach to relief work will require dissolving the artificial boundary between ‘political’ and ‘humanitarian’ functions. This means relief, medical and other organizations working in camps and conflict zones must be prepared to work in cooperation with international agencies and transnational women’s and human rights organizations to challenge national sovereignty claims, hardened borders and human rights abuses and to pressure governments to integrate or reintegrate forcibly displaced populations and provide them with economic, social, racial and gender justice.

GENDER, HEALTH AND HUMAN RIGHTS IN SITES OF POLITICAL EXCLUSION

Executive Summary

Rosalind P. Petchesky and Melissa Laurie

Italian philosopher Giorgio Agamben's political theory concerning 'states of exception' is a useful starting point for researchers and policy makers wanting to reconsider health and gender equity issues in light of the ways in which armed conflicts, forced migration and natural disasters reconfigure global politics. Our report focuses on a single site of exclusion, refugee and IDP camps, and the gendered health impacts of displacement due to armed conflict, violence and persecution. In our investigation, we examine the gendered dimensions of health for displaced populations, focusing on reproductive health, HIV/AIDS, and gender based violence. The evidence presented reveals a number of contradictions of refugee and IDP camps, highlighting the need for a rights based humanitarianism.

A 'state of exception' is the juridical situation in which a declaration of emergency powers, martial law or the suspension of ordinary constitutional norms and civil rights, previously associated with war, threat of armed attack or civil unrest, becomes indefinite if not permanent. Those who reside in these states of exception find themselves reduced to 'bare life,' stripped of the ordinary rights of citizens or even of human beings. They include detainees in the prisons and sites of "extraordinary rendition" classified as "enemy combatants" in the "war on terror"; refugees and internally displaced persons (IDPs) from both armed and ethnic conflict zones and natural disasters; as well as the undocumented migrants and trafficked persons detained at borders and checkpoints and in legal limbos in countries everywhere. Under present conditions of militarized global capitalism and a "war on terror" that knows no limits of time or space, states of exception have increasingly become the everyday reality of life for millions of people across the globe.

From a public health perspective, the aggregate of all these sites of exclusion constitutes an enormous concentration of the most vulnerable and at-risk groups, a key transfer point for viruses, violence, and damaged, discarded bodies. Yet major health surveys and much of the literature on social determinants of health still take national health systems as their statistical base; the populations residing in camps, huge and growing, simply are not counted. In addition, it is in these sites of exclusion where the indispensability and insufficiency of a human rights approach to gender and health equity issues are

revealed most directly. Residents in states of exception are cast outside the protections of citizenship and state laws. The situation of refugees creates a paradox, since one would imagine people who have become effectively stateless to be the 'purest' subjects of human rights. Yet such people are also those most lacking in any reliable forms of protection, respect, accountability, and methods of making claims and seeking enforcement. Thus sites of exclusion both mark the limits of human rights as currently understood and help to illuminate how gender equity in health access and outcomes always and everywhere intersects with a whole series of social, economic and cultural forces.

Currently, approximately eight major wars are underway. Along with these, about two dozen smaller conflicts in Asia, Africa, the Middle East and Latin America have been raging for decades and continue still. According to recent estimates, in 2005 there were some 10-12 million refugees and asylum seekers worldwide and an additional 24-25 million IDPs. This in itself is not a new phenomenon, but the nature of conflict has changed in the last twenty years. Wars have moved from inter-state to intra-state conflicts with civilian women, men, and children as the main casualties. Most of those displaced by conflict now remain inside their own borders as IDPs. IDPs suffer higher rates of morbidity, especially from malnutrition and infectious diseases, than do refugees, as well as a greater incidence of forced isolation, sexual and gender based violence, lack of shelter, and forced separation from family members. Women and children constitute between 70 and 80% of all IDPs, and women are roughly half of all refugees and asylum seekers. The gender disparity in IDP situations is directly related to militarized violence, reflecting the high number of absent men and boys, those who are killed or recruited to join combatant groups.

Reproductive Health

In our report we come to four important conclusions with regard to reproductive health in refugee and IDP camps. First, the location of camps in relation to both conflict areas and obstetric services is a critical determinant of maternal risk; where camps are contiguous to conflict zones or emergency obstetric services and hospitals are far away, risks of maternal mortality and morbidity increase significantly. Second, in spite of excellent efforts by agencies to provide a high standard of reproductive health services to populations in camps, most of these services are presently going to people in relatively stable, post-emergency situations, but far less to IDPs, whether in camps or dispersed outside them. Those caught in the most acute and dangerous stages of complex emergencies,

and who are thus most at risk, are not getting the services. Third, even where immediate conflicts have stabilized, the ravages of previous conflicts and the absence of viable health, political and economic infrastructure may completely undermine delivery of vital health care, including for reproductive health. This is all the more likely given that the countries that have generated the greatest number of refugees and IDPs are largely those with the highest under-5 mortality rates, highest fertility rates and youngest populations.

Finally, it is important to remark that poor maternal and pregnancy outcomes may reflect a variety of factors, and not always women's helplessness. Childbearing becomes a terrain of ethnic struggle in armed conflict and displacement sites; rape may become a way of "planting the seed" in the "enemy" population or, in response, childbearing may become a weapon to replace children or adults lost to war. But women do not always respond passively to these demands on their reproductive capacity; some evidence suggests that they may resist through clandestine abortions. Moreover, high rates of maternal mortality in disaster areas such as Afghanistan, Iraq, and Palestine reflect not only the terrible insecurity and violence there but also the total destruction of infrastructure—roads, hospitals and clinics, educational facilities, human resources, public order—that chronic conflict produces.

HIV/AIDS

The relationship between HIV/AIDS and armed conflict is both complex and context-specific, depending on a range of factors. Contrary to common assumptions, IDPs do not have consistently higher HIV infection rates than the general population, nor does armed conflict necessarily increase the risk of transmission. Rather, what matters is the phase and level of a conflict; the camp's location, accessibility and exposure to movements of people in and out; and the degree to which basic social structures (including health services) have broken down. In addition, HIV prevalence among the affected community pre-conflict, and among the surrounding community for those who have been displaced, exposure to violence during conflict and flight, and the level of interaction between the two communities will affect vulnerability.

Sexual and Gender Based Violence

Ample qualitative and anecdotal reports make it clear that refugees and displaced persons, especially women and girls, are exposed to relentless risks of abuse by armed combatants, government soldiers,

peacekeepers, aid workers, guards, brigands and sometimes their own spouses. Patterns of sexual and gender based violence intersect with both the economic deprivations of exclusion and deeply entrenched traditions of gendered labour. For example, women and girls in camps in Darfur and elsewhere are expected to perform traditionally gender-linked tasks such as searching for firewood, which sends them into insecure areas and exposes them to high rates of assault and sexual abuse. Further, we find that violence in the camps may also result from physically or socially structured insecurities. The standard humanitarian aid practice of separating potable water from groundwater means that latrines and showers are located at the opposite end of the camp from wells and taps, and women must walk far from their living areas at night to use the toilet or shower, thus risking assault from male residents. Elsewhere, male peacekeepers and humanitarian workers have been known to extort sexual “favors” from women and youth in return for safe passage or extra food rations.

Humanitarianism in the states of exception

In our analysis, we show that refugee and IDP camps embody a number of striking contradictions. First, while they are supposedly governed by international law and human rights, in reality the operation of such law and rights in sites of exclusion is often nonexistent. Second, the lines between war-making and nation-building and between the peacekeeping and humanitarian functions of UN agencies have blurred (the war in Iraq being the most recent example). Traditionally, humanitarian work was supposed to be politically neutral, but in reality this is often not the case. In addition, political neutrality becomes a barrier to reporting and enforcing human rights violations against displaced populations. The third contradiction is the false assumption that the camp represents an “emergency” intervention, thus a temporary way station en route to someplace else, whereas millions of refugees and IDPs face a sharply contrasting scenario. According to a recent UNFPA report, the average stay in refugee camps is 17 years. Moreover, as many critics of the current displacement regime note, the “emergency” mindset induces a crisis management mode among camp personnel that treats refugees or IDPs as passive, dependent victims, thereby undermining their autonomy.

This leads to a final key contradiction: refugee and IDP camps are supposed to be just that—“refuges,” shelters; yet typically they are places of demoralization, dehumanization and extreme danger. Many researchers, speaking from direct field observation, critique the ways in which local residents, the media and policy-makers perceive refugees and IDPs as both economically burdensome

and morally and physically threatening. Degrading stereotypes may infect the attitudes of humanitarian workers, whose interests are served by pathologizing, medicalizing and labelling the refugees as helpless and vulnerable or alternatively as cheaters, schemers and obstacles to efficiency.

The underlying assumption of UNHCR operations—that refugees can best be cared for when they are settled in camps—constructs an asymmetrical power relationship between forced migrants and those upon whom they are dependent for the means of survival and security. This may induce servile, helpless and dependent behaviour rather than giving people the tools to regain some control over their lives. On the other hand, in some settings, residents—particularly women—have demonstrated remarkable degrees of resilience and resistance, providing their own networks of mutual support (for example, in Lebanon in 2006) or refusing the conditions imposed by aid workers (for example, boycotting distant and dangerous latrines). These examples suggest that health and humanitarian interventions need to prioritize analyses and interventions that build on women’s local knowledge, resilience and potential empowerment and self-determination in times of crisis.

New Directions

Despite great differences in settings and inconsistencies in practices across sites, much of the evidence reviewed tells us that refugees in camps are more likely to receive services of all kinds than are IDPs and displaced persons scattered outside camps or, in some cases, even local residents who are not displaced. Further, a growing body of evidence shows some of the highest and most prolonged increases in excess mortality occurring outside camps in provinces, regions and countries affected by conflict. This is especially true in countries or territories such as Iraq, Afghanistan and Palestine where the whole society, in effect, becomes a camp, not of refugees but of military prisoners. At the same time, the pattern we observed of flows back and forth between camps, armed conflict zones, and endangered or neglected rural and urban areas suggests that camp boundaries in many complex emergencies cannot easily be immunized against viruses, violence or stolen food and medical supplies. As health researchers begin to address these problems by calling for greater “coverage” beyond the camps and more coordination with and responsibility of national governments, they are implicitly raising questions about the viability of the camp as a model of protection.

One model put forward to assure accountability and enforcement for IDPs and refugees is to invest in strengthening local and national institutions, giving local governments adequate human and financial resources to fulfil their obligations. This integrative model attempts to embed gender, health and humanitarian interventions for refugees, IDPs and conflict-affected people in a broader set of institutional and structural transformations. An alternative approach is a multi-sectoral model of responsibility that would invest resources in greater coordination across international and national nongovernmental agencies in an attempt to broaden and deepen the existing international regime.

We view the national capacity building and international/multi-sectoral approaches as interdependent rather than oppositional. Walter Kälin, the Representative of the UN Secretary-General on the Human Rights of Internally Displaced Persons, has formulated this hybrid perspective thus: “Where governments lack the will or capacity, international actors will need to be more directly involved in protecting the rights of the displaced, but in a way that seeks to reinforce rather than substitute for national [and also local] responsibility.” A genuine human rights approach to relief work will require dissolving the artificial boundary between “political” and “humanitarian” functions. As such, international organizations and NGOs will have to decide strategically when it is necessary to step out of the cover of neutrality, make demands on states to live up to their human rights obligations (including health and all other economic and social rights), and call governments to account when they refuse. Finally, we stress that an effective guarantor of human rights for refugees and IDPs is not feasible without continual pressure and activism from a third force—that of refugee/IDP subjects themselves and the transnational movements and organizations that are their advocates and allies.

Short of abolishing camps—whose foundations in violence and forced displacement make them incompatible with human rights and social justice in the long run—we urge the following measures to ensure the safety, dignity and empowerment of those who reside in camps:

1. Humanitarian, health and relief workers and agencies should adopt **conscious programs to discourage “victimization rhetoric,” racist and sexist stereotypes** of either dependency and helplessness or cheating and wiliness among the populations they serve and attitudes that promote such dependency. Instead, in providing services and assistance, they should **seek out and build on local networks, traditions, and practices of “community resilience,” self-help and mutual aid;**

- enlist local leaders and speakers —particularly women—in making decisions and designing relief programs** concerning everything from camp layout to food and job distribution to child care and health priorities; and attempt to develop democratic, participatory methods for engaging camp residents' involvement across gender, age, and ethnic divisions.
2. Where such networks and traditions tend to be heavily patriarchal and male-dominated, camp workers should see educational efforts concerning women's equality and empowerment and against sexual and gender based violence as an integral part of their mandate. Such efforts should fully engage men and youth as well as local women and should address male subordination in age and military hierarchies as well as violence against and subordination of women and girls. At the same time, they should be conducted in ways that take into account and respect local beliefs, traditions and values, raising questions and promoting open discussion rather than imposing alien values and moral judgments.
 3. Gender equity, women's empowerment, and participation in decision-making across lines of gender and age difference are difficult if not impossible in the absence of the most basic enabling conditions. Health rights and other social, economic and cultural rights are indivisible. Humanitarian and health workers in camps must work to assure the structural determinants that underlie an ability to participate, including decent housing, safe water, sanitation, physical safety, affordable cooking fuel, child care, care for the elderly, educational and sustainable livelihood possibilities, and freedom of movement and expression.
 4. To reside in sites of political exclusion is to lack accountability mechanisms for bringing grievances against abuses and wrongs—including those perpetrated by caregivers and peacekeepers. A new ethos of rights-based humanitarianism to address this problem is emerging, as reflected in documents like Sphere and the International IDP guidelines. **International donors should devote sufficient resources to support and strengthen new models of accountability and empowerment for camp residents, and UN bodies should work to assure that local governments respect and enforce these efforts.** Wherever possible, on-site accountability and grievance processes—for example, establishing a camp ombudsperson or complaints committees—should be linked to existing international human rights machinery, including the human rights treaty bodies and special rapporteurs as well as national and transnational human rights groups engaged in creating shadow reports. At the same time, efforts should be made to

5. Where conditions in surrounding locales and communities are relatively stable and functional, efforts should be made to better integrate displaced populations into these communities. Integrative and multi-sectoral models for meeting the needs of refugees and IDPs are not mutually exclusive but complementary. On the one hand, health, nutritional and other services provided to camp residents should be available to populations living near the camps, to break down the isolation of camps and to discourage their use as military staging areas. On the other hand, local clinics, services, schools and community and faith-based organizations should open their doors to and interact with camp residents on a voluntary basis. Attempts should be made to transcend the prevailing fragmentation of both services and donor streams into compartmentalized pockets (development, humanitarian assistance, post-conflict relief and reconstruction, health services, gender equity and women's empowerment). **The realities of complex emergencies and of the real lives of people caught in displacement and catastrophe call for a much higher level of cooperation across agencies, sectors and physical boundaries than currently exists.**

In the end, we find that the critical need is to develop gender-sensitive policies and programs that address the needs and disempowerment of men and boys as well as those of women and girls; to discard old stereotypes of women as always victims and men as always abusers. This rhetoric reinforces paternalistic attitudes in relief programs and overlooks the active responses of women refugees and IDPs. Indeed, it is clear that gendered relations of power in the sites of exclusion we have been describing are highly complex, context and culture-specific, and begging for further research. Like the emergencies themselves, responses must be complex and multi-dimensional.

I. Conceptual Framework – Why focus on sites of exclusion?

The camp is the space that is opened when the state of exception begins to become the rule. (Sergio Agamben, *Homo Sacer*)

This study sets out from several key premises. First, we agree with the observation of contemporary political theorists that, under present conditions of militarized global capitalism and a “war on terror” that knows no limits of time or space, what Agamben calls “states of exception” have increasingly become a “normal situation”—the everyday condition of life for millions of people across the globe. (Agamben 1998:168; Papastergiadis 2006; Hyland 2001) By “state of exception,” Agamben means a juridical situation in which what in previous regimes had been a declaration of emergency powers, a temporary imposition of martial law entailing suspension of ordinary constitutional norms and civil rights (usually in time of war, threat of armed attack or civil unrest), becomes indefinite if not permanent. In this condition, sovereignty itself, increasingly centralized, is defined by the capacity to determine when and where the state of exception exists, and more and more people find themselves reduced to “bare life,” stripped of the ordinary rights of citizens or those with “the right to have rights.” (Agamben 2005:1-7; Papastergiadis 2006)¹

Second, we adopt Agamben’s focus on “the camp” as the quintessential site where the state of exception is manifest in the contemporary global landscape. Agamben’s paradigm is the Nazi concentration camps, but the analysis applies just as well to all the proliferating sites of involuntary detention across the globe, from detention points for suspects in the US-led “war on terror” (Guantánamo, Abu Ghraib, Baghrum, and numerous secret sites of “extraordinary rendition”), to camps for refugees and internally displaced persons (IDPs), to prisons with physical walls as well as those with legal and civil barriers that constitute the limbo in which undocumented migrants and trafficked persons find themselves all over the world. “The camp” is thus both “a permanent spatial arrangement . . . outside the normal order,” one where “law and fact . . . have become indistinguishable,” and a moral and ontological situation. Despite its variations, those who reside in it have in common their exclusion from the circle of persons recognized as citizens or even fully human beings. Yet, paradoxically, they come to typify the current state of geopolitics. (Agamben 1998:169-71)

Conceptually, states of exception reveal “bare life” as everyday life stripped down, where it is impossible to separate health from war and human insecurity or gender relations from economic and political inequalities. Thus the camp offers an opportunity to apply up close our third underlying premise: that gender equity in health care always and everywhere intersects with a whole series of social, economic and cultural forces, including levels of armed and physical violence, employment and livelihood conditions, basic infrastructure

¹ Agamben is elaborating on Foucault’s concept of *biopolitics*, which Foucault defined as technologies of power applied to regulate entire populations—their mortality, morbidity, numbers and movement—an associated with modernity. Agamben expands the reach of Foucault’s analysis to argue that governance over life itself, the very conditions of life (i.e., survival)—throughout much of ancient and early modern history, a function associated with the “private” domain of the household—has become the *primary* function of State (or imperial) power. See Agamben 1998:5, 9; 2005:1,2; and Foucault 2003.

(water, sanitation, transport), cultural norms and practices regarding gender, race, ethnicity and religion, and possibilities for political participation and empowerment. Related to this is an understanding of gender as integral, context-specific, and inclusive of men as well as women and transgender persons. Men of all ages are among the vastly growing number of globalized and militarized bodies thrown into sites of exclusion, even though women and children may be the majority in many sites. Gay men, lesbians and transgender persons are both denied entry as cross-border migrants and denied full citizenship rights in their natal countries. Clearly the conditions of bare life have different meanings based on gender, sexuality and race/ethnicity as well as local and cultural circumstances. (Indra 1999; Giles and Hyndman 2004; Luibhéid 2002; Luibhéid and Cantú 2005; Petchesky 2005)

We argue that foregrounding states of exception as a way of understanding current gender dynamics in the social determinants of health is both conceptually useful and epidemiologically necessary. From an epidemiological perspective, the aggregate of all these sites of exclusion constitutes the real space where untold millions of people live, on the bare margins of national regimes and sometimes under contested international jurisdiction. As such, it represents an enormous concentration of the most vulnerable and at-risk groups as well as a key transfer point for viruses, violence, and damaged, discarded bodies. Yet major health surveys, from the Human Development Reports to UNAIDS reports, and much of the literature on social determinants of health still take national health systems as their statistical base; the populations residing in camps, whether those physically contained/detained or the huge number of cross-border and virtually stateless migrants, simply are not counted.

A fourth premise of this study is that a human rights approach to gender and health equity issues is *both indispensable and insufficient*. Again, sites of exclusion—“the camps”—reveal this most directly, insofar as their residents are precisely persons who have been cast outside the protections of citizenship and state laws. As Agamben notes, following Hannah Arendt, the situation of refugees embodies a paradox, since one would imagine people forcibly cast out from their homelands to be the “purest” subjects of human rights. Yet such people are also those most lacking in any reliable forms of protection, respect, accountability, and methods of making claims and seeking enforcement. If they are “so completely deprived of their rights and prerogatives that no act committed against them could appear any longer as a crime,” how can they be said simultaneously to be subjects of rights? (Agamben 1998:126, 171; Papastergiadis 2006:435) With regard to health, international recognition of “the right to the highest attainable standard of physical and mental health” as a fundamental human right, and one that is indivisible from all the other economic, social and cultural as well as civil and political rights, is solidly elaborated in a number of international documents. (CESCR 2000; Hunt 2004, 2007; and below) But the verbal pronouncement of this right and its full application to *all* persons regardless of gender, race or ethnicity, *including “asylum seekers and illegal immigrants” as well as “prisoners or detainees,”* is still a far cry from its practical realization, and nowhere more starkly than in the camps. As one writer puts it:

. . . ‘human rights’ clearly remain grounded in ‘belonging’ to a Nation-State, and consequently are of no use to those who find themselves Stateless, having left the country they were born in (whether for fear of ‘martyrdom’ or as a matter of material necessity) and been refused ‘naturalization’ elsewhere. . . .

Consequently, alienation of ‘rights’ grounded in national citizenship and the urgent need for another, less passive conception of subjectivity and freedom appear destined to become generalized conditions. (Hyland 2001:3)

Refugee and IDP camps

We have defined sites of political exclusion very broadly and believe it is urgent that public health advocates and practitioners bring this larger array of temporarily or permanently stateless populations into their priority agendas. Nevertheless, for practical reasons this paper will focus mainly on one particular kind of site—camps containing “refugees” or “asylum seekers” (the terms for those who flee across national borders) as well as those harboring internally displaced persons.² Moreover, while forced migration may be the result of a variety of crises, including economic displacement from famines or development projects and displacement from natural disasters (floods, hurricanes, tsunamis, earthquakes), most of the examples of health and gender justice issues we consider below reflect displacement due to armed conflict, violence and persecution. Objective conditions as well as space limitations, we believe, justify such a focus. In an increasingly militarized world, “the camp” becomes symptomatic not only of a generalized kind of order but also of the merger of order and violence, war and peace, and the penetration of “armed conflict zones” into “normal” life:

Throughout much of the world, war is increasingly waged on the bodies of unarmed civilians [now 60-90 % of all conflict casualties]. Where it was once the purview of male soldiers who fought enemy forces on battlefields quite separate from people’s homes, contemporary conflict blurs such distinctions, rendering civilian women, men, and children its main casualties. The violence of such conflict cannot be isolated from other expressions of violence. In every militarized society, war zone, and refugee camp, violence against women and men is part of a broader continuum of violence that transcends the simple diplomatic dichotomy of war and peace. . . [and] resists any division between public and private domains. (Gyles and Hyndman 2004:3)

In an important case study of the “militarized commerce” wedding corporate interests to both local and foreign government interests in Sudan, Audrey Macklin provides a stunning example of the ways in which macroeconomic, military and cultural forces combine in a toxic mix to engender displacement and drive up mortality and disease. She describes how an oil pipeline project in Sudan involving a consortium between the Canadian oil company Talisman and the Sudanese, Chinese and Malaysian governments in the mid-1990s not only

² The 1959 Refugee Convention and its 1967 Protocol define a refugee as: “any person who: owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.” The UN Secretary-General’s representative for internally displaced persons, endorsed by UNHCR, defines such persons as those “who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.” (*Guiding Principles on Internal Displacement* 2000)

exacerbated longstanding ethnic, racial and religious rivalries but also turned millions of people—Nuer and Dinka—“into outsiders in their own territory.” (2004:85) To protect the oil operations, not the people, the government relocated the Nuer and Dinka into “peace camps” and effectively militarized the entire region. As in so many IDP situations, women and children became the majority in these camps and faced a heightened risk of sexual violence—from male authorities in the camps extorting sex in exchange for food, from attacking militias, and from their own “soldier-husbands demanding sexual services in the name of ‘reproducing the nation’.” The serious health consequences included not only unwanted pregnancies and STDs but also increased maternal and infant mortality.

Macklin’s most ironic discovery about health care during her fieldwork in southern Sudan was a largely unused, new hospital built by the oil company to serve its “transplanted Arab laborers from the North”—laborers who were entirely male and Muslim. The company deliberately barred from access to the hospital the displaced southerners, who were mainly black African, non-Muslim, and female, “because they did not want southerners getting too close to the oil operations.” Thus gendered health inequities are inextricably linked to economic forces, race-ethnic divisions, and militarization. As a result, “military security and corporate security conjoin to trump human security, and the incubators in the Talisman hospital lie vacant while nearby, women watch their babies waste away.” (Macklin 2004:94)

According to recent estimates, in 2005 there were some 10-12 million refugees and asylum seekers worldwide and an additional 24-25 million IDPs.³ Weiss and Korn point out the “dramatic reversal” in the “ratio of refugees to IDPs” in the past twenty-five years, from 1982, when the number of international refugees was ten times greater than that of IDPs, to the present, when the latter have become two and a half times more numerous. (2006:1) This reversal reflects a number of changes associated with globalization and the unipolar geopolitics following the end of the Cold War, but particularly (a) the ascendancy of local, ethnic and communal conflicts and imperial (US-led) “policing” operations over international and regional wars; and (b) the recent backlash against the waves of cross-border exiles fleeing economic as well as military crises, with the consequent hardening of national borders to “aliens.” Scrutinizing this harsh process in the case of Australian policies toward Afghani and Indonesian refugees, Papastergiadis calls it “the invasion complex”—“the anxiety over the strength of national borders and national identity in a context of global fears.” (2006:440) Beginning in 2005, the total number of IDPs began to decline as the numbers of those able to return to their countries of origin (nearly 4 million that year) accelerated. (Norwegian Refugee Council 2006:9) Nonetheless, the wholesale concentration of internal and cross-border refugees in camps remains “a standardized, generalizable technology of power. . . in the management of displacement.” (de Alwis 2004:219)

Despite the widely hailed open borders of globalization, national sovereignty claims slam the door on cross-border migrants, and with a vengeance since September 11, 2001. Although they are most frequently fleeing the worst human rights violations, international asylum

³ Numbers vary depending on the method of counting and who is doing the counting; see UNHCR 2005, USCRI 2006, Norwegian Refugee Council 2006, and Weiss and Korn 2006. Spiegel (2002), drawing on the US Committee for Refugees’ World Refugee Survey 2001, places the estimated number of people “displaced by complex humanitarian emergencies” at 35 million, but he is no doubt combining IDPs and refugees here.

seekers not only face ethnic profiling, stringently policed borders, and impossible visa requirements. In the globalized state of exception—but especially in the US, UK, EU and Australia—they also meet the threat of indefinite detention as suspected “terrorists” in jails, camps or airport transit zones without the possibility of appeal or habeas corpus, contrary to all human rights norms, sometimes at great risk to their health and life. Current conditions of not only undocumented but also legal immigrants attempting to enter the US, which detains some 230,000 immigrants each year, illustrate these risks all too dramatically. A report by a bipartisan federal commission in Washington accused the Bush administration, “in its zeal to secure the nation’s borders and stem the tide of illegal immigrants,” of subjecting asylum seekers to strip-searches, shackles and detention in jails. (Swarns/NY Times 2/8/07) Another report by two advocacy groups in the US found “prisonlike” conditions in some of the nation’s privately run detention centers for immigrants, where women were denied health and prenatal care and children were separated from their parents. (Swarns 2/22/07) In June of 2007, *The New York Times* reported that 62 immigrants had died in administrative custody under the Immigration and Customs Enforcement agency since 2004, including a woman who had been a legal permanent resident of the country for 30 years and was detained upon returning from a trip to her native Barbados, then denied necessary treatment for high blood pressure, a fibroid tumor and uterine bleeding. (Bernstein/NY Times 6/27/07)

Border policing and surveillance techniques take aim at those deemed sexual and gender outlaws as well as the more predictable political, religious and racialized targets of the “war on terror.” Contributions to the scholarly anthology *Queer Migrations* document a century and a half of a “federal immigration control regime that sought to ensure a ‘proper’ sexual and gender order” by excluding Asian women (assumed to be prostitutes), cross-dressers, or anyone of “suspicious” sexual or gender identity, and more recently those infected with HIV/AIDS. (Luibhéid and Cantú 2005; Luibhéid 2002⁴) If anything, 9/11/01 provided an excuse to intensify these more traditional forms of policing borders based on racial, gender and heteronormative stereotypes. As Loescher puts it, “The war on terrorism has given policymakers and law enforcement agencies a ready pretext to abuse the rights of refugees and other immigrants.” (2002:52)

Like migrant detention sites, refugee and IDP camps embody a number of striking contradictions. On the one hand, they are supposed to be governed by international humanitarian law and human rights provisions. In reality, the operation of such law and rights in these “exceptional” spaces is practically nonexistent, and humanitarian aid workers “find themselves making decisions in a legal vacuum.” (Slim 1997:247) Until 1992, international law and organization had no jurisdiction whatsoever over forced migrants within their own countries; and still IDPs lack any “institutional sponsor or formal international legal framework” for their protection comparable to the United Nations High Commission on Refugees (UNHCR). (Weiss and Korn 2006:1, 2; Wille 2006) The resolute claims of national sovereignty still prevail over human rights enforcement in actual practice, but abetted now by the “war on terror.” According to the Norwegian Refugee Council, “in 80 per cent of the displacement situations where IDPs’ lives were in danger as a direct result of

⁴ On immigration restrictions for people with HIV and AIDS, see Herdt 1997 and Haour-Knipe and Rector 1997.

ongoing conflict, governments provided only partial protection, or none at all . . . 13 governments responded with indifference or outright hostility. . . .” In Colombia and other countries, the “war on terror” becomes the rationale to “deny the applicability of international humanitarian law to their internal conflicts.” (2006:14,16) In Southern Sudan, the government denies air landing rights to humanitarian organizations seeking to bring in food and medical supplies. (Macklin 2004)

This raises a second contradiction, epitomized in the war in Iraq, involving the blurring of lines between war-making and nation-building, and between the peacekeeping and humanitarian functions of UN agencies. Echoing Loescher, Antonio Donini, former director of the UN Office for the Coordination of Humanitarian Assistance to Afghanistan, says “the global war on terror casts a somber shadow on the prospects of principled humanitarianism.” Humanitarian work is supposed to be politically neutral, as refugee and IDP camps are supposed to be neutral spaces, zones of “mercy.” In reality, humanitarian aid workers and efforts frequently get caught up and both compromised and endangered in raging political conflicts. Because Northern donors control the funds for humanitarian assistance (which, unlike peacekeeping funds voted by the Security Council, are voluntary), and most large NGOs that do such work are based in the North, both UN and NGO aid workers are perceived and targeted by communities under occupation as enemies allied with the imperial North. (The bombing of UN headquarters and killing of its mission chief and 21 others in Baghdad in 2003 marked a dramatic and well-publicized example.) For the same reasons, “high-profile cases [e.g., Iraq and Afghanistan] suck up the cash while forgotten and often more deadly crises [e.g., Central Africa and the Democratic Republic of Congo] languish.” And, with the growing danger and politicization of such crises, more and more care providers have become for-profit contractors who have “joined the service of empire.” In these circumstances the whole enterprise of humanitarianism—including the provision of health care—becomes corrupted. (Donini 2004:38-39; Donini, Minear and Walker 2004)

A third contradiction of the camps is their definition as “emergency” interventions, thus temporary way-stations en route to someplace else (whether repatriation or permanent asylum and naturalization). Again, the reality for millions is in sharp contrast to this scenario of limit. According to a recent UNFPA report, the average stay in refugee camps is 17 years. As Harrell-Bond puts it, “despite their ostensible ‘temporary’ nature, these settings have become the main living environments for many refugees for years and, in some cases, for more than one generation.” (2002:56) Likewise, IDPs caught in situations of armed conflict may be “stuck in displacement for several years, many even for decades,” given the long duration of internecine conflicts in places such as Sudan, Central Africa, the Pakistani border with Afghanistan, Israel-Palestine, Colombia, and now Iraq. (Norwegian Refugee Council 2006:11) This long-term/“temporary” status of refugee and IDP camps creates a whole series of secondary contradictions. With regard to health care, the view of camps as “the emergency room of international health” may have the paradoxical effect that, in the post-emergency phase of crises, and especially in smaller camps, residents actually receive better medical care against infectious diseases than do those living outside the camps or in refugees’ countries of origin.⁵ But when the level of crisis escalates, health care providers often are

⁵ See UNFPA 2006:63; Walman and Martone 1999; Van Damme 1995; and below, Section II.

forced to abandon the site (as Médecins sans Frontières had to leave Iraq in 2004); or when camps grow large and unwieldy as well as insecure, infectious diseases and maternal mortality spiral out of control, as happened in the DRC (Democratic Republic of Congo) in 2005. (Van Damme 1999:361; Ahoua et al. 2006:202) Moreover, as many critics of the current displacement regime note, the “emergency mindset” induces a “crisis management” mode among camp personnel that treats refugees or IDPs as passive victims, thereby undermining their autonomy or even their humanity. (Hyndman 2004:203; Van Damme 1999:361; Pallis 2005; Harrell-Bond 2002)

This leads to a final contradiction: refugee and IDP camps are supposed to be just that—“refuges,” shelters; yet typically they are places of demoralization, dehumanization and extreme danger. Many researchers, speaking from direct field observation, critique the ways in which local residents, the media and policy-makers perceive refugees and IDPs as both economically burdensome and morally and physically threatening—as sources of pollution and contamination if not terrorist attacks. “The refugee is both malevolent and indolent; prepared to risk everything in order to get in, then happy to retire at the expense of the state.” (Papastergiadis 2006:433; Loescher 2002; de Alwis 2004) As with all forms of racism, these stereotypes have distinct sexual dimensions as well, with women refugees (often abandoned or widowed and left as heads of households) characterized as “loose” or as bad mothers, and men as either emasculated or sexual predators. (de Alwis 2004) Degrading stereotypes may infect the attitudes of humanitarian workers, “whose interests are served by pathologizing, medicalizing and labeling the refugees as helpless and vulnerable” or alternatively as cheaters, schemers and obstacles to efficiency. (Harrell-Bond 2002:57-58) Further, aid workers come with a whole set of preconceived “grids of understanding and formulas for action” that may have little relevance to the complicated cultures, conflicts, and local conditions that make up the reality of their “clients.” (Hyndman 2004:201; Indra 1999:18)

The underlying assumption of UNHCR operations—“that refugees can best be cared for when they are settled in camps” (Van Damme 1995:361)⁶—constructs an “asymmetrical power relationship” between forced migrants and “those upon whom they are dependent for the means of survival and security.” Aid givers “assume the power to decide who is deserving,” the crux of the power asymmetry. (Harrell-Bond 2002:55, 68) In addition, structural conditions in refugee camps may foster inhumane, at times even violent behavior toward refugees on the part of camp administrators. These conditions include hierarchical organization of UN and NGO personnel in the camps, with UNHCR officials taking the “senior” role. They also entail the “strict control” thought necessary to distribute food and medical aid “equitably” and in a way that prioritizes accountability to donors; indeed, any accountability of aid organizations seems directed toward donor governments rather than to aid recipients. Mechanisms to enforce such control can often be degrading and objectifying—for example, organizing the camp into a grid, having people line up or herding

⁶ This varies from situation to situation. In an interview on National Public Radio in the US, UN High Commissioner for Refugees Antonio Guterres stressed that the agency was not seeking to place the hundreds of thousands of Iraqis who have fled to neighboring Syria and Jordan in camps. In this situation, the strategic dangers of creating targets and staging areas in a bitter civil war may outweigh previous practice. (NPR, “All Things Considered,” 2/27/07) More generally, it is almost always the poorest, those with fewest resources and skills, who get stuck indefinitely in camps.

them into groups for head counts and food or medical distribution, and generally treating refugees of all ages like children. Rigid bureaucratic rules result in “absurdities,” such as refusing medical care to elderly or dying refugees whose cases were deemed too costly or to fall outside the definitions of “primary health care,” and denying assistance to any refugees except those living full-time in the camps (and hence under agency control). (2002:65-66)

On the other hand, the condition that most undermines human dignity in camps is the structured disaster they embody. Working under terrible psychological stresses, under-resourced, coping with “horrific” logistical and infrastructural problems, and often under the constant threat of physical danger and armed conflict, it is little wonder that aid workers sometimes blame the displaced themselves or take refuge in rigid rules. Loescher paints a vivid picture of the physical and human overlap between refugee camps and armed conflict zones. For purposes of order and containment, “governments prefer refugees to remain in camps and settlement areas close to the border of their home countries.” But this very concentration at the borders contributes to the use of refugee camps by rebel groups as organizing, recruiting and staging areas, thus “[drawing] refugee communities directly into cross-border conflicts.” The insecurity and militarization of the camps in turn exacerbate male violence and sexual abuse against women and children as well as constituting an environment of perpetual insecurity for aid workers. (Loescher 2002:49)

Women and children constitute between 70 and 80 percent of all IDPs, and women are roughly half of all refugees and asylum seekers. (Norwegian Refugee Council 2006; UNFPA 2006:57; Buscher and Makinson 2006) The gender disparity in IDP situations is directly related to militarized violence, many men and boys having been killed or recruited to join combatant groups. Below we will address in greater detail how gender divisions in the camps create particular problems related to health and political equality, including but not limited to gender based and sexual violence. Here we want to underline Hyndman’s point that “*women refugees’ are not vulnerable in any essential way*”; rather their vulnerabilities need to be understood as contingent upon a whole range of historical, cultural and context-specific conditions. (2004:200, emphasis added) Rape and other forms of violence are part and parcel of these complex grids of power and culture—for example, the traditional division of labor that assigns women and girls the job of collecting firewood, thus exposing them to the risk of attack by sending them wandering into dangerous areas outside the camp (see below).

Commenting on the hierarchical, insecure, and regimented conditions just described, Harrell-Bond calls this regime “undignified humanitarianism” and suggests that it induces helpless and dependent behavior rather than giving people the tools to regain some control over their lives. (2002:57-60) Yet evidence also exists that residents of camps, particularly women, are by no means always dependent or passive, suggesting we need models that break from stereotypes of helplessness and build on local capacities for women’s empowerment. In some circumstances, displaced women and refugees take advantage of shifting gender power relations in the camp or build on pre-existing communal traditions and networks to develop inventive strategies for survival and resistance. (Nuwayhid, Cortas and Zurayk 2007; de Alwis 2004; Hans 2004; Harrell-Bond 2002; and below) We shall argue that such examples of resistance and resilience demonstrate the emergence on the ground of new transnational

subjectivities that challenge the state of exception itself and the exclusionary categories of “citizens,” “migrants,” “refugees,” and “detainees” on which it rests.

Human Rights Approaches and Their Limits

Jacques Derrida has written, “we must (*il faut*) more than ever stand on the side of human rights,” but they “are never sufficient.” (in Borradori 2003:132) We referred to this seeming paradox of indispensability and insufficiency earlier and want to explore it further here. Concerning indispensability, human rights approaches to forced migration and displacement challenge the traditional international relations model that “takes the state as the unit of analysis and measures security by the state’s ability to protect itself and its institutions from military threat.” (Macklin 2004:80) Unlike the prevailing international relations model, human rights regard human beings as the primary reference points and subjects whom states are obligated to protect, in matters affecting their own citizens as well as strangers. Rather than the prerogative of national sovereignty and the state of exception, the idea of “sovereignty as responsibility” takes hold, meaning: “governments are responsible for the human rights of their citizens as part of the essence of statehood; when they are unwilling or unable to provide for the security and well-being of their citizens, an international responsibility arises to protect vulnerable individuals.” (Weiss and Korn 2006:3) From this perspective, humanitarian assistance, rather than a matter of “private charity or governmental largesse,” becomes one of basic human rights. (Harrell-Bond 2002:52)

In addition, human rights are ethically superior to other frameworks—such as utilitarianism and social contract theory—insofar as they subordinate cost-benefit analyses and crude self-interest to principles of social, economic, gender and racial justice. What this means, according to philosopher Martha Nussbaum, is that “society owes people . . . a basic level of support for nutrition, health, shelter, education, and physical safety,” as well as “effective guarantees of the major liberties of expression, conscience, and political participation” in order for them to realize their “basic human capacities,” across all gender, racial, ethnic, sexual, religious, and other differences. (Nussbaum 1999:20) The incorporation of concepts of justice into human rights discourse and documents has been an achievement of the last two decades, particularly through the work of feminist human rights advocates within the UN conferences of the 1990s and in consultation with human rights treaty bodies and special rapporteurs. Groups like DAWN (Development Alternatives for Women in a New Era), the Women’s Caucus for Gender Justice, the Center for Women’s Global Leadership, the Women’s Environment and Development Organization, and publications such as the journal *Health and Human Rights* have brought not only the principle of *indivisibility* (that political and civil rights are inseparable from economic, social, cultural and environmental rights) but also the *social* dimension of individual needs into international perspective. Their work demonstrates that human rights are an evolving, living body of ideas, not a static set of norms. (Petchesky 2003; Girard 2007; Cook 1995)

Three bodies of international law—based on treaties and consensus documents and statements interpreting them—define the rights of refugees and IDPs: general international human rights law (including that specific to health, gender equality, sexuality and reproduction); humanitarian law regarding the treatment of noncombatants in armed conflicts

(especially as contained in the Geneva Conventions and related protocols as well as the Statute of the International Criminal Court); and refugee law (1951 Convention on the Status of Refugees and its 1967 Protocol).⁷ As noted earlier, “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” is embedded in numerous international instruments signed by the great majority of UN member states.⁸ The specific terms and meanings of this right are spelled out in detail in General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR) and in the official reports of Paul Hunt, Special Rapporteur on the Right to Health, from 2004 to 2007. These documents exemplify the social justice construction of human rights that feminists and other transnational actors have strived to foreground. The Committee defines the right to health “as an inclusive right extending not only to timely and appropriate health care but also 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 housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.*” (CESCR 2000:para. 11, emphasis added) It also reemphasizes the Convention’s prohibition of discrimination “in access to health care and underlying determinants of health . . . on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status. . . .” (2000:para. 18)

Particularly pertinent to this study, General Comment 14 makes special mention of the obligation to promote women’s right to health, including reducing rates of maternal mortality, “protecting women from domestic violence,” and removing “all barriers interfering with access to health service, education and information.” Likewise, it specifies the obligation to provide equal access to “preventive, curative and palliative health services” to “all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants.” (2000:para. 34; and Hunt 2007:19) In a complementary vein, Walter Kälin, the current Representative of the Secretary-General on the Human Rights of Internally Displaced Persons, discusses the specifics of a “rights-based approach to humanitarian action” in his report of January 2006. Such an approach guarantees to IDPs not only “rights related to physical security and integrity (including protection of the right to life and freedom from torture and cruel and inhuman treatment, assault, rape, arbitrary detention, . . .” etc.); but also “fundamental rights related to basic necessities of life,” including food, potable water, shelter, sanitation and health services as well as all the fundamental economic, social, cultural and political rights (religious freedom, freedom of speech, political participation).

⁷ See Girard and Waldman 2000 and McGinn et al. 2004 for excellent summaries.

⁸ See the International Covenant on Economic, Social and Cultural Rights, article 12.1; the Convention on the Elimination of all Forms of Racial Discrimination, article 5(e); the Convention on the Elimination of All Forms of Discrimination against Women, articles 11.1(f) and 12; the Convention on the Rights of the Child, article 24; the African Charter on Human and Peoples’ Rights, article 16; the European Social Charter, article 11; and the respective programs of action of the UN conferences on human rights in Vienna (1993), population and development in Cairo (1994), social development in Copenhagen (1995) and women in Beijing (1995).

In his 2006 and 2007 reports, Kälin emphasizes the need to protect the rights of IDPs not only during the period of their displacement but also in the often unstable and still risky conditions of their return. For example, a mission to Sudan in 2005 found that many IDPs returning to the south were still being placed in relocated camps and “irregular settlements” and “remained without shelter, sufficient food, clean drinking water and access to medical services.” (Kälin 2006:9) Likewise, a mission to northern Uganda in 2006 found that, while security had improved sufficiently to allow IDPs to move closer to their fields and homes, “serious humanitarian and human rights problems persisted, including poor health and sanitation conditions; lack of access to education; and high levels of sexual and gender-based violence.” (Kälin 2007:6)

These accounts affirm once again the reality that states of exception and sites of exclusion bring starkly to light: that effective enforcement of the human rights to health and gender equity is inseparable from that of all the other economic and social, civil and political rights. Special Rapporteur Paul Hunt—who has perhaps done more than any single individual to bring the centrality of health as a human right and its gendered and sexual aspects to the attention of international civil society and intergovernmental organizations—stresses that the qualifiers “progressive realization” (that governments should improve their human rights implementation each year) and “resource availability” may apply to some health rights but may not in the least be used to justify unequal treatment of women and men. (Hunt 2007:16) Praising the work of international human rights organizations in recent years in advancing a health and human rights agenda, he quotes a 2005 Amnesty International publication recognizing “that there are many more prisoners of poverty than prisoners of conscience, and that millions endure the torture of hunger and slow death from preventable disease.” (Hunt 2007:6; Amnesty International 2005) In particular, Hunt focuses on avoidable maternal mortality as “not just a health issue” but a distinctly “human rights issue” involving violations of “women’s rights to life, health, equality and non-discrimination.” He points out the shocking discrepancies of scale, contrasting an estimated 25,000 death penalty executions in 2005 with 500,000 maternal deaths. And he recounts how these maternal deaths are vastly disproportionate among women in developing countries, women living in poverty worldwide, ethnic minorities and indigenous women. (Hunt 2007:10) When poverty and racial and ethnic persecution are compounded with the insecurities of armed conflict zones, refugee and IDP camps, the risks of maternal mortality and morbidity become worst of all.

Combining (a) the human rights to health, gender equity and equality with (b) the laws of war concerning rights of civilians in armed conflict zones and (c) humanitarian law with respect to refugees and IDPs creates a potentially powerful framework for challenging the globalized states of exception and holding states and international actors accountable. The reason why a human rights approach is indispensable and cannot be replaced by other recent approaches to securing human needs is that it is based on a principle of obligation, not charity; provides standards for evaluating programs and services from the standpoint of the needs and well-being of those they were designed to benefit; and requires mechanisms of accountability for enforcing those standards.⁹ As Paul Hunt writes, “effective and accessible

⁹ Other approaches include, for example, the concept of “global public goods” (Kaul, Grunberg and Stern 1999); the “capabilities” framework advanced by Amartya Sen and Martha Nussbaum as well as the United Nations Development Program (Sen 1999; UNDP 1998; Nussbaum 1999 and 2006); and the “human security”

mechanisms of accountability compel a State to explain what it is doing and why and how it is moving, as expeditiously and effectively as possible, towards the realization of the right to health for all.” (2007:21) Such mechanisms include the individual complaints procedures of the UN’s human rights treaty bodies, the regular reports that governments are expected to file before those bodies as well as shadow reports that national NGOs may present concerning progress or deficiencies in their government’s compliance with relevant human rights norms. Hunt, in his 2007 report, also emphasizes judicial accountability mechanisms, citing specific cases in which national and regional courts have upheld the human right to health in its various aspects. In one of these cases, the European Court of Human Rights rejected the United Kingdom’s effort to deport a man dying from AIDS to his country of origin in the Caribbean because it would have entailed depriving him of essential medical treatment. This was an example of judicial enforcement of the human right of “equal access for all persons, including prisoners, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services.” (Hunt 2007:19)

All this said, however, human rights by themselves are insufficient to meet the demands of justice. Derrida associates justice with “an aporia,” a “non-road,” “an experience of the impossible.” That is, it is something that is willed, desired, called for, never reducible to “a rule” or a simple calculation of equivalency (that which is “due,” the order of law or exchange of penalty for wrong). Justice is “incalculable” and therefore, in some sense, irrational (that is, unsusceptible to strict cost-benefit analysis). (Derrida 1992:16, 25) Human rights alone can never fulfill justice—least of all for the abjected denizens of the camps—because, for one thing, human rights remain bound to texts, formal procedures, and rules. Moreover, human rights discourse is stubbornly immersed in what Ratna Kapur has called “the tragedy of victimization rhetoric”—a variation of the helplessness and passivity that humanitarian assistance typically attributes to the displaced and excluded. (Kapur 2005) We need human rights, but we also need models that surpass formalism and utilize the power and local knowledge of the presumed victims.

By and large “the camp” is a site of judicial exclusion; how is it remotely possible for most refugees and IDPs sequestered in camps, often under the worst conditions of violence and anarchy, to file complaints, and to whom? The Sphere Project, initiated by a group of humanitarian organizations in 1997, is one recent effort to address these questions.¹⁰ Its Humanitarian Charter provides “that those affected by a disaster [including military conflict]

framework discussed earlier. These may be useful complements to a human rights approach but cannot substitute for it because of the important aspect of accountability and claims mechanisms.

¹⁰ Sphere is a set of minimum universal standards for the five core areas (water supply and sanitation, nutrition, food aid, shelter, and health services) of disaster assistance originally developed by an international collaboration of NGOs and the Red Cross and Red Crescent organizations. It is not legally binding but rather a set of standards and expectations for humanitarian action complete with indicators that reveal whether or not the standard has been attained. It was developed to improve the quality of humanitarian assistance as well as to enhance the accountability of the humanitarian system. Sphere sets out for the first time what people affected by disasters have a right to expect from humanitarian assistance. In a 2005 study commissioned by the UN Office for the Coordination of Humanitarian Affairs, 92% of the humanitarian (NGO and UN) agencies interviewed were using the Sphere standards. For more information on Sphere, see www.sphereproject.org and the 2004 Special Issue of *Disasters* Vol. 28, No. 2.

have a right to life with dignity and therefore a right to assistance,” and its attempt to set up a “humanitarian ombudsman” is meant to give the beneficiaries of this right a viable complaint mechanism. (Harrell-Bond 2002:75) Under this human rights strategy (still very much in the planning stages), UNHCR itself would become not merely a service-providing but also a rights-enforcing, i.e., a governance, regime. (Wilde 1998, cited in Harrell-Bond; Papastergiadis 2006) Harrell-Bond and Kälin, on the other hand, suggest that the best way to assure accountability and enforcement for IDPs and refugees is “to invest in strengthening local and national institutions,” giving local governments “adequate human and financial resources to fulfill their obligations.” (Harrell-Bond 2002:80; Kälin 2006:9, 2007:6)

Yet there is a sad irony in this quest to find formal legal solutions for those whose “alien” or displaced status casts them outside the bounds of citizenship or even humanity. Much of Hunt’s 2007 report is devoted to applauding the strides transnational civil society groups have made in not only taking on but also developing effective strategies for enforcing the human right to health at both national and international levels and achieving some real gains.¹¹ These gains point up the fact that accountability for promoting and respecting human rights is not simply a legal matter but is rather a *terrain of political struggle* whose vitality depends on active social movements. Without collective social movements that perform and lay claim to them, human rights remain empty abstractions.

But how can social movements be viable in the conditions of the camp? In fact, a study of Lebanese populations that endured Israeli air and naval attacks in July 2006 helps to move us beyond “victimization rhetoric” to recognize the local and communal roots of resistance. The study points out that, in the face of the Israeli offensive, some 750,000, mainly Shi’ite Lebanese internally displaced persons managed to survive the horror of those attacks with “minimal health impairments and no reports of disease outbreaks” or disorder.¹² They did so, according to the authors of the report, because of deeply ingrained practices of “community resilience” and “social support,” leading one another to various forms of community shelter and offering food and compassion across ethnic and religious lines. Much of this reflects the extraordinary organization of Hezbollah, but much too, they imply, reflects habits of mutual support, faith, and above all “resilience” developed over many years of civil war and resistance to aggression. The lesson, they argue, is the need for “a new paradigm” among humanitarian and public health workers that will allow people affected “to define their needs and to find the appropriate solutions during disasters, rather than having external organizations impose solutions on them.” (Nuwayhid, Cortas and Zurayk 2007)

¹¹ One striking example has been the campaign for access to essential medicines to treat HIV/AIDS and other deadly diseases, through organizations such as the Treatment Action Campaign (TAC) in South Africa and Médecins sans Frontières. This civil society-led campaign succeeded in galvanizing a loose coalition of developing country governments within and outside the WTO and putting the priority of access to medicines over intellectual property rights into international public discourse. Another is the success of transnational feminist groups in getting women’s reproductive rights into the “Cairo agenda” and onto the radar screen of many international agencies and governments. (See Petchesky 2003; Girard 2005, 2007)

¹² Some 1,100 persons lost their lives, one-third of them children, and thousands more were injured; but given the scale of the attacks, the loss of life and limb might have been much, much worse.

II. Gender and Health Issues in Forced Migration Settings

Militarization and Systemic Violence

In the post-Cold War world, international relations and humanitarian specialists have developed the concept of “complex emergencies” to describe the ways in which states of exception have not only proliferated but also come to encompass the compounded effects of armed violence, ethnic and nationalist conflicts (more often intra- rather than international), and economic crises linked to neoliberal policies. (Hyndman 2004:194-95)¹³ This concept recovers the point we made earlier about the impossibility of drawing boundaries between war and peace or between physical and social violence (including gender, race-ethnic and class inequalities), because contemporary wars occur in the sites of the most severe social divisions, calling forth multiple forms of crisis all at once. Civilian exposure to death and morbidity from armed attacks or landmines, absence of clean water and adequate sanitation, loss of arable land and shelter, severe nutritional deficits, and lack of access to health care, along with drastic human insecurity of every kind, all form part of a single disastrous web.¹⁴ Militarization is integrally linked to systemic violence. (Norwegian Refugee Council; Grein et al.; Gyles and Hyndman; Waldman and Martone)

Once again, Macklin illustrates the gender dimensions of this complexity most eloquently. She describes the horrific conditions among migrants from southern Sudan in refugee camps and squatter settlements on the outskirts of Khartoum in the 1990s, where 40 percent of the households were female-headed. In order to feed and provide medicine for their children (and sometimes an unemployed husband as well), many of these women—non-Arabic-speaking, low-skilled, subject to constant racial-ethnic discrimination—were forced to seek livelihoods in illegal activities such as brewing or selling traditional liquor. For many, this meant

¹³ “Complex emergencies” are typically characterized by (a) extensive violence and loss of life; (b) massive displacements of people; (c) widespread damage to societies and economies; (d) the need for large-scale, multi-faceted humanitarian assistance; (e) the hindrance or prevention of humanitarian assistance by political and military constraints; and (f) significant security risks for humanitarian relief workers. (Burkle 2006)

¹⁴ Chilling evidence of how this web operates appears in a recent report by four UN Human Rights Council Special Rapporteurs, who conducted a mission to Lebanon and Israel following the horrific outbreak of hostilities and bombing attacks there in July 2006. Without diminishing the “community resilience” emphasized by Nuwayhid, Cortas and Zurayk, we can note over a thousand Lebanese civilians, one-third of them children, were killed or wounded while fleeing the Israeli attacks, and an estimated one million were displaced (45 percent children); while 43 Israeli civilians were killed and several hundred thousand displaced and forced into shelters. The report highlights the ways in which Hezbollah’s organic functions in southern Lebanon as not only a military force but also “a political movement and social services enterprise,” running health clinics, schools, orphanages, housing reconstruction programs, and employment outlets, meant Israeli targeting of Hezbollah inevitably (and knowingly) involved the smashing of civilian infrastructure. During the conflict, the IDF targeted ambulances and medical convoys as well as health facilities, and disproportionate fatalities and injuries among poor women, children and elderly meant that “pre-existing inequalities” were deepened. Likewise, the Israelis who were killed or displaced tended to be poor and from the Israeli-Arab communities in the north. Those who fled were forced to survive with “lack of access to water, sanitation, electricity, health care and generally insecure housing “ or even in “open places,” while those who remained were mainly “elderly or people with disabilities.” Dangerous roads meant no one could reach emergency services, and while doctors reported no significant rise in maternal mortality and morbidity rates, “maternal health and the health of newborns were compromised.” Among the most serious health consequences were mental health problems and post-traumatic stress disorders. (Human Rights Council 2006)

imprisonment, along with their children, under the most deplorable conditions of inhumane treatment, malnutrition, disease and death. Thus, for them, armed conflict zones (the bombed villages they had fled), refugee camps and prison were contiguous spaces; “first the regime forces women to run for their lives, then it jails them for trying to find a way to stay alive,” and the entire web of exclusions forms a single deadly labyrinth. (Macklin 2004:88-89)

Currently, approximately eight “major wars” (defined by the United Nations as inflicting at least 1,000 deaths on the battlefield a year) are underway.¹⁵ Along with these, about two dozen smaller conflicts in Asia, Africa, the Middle East and Latin America have been raging for decades and continue as we write.¹⁶ While the total number of armed conflicts has declined since the early 1990s, a recent report by UNHCR points out that the post-9/11 global “war on terror” has “been used to justify new or intensified military offensives,” particularly in Aceh, Afghanistan, Chechnya, Georgia, Iraq, Pakistan, and Palestine. (UNHCR 2005) Besides acting as a green light to all kinds of repressive regimes, the US-led “war on terror” has made the situation of people forcibly displaced by local violence much more precarious, as they face closed borders, deportations and the extremes of human insecurity. Estimates suggest that three-quarters of those killed or wounded in these armed conflicts are civilian populations, typically one-half or more women and children.

In Iraq, the most recent and solidly evidence-based estimates of “the human cost of the war” are those done by an American and Iraqi team of public health researchers from the Bloomberg School of Public Health at Johns Hopkins University. Based on a population survey drawn from randomly selected clusters of households nation-wide, the study estimated over 600,000 “excess deaths” (that is, “number of persons dying above what would normally have been expected had the war not occurred”) for the period 2002-2006 from violent causes, and an additional 53,000 from “non-violent causes,” most likely deterioration of health services and the environment. (Burnham et al. 2006:1, 6). While small in comparison to civilian deaths during the Vietnam War or in the Congo more recently, these numbers “[dwarf] the median number of 18,000 deaths for all civil wars since 1945.” (Sambanis 2006) Yet the gendered profile of casualties in today’s wars is complex. According to the Hopkins study, the overwhelming preponderance of the estimated 600,000 violent deaths in Iraq has been among males of all ages, the majority ages 15-44, many of them belonging to or targeted by warring insurgent and rival sectarian groups. (Burnham et al. 2006:9) But other evidence suggests that the majority of those killed by “coalition forces” (the US and UK primarily) have been civilian women and children.¹⁷ And among children (under 15) in Iraq, violent deaths (and, one supposes, “excess” deaths from non-violent causes) have been remarkably gender egalitarian.

If we widen the definition of “human cost” to include displacements and assaults as well as deaths and morbidities, the impacts on women and girls become much more visible. UNHCR estimates that, as of late 2006, some 2 million Iraqis had fled to neighboring states (mainly

¹⁵ The following section has been adapted from Corrêa, Parker and Petchesky (2007).

¹⁶ See the Global Security website for this data, at <http://www.globalsecurity.org/military/world/war/>.

¹⁷ Deaths attributed to “coalition forces” have declined as a total proportion of deaths in Iraq since 2004 but have continued to increase in number along with deaths from insurgents and rival ethnic and religious factions—see Burnham et al., p. 10.

Syria and Jordan), with 2,000-3,000 continuing to leave each day. An additional 425,000 have become internally displaced since the US invasion in 2003 (many more prior to that), a number that continues to grow at a rate of some 40-50,000 a month. This means a total of around 1 in 8 Iraqis is displaced. (Harper 2007) Many of those who survive armed violence, like the people of Darfur, flee into precarious refugee zones in the desert. In Sudan's Darfur region, an estimated 200,000 people have been killed and millions more displaced from their homes—women and children in massive numbers—while those who survive find themselves in IDP camps with few health or sanitary facilities and pitifully low food rations. And of course women and girls caught in armed conflict zones and in refugee and IDP camps may face a significantly heightened risk of maternal mortality, sexual violence and HIV infection, depending on the political and geographical situation of the camps¹⁸ (see below). The Norwegian Refugee Council estimates “that up to one-third of the internally displaced do not have regular access to clean drinking water and adequate sanitation facilities” and emphasizes their greater vulnerability “to malnutrition and diseases than the non-displaced population.” (2006:23) One can only imagine (because we have no empirical studies) what the lack of sanitary facilities and supplies must mean for displaced women and girls. No toilets or paper or sanitary napkins; waiting all day until dark to relieve yourself; wearing dirty rags during menstruation; the related reproductive tract infections, fistulae, pain, festering and possible infertility; the abjection, rejection and shame. Hunger is universal, but sanitation is profoundly gendered. (Mukherjee 2002)

The paucity of surveys of any kind, much less gender-sensitive ones, assessing the health and nutritional needs of IDPs presents a major problem for generating useful policies and interventions. Even where studies of particular refugee and IDP sites do exist and incorporate health indicators, attention to the specifics of gender are strikingly absent—the major exceptions being the growing number of studies looking at maternal and reproductive health needs and gender-based violence in such sites (see below).¹⁹ Two major reasons contribute to this absence. First is the fact that most data collected on complex humanitarian emergencies focus on the acute emergency phase, when “political interest, media attention and funding [are] greatest.” During this phase, researchers, resources and aid providers are concerned overwhelmingly with indicators associated with excess mortality. In the post-emergency phase (i.e., the years upon years when refugees and IDPs languish in camps), when mortality rates tend to decline, when funding and international attention recede, studies of health and gender conditions barely exist. (Spiegel et al. 2002:2, 6) A second and related reason is the prevailing tendency for research and analysis in international public health, still invested in the “global burden of disease” and DALY (disability life-adjusted years) frameworks, to

¹⁸ Mixed reports on both level of HIV risk and access to reproductive and maternal health services reflect differing conditions in refugee camps. For those that are relatively isolated, away from constant inflows of combatant or migrant men (e.g., Sierra Leone and Sudan), women's and girls' HIV prevalence rates may actually be lower than in their communities of origin. Likewise, women and girls may have better access to reproductive and maternal health services in refugee camps than they would within either the host or origin countries, unless levels of armed conflict and insecurity make it too dangerous for service providers to remain in the camps—as in Darfur or many places in Iraq. See UNFPA 2006; McGinn et al. 2004; and Hynes et al. 2002 for interesting examples.

¹⁹ A study in the *British Medical Journal* of former UNITA members and their families in Angola, for example, pays attention to gender and age differences in mortality generally and malnutrition-related mortality specifically but no other issues that might severely compromise women's wellbeing (Grein et al. 2003).

concentrate on conditions of mortality and severe morbidity that threaten productivity and to ignore the kinds of daily suffering and ill health that women—especially the poorest and most vulnerable—have been socialized to endure without complaint and without stopping their everyday tasks of maintaining families, even in the most deprived circumstances of the camps. Reproductive tract infections, lack of contraceptives or sanitary supplies, abdominal and back pain, vaginal discharges, sexual abuse, emotional stress—all become part of everyday life rather than health problems meriting intervention. (Petchesky 2003)

When we consider the much higher proportion of women and children in IDP camps relative to refugee camps, the disparity in health conditions and outcomes between them becomes another clear but unnoticed gender issue. A 2001 *Lancet* article reports evidence that IDPs (up to 80 percent of whom are women and children) suffer “higher rates of morbidity,” especially from malnutrition and infectious diseases, than do refugees, as well as greater incidence of “forced isolation, torture or abuse, lack of shelter, and forced separation from family members.” (Salama, Spiegel and Brennan 2001) This finding parallels that of the Norwegian Refugee Council, which notes extremely high mortality rates, rates of preventable infectious diseases, and water-borne diseases related to poor sanitation and lack of clean water among IDPs in many countries. Such differences are not only gendered but also highly political and need to be understood as such. In the first place, “the failure of the international community to mount a more effective response to IDP crises” stems from the old habit of deference to national sovereignty, fear of endangering existing UN programs in countries, and a “development”-oriented mindset that finds it difficult to relate to human rights and humanitarian issues. (2006:19) Second, malnutrition and famine are most always socially constructed, abetted by the politics of internal ethnic conflicts and governments’ refusal to allow transport of food and medical supplies. Third, even among IDPs there are differences in treatment and health consequences, and these are often based on race-ethnic exclusions or political considerations. Thus “while IDPs in Europe generally have satisfactory access to water, sanitation and health care, Roma IDPs usually live in informal settlements with very poor sanitary conditions.” IDPs in Burundi and Afghanistan “enjoy better health care in camps than in their places of origin,” while those in Somalia, Ethiopia, northern Uganda and Sudan are in the worst conditions imaginable. And IDPs in the Palestinian Territories are so restricted in their movement that they cannot access health services very nearby (see below, regarding childbearing). (Norwegian Refugee Council 2006:24-25)

Ultimately, the most severe constraint determining lack of access to nutrition and health care among so many IDPs and refugees is the militarization of their environment. Military insecurity and armed conflict interfere with food distribution and often mean the complete breakdown of health services and depletion of aid workers. A study by Spiegel and his associates of health programs in refugee camps in seven countries found that better health indicators and lower mortality rates correlated not only with more adequate water supplies and higher numbers of health workers per person but also with the camp’s location. Camps “situated closer to the border or area of conflict” experienced “increased trauma morbidity” and crude mortality rates ten times higher than those located at least 50 km from the border or conflict zone. (Spiegel et al. 2002:6)²⁰

²⁰ The study was conducted between 1998 and 2000 in a total of 52 camps in Azerbaijan, Ethiopia, Myanmar, Nepal, Tanzania, Thailand and Uganda.

This raises a critical question that is a subject of constant debate and anguish among humanitarian organizations, especially since the Rwandan genocide of the 1990s. What should be the relation of humanitarian efforts to outside military intervention? When if ever should such intervention be called for? Fiona Terry of Médecins sans Frontières (MSF) points out the sobering truth that humanitarian relief in the form of food supplies and medical care is useless “when the civilians it is intended to assist are in greater danger of losing their lives to violence.” (Terry 2001:1432) On the other hand, except in cases of outright genocide, military action by outside powers has more often led to more killings, genocide and mass expulsions rather than protecting civilians (as in Kosovo and Iraq). Several assessment studies call for greater coherence between military/political and humanitarian agendas. (Salama et al. 2004; Waldman and Martone 1999) But military organizations and humanitarian organizations have very different purposes as well as cultures: “. . . the imposition of peace, like the creation of all political order . . . , inevitably generates its quota of ‘victims,’ ‘excluded’ and ‘powerless’ people who are either doomed to violent death or deprived of water, food, medical care and shelter”—precisely the purposes that humanitarian relief is supposed to serve.” (Weissman 2004:208) Moreover, “Military forces are trained and equipped to provide medical care and facilities to a predominately male, adult, healthy population.” The medical supplies they do have are insufficient in quantity and “not adapted to the needs of refugees”—certainly not to those of women and girls facing rape, unwanted pregnancy, reproductive tract infections, and obstetric emergencies. (Terry 2001:1431)

Reproductive Health

It seems self-evident that women and girls caught in armed conflict situations and refugee and IDP camps “are at high risk of rape, unwanted pregnancies, unsafe delivery and sexually transmitted diseases (STDs), including HIV and AIDS.” This is all the more likely given that the countries that have generated the greatest number of refugees, asylum seekers and IDPs are to a large extent those with the highest under-5 mortality rates, highest fertility rates, and youngest populations.²¹ (USCRI 2006; Spiegel 2004) Until quite recently international agencies and NGOs concerned with the health of refugees and IDPs were focused primarily on malnutrition and communicable diseases. In the past decade, however, they have come to embrace access to reproductive health information and services as a basic human right with particular importance for women and girls and attempted to make reproductive health care a standard component of refugee health services. (Girard and Waldman 2000:167; Hynes et al. 2002; McGinn et al. 2004) This awareness and its transformation into explicit policy guidelines reflect the coincidence of two cataclysmic world events, one negative and one positive, during the mid-1990s: the civil wars and horrific displacement crises in Bosnia and Rwanda, with their terrible toll in rapes and unwanted pregnancies; and the 1994 International Conference on Population and Development in Cairo, whose Program of Action defined reproductive and sexual health in a broad, integrative way as part of primary health care and of basic human rights.²² Full recognition and incorporation of the ICPD agenda into

²¹ These include Afghanistan, Iraq, Palestine, Sudan, DRC, Burundi, Somalia, Liberia and Colombia.

²² See Petchesky 2003, Chs. 1 & 2, and Girard 2004 for a full analysis of the provisions contained in the Cairo Program and its elaboration in the 1995 Platform for Action of the Beijing Women’s Conference as well as the political dynamics surrounding those negotiations. The Cairo and Beijing frameworks understand reproductive

humanitarian aid policies is evident in both the 2004 revision of the Sphere Charter and its Minimum Standards in Disaster Response (see above) and, more comprehensively, in the 1999 interagency Field Manual governing Reproductive Health in Refugee Situations,²³ co-authored by WHO, UNFPA and UNHCR and sponsored by some three dozen international agencies and NGOs working in the reproductive health and humanitarian aid fields.

The Field Manual not only adopts the ICPD-Beijing definition of reproductive health and its extension to include sexual and gender-based violence, sexually transmitted diseases and HIV/AIDS, and the reproductive health of young people, along with the more traditional areas of safe motherhood and family planning. It also emphasizes the central importance of “providing adequate food, clean water, shelter, sanitation and primary health care (PHC) [as] priority activities in any refugee emergency” that have direct bearing on reproductive health. (UNHCR 1999:2) Moreover, the spirit of Cairo and Beijing resonate in its emphasis on quality of care and integrating services (1999:4-5); the comprehensive nature of its Minimum Initial Service Package (MISP);²⁴ its provisions for a pro-active distribution system for making good-quality condoms accessible to all who need them (1999:50-51); its insistence on services to deal with unsafe abortion and post-abortion complications;²⁵ and its requirement that service providers involve women refugees, including traditional birth attendants (TBAs), in committees and other forms of popular participation to raise awareness and to ensure reproductive and sexual health and safety from sexual violence. (1999:38)

Yet this formal recognition and implementation on paper does not necessarily signify effective implementation on the ground, especially for IDPs. According to the Norwegian Refugee Council, “Despite their pressing needs, displaced women were in general unable to access reproductive health services in at least a third of the countries undergoing internal displacement in 2005,” mainly because of “prohibitive fees, lack of healthcare infrastructure and insecurity.” In both refugee and IDP settings, the MISP is “rarely implemented at the onset of an emergency”—when perhaps the need is most desperate. (Buscher and Makinson 2006) Many failures in practice, despite good intentions, stem from the structural and systemic problems of the camps, including “lack of coordination” among different responsible agencies, “serious gaps in services,” and “a vertical approach to reproductive health services” that is inconsistent with the ICPD’s integrated approach. In addition, “many

health, sexual health (including prevention and treatment of HIV/AIDS and other STIs), sexual and gender-based violence, adolescent health, and women’s and girls’ empowerment in all aspects as inseparable parts of a whole. This paper separates them for analytical purposes but firmly agrees with the integrative approach.

²³ The manual is meant to cover IDPs and recent returnees as well as refugees.

²⁴ The manual states that the MISP is “not just kits of equipment and supplies” but “a set of activities that must be implemented in a coordinated manner by trained staff.” (1999:11)

²⁵ Due to the global politics of abortion and ideological positions of right-wing and religious groups, international law does not yet recognize safe legal abortion as a human right. The ICPD Program does, however, urge governments to make all abortions safe where they are “not against the law” and to provide “access to quality services for the management of complications arising from [unsafe] abortion” whether or not it is legal. (ICPD Par. 8.25) The Beijing Platform goes further and urges governments to “consider reviewing laws containing punitive measures against women who have undergone illegal abortions” (para. 106k); and the five-year follow-up “Key Actions” document for ICPD states that “in circumstances where abortion is not against the law, health systems should train and equip health service providers” to ensure that abortion “is safe and accessible” (Para. 63, iii). (Petchesky 2003:39)

of the most needed and simplest reproductive health interventions for refugees, such as emergency contraception or condom distribution to adolescents, remain mired in ideological controversies.” (Girard and Waldman 2000:167, 172) Specifically, US government policies under the Bush administration have exacerbated desperate reproductive health needs in sites of exclusion, as in poor countries across the globe, by restricting funds for UNFPA, imposing the “global gag rule” on any abortion counseling or advocacy by service providers, and prioritizing abstinence over condom use in HIV/AIDS foreign aid programs.²⁶ Meanwhile, UNFPA reports that “an estimated 25 percent of refugee women of reproductive age will be pregnant at any one time,” and that unprotected sex and high-risk pregnancies are particularly common among teenage girls in camps: “In war-torn Southern Sudan, girls were found to be more likely to die in pregnancy and childbirth than [to] finish primary school.” (2006:63)

Because so much of what is known about the reproductive health status of refugees and IDPs is based on supposition or anecdote, some groups of researchers have attempted to conduct evidence-based studies comparing the reproductive health outcomes of refugees and displaced persons with those of comparable non-refugee populations. Recent studies have led to a revised perception, based on new evidence, “that women living in camps may actually benefit from better access to reproductive health services, including family planning, than women in the host country or in their country of origin.” (UNFPA 2006:63) In a two-year retrospective study of 688,766 refugee and internally displaced persons living in 52 post-emergency phase camps in seven countries, Hynes and her colleagues found that overall the refugee and IDP groups they studied had lower crude birth rates, lower maternal mortality ratios, lower neonatal mortality rates, and lower percentages of low birth weight newborns than did their respective host country and country-of-origin populations (or, in the case of IDPs, the non-displaced population in their country).²⁷ These outcomes reflected the better access camp residents had to preventive and curative health services located “within a maximum of 5 km from where they lived”; “emergency obstetric services at little or no cost” located “within 12 hours” travel distance (associated with lower maternal mortality); as well as free transportation to the referral hospital. All but one of the 52 camps provided family planning services, and all of these offered condoms, injectable contraceptives and IUDs. Availability of maternal supplemental food programs may have contributed to reduction in the incidence of low birth weight infants. Very little data was available, however, on the incidence of abortions or complications from unsafe abortions. (Hynes et al. 2002:601, 599)

In a paper commissioned by the London-based Humanitarian Practice Network, McGinn et al. attempted to assess the implementation of the Interagency Field Manual and the 2004 revision of the Sphere guidelines with respect to “reproductive health for conflict-affected people.” Looking at the five focal areas of safe motherhood, fertility and family planning, STI and HIV/AIDS prevention and treatment, gender-based violence, and adolescent reproductive and sexual health, they found a more mixed and inconclusive picture, with still a shortage of empirical evidence. Fertility rates and pregnancy outcomes among populations

²⁶ For critique and analysis of US foreign policies related to reproductive and sexual health, see Girard 2004, and the websites www.genderhealth.org, www.iwhc.org, and www.crr.org.

²⁷ Groups studied, in 1998-1999, were Cambodians in Thailand, Burmese in Thailand, Bhutanese in Nepal, Somalis in Ethiopia, Sudanese in Ethiopia, Sudanese in Uganda, Rwandans in Uganda, Burundians in Tanzania, Congolese in Tanzania, and Azerbaijanis in Azerbaijan. See Hynes et al. 2002:Table 1.

in conflict-ridden zones tend to vary in relation to the stage and level of the conflict, with birth rates going down and incidence of unsafe abortion and maternal mortality ratios (already quite high in the countries affected) going up during the most intense phases. Though reliable data are scarce, some evidence suggests very high rates of unsafe and self-induced abortions and abortion complications in conflict settings in sub-Saharan Africa and Burma. Moreover, services geared specifically to adolescents—for whom STIs and unsafe abortions remain major health risks—are lacking in most settings. Referring to the study by Hynes et al., the McGinn paper states:

The available data on maternal and pregnancy outcomes suggest that poor outcomes are common in many populations affected by armed conflict, especially in the emergency phase of a conflict and in countries where the infrastructure has been devastated by protracted warfare. However, these outcomes may be no more common than in extremely poor host or home countries with a dearth of infrastructure and services. Indeed, women in refugee camps may in fact receive better care than was available in their home country or is available to the local population. (McGinn et al. 2004:11)

The ironic situation in which residents of refugee camps sometimes receive more and better quality sexual and reproductive health services than local populations may “create resentment” or, conversely, may help to stimulate improved services for those populations. McGinn et al. mention a study in rural Guinea where “rates of major obstetric interventions” increased most significantly for the general population in those areas where high concentrations of Liberian and Sierra Leonean refugees had settled. (2004:12; Girard and Waldman 2000:173) But this ripple effect seems rare, if worthy of replication, given the reluctance of local governments and the tendency to treat refugee and displaced groups with disdain. And at this writing, civil violence and conflict in Guinea itself have upset the previous stability. In Darfur’s IDP camps, where women do receive some rudimentary health services, they complain of long queues, lack of medicines, compulsory fees for medicines supposed to be free, and high costs of complicated hospital deliveries. (Editorial/FMR 2007:42)

It is important to remark, moreover, that “poor maternal and pregnancy outcomes” may reflect a variety of factors, and not always women’s helplessness. Childbearing, and women’s pregnant bodies, becomes a terrain of ethnic struggle in armed conflict and displacement sites. In highly racialized ethno- and nationalist conflicts, as in Bosnia, rape may be used as a way of “planting the seed” in the “enemy” population or, in response, childbearing may become a “demographic weapon” to “replace children or adults lost to war.” (McGinn et al. 2004:6; Eisenstein 1996) But women do not always respond passively to these demands on their reproductive capacity. Macklin found, in her interviews with displaced people in Southern Sudan, a repeated refrain that “women are not having babies anymore.” Much of the perceived fertility decline may have been due to malnutrition, stillbirths and miscarriages. But research among the Western Dinka shows that women IDPs in Sudan (and likely elsewhere), facing sole responsibility for their children, under constant threat of sexual and military violence, insecurity and harsh deprivation, cope with their

“reproductive suffering” through a common though clandestine practice of unsafe abortions, even where the practice is not accepted. (McGinn et al. 2004:96-97; Jok 1999)

Three important conclusions are evident from this assessment, confirming our earlier analysis. First, the location of camps in relation both to conflict areas and obstetric services is a critical determinant of maternal risk. With respect to the large-scale research reported by Hynes et al., “no camp had an operating theater in which life-saving surgery such as repair of a ruptured bowel or caesarian section was possible. Time or distance to referral hospitals can affect maternal mortality and obstetric intervention rates.” (Spiegel et al. 2002:2) Second, in spite of excellent efforts by agencies like UNFPA, WHO, UNHCR and UNICEF and NGOs like the Marie Stopes Society, the International Rescue Committee and MSF to provide a high standard of reproductive health services to refugees in camps, most of these services are presently going to people in relatively stable, post-emergency situations, but far less to IDPs, whether in camps or dispersed outside them. Those caught in the most acute and dangerous stages of complex emergencies, and who are thus most at risk, are not getting the services—in large part no doubt because the danger and chaotic conditions are just too severe for any sort of administration to function. Refugees and IDPs in camps are more accessible and “manageable.” Third, even where immediate conflicts have stabilized, the ravages of previous conflicts and the absence of viable health, political and economic infrastructure may completely undermine delivery of vital health care, including for reproductive health.

One of the most dramatic examples is Afghanistan, where, after five years of US and NATO-led military intervention to root out Al Qaeda and end Taliban rule, the supposedly sovereign government in Kabul is barely holding on and Al Qaeda training camps, tribal warlords and Taliban strongholds are fully resurgent. (Mazzetti and Rohde/NY Times 2/19/07) When the Taliban was in power in the 1990s, prior to the US invasion after 9/11/01, Afghanistan had one of the world’s highest maternal mortality ratios—reported by WHO as 820 per 100,000 live births and attributed largely to the draconic restrictions on women’s mobility and health care access under the world’s most misogynist regime. Yet two years after the Taliban had been ousted, documented maternal mortality ratios were even higher, reaching 1600 per 100,000 live births according to UNICEF—in one province, the highest recorded anywhere. “Almost half of the reported deaths of Afghan women of childbearing age are due to complications of pregnancy or childbirth, 87% of which are considered preventable”; and, at 161 per 1,000, Afghanistan’s infant mortality rate is also the highest in the world. (del Valle 2004:10; Salama, Spiegel, et al. 2004; CDC 2002) Little wonder a recent publication on this subject is entitled “Where Giving Birth Is a Forecast of Death.” (Bartlett et al. 2004)

Hernan del Valle of MSF questions the tendency to explain this reproductive disaster in terms mainly of cultural and religious factors, pointing instead to the war’s total destruction of Afghanistan’s infrastructure, roads, hospitals and clinics, educational facilities, and human resources—a calamity that affects everyone and not just pregnant women:

For the vast majority of rural Afghans, health facilities remain inaccessible, under-staffed and under-equipped. Roads and transport are rarely available, and pregnant women often have to travel several hours by donkey to seek

health care. It is not surprising that almost all of them deliver at home without qualified assistance. (2004:11)

. . . the issue in Afghanistan is arguably not so much one of access to health services for women but rather an issue of absolute lack of facilities. As one Afghan woman said when interviewed: “Well, the question is not if I *would* go or if I would be *allowed* to go [to a health facility] by my husband, but rather where I *could* go . . . We would certainly use those services if they were accessible and proven to be reliable. (2004:10-11)

In the Palestinian territories, besieged on all sides by Israeli Defense Forces, curfews, restrictions on movement, and the need to pass through severely guarded checkpoints to reach functioning health care centers and obstetric services, the reproductive health toll has also been dramatic. In a large-scale representative study of Palestinian women, Rita Giacaman and her associates at Bir Zeit University report an increasing number of women who have given birth at checkpoints because of being detained there and of neonatal deaths as a consequence. These actual documented cases are only the “tip of the iceberg,” since the stresses associated with constrained conditions of childbearing for Palestinian women no doubt produce additional maternal and infant mortalities and morbidities. Complicating the situation are tensions between biomedical and more traditional models of birthing (administered by TBAs, or *dayats*). Most Palestinian women, reflecting the prevailing biomedical thinking, state a preference for hospital over home births (coinciding with historic Israeli government policy, which viewed hospital births as a means to register and count Palestinian population growth). But government maternity services operated under the Palestinian Authority since the Oslo Accords have been unable to meet basic needs or provide a sufficient number of birth attendants due to the continuing emergency, lack of resources, and withdrawal of international aid—most stringently since the election of a Hamas government in 2006. (Giacaman et al. 2005, 2006)

So the situation continues to worsen with no end in sight; there is no such thing as a “post-emergency” for Palestinians; and, with the wall blocking the West Bank and the siege on Gaza, all of the Palestinian territories are one big camp. Mirroring Afghanistan in many ways, it is a situation in which gender and reproductive health inequities are an inseparable aspect of a larger, all-encompassing web of infrastructural disintegration and militarized daily terror. The international women’s organization, MADRE, reported in July 2006:

Palestinians in Gaza, including three-quarters of a million children, are facing severe shortages of food, water, and medicine, and continue to be threatened by an Israeli military campaign that has killed more than 103 people since June 28. The Israeli siege is producing a public health crisis, as garbage piles up in sewage-strewn streets and people go without refrigeration or water in scorching temperatures. Seventy percent of Gazans are now unable to meet their daily food needs, the health system is nearing collapse, and children are showing signs of trauma and exhaustion. (MADRE 2006)

In Iraq as well, physical conditions present an appalling list of everyday threats to life and limb: lack of medicines, sanitation or adequate nutrition; over two-thirds of the population without potable drinking water; prevalent diarrhea and pulmonary infections among children and the elderly; overtaxed and shrinking health care facilities; a countryside riddled with unexploded ordinance, land mines and depleted uranium; and of course the constant threat of suicide bombs and, now, the US's stepped-up aerial war that never, ever avoids killing and maiming civilians. "In April 2005 doctors in Baghdad reported a significant increase in the number of babies born with deformities," attributed to depleted uranium (Lasky/Code Pink 2006). A recent letter presented to Prime Minister Tony Blair and signed by 100 doctors asserts "that conditions in Iraqi hospitals constitute a breach of the Geneva Convention" and are costing the lives of hundreds of sick and injured children left to die because of the lack of medicines, antibiotics, milk, and other basic medical and nutritional supplies. Infant mortality and child malnutrition rates have nearly doubled since the invasion. It is suspected that pharmaceuticals are being diverted from Iraqi warehouses into a regional black market, and the shortage of doctors—with some 2,000 murdered and 250 kidnapped between the invasion and the end of 2006—has reached devastating proportions. (Chelala 2007)

Conditions in Iraq make it impossible to get accurate figures on recent maternal mortality, but a UNFPA study in November 2003 found the ratio had nearly tripled since 1990, to 370 in 100,000 (31 times the US ratio). (UNFPA Study 2003; Ciezadlo) A lot of this increase was due to harsh UN sanctions during the 1990s, when Saddam Hussein was still in power, but even under Saddam Hussein, women in Iraq prior to the US-led war had full access to prenatal care and trained birth attendants as well as to education and professional employment. (Lasky 2006) In contrast, the UNFPA study found that 40 percent of pregnant women got no prenatal care and up to 65 percent gave birth at home, without skilled attendants. Doctors in the few functioning hospitals are way too overwhelmed with the dying and wounded to bother with women undergoing childbirth, to say nothing of those who have been raped. We can only imagine how the maternal death and morbidity figures must have increased with the escalating violence and civil war the occupation has triggered.

According to a 2005 report in the *Christian Science Monitor*, not only many pregnant women in Iraq but also their doctors are unable to navigate the dangerous roads to get to a clinic—when there is a clinic. (Ciezadlo) Thanks to the failed Iraq Reconstruction program, with its rampant corruption and lax oversight, independent inspectors reported in April 2006 that "a \$243 million program led by the United States Army Corps of Engineers to build 150 health care clinics in Iraq has in some cases produced little more than empty shells of crumbling concrete and shattered bricks cemented together into uneven walls"; out of 150 clinics projected, a mere 20—and those with staggering structural defects—had actually materialized. (Glanz 2006)

Like the dead and mutilated bodies of civilians—including those of women who die needlessly in pregnancy and are victims of war crimes as much as those killed by bombs—these empty shells symbolize the meaning war gives to health care, and to human rights. Iraq, Afghanistan and Palestine represent entire societies where the "war on terror" has made a mockery of every international human rights provision related to health, gender, sexuality, economic and social standards, and the international rules of war; where overall insecurity

renders delivery of the most minimal health services impossible; and where everyone lives in “the camp,” a virtual prison.

HIV/AIDS

If anything has conjoined with fears of terrorism and racism to feed the recent “invasion complex,” it has been the HIV/AIDS pandemic. Yet, because of the multiple assaults and exclusions they confront, internal and external migrants and refugees are more likely to be the victims of transmission than its vectors. (UNFPA 2006:16; Spiegel 2004)²⁸ Forced migrants (those fleeing economic as well as political and military crisis) are caught in the double bind that exclusion creates: “Discrimination, already endemic to the migrant and refugee’s position, is exacerbated by HIV/AIDS, preventing [migrants] from seeking out appropriate health care and social support.” (Williamson 2004) Besides outright discrimination, government policies simply let displaced populations fall through the cracks in this area of health care and service provision as in so many others. National HIV/AIDS strategic plans and requests to donors almost never take into account their refugee populations and often ignore their internally displaced citizens as well. (Spiegel 2004) Not only national governments but also international agencies have been slow to recognize HIV/AIDS prevention and treatment as a critical priority for refugees and IDPs. Although its own estimates show refugees constitute between 25,000 and 35,000 of the nearly 6.5 million persons worldwide needing antiretroviral treatment, it was only at the end of January 2007 that UNHCR launched a policy to ensure HIV-positive refugees and IDPs across the globe have access to necessary ARV treatment, care and support in the “earliest possible stages of an emergency response to forced displacement.” (*IRIN News* 29/1/07)

Many plausible reasons exist to confirm the general perception that forced migrants and civilians caught in armed conflict situations, especially women and youth, will be particularly vulnerable to HIV infection. (Save the Children 2002; Spiegel 2004) In a working paper for the Oxford University Refugee Studies Center, Katherine Williamson summarizes these factors. First, female forced migrants, whom Williamson calls “the most vulnerable of the most marginalized,” “are exposed to exploitation by soldiers, rebels, officials, the military and other refugees [including husbands].” The risk here is not only sexual violence and degradation but also infection, since male combatants in civil conflicts and military personnel generally—including UN peacekeepers—are known to have HIV prevalence rates two to three times higher than those of civilian populations. This has been true of armies in Angola, Zimbabwe, the Congo and elsewhere in sub-Saharan Africa, the region beset by the highest HIV prevalence in the world as well as the deep poverty and armed conflict that abet it. (Williamson 2004:2,13,15; Spiegel 2004) Second, the dire conditions in the camps—overcrowding, poor sanitation, insecurity, unemployment—also contribute to exposure of women and youth to unsafe sex, both unwanted and wanted. Whether in the form of rape, extortion, survival sex for money or food or safe passage out of the country (documented among women in Sierra Leone), or just turning to sex for diversion or comfort, women and young male and female refugees and IDPs may face elevated risks of infection: “. . . in

²⁸ “On the whole, refugees migrate from countries in conflict with lower HIV prevalence to more stable host countries with higher HIV prevalence” (referring specifically to refugees from Sudan and Somalia to Uganda and Kenya).—Spiegel 2004:326 and Fig. 5.

Guinea, Liberia and Sierra Leone it has been found that refugee children and internally displaced youths are being forced to exchange sex for relief supplies and security by local aid workers, peacekeeping soldiers and refugee leaders in a system so endemic and prolific that many involved have no idea that relief is meant to be free.” (Williamson 2004:13-15)

Yet, as in the case of maternal and reproductive health risks, more evidence-based studies present a mixed picture when it comes to actual rates of HIV and AIDS among refugee and displaced populations. Summing up these research findings, the Norwegian Refugee Council report says: “Data does not support the general perception that IDPs have consistently higher HIV infection rates than the general population nor that conflict necessarily increases the risks of HIV/AIDS infections.” (2006:25) In fact, studies conducted by Spiegel, who is senior HIV/AIDS Officer at UNHCR, and his associates; McGinn et al. summarizing existing data up until 2004; and the 2006 UNFPA report on women and international migration all concur that the relationship between HIV and armed conflict is both “complex” and “context-specific,” depending on a range of factors. These include, once again, the phase and level of a conflict; the camp’s location, accessibility and exposure to interactions of people; and the degree to which basic social structures (including health services) have broken down. In addition, “HIV prevalence among the affected community pre-conflict, the HIV prevalence among the surrounding community for those who have been displaced, exposure to violence during conflict and flight and the level of interaction between the two communities” will affect vulnerability. (Spiegel 2004:324; Salama et al. 2004)

In his analysis of “HIV/AIDS among Conflict-Affected and Displaced Populations,” Spiegel contrasts two different scenarios: Sierra Leone, southern Sudan and Angola, where protracted struggles coincide with lower HIV prevalence rates among affected and displaced populations, despite high rates of sexual violence; and eastern DRC and Ivory Coast, where conflict and high levels of sexual violence seem to be contributing to elevated HIV-infection rates among affected populations and in host countries. The difference, according to this study, has to do with lower levels of prevalence to begin with in the first group of countries as well as the relative isolation and lack of mobility of the affected populations over an extended period of time. McGinn et al. likewise contrast situations—in Mozambique and Uganda particularly—where the combination of high rates of STIs/HIV, military and sexual violence, commercial sex and collapse of health services seem to have escalated the risk of infection for affected populations; and those in Sudan, Sierra Leone and Angola, where “low initial prevalence rates, combined with the inaccessibility of much of the population, may have slowed the spread of AIDS.” (McGinn et al. 2004:7-8) It would seem, then, that “prolonged crises may serve to temporarily slow the spread of HIV by isolating populations and disrupting transportation routes and rural-to-urban migration.” However, UNFPA warns that, with the return to stability, when “people are again able to move freely, countries risk a post-conflict surge in HIV prevalence if prevention programs are not forthcoming.” (UNFPA 2006:63; McGinn et al. 2004:8)²⁹

²⁹ This assumption gains strength from significant evidence in Southern Africa and elsewhere associating migration generally, especially among male laborers, with increased commercial and transactional sex and spread of HIV/AIDS. (AIDSPortal 2007; Klugman 2000; Preston-Whyte et al. 2000)

UNHCR's surveillance since 2002 of "pregnant women in more than 20 camps housing some 800,000 refugees in Kenya, Rwanda, Sudan and Tanzania" also found lower HIV prevalence rates compared to the surrounding host communities among all but those in Sudan. (Spiegel 2004:324-26) Although Spiegel does not elaborate on the reasons for this difference, it seems reasonable to assume, based on findings summarized above regarding reproductive health services, that refugees in camps in relatively stable settings (which would exclude Sudan) are receiving basic health and nutritional services, and experiencing levels of security, superior to those available to most IDPs, especially in settings that are still riven with conflict. In a statement appearing to refer primarily to cross-border refugees in camps, the 2006 UNFPA report confirms this view:

A 2004 global evaluation of 8.5 million displaced people found that almost all camps offered at least one family planning method, including oral contraceptives (96 percent) and condoms (95 percent). In addition, HIV prevention education was offered in 89 percent of the sites, and diagnosis and treatment of STIs was available in 84 percent of the sites. . . . In Kenya, refugees actually knew significantly *more* about preventing HIV than counterparts in their host community or their compatriots in southern Sudan: 72 percent of the camp refugees knew about the three main methods of HIV prevention compared to only 32 percent of the local population.³⁰

All recent studies of HIV/AIDS, forced migration and armed conflict agree on the need for further research to refine these preliminary findings. Nonetheless, it is possible to draw some general conclusions, albeit contradictory ones. Once again, as in the case of reproductive health services, we see that refugees confined in camps, in locations relatively removed from armed conflict zones and the worst insecurity conditions, are more likely to receive essential preventive, palliative—and now, with UNHCR's new ARV policy—curative services. IDPs both within and outside camps, especially when they are caught in the cross-fire of the worst ethno-conflicts and the "war on terror," are more likely to suffer and die from HIV infection and the violence that too often conveys it. On the other hand, the evidence suggests that when conflicts subside and displaced people return to some degree of normal life and intermixing, in some locales the risk of infection may actually increase: "The end of the conflict. . . may in fact do more to increase the risk of HIV transmission than the conflict itself, as refugees return from camps in areas where prevalence rates are higher." (McGinn et al. 2004:8) Another quite disturbing contradiction lies in the fact that removal and inaccessibility (de facto quarantine?) seem to "protect" those displaced by conflicts from the risk of HIV and other STIs; yet effective maternal and reproductive health services in camps, especially for obstetric emergencies, require accessibility to hospitals with surgical facilities, which probably means to urban areas. So how are the reproductive and sexual health needs of forced migrant women to be addressed in these complicated dilemmas? Worse, the notion of the camp as a site of "protection" flies in the face of all existing evidence to the contrary—that camps are often a space of danger and insecurity at least as much as aid. The state of exception is by nature a state of incoherence.

³⁰ The mention of 2004 in this statement seems to be in error, since the source cited—a Reproductive Health Response in Conflict Consortium conference report—is dated 2003. The study cited regarding Kenyan refugees is a UNHCR report from 2005. The reference to "displaced people" is mainly to refugees in camps, not IDPs.

Gender and Sexual Violence and the Complexities of Power

Threading through every aspect of our analysis thus far has been the recurrent theme of violence—sexual, gender-based, military and existential, in a dense continuum. Since the Vienna Conference on Human Rights and Declaration on Violence against Women in 1993, a global feminist movement has brought sexual and gender-based violence out into the open as a serious human rights issue and more recently, under the statute of the International Criminal Court, a recognized war crime and crime against humanity, in some circumstances a form of genocide. (UN/ICC 1998; Bunch and Reilly 1994; Copelon 2000; Spees 2003) The UNHCR, the Inter-Agency Standing Committee (IASC), and the Guiding Principles on Internal Displacement have all published safeguards and standards to address gender-based violence in humanitarian crises. (UNHCR 2001; IASC 2004 & 2005; Guiding Principles) But the magnitude of the problem of persistent gender and sexual violence in complex emergencies is still formidable, prompting the Norwegian Refugee Council to assert: “The gap between these standards and reality remained abysmal in 2005 for most displaced women and girls.” (2006:26) Although population-based studies on the subject are scarce, due to the shame and stigma that inhibit both victims and researchers,³¹ ample qualitative and anecdotal reports make it clear that refugees and displaced persons, especially women and girls, are exposed to relentless risks of abuse by armed combatants, government soldiers, peacekeepers, aid workers, guards, brigands, and sometimes their own spouses. (Marsh, Purdin & Navani 2006) According to UNFPA, “experts believe young boys [are] also victimized” by these purveyors of abuse, but “tremendous stigma prevented any discussion of the matter.” (2006:61)

Fieldwork reports abound and tell a horrific story of relentless acts of exploitation against “the most vulnerable of the most marginalized.” Marsh, Purdin and Navani divide these acts into two categories—“sexual violence perpetrated as a method of warfare” and “opportunistic sexual violence perpetrated within the climate of impunity present in war zones.” (2006:135) We will add to this schema acts perpetrated within refugee and IDP camps that may not be directly within war zones, as well as forms of gender violence by a range of actors—including even aid workers—that may not be sexual. In the first category, Macklin’s study of displaced women in southern Sudan tells of how rape supplements bombing to become “a weapon of dispersal,” used to terrorize whole villages and provoke them to flee into camps, where they are subject to constant surveillance. (Macklin 2004:87) This is one way rape becomes a deliberate form of “ethnic cleansing” (genocide), echoing similar patterns in Bosnia and Rwanda and foreshadowing the more recent atrocities by Janjaweed forces in Darfur. In a 2005 joint study they conducted in Darfur, UNFPA and UNICEF found “that women and girls are subjected to sexual violence on a daily basis.” (Marsh, Purdin & Navani 2006:142; UNFPA & UNICEF 2005) Macklin describes how, once in IDP camps, women find themselves “taxed” by military, police and security personnel for

³¹ “Research ethics preclude asking an individual if she has experienced sexual violence when appropriate services are not available, which is the norm in emergency situations. Asking such questions can put researchers at risk of physical harm, arrest, or expulsion; and answering such questions can put respondents at risk of physical harm, arrest, or social sanctions.” (Marsh, Purdin and Navani 2006:135)

entering and leaving the camp and exposed to sexual rampages after curfew. (2004:90) The UNFPA 2006 report illustrates similar abuses of children:

Armed groups often prowl the camps in search of children to abduct and recruit as combatants and, if girls, as sexual slaves, cooks and cleaners. Near northern Uganda, aid workers report that girls are ingratiating themselves with camp middlemen in order to avoid being passed on to armed groups (2006:61)

Similar experiences have been documented among Somali refugee women in northeast Kenya (Hyndman 2004), Sudanese women and girls as young as ten years old in Chad (UNFPA 2006:62), as well as in the DRC, Sierra Leone, Liberia, East Timor, Ivory Coast, Colombia, and Burundi. (Marsh, Purdin & Navani 2006:137) According to Physicians for Human Rights, for the 50,000-64,000 Sierra Leonean women who may have suffered such abuses, “the experience of sexual violence during the conflict period was equal to a lifetime’s worth of sexual violence in the same population in non-conflict times.” (cited in Marsh, Purdin & Navani 2006:138) In Burundi, MSF reported 40 raped women and girls seeking its help each week in 2005 and probably many more that never reported. (Norwegian Refugee Council 2006:26) The health consequences of such sexual violence are bad enough in themselves but compounded when rape survivors, especially young unmarried girls and boys, do not seek medical attention because of shame or do not seek medical assistance for births and infants that result from rape.

Recently a great deal of attention has gone to the relation between militarized sexual violence and firewood collection, especially among displaced women and girls in arid parts of northeast Africa. Somali and Ethiopian refugee women in Kenyan camps, Sudanese in eastern Chad, and women and girls in IDP camps in Darfur have all been terrorized by armed groups who rape them when they leave the camps in search of firewood or fodder. In Darfur, this may be the greatest source of sexual assaults, with some 200 cases per month reported by MSF. In order to gather scarce branches, the women must walk sometimes for hours a day and in a radius of several km from the camp. (FMR 27:42; Hyndman 2004; UNFPA 2006:61) Here patterns of sexual and gender based violence intersect with both the economic deprivations of exclusion and deeply entrenched traditions of gendered labor. Having once made their livelihoods from farming and herding in their original villages, the women now have lost access to arable land and animals and must earn a meager living from collecting and selling firewood or trading it for food and also must depend on humanitarian aid foods (mostly grains) that require water and cooking. As women, they are the ones expected to tend to food-related tasks and always to collect the firewood. Not only is this seen as “women’s work” in normal conditions but also it is considered less dangerous for women in armed conflict and displacement zones because of “the commonly held belief that men and boys would be killed if they were the ones to leave the security of the camp and forage for the family. This leads the family to the decision to send out women and girls who are seen as risking ‘only’ rape.” (Marsh, Purdin & Navani 2006:142; Editorial/FMR 27:42)

Both women and men in conflict-affected sites of displacement must make strategic decisions at all moments about just keeping themselves and their children alive. Macklin’s

eloquent description of the gendered fears of Dinka and Nuer in southern Sudan might represent the agonies of IDPs and refugees in many similar bare-life situations:

Men worry about being killed by the GoS [Government of Sudan] or its allies, whether as civilians or as combatants in rebel forces. Women worry that they and their children will be abducted and enslaved by government-sponsored militia—if they are not killed outright. They also dread the moment when their boy children will be turned into child soldiers to fight in rebel armies against the GoS. Women fear rape by militia, rape by men who distribute aid in exchange for sex, and rape by husbands who demand that they replace dying children by producing still more children who will grow up to wage the national struggle—that is, if the women survive their pregnancies and the children survive to adolescence. (Macklin 2004:82)

One of the most disgraceful aspects of sexual violence aimed at refugees and IDPs is that inflicted by peacekeepers and aid workers, the very persons mandated to provide protection. In 2002 the world was shocked by reports that UN peacekeepers as well as UN and NGO relief staff were systematically bartering food and supplies in exchange for sex from camp residents, especially girls aged 13-18 but probably also from young boys. (UNFPA 2006:61) In the DRC, for example, not only did a UN investigation confirm “that sexual contact with peacekeepers occurred with regularity, usually in exchange for food or small sums of money,” but also a pattern was revealed in which money or food had been given “afterwards to make the rape look like a consensual transaction.” (Marsh, Purdin & Navani 2006:137) It is noteworthy that this sort of behavior became public and prompted a General Assembly resolution calling for an investigation and a “zero tolerance” policy on the part of the Secretary General (see UNFPA 2006) when it occurred in African settings by predominantly African and Asian peacekeepers. For there is nothing new here, only the sordid shadow of militarist sexual behavior in armed conflict settings throughout much of recent history—for example, evidence of sexual violence against children in Kosovo or against Iraqi women, men and girls by soldiers and “peacekeepers” from the US. (Giles and Hyndman 2004; Correa, Parker and Petchesky 2007; Enloe 2000 & 2007)

The level of violence against women in the Sunni and Shi’a areas of southern and central Iraq has escalated to an alarming degree. This violence takes the form of widespread rapes, assaults, and harassment of women and girls in the streets and other public spaces by US forces and military contractors and ordinary criminals and roving gangs. (Lasky 2006) In addition, *The Guardian*, Al Jazeera, and General Taguba’s report on Abu Ghraib prison, show a pattern of rapes and other sexual humiliation of Iraqi women detainees in US-run prisons, some of them seized by US military forces as hostages in order to extract information about male relatives.³² (Danner 2004; Hersh 2004) More recently, horrifying reports have come to light of rapes and murders of Iraqi women and their families in their own homes by US soldiers, under the pretext of rooting out “insurgents.” (Wong/NY Times,

³² Army and FBI documents secured by the American Civil Liberties Union through the Freedom of Information Act reveal numerous reports of rapes and other abuses of Iraqi women detainees by US military guards and interrogators, including the sodomization of a 73-year-old woman. See <http://www.aclu.org/torturefoia/released>. None of this appeared in the mainstream US press before 2006.

7/1/06; Zangana 2006) In a perverse double jeopardy, gender-based violence also takes the form of honor killings by family members, or sometimes suicides, of women and girls whose families feel “defiled” by such assaults. Moreover, the growing power of Shiite militias has brought a Taliban-like situation of public executions of women and girls. The Organization of Women’s Freedom estimates “that at least 30 women are executed monthly [in Iraq] for honor-related reasons” (Ramdas 2006). As a result, women and girls are afraid to leave their homes—so, along with loss of access to food, safe water, electricity and jobs, Iraqi women find their physical mobility greatly restricted. And Iraqi men who are kidnapped and tortured feel “like women,” unable to protect their families and also afraid to leave home. Reporting from Mahmudiyah, a town south of Baghdad where a 14-year-old Iraqi girl was raped and, along with her father and mother and 9-year-old sister, murdered by US soldiers, Haifa Zangana told *The Guardian*: “Today, four years into the Anglo-American occupation, the whole of Iraq has become Abu Ghraib, with our streets as prison corridors and homes as cells.” (Zangana 2006; Reuters 2007)³³

In their assessment of reproductive and sexual health policies and programs in humanitarian settings, McGinn et al. warn that the literature may be placing too much emphasis on military related sexual and gender violence and ignoring that which is more everyday and internal to the camps: rapes and assaults by other refugees, family members, and even aid workers. Sometimes such incidents result from the intersection of traditional gender divisions, male unemployment and generalized insecurity in a way that internalizes the firewood situation. Ondeko and Purdin (2004) report the case of Sudanese refugees who have lost their land, leaving women busy cooking and collecting water and firewood (their traditional tasks) most of the day and men idling around. The resultant male frustration is associated with high levels of domestic violence. Hans (2004) describes a nearly identical situation among Afghan women in India who escaped the brutality of the Taliban only to face their unemployed husbands’ violence in exile. Likewise, de Alvis (2004) finds an escalated level of domestic violence against women, associated with male unemployment, among displaced Muslims in Sri Lanka. In situations like these, or similarly among Afghan refugees in Pakistan, men—who tend to dominate community decision-making and run the mosques—may attempt to impose stricter forms of religious control on women (purdah, constant surveillance, veiling) than they did in their countries of origin. (de Alvis 2004:222-23; UNFPA 2006:60)

Violence in the camps may also result from physically or socially structured insecurities. The physical space and arrangement of IDP and refugee camps are rarely designed with issues of security and women’s and girls’ need for privacy in mind. So the standard humanitarian aid practice of separating potable water from groundwater means that latrines and showers are located at the opposite end of the camp from wells and taps, and women must walk far from their living areas at night to use the toilet or shower, thus risking assault from male residents. (de Alvis 2004; UNFPA 2006) A tendency by camp authorities to honor traditions of male authority may result in the hiring of displaced men to assist in food distribution or other tasks. Men placed in such a potentially powerful position then resort to “sexual blackmail,”

³³ It is crucial to understand that women and girls are not the only victims of militarized sexual violence. For an analysis and critique of the sexual abuse of men in Abu Ghraib, Guantánamo, and other Iraqi prisons and its implications for theories of gender and sexuality, see Petchesky 2005 and Correa, Parker and Petchesky 2007.

extorting “sex in exchange for food rations.” (Macklin 2004:90) As suggested earlier, aid workers with international agencies or NGOs may themselves indulge in such practices or may become physically abusive. Harrell-Bond reports camp workers beating Somali women refugees in Kenya on the ground that “Somali women need this because they don’t understand like men.” She also describes an incident she witnessed involving registration of Burundian refugees in Tanzania in which the workers grabbed a pregnant woman with a baby in her arms and a toddler behind, accusing her of being a “recycler,” pulled her out of the line and began beating her with sticks. (2002:63) In all these cases, the matter at stake is power.

But it would be wrong to assume that women are invariably powerless, even in the most desperate circumstances of the camp, or that they do not develop creative and sometimes quite effective means of resistance. And it would be just as wrong to assume that displaced men and boys are never victimized or pulled by forces beyond their control. Several authors caution against seeing the camp as a “monolith” and ignoring the ways in which it often reflects a more fluid type of power dynamic including survival strategies, anger and active resistance on the part of residents. They also stress the need to avoid imposing a clichéd victimization rhetoric on women, a rhetoric that reinforces paternalistic attitudes in relief programs and overlooks the active responses of women refugees and IDPs. (Papastergiadis 2006:437; Harrell-Bond 2002; Turner 1999) Harrell-Bond, while decrying the beating of the Burundian woman in Tanzania who was accused of “recycling” (i.e., shifting to another camp to obtain more resources), also recognizes this as a strategy for surviving conditions of severe deprivation—a strategy frequently deployed no doubt by women household heads: “To maximize access to scarce resources, individual family members shift between camps, falsely register household members, assume more than one identity and, very frequently, conceal deaths.” (2002:61) De Alwis tells the remarkable story of displaced Muslim women in northwestern Sri Lanka who refused to go along with the aid agencies’ “grids of intelligibility” and rejected the hazardous “scurrying back and forth between well and toilet” during the night; they simply appropriated the outdoor area near the wells as their toilet. These same women also insisted that representatives of the aid organizations bring them pots, pans, grinders and other kitchen utensils—not the usual “emergency” items humanitarian organizations tend to give priority. By redefining what counts as “necessity,” the women were reinventing the kitchen as “home” and resisting “the fracturing of the material core of the ‘home’ through the disparate dispersal of toilets, wells, and grinding stones across the . . . camp.” (de Alwis 2004:225-27) These examples echo the study of “community resilience” and survival against odds among displaced Lebanese during the July 2006 war and reaffirm the call for analyses and interventions that build on “the resilience and self-control of [local] populations in times of crisis.” (Nuwayhid, Cortas and Zurayk 2007:)

Spaces for women’s self-assertion and empowerment will no doubt vary across different refugee and IDP sites and be more open or constricted depending in part on the policies and practices of humanitarian agencies. In some cases, assuredly, “relief organizations tend to work through what remains of previous social structures. As these tend to be heavily male-dominated, camp structures also tend to be male-dominated and women have little say in the organization and distribution of relief supplies, with the result that their particular needs may not be addressed.” (Williamson 2004:14) Elsewhere, however, field workers from UNFPA, IRC, and other agencies have built not just “charity” but gender equity and empowerment

into their programs. (UNFPA 2006) A striking example is the effort among humanitarian workers in Darfur to create women's centers and community-based networks where women's groups can devise their own strategies for addressing "gender-based violence through community structures." Among the most successful of these strategies have been "firewood patrols" organized by committees of displaced women leaders, who "draw up specific guidelines for the patrols, choose times and locations and ensure the presence of translators in the patrols." The committee meetings become a kind of forum where women and girls can discuss their concerns; one such meeting in West Darfur "brought together over 400 women and girls to discuss coordination with AU [African Union] representatives." (Marsh, Purdin & Navani 2006:142; Patrick/FMR 2007:40)

Simon Turner, in a working paper for UNHCR based on fieldwork among Burundian Hutu refugees in Tanzania, reveals the male side of "women's empowerment" policies in refugee camps. His account shows both how structural and social conditions within the camp may work to undermine traditional patriarchal relations and also how deliberate attempts to overturn these power relations may be fraught with complications. Moreover, it shows very interesting discrepancies between camp residents' perceptions of changes in traditional power arrangements and actual realities. Turner's survey of attitudes among camp residents (both male and female) found a pervasive sense that "Old authorities are losing their grip and a new authority—represented most strongly by UNHCR—is in control of resources, livelihoods, and ideological formations," including the attempt to enforce a policy of strict gender equality. In these perceptions, the traditional authority of men, particularly older and "big men," as heads of households, breadwinners and community leaders was being replaced by the agencies' control over food distribution and their promotion of "special programs for women and other disadvantaged groups." As one respondent put it, "People are not taking care of their own life. They are just living like babies in UNHCR's arms." Most men interviewed felt that "women no longer respect them," do not conform to the Hutu ideal of womanly obedience and submission, and are becoming "loud-mouthed" and sexually promiscuous. (1999:147-48) Structural conditions—the lack of privacy, the visibility into everyone's spaces—contribute to the breakdown not only of gender but also of generational and intra-male hierarchies, as children and women become aware that "big men" and fathers no longer control incomes or receive more and better food. (1999:146,149-50)

This case illustrates patterns in which international agencies and NGOs running refugee camps may become a kind of colonial power, controlling all food and resources and leaving traditional male authority figures feeling "emasculated" in ways reminiscent of colonized and enslaved men. Turner confirms that "gender equality was an explicit aim of the relief operation," including active efforts to promote women's and girls' vocational training, women's committees, and their election to positions of camp leadership. (1999:147) Yet the reality he describes, particularly for young men, is strikingly different from the feelings of defeated masculinity these policies seem to have incited. What he found was that, in their determined attempt to recover a sense of "manhood," young men had developed a number of strategies to assert their masculinity and hence their power. This included dominating virtually all positions as street and village leaders (elected), which enabled them to attend meetings with UNHCR, NGO and Tanzanian authorities—i.e., to *represent* the camp. It meant gaining access to jobs with relief agencies within the camp, jobs that provided both

small salaries and other perquisites (e.g., extra food). And it also included involvement in (prohibited) political parties, giving the young men “a sense of belonging” and purpose that transcended “life in the camp.” (1999:151-53) He thus concludes “that, in spite of UNHCR and NGOs encouraging the ‘empowerment’ of women and in spite of refugees complaining that women no longer obey their husbands, men still dominate decision-making. . . .” (154)

It seems very clear that gendered relations of power in the sites of exclusion we’ve been describing are highly complex, context and culture-specific, and begging for further research. Women’s traditional roles of cooking and childcare may be additionally burdensome—even dangerous—responsibilities in the camps, but they may also become sources of solace, activity, and a refurbished sense of continuity with the past and “home.” In some settings—as among the Afghan refugees in India Hans studied—women and girls may find “new identities” and possibilities in a situation far from the traditions of female subordination they left behind, whereas men cling to the dream of the lost “nation” and sink into alienation and despair. (Hans 2004:244) Assisted by NGOs and relief agencies, women in IDP and refugee camps may create new forms of assertion and empowerment, or they may find these efforts thwarted by persistent or new patriarchal patterns. Despite a pervasive sense of declining male authority, young men may exploit conditions in the camps to create new/old vehicles for asserting their own superiority. Yet, at the same time, in situations of armed and ethnic conflict, men and boys are often forced into the distorted forms of masculinity brought by militarism and war, conscripted into becoming “military men” even when they are still just children and thus subjected to continual risk of death and brutalization. (Phillips 2001) And, while there is a great need for better evidence to document this, boys within camps and militarized displacement settings—like men detained as “enemy combatants” in the prisons of the “war on terror”—are surely subject to sexual abuse and violence and to intra-male age hierarchies that degrade and subordinate them just as ruthlessly as they do women and girls.

All this points to the critical need for humanitarian agencies and NGOs to develop gender-sensitive policies and programs that address the needs and disempowerment of men and boys as well as those of women and girls; to discard old stereotypes of women as always victims and men as always abusers. (Brun 2000:10) Such programs would have to encompass all aspects of service provision, including reproductive, sexual and primary health care, sexual and gender-based violence, employment, and decision-making. Our analysis also raises the challenge of understanding power dynamics in the camps—their structural and “neo-colonial” as well as their more traditional dimensions—in all their complexity, and creating programs that respond to and enlist the direct participation of *all* camp residents regardless of gender, ethnicity or age but in ways that take into account local cultural norms. Yet such worthy goals may be a complete contradiction in the camp, just as enforcement of human rights becomes an oxymoron in states of exception. It may be necessary to confront the camp itself and begin to puncture and eventually dissolve its boundaries.

III. Conclusion – Beyond the Camps?

Despite great differences in settings and inconsistencies in practices across sites, much of the evidence reviewed above tells us that refugees in camps are more likely to receive services of

all kinds than are IDPs and displaced persons scattered outside camps or, in some cases, even local residents who are not displaced. At the same time, a growing body of evidence shows some of the highest and most prolonged increases in “excess mortality” occurring outside camps in provinces, regions and countries affected by conflict. This is especially true in countries or territories such as Iraq, Afghanistan and Palestine where the whole society, in effect, becomes a camp, not of refugees but of military prisoners. Further, the pattern we observed of flows back and forth between camps, armed conflict zones, and endangered or neglected rural and urban areas suggests that camp boundaries in many complex emergency situations cannot easily be immunized against viruses, violence or marauded food and medical supplies. As health researchers begin to address these problems by calling for health and humanitarian interventions to extend greater “coverage” beyond the camps, to include a wider radius of conflict-affected people and more coordination with and responsibility of national governments, they are implicitly raising questions about the viability of the camp as a model of “protection.” (McGinn et al. 2004; Salama et al. 2004; Waldman and Martone 1999) Is the camp an efficient and secure way to provide health services, or is it rather a form of inhumane detention and exclusion?

In a suggestive study from the mid-1990s comparing the case of Rwandan Tutsi refugees in Goma, Zaire with that of refugees in Guinea in the same period, Van Damme argues that in Guinea, where refugees were deliberately not placed in camps but rather dispersed and settled among the residential population, everyone benefited. The refugees had more autonomy and self-respect, and both refugees and local residents experienced significantly improved health outcomes. This was because the Guinean government used the inflow of refugees as an opportunity (rather than a threat) to set up health stations offering free health care to all inhabitants, regardless of nationality. As a result, “the health care system in the refugee-affected region is now by far the best developed in the country, benefiting Guinea [sic] and refugees alike.” In contrast, the camps in Goma suffered huge cholera and other epidemics involving 50,000 deaths, and refugees sank into passivity, dependence, and nutrition-related diseases that grew worse the greater the size of the camps. (Van Damme 1995) Harrell-Bond describes a similar contrast, this one temporal rather than geographic, involving Sudanese, Rwandan and Ugandan refugees in Kenya. In the early 1990s, Kenya resisted setting up camps, instead integrating its guests into local civil society-run programs and trades, under the authority of the Ministry of Home Affairs and the National Secretariat for Refugees, and respecting their “basic rights . . . to work, to education, and to freedom of movement.” With the increase in immigrants as emergencies escalated, however, Kenya’s capacity (or will) to absorb them faltered, external agencies and foreign NGOs began to take over, and the movement to camps and exclusion—and abdication of local and national responsibility—became the rule. (Harrell-Bond 2002:79-80, citing Verdirame 1999)

Harrell-Bond concludes from these sad cases, and her own more positive experience in Uganda, that “it is best to invest in strengthening local and national institutions” to respect and protect the human rights of refugees (and presumably also IDPs). She argues there is a fallacy in the belief “that it is possible to bring about improvement in isolation from the state that hosts the refugees, its institutions of governance and civil society”—and, one would add,

its basic health and transportation infrastructure. (2002:80-85)³⁴ This parallels the conclusion of del Valle, who argues that efforts to improve maternal health for women in Afghanistan “must be incorporated into a comprehensive public health plan aimed at achieving free access to basic health care for the majority of the population.” (2004:11) Both researchers are proposing a more integrative model, one that embeds gender, health and humanitarian interventions for refugees, IDPs and conflict-affected people in a broader set of institutional and structural transformations. Harrell-Bond’s approach in particular voices skepticism about whether “we need a new [international] regime to promote respect for the rights of refugees” (such as the Sphere Project) rather than a total rethinking of that regime and an enabling of national and local capacity. (2002:77) That approach also coincides with the position of MSF and other humanitarian NGOs that insist on preserving their own “neutrality, impartiality and independence” within a “humanitarian space” and eschew “broadening their roles to undertake state functions.” (Tong 2004; Terry 2002; *The Lancet* 2002) It evokes the idea of “sovereignty as responsibility” more than international responsibility and governance.

An alternative approach is one that stresses greater coordination across agencies and a multi-sectoral model of responsibility that would actually broaden and deepen the existing international regime. In this view, given the reality that millions of displaced people do live in camps and have no safe or welcoming place to go, the urgent need is to promote their human rights by vastly improving their health, housing, educational and economic possibilities; expanding their physical safety, freedom of movement and expression; and giving them—especially disempowered women and girls—voice in all key areas of decision-making. This international or multi-sectoral model recognizes that gender equity and health rights are inseparable from a wide range of other economic, social and political rights that no single agency can guarantee by itself. Thus, for example, “no single sector or agency can adequately address gender-based violence prevention and response.” Services to address these “must be the outcome of coordinated activities among the constituent community, health, and social services, and legal and security sectors.” (Marsh, Purdin & Navani 2006:140) Likewise, effective health care is reliant on not just health professionals and supplies but also safe water, sanitation, transport, roads, literacy, security, and a whole range of interconnected social needs, requiring collaboration of many different international organizations as well as NGOs. (Salama et al. 2004) This movement in the direction of “clusters” or greater multi-sectoral coordination and responsibility (Kälin 2006; Weiss and Korn 2006) will also require bridging the gap between “relief” and “development” regimes and donor flexibility to fund across these now separate domains. (Salama et al. 2004; McGinn et al. 2004)

The international model also calls for greater accountability of international agencies, particularly UNHCR, and mechanisms for enforcing it, that is, “a rights-based approach to humanitarian action.” (Kälin 2006:5) Certainly what is needed is not more codification of refugees’ and IDPs’ rights, or women’s and children’s rights, which exists in countless international documents. The big loopholes are effective mechanisms of accountability and enforcement, presenting strong obstacles to the realization of the international model.

³⁴ She uses the example of her own work in Uganda training local judicial and prison officials and police in human rights laws affecting refugees, including their rights to work, freedom from physical violation, freedom of movement, etc., and the use of courts to hear asylum appeals (pp. 81-84).

Evaluating UNHCR's accountability mechanisms, Mark Pallis recalls the "emergency mindset" that underlies the entire history of UN humanitarian work—the international community jumping into crisis situations when states are unwilling to act—and the ways in which it precludes long-term institutional planning, funding or institution building. The presumed temporary nature of the camps, the host governments' reluctance to do anything that might prolong the presence of "aliens" in their midst, and the entrenched (and, since 2001, revitalized) claims of national sovereignty put UNHCR in a delicate position. It becomes "unlikely that good relations would be put at risk in order to design participatory accountability systems which may appear to negate the authority of the host state." (Pallis 2005:29-30)

Nonetheless, given the record of human rights violations and abuses by relief workers in the camps, Pallis recommends moves in a direction that would strengthen existing accountability mechanisms within UNHCR and make it into something more like a responsive government than a benevolent dictator. This would mean its current role administering the lives of millions of people living in "development camps," including "a wide range of administrative, judicial, or quasi-judicial and semi-judicial powers" (protection, punishment, maintaining order, contracting out responsibilities, as well as delivering services), should be fully transparent and subject to an explicit oversight and complaints procedure. (2005:11)³⁵ Such a procedure might involve the ability of individual refugees to file complaints against abuses to UNHCR's Inspector General's Office as well as analysis and review by the agency's Evaluation and Policy Analysis Unit. It would mean that refugees must be "seen as holders of rights, rather than as beneficiaries of assistance," and must be empowered to make use of any procedures that are set up. Ideally, "Promotion of rights, coupled with avenues for complaints and participation, would lead to more remedies for individuals and greater parity in dialogue between UNHCR and refugees." (2005:38)

We view the national capacity-building and international/multi-sectoral approaches to enforcing the human rights of excluded and displaced persons as interdependent rather than oppositional. Walter Kälin has formulated this hybrid perspective thus: "Where governments lack the will or capacity, international actors will need to be more directly involved in protecting the rights of the displaced, but in a way that seeks to reinforce rather than substitute for national [and also local?] responsibility." (2006:5) But how do international agencies become the protectors and enforcers of human rights in the absence of national political will without also transforming camps into small governments, autonomous communities? In other words, given the de facto long-term reality of many camps (decades and more—think of the Palestinians in the West Bank, Gaza and Lebanon), doesn't full protection of rights require providing "viable income generation activities for IDPs," especially women and girls, and "schools and comprehensive education" for children and youth as well as functioning health and security systems? (Buscher and Makinson 2004)

³⁵ The one area in which Pallis suggests UNHCR should concede its current activities to national governments is that of refugee status determination, which it currently conducts in some 80 countries. If such determinations (including asylum applications) were fully in the hands of states, he argues, asylum seekers would have access to procedural safeguards, including appeals, judicial review and parliamentary oversight. Of course, the reality in many states—especially those in the North to which refugees might wish to come—is very different, especially under the iron fist of the "war on terror," as we saw earlier.

And, if this community-building model seems utopian, doesn't a genuine "human rights approach" to relief work require dissolving the artificial boundary between "political" and "humanitarian" functions and recognizing that international organizations and NGOs will have to decide strategically when to step out of the cover of neutrality and make demands on states to live up to their human rights obligations (including health and all other economic and social rights) and to call governments to account when they refuse? That is, demand that refugees and IDPs be given all the basic rights due to citizens? In either case, there seems no way to protect the human rights of those in camps without abolishing the camps *as camps*.

Again, we are left with a vicious circle and the reality that "human rights are never sufficient." Many researchers and the Sphere and IDP guidelines themselves emphasize the need to treat refugees and IDPs—both the short-term and the long-term inhabitants of sites of exclusion—as active agents rather than helpless victims; to find ways of giving the excluded their own voice. Seeing refugees, especially women, "as survivors not victims" has almost become a mantra in the humanitarian field. (Pallis 2005; Weissman 2004; Harrell-Bond 2002; The Sphere Project 2004) But oppressed and excluded groups cannot be "given" a voice; they must take and proclaim it. We are convinced that neither the national nor the international model of accountability nor some kind of hybrid of the two can become an effective guarantor of human rights for refugees and IDPs without continual pressure and activism from a third dimension—that of refugee/IDP subjects themselves and the transnational movements and organizations that are their advocates and allies. This has special importance for issues of gender equity in sites of exclusion as everywhere else. For without the persistent activism of women's health, human rights and peace activists for decades, there would never have been a Cairo Program of Action nor a Beijing Women's Platform nor all the many instruments—special rapporteurs' reports, Sphere Humanitarian Charter and Minimal Standards, Inter-Agency Standing Committee Policy Statement on the Integration of a Gender Perspective in Humanitarian Assistance, Interagency Field Manual on Reproductive Health in Refugee Situations, etc.—that have today incorporated human rights principles into the refugee and IDP regimes.

Impressive examples exist of practical efforts to enforce recognition and implementation of women's rights to decision-making power and gender-specific protections and amenities in the realms of health, nutrition, sexuality, freedom from violence, and economic and educational opportunities. Such efforts put a high priority on women's direct participation, enlisting women frontline workers as well as international agency representatives and NGOs "to facilitate a systematic consultative process with women in the day-to-day management of the camps and membership in camp committees." Gururaja describes the work of UNICEF in Palestinian refugee camps in Lebanon, where (similar to the Tanzanian camps Turner visited) men traditionally controlled the "popular committees" responsible for local camp policy. Through a series of seminars with women's association members as well as consultations with the male heads of committees, UNICEF workers helped the women to select their own representatives and to lobby for their appointment to the committees, training them in organizational, communication and lobbying skills along the way. The women succeeded in obtaining representation on four popular committees. (Gururaja 2000) This effort is reminiscent of the women's committees and "firewood patrols" established in Darfur IDP

camps and illustrates the ways in which feminist activists on the ground have become critical to the implementation of gender equity principles in camps.

Another recent example is a set of “Guidelines for Gender Sensitive Disaster Management” produced by the Asian Forum on Women in Disasters, a group of NGOs and aid agency representatives that met in Chennai following the 2006 tsunami. Though related to a “natural” rather than the “unnatural” disasters we have been discussing, this report thoroughly outlines every conceivable dimension of women’s health, security, nutritional and security needs in “camp” situations, including the structural design of camps and “adequate toilet and bathing facilities.” It could serve as a useful guide for all agencies and NGOs involved in relief work—a spelling out of the concrete meaning of “gender equity” in sites of exclusion. (APWLD 2006) It also reinforces once again the fact that both policies of gender equity and women’s empowerment and their practical implementation are the result of women’s movement activism and the alliance, and sometimes overlap, between activists and service providers. (Petchesky 2003)

Turner’s provocative analysis reminds us of the deeply entrenched codes of masculinity and femininity that make realization of such “best practices” quite difficult in many local contexts. Part of the answer here has to be a much more thoughtful and deliberate effort to engage men and boys in programs to empower (not just protect) women and girls, including reproductive and sexual health, HIV/AIDS, and sexual and gender-based violence programs. But such “male involvement” has to be fully sensitive to local cultural and religious norms, knowledgeable about local histories, and not simply imposed in a way that would be correctly perceived as intrusive if not neo-colonial. (Harris 1999) Moreover, it needs to be framed in terms of a gender analysis that brings into the open the reality of sexual abuse and violence against men and boys as well as transgender persons and understands that as “gender-based violence.” Moving beyond the stereotypes of women as victims and men as abusers, like moving beyond the camp, will require a thorough rethinking of gender meanings and how to transform them in some of the most resistant and resource-deprived conditions on the globe. This work—which is really the work of transnational gender and sexual rights movements—has only just begun.

* * *

Given the complex realities described above, we propose the following considerations for policy-makers and advocates concerned about the injustices and deprivations of existing camp situations. In the long term, we agree with the integrationists who propose to abolish camps as intrinsically unjust because founded on the violence of forcible uprooting and exclusion. An “abolitionist” path would favor strategies to integrate displaced populations as quickly and safely as possible back into viable, secure communities, whether their own or new and welcoming ones. This would mean treating refugees and IDPs as full citizens of the societies where they are located and at the same time focusing on providing good quality health services, housing, livelihoods, protection from violence and abuse, and access to education and participation in political decision-making to *all* persons, regardless of their place of origin (Guinea in the mid-1990s is a good model). We believe international agencies and NGOs working in the areas of humanitarian and refugee services, peace-building, health,

and gender equality have a moral obligation to bring pressure on governments to welcome and integrate forcibly displaced persons, both from among their own citizens and from elsewhere, and to call upon wealthy countries, donors and the international community to generate the resources to make this a practical possibility. A human rights and social justice perspective on humanitarian assistance, as well as the principles of health as a human right, ultimately can only mean this.

At the same time, we recognize that, in the world as it is, a range of man-made and natural disasters may make returning home or being at home temporarily unthinkable. In addition, some states and communities are not healthy or hospitable environments for whole groups of people—hence the mass voluntary as well as forced migrations that now characterize the planet. Extreme violence and insecurity, exacerbated if not caused by racial and ethnic hatreds, may make camps a necessary evil in the short term, and place particularly onerous burdens on women, children and youth. In such situations, we urge the following measures to ensure the safety, dignity and empowerment of those who reside in camps or their equivalent:

1. Humanitarian, health and relief workers and agencies should adopt **conscious programs to discourage “victimization rhetoric,” racist and sexist stereotypes** of either dependency and helplessness or cheating and wiliness among the populations they serve, and attitudes that promote such dependency. Instead, in providing services and assistance, they should **seek out and build on local networks, traditions, and practices of “community resilience,” self-help and mutual aid; enlist local leaders and speakers —particularly women—in making decisions and designing relief programs** concerning everything from camp layout to food and job distribution to child care and health priorities; and attempt to develop democratic, participatory methods for engaging camp residents’ involvement across gender, age, and ethnic divisions. (Firewood patrols and committees in Darfur offer a good model.)
2. Where such networks and traditions tend to be heavily patriarchal and male-dominated, **camp workers should see educational efforts concerning women’s equality and empowerment and against sexual and gender based violence as an integral part of their mandate. Such efforts should fully engage men and youth as well as local women and should address male subordination in age and military hierarchies as well as violence against and subordination of women and girls.** At the same time, they should be conducted in ways that take into account and respect local beliefs, traditions and values, raising questions and promoting open discussion rather than imposing alien values and moral judgments. (See Harris 1999 and 2003, for an excellent example.)
3. Gender equity, women’s empowerment, and participation in decision-making across lines of gender and age difference are difficult if not impossible in the absence of the most basic enabling conditions. **Health rights and other social, economic and cultural rights are indivisible.** Humanitarian and health workers in camps must work to **assure the structural determinants that underlie an ability to participate,** including decent housing, safe water, sanitation, physical safety, affordable cooking

fuel, child care, care for the elderly, educational and sustainable livelihood possibilities, and freedom of movement and expression.

4. To reside in sites of political exclusion is by definition to lack accountability mechanisms for bringing grievances and gaining redress for abuses and wrongs—including those perpetrated by caregivers and peacekeepers. A new ethos of rights-based humanitarian service delivery to address this problem is emerging, as reflected in documents like Sphere and the International IDP guidelines. **International donors should devote sufficient resources to support and strengthen new models of accountability and empowerment for camp residents, and UN bodies should work to assure that local governments respect and enforce these efforts.** Wherever possible, on-site accountability and grievance processes—for example, establishing a camp ombudsperson or complaints committees—should be linked to existing international human rights machinery, including the human rights treaty bodies and special rapporteurs as well as national and transnational human rights groups engaged in creating shadow reports. At the same time, efforts should be made to strengthen the capacity of local and national courts and administrations as enforcers of refugee and IDP rights. International, national and local strategies can reinforce one another.

5. Where conditions in surrounding locales and communities are relatively stable and functional (i.e., not ridden with extreme armed violence and ethnic hatred), efforts should be made to better integrate displaced populations into these communities. Integrative and multi-sectoral models for meeting the needs of refugees and IDPs are not mutually exclusive but complementary. On the one hand, health, nutritional and other services provided to camp residents should be available to populations living near the camps, to break down the isolation of camps and to discourage their use as military staging areas. On the other hand, local clinics, services, schools and community and faith-based organizations should open their doors to and interact with camp residents on a voluntary basis. Attempts should be made to transcend the prevailing fragmentation of both services and donor streams into compartmentalized pockets (development, humanitarian assistance, post-conflict relief and reconstruction, health services, gender equity and women’s empowerment). **The realities of complex emergencies and of the real lives of people caught in displacement and catastrophe call for a much higher level of cooperation across agencies, sectors and physical boundaries than currently exists.**

Building effective mechanisms for participation in decision-making and nurturing respect and empowerment for women and girls—both among refugees and IDPs and between them and those who are there to provide assistance and care—is a necessary part of a rights-based health program, in camps or anywhere else. Increasing civil (as opposed to hostile) interconnections between camp residents and their neighbors in surrounding areas is a strategy to recognize the human rights and full citizenship of refugees and IDPs and eventually to transform camps from isolated depositories into actual communities if not homes—that is, to make camps as unlike camps as possible.

BIBLIOGRAPHY

- Agamben, G. *Homo Sacer: Sovereign Power and Bare Life*, trans. D. Heller-Roazen. Stanford University Press: Stanford, CA, 1998.
- Agamben, G. *State of Exception*, trans. K. Attell. University of Chicago Press: Chicago, 2005.
- Ahoua, L. et. al. High Mortality in an Internally Displaced Population in Ituri, Democratic Republic of Congo, 2005: Results of a Rapid Assessment Under Difficult Conditions. *Global Public Health* 1(3): 195-204, 2006.
- AIDSPortal. Migration Played Key Role in HIV Spread in South Africa. Available at www.aidsportal.org/News_Details.aspx?ID=3951, Feb. 14, 2007.
- Asia Pacific Forum on Women, Law and Development (APWLD). *Guidelines for Gender Sensitive Disaster Management*. APWLD: Chiang Mai, Thailand. Available at (www.apwld.org/asianforum_women_in_disasters.htm), 2006.
- Bartlett, L. et al. Where Giving Birth Is a Forecast of Death: Maternal Mortality in Four Districts in Afghanistan, 1999-2002. *The Lancet* 365:864-870, 2004.
- Bernstein, N. New Scrutiny as Immigrants Die in Custody. *The New York Times*, 26 June 2007.
- Borradori, G. *Philosophy in a Time of Terror: Dialogues with Jürgen Habermas and Jacques Derrida*. University of Chicago Press: Chicago, 2003.
- Brun, C. Making Young Displaced Men Visible. *Forced Migration Review* 9:10, 2000.
- Bunch, C. and N. Reilly. *Demanding Accountability: The Global Campaign and Vienna Tribunal for Women's Human Rights*. Center for Women's Global Leadership: New Brunswick, NJ, 1994.
- Burkle, F.M. Complex Humanitarian Emergencies: A Review of Epidemiological and Response Models. *Journal of Postgraduate Medicine* 52:110-115, 2006.
- Burnham, G., et al. The Human Cost of the War in Iraq: A Mortality Study, 2002-2006. Bloomberg School of Public Health, Johns Hopkins University and School of Medicine and Al Mustansiriya University: Baltimore, MD and Baghdad, Iraq, 2006.
- Buscher, D. and C. Makinson. Protection of IDP Women, Children and Youth. *Forced Migration Review* 24:15 (special issue on Putting IDPs on the Map), 2006.
- Center for Reproductive Law and Policy, *Bringing Rights to Bear: An Analysis of the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights*. University of Toronto International Programme on Reproductive and Sexual Health Law: Toronto and Center for Reproductive Law and Policy (Center for Reproductive Rights): New York, 2002.
- Centers for Disease Control and Prevention (CDC). Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability. Report with Afghan Ministry of Public Health and UNICEF, 6 November 2002.
- Chelala, C. Iraqi Survivors Face Health-Care Collapse. *The Japan Times*, Feb. 23, 2007.
- Ciezahl, A. In Iraq, Giving Birth Is Complicated by War. *The Christian Science Monitor*, <http://www.csmonitor.com/2005/0630/007s02-woiq.html>, June 30, 2005.
- Committee on Economic, Social and Cultural Rights (CESCR). General Comment No. 14, The right to the highest attainable standard of health. United Nations Economic and Social Council, Doc. No. E/C.12/2000/4, 2000.
- Cook, R. J., ed. *Human Rights of Women: National and International Perspectives*.

- University of Pennsylvania Press: Philadelphia, 1994.
- Copelon, R. Gender Crimes as War Crimes: Integrating Crimes against Women into International Criminal Law. *McGill Law Journal* 46(1):217-40, 2000.
- Corrêa, S., R. Parker and R. Petchesky. *Sexuality, Health and Human Rights*. Routledge: London and New York, forthcoming 2007.
- Danner, M. *Torture and Truth: America, Abu Ghraib, and the War on Terror*. New York Review Books: New York, 2004.
- De Alwis, M. The 'Purity' of Displacement and the Reterritorialization of Longing: Muslim IDPs in Northwestern Sri Lanka. In *Sites of Violence: Gender and Conflict Zones*, ed. W. Giles and J. Hyndman. University of California: Berkeley, 2004.
- Derrida, J. Force of Law: The 'Mystical Foundation of Authority'. In *Deconstruction and the Possibility of Justice*, ed. D. Cornell, M. Rosenfeld and D. G. Carlson. Routledge: New York and London, 1992.
- Donini, A. Taking Sides: the Iraq Crisis and the Future of Humanitarianism. *Forced Migration Review* 19:38-40, 2004.
- Donini, A., L. Minear, and P. Walker, The Future of Humanitarian Action: Mapping the Implications of Iraq and Other Recent Crises, *Disasters* 28(2):190-204, 2004.
- Enloe, C. *Maneuvers: The International Politics of Militarizing Women's Lives*. Berkeley: University of California Press, 2000.
- Enloe, C. *Globalization and Militarism: Feminists Make the Link*. Rowman & Littlefield: Lanham, MD/Plymouth, UK, 2007.
- Editorial. Who Is Responsible for the Care of Refugees? *The Lancet* 360:1897-98, 2002.
- Editorial. Listening to the Women of Darfur. *Forced Migration Review* 27:42-43, 2007.
- Eisenstein, Z. *Hatreds: Racialized and Sexualized Conflicts in the 21st Century*. Routledge: New York, 1996.
- Foucault, M. "Society Must Be Defended": *Lectures at the Collège de France, 1975-1976*. Picador: New York, 2003.
- Giacaman, R., N.M. Abu-Rmeileh, and L. Wick. The limitations on choice: Palestinian women's childbirth location, dissatisfaction with the place of birth and determinants. *European Journal of Public Health* 17(1):89-91, 2007.
- Giacaman, R., et al. The politics of childbirth in the context of conflict: policies or de facto practices? *Health Policy* 72:129-139, 2005.
- Girard, F. Global Implications of US Domestic and International Policies on Sexuality, IWGSSP Working Papers, No. 1 (June). Center for Gender, Sexuality and Health, Dept. of Sociomedical Sciences, Mailman School of Public Health, Columbia University: New York, 2004.
- Girard, F. Negotiating Sexual Rights and Sexual Orientation at the UN. Sexuality Policy Watch: Rio de Janeiro (www.sxpolitics.org), forthcoming 2007.
- Girard, F. and W. Waldman. Ensuring the Reproductive Rights of Refugees and Internally Displaced Persons: Legal and Policy Issues. *International Family Planning Perspectives* 26(4):167-173, 2000.
- Glanz, J. U.S. Pays for 150 Iraqi Clinics, and Manages to Build 20, *The New York Times*, April 30, 2006.
- Grein, T., et al. Mortality among Displaced former UNITA Members and Their Families in Angola: A Retrospective Cluster Survey. *British Medical Journal* 327:1-5, 2003.
- Guiding Principles on Internal Displacement. Annotations by Walter Kälin. *Studies in*

- Transnational Legal Policy* 32, The American Society of International Law and The Brookings Institution Project on Internal Displacement, 2000.
- Gururaja, S. Gender Dimensions of Displacement. *Forced Migration Review* 9: 13-16, 2000.
- Gyles, W. and J. Hyndman. Introduction: Gender and Conflict in a Global Context, in *Sites of Violence: Gender and Conflict Zones*, ed. W. Gyles and J. Hyndman. University of California: Berkeley, 2004.
- Hans, A. Escaping Conflict: Afghan Women in Transit. In *Sites of Violence: Gender and Conflict Zones*, ed. W. Giles and J. Hyndman. University of California: Berkeley, 2004.
- Haour-Knipe, M. and R. Rector, eds. *Crossing Borders: Migration, Ethnicity, and AIDS*. Taylor and Francis: London, 1997.
- Harper, A. Iraq's Neglected Humanitarian Crisis. *Forced Migration Review* 27:61-62 (special issue on Sexual Violence), 2007.
- Harrell-Bond, B.E. Can Humanitarian Work with Refugees Be Humane? *Human Rights Quarterly* 24(1):51-85, 2002.
- Harris, C. Reproductive Health of Refugees: Lessons Beyond ICPD. Paper for Conference on Refugees and the Transformation of Society, The Netherlands, April 1999.
- _____. Health Education for Women as a Liberatory Process? An Example from Tajikistan, in H. Afshar and S. Barrientos, eds., *Women, Globalization and Fragmentation in the Developing World*. Women's Studies at York Series: Hampshire, UK, 1999.
- _____. Involving Men: The Khatlon Women's Health Project in Tajikistan, in R. Petchesky, *Global Prescriptions*. Zed Books: London, 2003, 214-215.
- Herd, G., ed. *Sexual Cultures and Migration in the Era of AIDS*. Clarendon Press: Oxford, 1997.
- Hersh, S. M. *Chain of Command: The Road from 9/11 to Abu Ghraib*. Harper Collins: New York, 2004.
- Human Rights Council. Mission to Lebanon and Israel, Report of 4 Special Rapporteurs. Human Rights Council, 4th Sess., Doc. No. A/HRC/2/7. United Nations Human Rights Council: Geneva, Oct. 2006.
- Hunt, P. Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. United Nations Human Rights Council, 4th Sess., Doc. No. A/HRC/4/28, 2007.
- Hyland, M. Refugee Subjectivity: 'Bare Life' and the Geographical Division of Labour. *Log*, Issue 13 (www.physicsroom.org.nz/log/archive/13/refugeesubjectivity/), 2001.
- Hyndman, J. Refugee Camps as Conflict Zones: The Politics of Gender. In *Sites of Violence: Gender and Conflict Zones*, ed. W. Giles and J. Hyndman. University of California: Berkeley, 2004.
- Hynes, M., et al. Reproductive Health Indicators and Outcomes among Refugee and Internally Displaced Persons in Postemergency Phase Camps. *Journal of the American Medical Association* 288(5):595-603, 2002.
- IASC (Inter-Agency Standing Committee). Statement of Commitment on Gender Based Violence in Emergencies, <http://www.humanitarianinfo.org/iasc/publications.asp>, 2004.
- IASC. Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies. IASC:

- Geneva, 2005.
- Indra, D. M. Not a "Room of One's Own": Engendering Forced Migration Knowledge and Practice, in *Engendering Forced Migration: Theory and Practice*, ed. D.M. Indra, Berghahn Books: New York:1-22, 1999.
- IRIN News. UNHCR Launches Policy to Provide Refugees with Access to Antiretroviral Treatment. Integrated Regional Information Networks (UN Office for the Coordination of Humanitarian Affairs) (www.irrinnews.org/), Jan. 29, 2007.
- Jok Madut, J. Militarization and Gender Violence in South Sudan, *Journal of African and Asian Studies* 34(4):427, 1999.
- Jok Madut, J. Militarism, Gender, and Reproductive Suffering: The Case of Abortion in Western Dinka, *Africa: Journal of the International African Institute* 69(2):194-212, 1999.
- Kälin, W. Specific Groups and Individuals: Mass exoduses and displaced persons. Report of the Representative of the Secretary-General on the Human Rights of Internally Displaced Persons. United Nations Economic and Social Council, Doc. No. E/CN.4/2006/71, 2006.
- Kälin, W. The Future of the Guiding Principles on Internal Displacement. *Forced Migration Review* 24:5-6 (special issue, Putting IDPs on the Map), 2006.
- Kälin, W. Report of the Representative of the Secretary-General on the Human Rights of Internally Displaced Persons. United Nations Human Rights Council, 4th Sess., Doc. No. A/HRC/4/38, 2007.
- Kaul, I., I. Grunberg and M.A. Stern, eds. *Global Public Goods: International Cooperation in the 21st Century*. UNDP/Oxford University Press: New York, 1999.
- Klugman, B. Sexual Rights in Southern Africa: A Beijing Discourse or a Strategic Necessity? *Health and Human Rights* 4:144-173.
- The Lancet*, Editorial. Who Is Responsible for the Care of Refugees? *The Lancet* 360:1897, 2002.
- Lasky, M. P. Code Pink. *Iraqi Women under Siege*. Report by CODEPINK: Women for Peace and Global Exchange, www.codepink4peace.org, 2006.
- Loescher, G., Blaming the Victim: Refugees and Global Security. *Bulletin of the Atomic Scientists* 58(2):46-53, 2002.
- Luibhéid, E. *Entry Denied: Controlling Sexuality at the Border*. University of Minnesota Press: Minneapolis, 2002.
- Luibhéid, E. and L. Cantú Jr., eds. *Queer Migrations: Sexuality, U.S. Citizenship, and Border Crossings*. University of Minnesota Press: Minneapolis, 2005.
- Macklin, A. Like Oil and Water, with a Match: Militarized Commerce, Armed Conflict, and Human Security in Sudan, in *Sites of Violence: Gender and Conflict Zones*, ed. W. Gyles and J. Hyndman. University of California: Berkeley, 2004.
- MADRE. War on Civilians: A MADRE Guide to the Middle East Crisis. <http://madre.org/articles/me/waroncivilians.html>, July 19, 2006.
- MADRE. *Promising Democracy, Imposing Theocracy: Gender Based Violence and the US War on Iraq*. MADRE: New York, 2007.
- Marsh, M., S. Purdin and S. Navani. Addressing Sexual Violence in Humanitarian Emergencies. *Global Public Health* 1(2):133-146, 2006.
- Mazzetti, M. and D. Rohde. Terror Officials See Al Qaeda Chiefs Regaining Power. *The New York Times*, Feb. 19, 2007.

- McGinn, T. et al. Reproductive Health for Conflict-Affected People: Policies, Research and Programmes. Humanitarian Practice Network (HPN), Overseas Development Institute: London, 2004.
- McGinn, T. and S. Purdin. Reproductive Health and Conflict: Looking Back and Moving Ahead. *Disasters* 28(3):235-238, 2004.
- Mukherjee, V. N. National and State Population Policies in India: Gender Matters. Seminar 511, 2002.
- Norwegian Refugee Council. *Internal Displacement: Global Overview of Trends and Developments in 2005*. Internal Displacement Monitoring Center: Geneva, 2006.
- Nussbaum, M. *Sex and Social Justice*. Oxford University Press: New York, 1999.
- Nussbaum, M. *Frontiers of Justice: Disability, Nationality, Species Membership*. Harvard University Press: Cambridge, MA, 2006.
- Nuwayhid, I., C. S. Cortas and H. Zurayk. Resilience during War and Its Implications for Public Health Interventions, Education, and Training. Paper presented at the Global Forum for Health Research Annual Meeting, Cairo, Egypt, 29 Oct.-2 Nov. 2006 (revised).
- Okata, S. and A. Sen. Human Security Now – Final Report of the United Nations Commission on Human Security, 2003 (www.humansecurity-chs.org/).
- Ondeko, R. and S. Purdin. Understanding the Causes of Gender-based Violence. *Forced Migration Review* 19:30, 2004.
- Pallis, M. The Operation of UNHCR's Accountability Mechanisms. International Law and Justice Working Paper 2005/12. Institute for International Law and Justice/New York University: New York, 2005.
- Papastergiadis, N. The Invasion Complex: The Abject Other and Spaces of Violence, *Geography Annual* 88:4:429-442, 2006.
- Patrick, E. Sexual Violence and Firewood Collection in Darfur. *Forced Migration Review* 27:40-41, 2007.
- Petchesky, R. *Global Prescriptions: Gendering Health and Human Rights*. Zed Books: London/Palgrave: New York, 2003.
- Petchesky, R. Rights of the Body and Perversions of War—Ten Years Past Beijing. *International Social Science Journal*, UNESCO: Paris, 2005.
- Phillips, O. Conscripts in Camp: Making Military Men. *African Gender Institute Newsletter* 8 (<http://web.uct.ac.za/org/agi/pubs/newsletters/vol8/camp.htm>), 2001.
- Preston-Whyte, E. et al. Survival Sex and HIV/AIDS in an African City. In *Framing the Sexual Subject*, ed. R. Parker, R. Barbosa and P. Aggleton. University of California: Berkeley, 2000.
- Ramdas, K. N. Women's Rights Another Victim of the Iraq Catastrophe. *The Baltimore Sun*, Dec. 22, 2006.
- Reuters. Soldier Weeps Describing Role in Rape and Killings in Iraq. *The New York Times*, Feb. 22, 2007.
- Salama, P., P. Spiegel and Richard Brennan. No Less Vulnerable: The Internally Displaced in Humanitarian Emergencies. *The Lancet* 357:1430-1431, 2001.
- Salama, P. et al. Lessons learned from complex emergencies over past decade. *The Lancet* 364:1801-13, 2004.
- Sambanis, N. It's Official: There Is Now a Civil War in Iraq. *The New York Times* Op-Ed, July 23, 2006.

- Save the Children UK. *HIV and Conflict: A Double Emergency*. Save the Children: London, 2002.
- Sen, A. *Development as Freedom*. Alfred A. Knopf: New York, 1999.
- Slim, H. Doing the Right Thing: Relief Agencies, Moral Dilemmas and Moral Responsibility in Political Emergencies and War. *Disasters* 21(3): 244-257, 1997.
- Spees, P. Women's Advocacy in the Creation of the International Criminal Court: Changing the Landscapes of Justice and Power. *SIGNS* 28 (summer):1233-54, 2003.
- Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*. The Sphere Project: Geneva (<http://www.sphereproject.org>), 2004.
- Spiegel, P. et al. Health Programmes and Policies Associated with Decreased Mortality in Displaced People in Post-emergency Phase Camps: A Retrospective Study. *The Lancet* 360:1927-34, 2002.
- Spiegel, P.B. HIV/AIDS among Conflict-Affected and Displaced Populations: Dispelling Myths and Taking Action. *Disasters* 28(3): 322-339, 2004.
- Swarns, R. L. U.S. May Be Mishandling Asylum Seekers, Panel Says. *The New York Times*, Feb. 8, 2007.
- Swarns, R. L. Two Groups Compare Immigrant Detention Centers to Prisons. *The New York Times*, Feb. 22, 2007.
- Terry, F. Military Involvement in Refugee Crises: A Positive Evolution? *The Lancet* 357:1431-32, 2001.
- Tong, J. Questionable Accountability: MSF and Sphere in 2003. *Disasters* 28(2):176-189, 2004.
- Turner, S. How Life in a Refugee Camp Affects Gender, Age and Class Relations. UNHCR: Geneva, 1999.
- U.S. Committee for Refugees and Immigrants (USCRI), *World Refugee Survey 2006*.
- UNFPA Study Finds maternal Deaths Have Tripled in Iraq. www.PLANetWire.org (Communications Consortium Media Center), Nov. 5, 2003.
- United Nations Development Programme (UNDP). *Human Development Report 1998*. Oxford University Press: New York, 1998.
- United Nations/International Criminal Court (UN/ICC). *Rome Statue of the International Criminal Court*. Doc. A/CONF.183/9, July 17, 1998.
- United Nations High Commission for Refugees (UNHCR). *Inter-agency Field Manual on Reproductive Health in Refugee Situations*. UNHCR: Geneva, 1999.
- UNHCR. Prevention and Response to Sexual and Gender-based Violence in Refugee Situations. Inter-agency Lessons Learned Conference Proceedings. UNHCR: Geneva, March, 2001.
- UNHCR. *Global Refugee Trends*. UNHCR: Geneva, 2005.
- United Nations Population Fund (UNFPA). *State of World Population 2006: A Passage to Hope, women and International Migration*. United Nations Population Fund: New York, 2006.
- UNFPA & UNICEF. The Effects of Conflict on Health and Well-being of Women and Girls in Darfur. http://www.unicef.org/emerg/darfur/files/sitan_unfpaunicef.pdf, 2005.
- United Nations, *Programme of Action of the International Conference on Population and Development, Cairo*. 1994.
- Valle, H. del. Beyond the *Burqa*: Addressing the Causes of Maternal Mortality in Afghanistan, *Forced Migration Review* 29:10-12, 2004.

- Van Damme, W. Do refugees belong in camps? Experiences from Goma and Guinea. *The Lancet* 346(8971):360-362, 1995.
- Verdirame, G. Human Rights and Refugees: The Case of Kenya. *Journal of Refugee Studies* 12(1):54-77, 1999.
- Waldman, R. and G. Martone. Public Health and Complex Emergencies: New Issues, New Conditions. *American Journal of Public Health* 85(10):1483-1485, 1999.
- Walker, P. and S. Purdin, *Birth Sphere*. *Disasters* 28(2):100-111, 2004.
- Weiss, T. G. and D. A. Korn. *Internal Displacement: Conceptualization and Its Consequences*. Routledge: London and New York, 2006
- Weissman, F. Humanitarian Action and Military Intervention: Temptations and Possibilities. *Disasters* 28(2): 205-215, 2004.
- Wilde, R. Quis Custodiet Ipsos Custodes?: Why and How UNHCR Governance of 'Development' Refugee Camps Should be Subject to International Human Rights Law. *Yale Human Rights & Development Law Journal* 1:107-128, 1998.
- Wille, P. F. Placing IDPs on the International Agenda: Lessons Learned. *Forced Migration Review* 24:7 (special issue, Putting IDPs on the Map), 2006.
- Williamson, K. AIDS, Gender and the Refugee Protection Framework. RSC Working Paper No. 19. Refugee Studies Centre, University of Oxford, August 2004.
- Wong, E. G.I.'s Investigated in Slayings of 4 and Rape in Iraq. *The New York Times*, July 1, 2006.
- Zangana, H. All Iraq Is Abu Ghraib. *The Guardian*. Available at http://commentisfree.guardian.co.uk/haifa_zangana/2006/07, July 5, 2006.