

### Chapter 3: War and Women's Health

On a hot Saturday afternoon in January, we travelled about an hour out of Liberia's capital city of Monrovia to visit a camp of displaced people who had fled, not for the first time, from fighting in Lofa province. Compared to the well-organized camps for Sierra Leonean refugees near the city, this camp for Liberians was chaotic. A large water bladder provided by a non-governmental organization (NGO) was the only source of clean water. There were no health care services, no shelter; in fact, there were hardly any services at all. The people were frightened. There had been fighting nearby recently and they wanted to move closer to Monrovia for safety. A delegation had been sent to the capital to appeal to the authorities for permission to relocate, but so far there had been no response. Then, the night before we arrived, fighting broke out again, even closer to the camp. In a panic, the people had packed up their small shelters and their remaining possessions. When we arrived, most were sitting on the ground in the open air, frightened and desperate to get away.

We gathered together a group of women and asked them what was happening. "We are from Lofa, where there is fighting between the Government and the rebels," said Lina, a dignified woman of about 50. "This is the fourth time many of us have moved since the fighting started. We have appealed to the Government for safety, but they don't care about us because they think we are supporters of the rebels. If we supported the rebels, why would we be running from them?"

Lina was a trained nurse who had worked in a clinic in the north until the fighting started. She was articulate and well educated, an unusual person to find in this group of poverty-stricken rural people. Most educated Liberians in her position would have found their way to the capital or to another country by this time, but she had stayed here where people needed her. It was clear that the other women trusted her and looked to her to speak for them. Yet she was tired and discouraged.

"We came here two weeks ago," she told us, "and we have received hardly any help at all – only a little bit of food and that water. There are hundreds of people here – men, women and children. People are exhausted, sick and unable to take any more fighting. They tremble when they hear the mortars at night, and we all fear that this area will be attacked at any time. I am the only one here to nurse all these people – there's not even a midwife. There are so many women who are pregnant and no one else to help with them. If there is a problem, they will just have to die here because I have no supplies, no transport, and no way to help. I don't know how anyone can look at these women and not help them, not let them be in a safe place."

Young women, many with babies in their arms, gathered around, nodding in agreement as Lina spoke. When we asked why so many were pregnant, they laughed at such a silly question. "How could we avoid it? Do you think anyone would want to give birth here?" they asked. They were there with their husbands or boyfriends; they had no access to contraceptives and, in their situation, no power to refuse sexual relations. Some said that children were the only good things they had, their only happiness. But others said that it was a bad time to have children and they would have preferred to wait until they were settled, with a house or a job. As more and more women gathered around, we asked their ages. They were much younger than they looked. The months of hunger and living on the run had aged them. They had been abandoned by their own government and

by the international community. They were the cast-offs of a long and complicated conflict that few journalists bothered to cover any more.

We asked Lina what she needed. “Everything!” she replied. “I need soap and cotton and antibiotics and aspirin. Children here have diarrhoea, infections and lice. Men have old wounds that are infected, or burns or other problems. Women have venereal problems, injuries from walking, burns and miscarriages. Old people have so many problems. We have people who are seriously mentally ill, who don’t even know who or where they are. I don’t have anything except the small amounts of medicine that an NGO left here a week ago. But at least I try to keep records of births and deaths. I do that for history.”

At a far corner of the camp, next to a ditch, a young mother of newborn twins sat in front of a makeshift hut of twigs and cloth. She looked about 17 years old and was sitting on a straw mat, with her family gathered around her. She had one tiny baby lying on her legs and another at her left breast. Her right breast was swollen to the size of a basketball. Her eyes teared up and she grimaced with pain when she touched it. Her husband explained that she had given birth to the twins a week before, just as they arrived in the camp; she now had a breast infection and her milk was contaminated. He said that Lina had told her not to feed with that breast, but when she didn’t nurse, the breast got even more painful. “We need antibiotics, but we have no money and no way to get to the town even if we could buy medicine. There is no transport and they won’t let us past the checkpoint.” A colleague from a Liberian NGO who was accompanying us gave the husband some small bills from his pocket. “I don’t know if they can make it through to Monrovia,” he told us, “but maybe they can bribe someone.”

The situation of the people in that camp in Liberia was about the worst we had seen in all our visits to war-affected areas. They were people with nothing – and with no international or local groups to help them. They had absolutely no rights and were at the mercy of a war they did not understand. We wished we had brought medicines or food and had the power to do more than tell the world about them. We wanted to linger, to learn more, to understand how this could happen, but the government official with us insisted that we leave by 5 p.m. The UN security officer who had accompanied us was puzzled by his insistence and seemed to think that the official knew or feared that something was going to happen.

Evidently he was right. The next day we learned that the camp had been attacked only two hours after we left. No one knew what had happened to the hundreds of people who had been trapped there, and no one from the international community was allowed to go there. We never found out if Lina and the others were able to get to safety. We cannot imagine how the young girl with twins could have been able to move quickly enough to escape. The faces of the women we met haunt us.

Since that January day, tens of thousands more Liberians have fled the fighting, which has moved closer and closer to Monrovia. The neat camps supported by the Office of the United Nations High Commissioner for Refugees (UNHCR), once filled with refugees from Sierra Leone, have been abandoned, their residents crossing back into their own country. Some of the displaced Liberians we met have scattered to the woods. Others have crept into the city to live on the streets. Many have perished. There is no better example today of the horror and absurdity of war. How can this happen in the 21st century?

Armed conflicts have been major causes of disease, suffering and death for much of human history. The fatalities, injuries and disabilities suffered on the battlefield are obviously direct effects of conflict. But there are also health consequences from the breakdown of services and from population movements. The diverting of human and financial resources away from public health and other social goods contributes to the spread of disease. These indirect consequences of war may remain for many years after a conflict ends. Both the experience of conflict itself and the impact of conflict on access to health care determine the physical health and the psychological well-being of women and girls in very particular ways. Women are not only victims of the general violence and lack of health care – they also face issues specific to their biology and to their social status. To add to the complexity of the picture, women also carry the burden of caring for others, including those who are sick, injured, elderly or traumatized. This in itself is stressful and often contributes to illness.

### **The General Impact of Armed Conflict on Health: Women are not exempt**

The exact number of deaths and injuries due to war is unknown since chaotic conflict situations make it difficult, if not impossible, to monitor death and injury rates. A few examples, however, show the harm that war brings. In December 1998, when the civil war in Congo restarted, a third of Brazzaville's population – about a quarter of a million people – fled into the forests. They remained trapped for several months, with no access to international aid. In May 1999 surveys and data collection from people returning to the capital allowed officials to document the health consequences of the war. Death rates were more than five times what would be considered an emergency.<sup>1</sup> Earlier studies in the 1980s in Ethiopia, Mozambique and Sudan came up with similar findings: during periods of conflict, the mortality rates of internally displaced persons (IDPs) in each country ranged between 4 and 70 times the rates for non-displaced persons in the same country.<sup>2</sup>

In 2000 alone, conflict is estimated to have directly resulted in 310,000 deaths, with more than half taking place in sub-Saharan Africa. If the commonly held ratio is accurate – nine indirect deaths for every direct death caused by conflict – then approximately 2.8 million people died in 2000 of some conflict-related cause.<sup>3</sup> Arguably the figure is much higher. When the direct fatalities are estimated by age and sex, children and adolescents account for a significant proportion of the deaths. The highest mortality rates are among men aged 15 to 44, but a quarter of direct mortality is among women. The greatest number of deaths of women is among those aged 15 to 29; some 25,000 women in this age group died directly of conflict in 2000.<sup>4</sup>

The International Rescue Committee has estimated that between August 1998 and April 2001, there were 2.5 million excess deaths (i.e., above the number normally expected) in the five eastern provinces of the Democratic Republic of the Congo (DRC), where armed groups have been fighting each other as well as attacking civilians. Only 350,000 of these deaths were directly caused by violence; the majority stemmed from disease and malnutrition. One in eight households had experienced at least one violent death; 40 per cent of these deaths were of women and children. There were more deaths than births in many of the areas studied and, in one area, 75 per cent of the children died before they reached the age of two.<sup>5</sup> This is an astounding indictment of the warring

factions and of the international community, which has virtually ignored the horrific conditions in the eastern DRC.

### **Damage to health systems**

Civil wars often result in severe damage to health services since health facilities and personnel may become targets. In Rwanda, over half the health workers were killed during the genocide, the health infrastructure was destroyed and administrative capacities were disrupted.<sup>6</sup> In the DRC, “Years of war have devastated the health system, and the effects on the well-being of the population are cataclysmic,” according to the Minister of Health.<sup>7</sup> It is estimated that no more than 5 per cent of blood used for transfusions is being screened, either because facilities have been destroyed or the resources are not available. In Bosnia and Herzegovina, 40 per cent of physicians, 60 per cent of dentists and 30 per cent of nurses left the country during the war and have not returned.<sup>8</sup> In circumstances such as these, it is impossible to provide even the most basic health support without massive aid from the international community.

In many conflicts, health workers have become targets. In El Salvador and Nicaragua, dozens were kidnapped or assassinated. In the occupied Palestinian territories, there have been attacks on ambulances and medical personnel, leaving a significant proportion of the civilian population without emergency services.<sup>9</sup> In addition, ambulances have been unable to get access to women, or to get them to hospitals through the checkpoints.

Sanctions can also undermine health systems. In Iraq after the Gulf War, basic care for the entire population declined because of damaged infrastructure and the sanctions, which affected the distribution of food and medical supplies. Women’s access to gynaecological care decreased dramatically. In Serbia during the sanctions period, the mortality of women aged 25 to 44 was significantly higher than in previous years, mainly due to urogenital diseases and endocrine disorders such as diabetes. Normally these diseases can be treated with relative ease, but they can be fatal in the absence of medical supplies. In the case of Serbia, these became expensive and took long periods to be cleared.<sup>10</sup> A study of economic embargoes in Cuba, Haiti, Iraq, Nicaragua, South Africa and Yugoslavia found that economically vulnerable groups, particularly women and children under five, suffer most from the deterioration in the health sector caused by sanctions.<sup>11</sup>

### **Infectious diseases**

“I don’t know what we would do here if measles broke out or if there was a cholera epidemic. There’s just no capacity to handle the situation, not enough transport, not enough health workers. We just pray for good luck.”

NGO worker in Somalia

Historically, war and displacement have always been associated with epidemics and the spread of disease from one area to another. The highest rates of death and illness among displaced populations stem from diseases such as measles, diarrhoea, pneumonia, malaria, cholera, meningitis and tuberculosis, with malnutrition playing an important role in many cases.<sup>12</sup>

The flight of half a million Rwandans in 1994 across the border into North Kivu, DRC (then Zaire) overwhelmed the resources of humanitarian groups trying to help. During the first month of the influx, almost 50,000 refugees died. This was almost entirely due to epidemics of diarrhoeal diseases caused by poor sanitation and inadequate water supplies. The highest death rates were among children under five and women.<sup>13</sup> In Afghanistan, current tuberculosis infection rates as high as 325 per 100,000 indicate a serious problem. Women make up 67 per cent of all registered cases, compared to 37 per cent of cases worldwide.<sup>14</sup> This is undoubtedly due to the conditions under which women have been living during the past years – kept inside crowded dwellings, unable to move about freely outdoors and lacking access to health care.

### **Injuries and wounds**

Civilian casualties from injuries and wounds can be very high during guerrilla warfare and when small arms and landmines are used. Women and children are often the most exposed to these dangers, especially if they are primarily responsible for gathering fuel or water. Most of the civilian casualties of the 23-year war in Afghanistan have been a direct result of ballistic or landmine injuries. In 1995, long before the current fighting, Afghanistan had the highest population-based rates of landmine injuries and the highest mortality, even in comparison with such heavily mined countries as Bosnia, Cambodia and Mozambique.<sup>15</sup> Although the numbers are not documented, women are much less likely than children and men to have access both to treatment and to rehabilitation and prostheses. In Angola women and girls who have lost limbs from mine injuries have faced social isolation and economic loss. In Sierra Leone the brutal fighters of the Revolutionary United Front (RUF) chopped off the arms and legs of many women, leaving them unable to farm or to care for their families.

### **Environmental harm**

Exposure to chemical warfare or the environmental effects of conflict can harm health directly and for long periods of time. In the case of nuclear testing, preparation for war has exposed many to radiation, causing a dramatic increase in cancer and other health problems; women's reproductive health is especially susceptible to the effects of radiation. Women living downwind from Pacific islands where nuclear testing has occurred have given birth to what they describe as 'jellyfish babies' with transparent skin and no bones. Unfortunately politics has often prevented scientific research in this area.

Causality has not yet been proven but there is, for example, some indication that the Gulf War exposed both civilians and combatants to harmful substances. There appeared to be an increase in miscarriages and pregnancy complications among women in the Gulf States during the two years after the war, possibly due to chemical residues from weapons that leaked into the food chain or because of smoke pollution from the Kuwaiti oil fields – although the increase may also have been related to stress.<sup>16</sup> Women soldiers deployed to the Gulf War theatre reported a higher than average incidence of abnormal Pap smears as well as a cluster of problems including fatigue, joint pain, hair loss, irritability, memory difficulties and insomnia.<sup>17</sup>

## **Mental health and stress-related disease**

Armed conflict traumatizes both combatants and civilians – on a daily basis and sometimes for the rest of their lives, long after the war is over. Numerous studies of the psychological state of refugees, war-affected populations and ex-combatants show that the experience of violence makes a deep impression on the human psyche. People's responses differ according to their own personalities, the levels and types of violence they experience and their cultural interpretations of the conflict, yet it is increasingly clear that if left untreated, the psychological impact of war can severely diminish the quality of life and even threaten a whole society. War-affected populations suffer high rates of anxiety, depression and post-traumatic stress disorders. Those who have been tortured may require intensive therapy in order to carry on with their lives. Refugees who leave their communities and countries also experience what one specialist calls 'cultural bereavement', a grieving for home, language or traditions.<sup>18</sup> Those who are granted asylum in rich countries with very different cultures from their own experience social isolation and high levels of depression.<sup>19</sup>

Studies of combatants indicate that increased exposure to combat is a predictor of severe wartime violence,<sup>20</sup> which may contribute to the atrocities committed in some long conflicts. Once combatants are inured to extreme violence, it is difficult for them to revert later on to more normal, healthy attitudes towards conflict resolution. There seems to be a pattern of increased homicide rates after wars, which does not bode well for societies that have suffered years of atrocities, often at the hands of very young combatants.

In the countries we visited, we were overwhelmed by the depth and intensity of women's psychosocial needs. In eastern DRC, one international aid worker told us, "What we are confronting here – and in so many conflict zones where we work – is the need for a massive psychosocial programme of trauma counselling, which we are utterly unprepared for. It will have to be very long-term, with very skilled people, and I don't know whether the will is there for something so ambitious, never mind the resources." A social worker in the West Bank echoed the same concern. "Every single one of us, including the carers, needs extensive psychological help. Where is it ever going to come from?"

## **Specific Effects of Conflict on Women's Health and Well-being**

In the past few years, there has been growing attention to gender issues as they affect and are affected by humanitarian programmes. Agencies such as the World Food Programme (WFP), the United Nations High Commission for Refugees (UNHCR) and the United Nations Children's Fund (UNICEF), as well as the many NGOs involved in emergency relief, have begun to think more carefully about the gender impact of their interventions. Yet studies of the health effects of conflict have rarely focused on women (with the exception of reproductive health), and most of the data on conflict mortality and morbidity (illness) are not broken down by gender. Women are seldom mentioned as a special group, but are lumped together with children as 'vulnerable groups'. Yet women have particular experiences and exposure to circumstances that affect their health. They also have patterns of access to health care that are different from those of children and men.

## **Malnutrition**

Famine and the resulting malnutrition and disease killed thousands during the 20th century and most of these deaths were the fault of humans, not nature. Almost always, civil conflict and human rights abuses either paved the way for famines, such as those in Biafra in the 1960s and the Horn of Africa in the mid-1980s, or prevented food aid from reaching starving communities, as happened in Angola more recently. Women and children die at extremely high rates in such circumstances. Even in relatively affluent regions, war can lead to malnutrition, as it did in Bosnia in the early 1990s, where the death rate in one Muslim enclave reached four times the pre-war rate, mainly from severe malnutrition.<sup>21</sup>

Because of women's physiology, they are vulnerable to vitamin and iron deficiencies that affect their health and energy levels as well as their pregnancies. Iron deficiency anaemia is a serious health condition for women of reproductive age and can be fatal for pregnant women. A study among Somali refugees indicated that up to 70 per cent of women of reproductive age were anaemic, probably caused by a lack of iron in the diet or by malaria, which depletes the body's stores of iron.<sup>22</sup>

A recent nutritional survey in Afghanistan showed a 9.8 per cent rate of scurvy (vitamin C deficiency) among women of child-bearing age,<sup>23</sup> caused by lack of fruits and vegetables, which in turn may be related to the poor status of women and the preferential feeding of men and boys. An epidemic of konzo, a type of paralysis, occurred among women and children in Mozambique during the last year of the war there, caused by eating insufficiently cooked bitter cassava, which has a high cyanide content. Unable to farm their usual crops because of the war, rural people began to depend on the bitter cassava as a food source.<sup>24</sup>

## **Reproductive health**

Women's reproductive health problems during conflicts may range from having no sanitary supplies for menstruation to life-threatening pregnancy-related conditions, from lack of birth control to the effects of sexual violence. In the past two decades, women have also had to deal with the deadly spread of HIV/AIDS.

**Menstruation needs:** It is obvious that refugee and displaced women between the ages of 10 and 50 need a way to handle their menstruation, yet strangely it is only in the past few years that humanitarian agencies have begun to include sanitary supplies in the package of relief items provided in emergencies. Without such supplies, girls have to stay home from school, mothers cannot take their children to health facilities and women may miss work or training. Providing clean cotton rags or modern sanitary products allows women to move about freely during their menstruation, instead of sitting at home or in their tents, isolated from others. Nevertheless, a 2000 UNHCR study found that despite headquarters' directives, many of its own staff members were not providing sanitary supplies in camp settings.

**Pregnancy and delivery:** Pregnancy and delivery can be dangerous for women in the best of circumstances. In poor countries, maternal mortality is nearly 40 times the rate in the industrialized nations.<sup>25</sup> In countries suffering conflict, women are at even greater risk since they generally cannot get prenatal support or emergency obstetric care.

In the DRC approximately 42,000 women died in childbirth in 2001.<sup>26</sup> One mother in 50 dies giving birth in Angola.<sup>27</sup> In Afghanistan years of poverty, neglect of health facilities and policies restricting the movement of women were catastrophic for women's health. Because the country lacks simple delivery and emergency obstetric services, maternal deaths are among the highest in the world.

Conflict can have indirect consequences as well. In Eritrea the recent war with Ethiopia caused a redeployment of scarce health resources to the front lines, resulting in declines in maternal health care in areas far from the conflict. During flight and acute emergency periods, spontaneous abortions (miscarriages) can increase precipitously from the physical and mental stress; women who suffer miscarriages require immediate assistance to save their lives and protect their fertility.

Lack of access to appropriate medical care may not be the only cause of poor pregnancy outcomes. The exposure to trauma and violence itself may have an effect on pregnancy. In southern Sudan, when one community experienced a high number of miscarriages, the villagers blamed it on the fighting. A nurse told investigators that the unremitting smoke and noise from heavy artillery in 1991 could have made women miscarry, and women fleeing aerial bombing had suffered back pain followed by miscarriage.<sup>28</sup> A study in Santiago, Chile, on the relationship between pregnancy complications and sociopolitical violence in 1985-1986 suggests that the Sudanese villagers may be right. Chilean women who lived in neighbourhoods with high levels of violence, including bomb threats, military presence and demonstrations, were five times more likely than women in other neighbourhoods to experience pregnancy complications such as preterm contractions, rupture and haemorrhage.<sup>29</sup>

**Unwanted pregnancies:** Unplanned and unwanted pregnancies present serious problems for women in any circumstance and can be particularly stressful for those who are displaced and separated from family and support systems. Women who have been using family planning to postpone or avoid pregnancy in their home communities should be able to continue when they become refugees. In fact, their needs may be even greater. Women and couples who did not use family planning deserve the chance to start doing so should they choose. Yet family planning has only recently become a regular part of health services in relief situations, and even now these services are not always available.<sup>30</sup>

Ensuring that family planning is a standard part of emergency programmes is easy. Finding ways to help victims of 'forced pregnancy' is much more difficult. The strategy of forcibly impregnating women as part of an ethnic cleansing campaign has occurred in recent conflicts in Bosnia and Herzegovina, East Timor, Kosovo, Rwanda and Sudan. Tens of thousands of women in these areas (and elsewhere) suffered the trauma of being raped repeatedly and impregnated by the rapist. The health and psychosocial needs of women who have endured these attacks are intricately entwined and require particularly sensitive responses.



Bosnian women who were sexually violated and intentionally made pregnant faced terrible choices. Some, who were able to get services early enough, chose abortion. Others continued their pregnancies and abandoned their babies at birth without ever seeing them. Of the few who kept their babies, many experienced family rejection and social isolation. Kosovar women also faced such choices. Rape is such a stigma that many resorted to abortion just so the men in their families would not know they had been raped. Many women we spoke to described an implicit understanding between men and women that amounted to a sad charade: The men never asked what had happened to the women and the women never offered to tell.

In Sierra Leone many women were raped by armed groups intent on sowing terror wherever they went and still others were forced into prostitution to support themselves and their families. But abortion is illegal in Sierra Leone and most women have no choice about whether to continue with an unwanted pregnancy. One 14-year-old sex worker, who was three months pregnant, told us she would have ended her pregnancy but did not have enough money to pay for an abortion, which was available 'underground'. The cost was \$100 – more than the average annual income of most Sierra Leoneans and more money than the girl had seen throughout her whole life.

**Adolescent pregnancy and other risks:** Young people who have lost family guidance and community support because of conflict are particularly vulnerable to engaging in risky behaviour as well as to sexual exploitation. In Colombia, violence and displacement have been accompanied by an increase in teenage pregnancies as well as unsafe abortions. We spoke with the World Health Organization (WHO) representative in Liberia, who estimates that up to 80 per cent of displaced girls have had an induced abortion by the age of 15, and we met girls there as young as 11 who were pregnant. Such early pregnancy has serious implications for the health and well-being of young girls, whose bodies have simply not developed enough to deliver safely and who are not mature enough to be parents. Girls aged 10 to 14 are five times more likely to die in pregnancy and childbirth than women aged 20 to 24. Unsafe abortions also carry great risk for the approximately 2 million young women aged 15 to 19 who undergo them every year.<sup>31</sup>

**Sexually transmitted infections (STIs):** In a women's training centre outside Freetown, Sierra Leone, where many young women abducted by the rebels during the long war were receiving vocational training and learning how to read, we spoke to a nurse about the women's health. "Our most urgent need right now is antibiotics," she said. "Almost all the girls here have STIs and when we have enough drugs I treat them. But right now I can't." She noted that many of the women had had these STIs for many years, presumably since they were first abducted and sexually assaulted, but even after treatment they became re-infected: Either they were having relations with untreated partners or they were so desperate for money they were having unprotected sex with strangers. "Some of them have syphilis," the nurse told us, "which can eventually kill them and their unborn baby if they get pregnant. But even simpler infections can easily develop into pelvic inflammatory disease and cause infertility. It would be such a shame for these girls, who are trying so hard to get their lives back in order, to have to suffer the stigma that infertility carries in our society. It would ruin their marriage prospects altogether."

STIs are reaching epidemic proportions globally. Yet most are relatively easy to treat, using a simple diagnostic approach that does not require laboratory analysis. It is hard to understand why this health issue is so neglected in emergency situations, especially since STIs spread so quickly in displaced populations. A study of Rwandan women attending antenatal clinics in refugee camps in Tanzania found that over 50 per cent were infected with some form of STI.<sup>32</sup> STIs are notoriously prevalent among military populations around the world (who have up to two to five times the rate for civilians), so conflict situations that involve extensive contact between civilians and combatants are especially likely to show high levels of these infections.

### **Effects of sexual violence**

The health impact of sexual violence can be disastrous. Injuries, unwanted pregnancies, sexual dysfunction and HIV/AIDS are among the physical consequences. The mental effects include anxiety, post-traumatic stress disorders, depression and suicide.<sup>33</sup> Although global attention has been focused for more than a decade on sexual violence as a strategy of war and as a human rights issue, the women who have suffered need direct support immediately, which they are still not getting. Rape often involves serious physical damage to a woman's body, requiring treatment for abrasions and tears; some women even need suturing. Antibiotic treatment is necessary. If provided within 72 hours, emergency contraception can prevent an unwanted pregnancy. With the widespread use of rape in war, health systems must be prepared to provide such treatment and ensure that staff are trained to deal sensitively with patients.

The burden can be enormous. In a six-month period in 1999, hospitals in Brazzaville treated 1,600 cases of rape.<sup>34</sup> A recent report by Physicians for Human Rights indicates that over 50 per cent of Sierra Leonean women experienced sexual violence of some type during the conflict there; many continue to suffer from serious gynaecological problems.<sup>35</sup>

### **Mental Health**

In one camp for Sierra Leonean refugees, a social worker offered us her analysis of the differing ways men and women react to camp life. The men, she said, lose their identity and their dignity. They sit around all day and then take out their frustrations on the women and children at night. In her view, the women are different. "They cope because they have to. They bend with the situation."

But how far do women have to bend before they break? In Morina, a small village outside Skanderaj in the heart of Kosovo, about 40 Albanian women and girls met with us to talk about their lives. They invited us into a large communal room where we sat on carpets and cushions around the walls. The women were restless, burning with the desire to communicate their common experience, their common trauma. Apart from one seven-year-old boy in the room, this village had lost all its men when Serbian forces attacked on 2 April 1999. As they told their stories many women wept, wiping their eyes with the corners of their headscarves.

“When the Serb forces came we were all gathered into a burned-out barn. They took the men out with their hands up, they put them against a wall and they were all killed.”

“My husband and son are missing, my in-laws were all killed.”

“My father-in-law was executed with his four brothers, my husband is missing along with nine other relatives.”

One woman shared the hard choices they had had to make: “We women started walking towards Skanderaj but we had to leave my mother-in-law behind as she was paralysed.” We listened in stunned silence as they described the fear that drove them from place to place. Having received no psychological support, they remained lost inside their pain, as though April 1999 had been only yesterday.

Another group caught in the past by the unresolved question of missing husbands and sons is the Mothers of Srebrenica, whose anger over the events of a decade ago spilled out in the first moments of our meeting. “Many people have acquired their PhDs studying us, but no one helps us,” one woman said bitterly. “We have no rights, and those who should help do not want to. We are slowly dying. No one who was not in Srebrenica can know what we have lived through – how difficult it was to watch people die of hunger, children going from house to house asking for bread, so exhausted that there was no light in their eyes. We have to go on with our lives, but how? I had two beautiful sons and a husband; now I have nothing.”

In many other conflict zones women have received little help in dealing with the trauma they experienced, although a few NGOs, with support from groups like UNIFEM and the United Nations Population Fund (UNFPA), are trying to tackle the problem. In Rwanda, AVEGA, a self-help organization of widows offering both physical and psychological care, has estimated that four out of five women have continued to suffer psychological trauma since the 1994 genocide. The AVEGA counsellors – whom we met in their modest house where every wall has photographs of strong, smiling women survivors – told us that many girls still have nightmares, and insist that they do not want to get married or ever have a sexual relationship. The Bosnian women’s group Medica Zenica also provides both medical care and psychosocial assistance to women victims of sexual violence. They run a mobile clinic to treat gynaecological and obstetric problems. Their psychosocial workshops link local populations with returnees and the internally displaced, recognizing that shattered communities cannot be put back together without psychological support. “During the war we were open to everyone, but now it is more difficult to get donor funding, so we have to prioritize war-traumatized women,” a representative of Medica Zenica told us. Like a number of women’s groups we met in the occupied Palestinian territories and in Belgrade, Medica Zenica also runs a telephone hotline for women who need to talk about memories of war trauma and the taboo subjects of rape and domestic violence.

The women in settings where mental health issues are discussed, or where there are self-help groups, are fortunate. In Somalia we heard estimates that nine out of ten women were traumatized in some way or another, but very few of the women we met mentioned the need for psychosocial support, partly because they did not know such a thing existed and partly because, they told us, it would be embarrassing to admit they needed help. A young woman, Sahir, described to us her feelings of desolation. She often

thought of suicide, she said. Sahir saw her father and brother killed; she was then raped and had a gun thrust so deeply into her vagina that she will never be able to bear children. Like many other traumatized women we met, Sahir chose to speak to us, strangers whom she would never see again, as a way to find a brief release not available in her daily life.

What we know about the psychological impact of conflict on individuals is mixed. There are numerous studies on post-traumatic stress among combatants (mostly men) and on the effects of war on children. There is a whole body of literature on psychiatric treatment for torture victims (again, mainly men), and there are various schools of thought on rape counselling. But shockingly little attention has been paid to the effects of conflict on the psychosocial status of women or on how women process and cope with their experiences. One very recent study of trauma in non-conflict situations indicates that there may be gender differences in the response to trauma. The study found that, although the lifetime prevalence of traumatic events is slightly higher for men, women run twice the risk of developing post-traumatic stress disorders, suggesting that certain types of trauma may have a deeper and longer-term psychological impact on women.<sup>36</sup>

Of course, it is not only women's mental health that is important. Healthy psychosocial adjustment of men and boys who have experienced violence and conflict is also important to their families and communities. There are numerous indications that combat exposure and post-traumatic stress in men lead to higher levels of substance abuse and domestic violence. There is also some evidence that post-traumatic symptoms can abate for years, but then return in later life, particularly in stressful situations.<sup>37</sup> This has implications for women as caregivers.

### **Burden of care for others**

In every society women bear the brunt of the burden of caring for those who are ill. This does not change when women are in the midst of war; they still try to protect and care for their children and the elderly, and they still provide support for their husbands, their siblings and their parents. The responsibility of care for others is so embedded that even in the most desperate conditions, women still try to take care of everyone around them. In our travels, we heard about the despair women felt when they watched their loved ones suffer or die, when their children were abused or starved or when they had to leave elderly relatives behind as they ran for their own lives. The guilt and helplessness that the women felt in these situations, and still feel, is an almost unbearable burden.

At the same time, the social responsibility of caring for the ill or disabled adds heavily to the workload of women in conflict and post-conflict situations. One woman whose child had been severely disabled by a landmine told us that her whole day is taken up with feeding and washing the child and helping him learn how to read, which she sees as his only hope of relief from his disability. Other women spoke of trying to keep the peace in households where husbands are depressed and drink too much, lashing out at their children. Still others spend hours lining up to get food for their families or offer sex to strangers for the money to buy medicine. Truly the time and the emotional energy these women spend on caring for others is incalculable.

## **Women's Health Needs: What must be done?**

Clearly, women in conflict situations need sufficient food, safe drinking water, protection from violence, basic primary and reproductive health care, and psychosocial support. These are extensions of what women need anywhere. Yet even though war-affected women have greater needs, they often end up with few, if any, services.

The knowledge and the tools exist to protect women's health, even in complex emergencies – but is the political will there? There are guidelines for psychosocial counselling, for providing reproductive health services, for ensuring safety in camp situations, for gender-aware food distribution. But these services and protection arrangements still remain the exception, not the norm.

In the area of reproductive health, for example, a large group of NGOs, UN agencies and bilateral donors have worked together to determine the standards which should be applied and have developed a Minimum Initial Service Package of supplies and interventions to be provided in emergency situations. WHO, UNHCR and UNFPA have produced a field manual that provides detailed guidelines for basic care during acute emergencies and for expanded services when the situation stabilizes. An accompanying set of pre-packaged supplies, stocked by UNFPA for immediate deployment, includes everything needed for various interventions, from safe home-birthing to family planning to STI treatment to hospital-based emergency obstetric care. Training health staff to attend to reproductive health is also an important part of the package.

There is also international policy support for these concerns. The Programme of Action of the International Conference on Population and Development (ICPD), endorsed by 179 nations in Cairo in 1994, recognized the need to ensure reproductive rights and provide reproductive health care in emergency situations, especially for women and adolescents.

Five years later, at a special session of the General Assembly, governments reaffirmed that:

“Adequate and sufficient international support should be extended to meet the basic needs of refugee populations, including the provision of access to adequate accommodation, education, protection from violence, health services including reproductive health and family planning, and other basic social services, including clean water, sanitation, and nutrition.”<sup>38</sup>

Yet although attention to reproductive health in emergencies has increased dramatically in the past five years, it is still not institutionalized as a part of every humanitarian response, partly because the humanitarian community has had difficulty internalizing gender concerns and partly because funds have fallen short.

The same applies for psychosocial support. Although there is less consensus on the effectiveness of different types of intervention, there is a growing awareness of the need to provide basic counselling for victims of conflict, and particularly for women who have experienced sexual violence. A number of groups, such as the International Rescue Committee, have developed programmes of intervention, but again these are only in a few countries because of limited funding. An important area of work is that of supporting indigenous modes of healing, which can be more effective than Western-style counselling

in many contexts. For instance, ritual purification ceremonies have been successful in West Africa. Faith-based support has also been critical for healing, yet is often neglected in the humanitarian response.

There are good examples of health support that can be built on. In a three-month period in 1999 Albania received, accommodated and cared for almost 500,000 refugees from Kosovo, yet there were no serious outbreaks of infectious disease. The Albanian Government coordinated with numerous UN agencies and NGOs to ensure that all the camp populations had food and water, basic primary health care and protection against infectious diseases. For the first time, reproductive health care was widely provided and psychosocial needs were anticipated, even if services were still very basic. As a result, most of the refugees were able to return to Kosovo a few months later with their physical health intact.

Even in the most difficult circumstances, programmes can be up and running quickly. A good example is the initiative from the DRC, when government and insurgent health personnel met together in Nairobi with NGOs, UN agencies and donors to map out a plan to reduce their nation's extraordinary rates of mortality. They developed a unique minimum package of services, designed for war conditions and aimed at immediately reducing avoidable deaths. The package set out 30 actions to be taken in health zones in crisis, directed at the seven leading causes of death and ill health: malaria, measles, diarrhoeal diseases, acute respiratory infections, malnutrition, pregnancy-related problems and HIV/tuberculosis. To be included, the actions had to satisfy a dual standard: They had to show proven cost-effectiveness in saving lives and be practical under local conditions.<sup>39</sup>

Another lesson to be learned is from Guinea where, instead of establishing separate services for refugees, the local health system was strengthened to allow it to support the additional population. The integration of Liberian and Sierra Leonean refugees with the local populations had a positive effect not only on the well-being of the refugees but also on the health of their Guinean host communities. The refugee assistance programme contributed to the improvement of the health system by strengthening its economic base – UNHCR paid fees for the refugee services – and by repairing roads and bridges for transporting food aid. The programme helped local and refugee women alike to obtain better antenatal care and childbirth assistance.<sup>40</sup> The number of health providers in the area increased from three to 28, and a new ambulance improved emergency care.

The presence of the refugees also transformed the economy in remote rural villages of Guinea. Farmers planted more crops to feed the growing numbers of people, trade increased and more money circulated, since even the most desperate refugee families managed to bring some resources with them. In this case, refugee assistance was able to support the refugees' own coping mechanisms instead of creating dependency in camps. No new health agencies arrived on the scene; instead, the Ministry of Health and Médecins sans Frontières, long a partner in the area, simply intensified their work. They developed an integrated approach that was cost-effective and development-oriented. The overall yearly cost of medical assistance to the refugees was estimated at \$4 per person, much lower than the yearly cost of medical services in refugee camps which averages \$20 per refugee.

Many humanitarian agencies would do more for women's health, and for health in general, if they only had the staff and the resources. Yet health programmes are

notoriously underfunded. Each year, when the annual UN Inter-Agency Consolidated Appeals are launched for countries in crisis, health programmes receive less than a quarter of the funds requested. For some countries, donors provide no emergency support for the health sector at all. Within the health sector, some issues appeal to donors more than others: Children's health gets more attention than women's health; immunization gets more attention than HIV prevention. Yet our examples show that with sufficient resources and will, and with women's participation in planning and providing services, there are ways to provide good, efficient and sensitive health care during and after conflicts. So what is the problem? It appears to be a matter of establishing that women in conflict zones have the same human rights as other women and that the international community bears some responsibility for helping them protect and rebuild their lives.

It is tragic that basic health care for war-affected women must compete with food, shelter and clearing landmines. All of these interventions are required to ensure that people survive as healthy, contributing members of their societies. The needs of war-affected populations are all linked. Providing health services alone cannot save lives if other vital requirements – for security, food, water, shelter, sanitation and household goods – are not satisfied. Surely there is enough money to support all of these important interventions. Surely the physical and mental health of individuals and communities is critical for conflict resolution, for national rehabilitation and for recovery.

### **On Women's Health the Experts call for:**

**1. Psychosocial support and reproductive health services for women affected by conflict to be an integral part of emergency assistance and post-conflict reconstruction.** Special attention should be provided to those who have experienced physical trauma, torture and sexual violence. All agencies providing health support and social services should include psychosocial counselling and referrals. UNFPA should

take the lead in providing these services, working in close cooperation with WHO, UNHCR and UNICEF.

**2. Recognition of the special health needs of women who have experienced war-related injuries, including amputations,** and for equal provision of physical rehabilitation and prosthesis support.

**3. Special attention to providing adequate food supplies for displaced and war-affected women, girls and families in order to protect health and to prevent the sexual exploitation of women and girls.** The World Food Programme (WFP) and other relief agencies should strengthen capacities to monitor the gender impact of food distribution practices.

**4. The UN, donors and governments to provide long-term financial support for women survivors of violence** through legal, economic, psychosocial, and reproductive health services. This should be an essential part of emergency assistance and post-conflict reconstruction.

**5. Protection against HIV/AIDS and the provision of reproductive health care through the implementation of the Minimum Initial Services Package (MISP) as defined by the Interagency Manual on Reproductive Health for Refugees (WHO, UNHCR, UNFPA, 1999).** Special attention must be paid to the needs of particularly vulnerable groups affected by conflict, such as displaced women, adolescents, girl-headed households and sex workers.

**6. Immediate provision of emergency contraception and STI treatment for rape survivors** to prevent unwanted pregnancies and protect the health of women.